Wisconsin Public Employers
Group Health Insurance Program for
Participating Local Government Employees and Annuitants

It's Your Choice 2014 Decision Guide

To Help You Choose Your Group Health Insurance Plan

Enrollment Period

October 7 to November 1, 2013

Turn The Page
To Explore Your Options For Health Insurance Coverage

ET-2128d-14 (10/13)

How to Choose Your Group Health Insurance Plan

The *It's Your Choice Decision Guide* is filled with information to help eligible employees, annuitants and continuants select one of the many health plans offered by the Wisconsin Public Employers Group Health Insurance Program. This page will assist you in your choice.

1. Open this *It's Your Choice Decision Guide* to the map on Page 25 and locate your county on the map.
2. On the grid below, list the plan codes of the health plans available in your region (keeping in mind how far you are willing to travel for covered services).
3. Using the health plan codes on Page 24, list the plan names associated with the codes in your chart.
4. Note the monthly premium cost for single or family coverage below. Employees will receive this information from their benefits/payroll/personnel office. Some employers have selected to have employee contribution rates based on plan Tiers. Information on plan Tiers is on Page 23. Annuitants and continuants should see Page 21.
5. View the *Health Plan Descriptions* and *Report Cards* (found on Pages 34-68) and list the overall rating below. Consider the following and note anything that stands out when considering your or your family's health needs, then list it under Notes below:
   - **Provider Networks Including Specialists and Hospitals**
   - **Referrals and Prior Authorizations**
   - **Dental, if Offered, and Information on the Network**

NOTE: For specific network and other plan information, you will need to call each plan directly or visit their website. Contact information can be found in the upper left-hand corner of each plan description page or on the inside back cover of this *It's Your Choice Decision Guide*.

Plan Code	Health Plan Name	Premium Rate	Overall Rating (★★★★)	Notes

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Cover photo of Swix American Birkebeiner courtesy of Photographer Brett Morgan. Internal photos courtesy of the University of Wisconsin-Madison.

Every effort has been made to ensure that the information in this guide 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.

IMPORTANT CHANGES— EFFECTIVE JANUARY 1, 2014

Generally, if you plan to stay with your current plan and you are not changing your coverage, you do not need to take any action during the It's Your Choice Open Enrollment period. However, you should review the following grid to understand how your coverage may change. 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.

Health Risk Assessments (HRAs) and Biometric Screenings	
All plans	HRAs are a great tool to help you understand and potentially improve your health. Again in 2014, health plans may offer wellness assessments. Members who complete both the HRA and biometric screening are eligible to receive a $150 incentive from their health plan. Contact the health plan or visit **wellwisconsin.wi.gov** for more information on wellness benefits.
New Shared Decision Making Requirements	
All plans that offer Uniform Benefits (Insured HMOs, PPOs and SMP)	Members are required to complete their health plan's shared decision making program for low back pain before they are able to obtain prior authorization for low back surgery. Contact the health plan for more information about shared decision making and prior authorization requirements for specific procedures.
Changes to Dental Coverage	
All plans	Dental benefits for 2014 are the same for all health plans if a health plan offers dental benefits. To find out whether a health plan offers Uniform Dental benefits, go to the *Health Plan Description* pages in the *Choose Your Health Plan* section. To determine which dental benefits are covered, see the Uniform Dental Certificate of Coverage in the *Uniform Benefits* section of the *It's Your Choice 2014 Reference Guide*. For more information on Uniform Dental Benefits, see *Frequently Asked Questions* 2 through 7 beginning on Page 9 of this guide.

New Health Plans	
Dean Health Insurance-Prevea360	Offered in eight counties in northeast Wisconsin including: Brown, Kewaunee, Manitowoc, Marinette, Oconto, Outagamie, Sheboygan and Menominee.
WEA Trust PPO-South Central	Offered in Dane County in south central Wisconsin.
Health Plan No Longer Available	
Anthem Northwest	Anthem Northwest is no longer available. Subscribers who have this plan must select another plan.
State Maintenance Plan (SMP)	SMP is no longer available in Oneida and Price counties. Subscribers who have this plan must select another plan or will be limited to the SMP providers remaining in other areas.
Health Plan Provider Network Changes	
Health plans listed below and on the top of the next page have made significant changes by adding or terminating contracts with provider groups in two or more counties. Other plans have also made changes. Refer to the map on Page 25 and call the health plan for more details.	
Arise Health Plan	Added providers in Winnebago County. Lost some providers in Door County.
Physicians Plus	Added providers in Jefferson and Walworth counties.
WEA Trust PPO-East	Expanding into Forest, Oneida, Price and Vilas counties.
WEA Trust PPO-Northwest	Will offer two distinct provider networks—the Chippewa Valley or the Mayo Health System. You must select one network for yourself and any covered family members. See the health plan's description page for more information. Expanding into Iron County.

Choose Wisely

Health Plan Tier Changes	
Changing to Tier 1	• Anthem Blues (Northeast and Southeast)
Health Plan Name Changes	
Dean Health Insurance	Changing from Dean Health Plan
Gundersen Health Plan	Changing from Gundersen Lutheran Health Plan
Network Health	Changing from Network Health Plan
UnitedHealthCare of Wisconsin	Combining UnitedHealthCare of Wisconsin Northeast and Southeast. Individuals in these networks will be automatically moved into the combined plan and do not have to file an application.
Information on ETF's Internet Site	
Online Help	The *It's Your Choice Decision Guide* and *It's Your Choice Reference Guide* are available at **etf.wi.gov**. Any known printing discrepancies will be clarified on this site. Other information is also available about insurance programs. Look for the red envelope to sign up for ETF E-Mail Updates for the most current information at **etf.wi.gov**.
Health Insurance Marketplace	
All plans	Health insurance Marketplaces (also known as the Exchanges) are available to individuals this fall and are separate from our program. These may be of particular interest to some of our members, including annuitants who are paying their health insurance premiums through annuity deduction or directly to their health plan. For more information visit **www.HealthCare.gov**, call 1-800-318-2596, see *Frequently Asked Question 8* in this guide and the Marketplace Notice in the *It's Your Choice Reference Guide* under the *State and Federal Notifications* section.

myETF BENEFITS SYSTEM INSTRUCTIONS

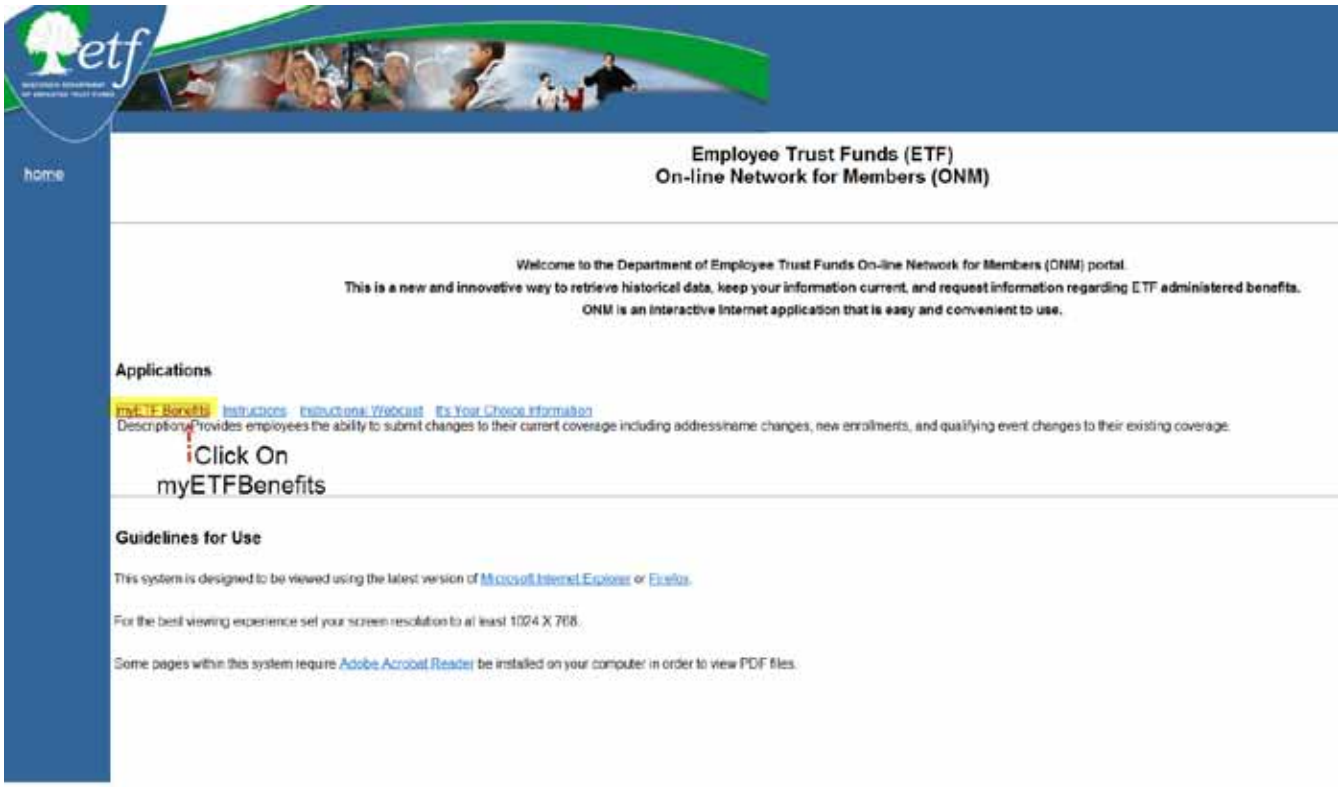
Employees and annuitants are encouraged to submit their It's Your Choice Open Enrollment changes via the myETF Benefits Online Health Insurance Enrollment System. Enrolling in a health insurance plan is a quick and easy process through our dedicated and secure website.

If you don't have access to a computer, you may submit your enrollment change on a paper application (on Page 81). Employees should submit it to their benefits/payroll/personnel office. Initial enrollment must be established through your employer. Annuitants and continuants should send the form to ETF. The address appears on the back cover of this guide.

All changes must be entered online, submitted, faxed or postmarked no later than November 1, 2013.

Step 1

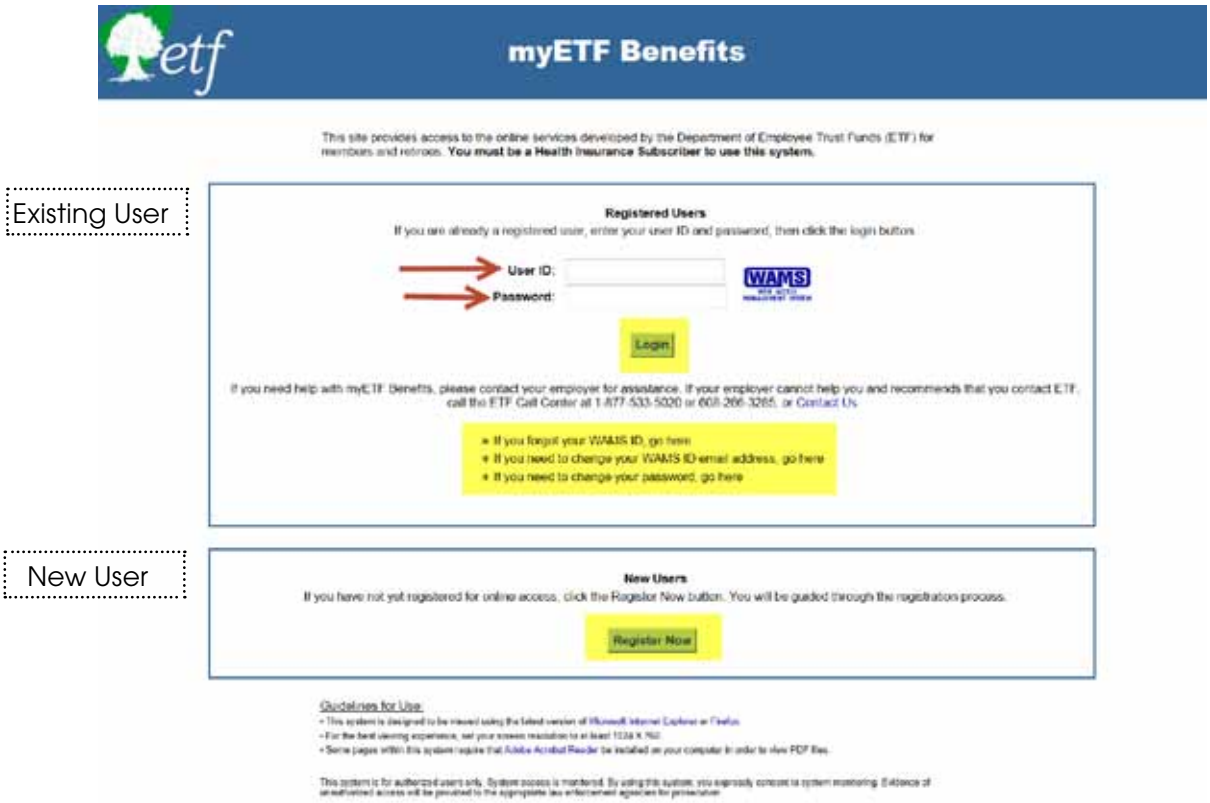
Go to **myETF.wi.gov/ONM.html** (Online Network for Members). In order to login, you will need a Web Access Management System (WAMS) ID and your ETF Member ID (explained in Step 3). Click on the **myETF Benefits** link to begin the login steps.



Step 2—myIdentity Verification (WAMS ID)

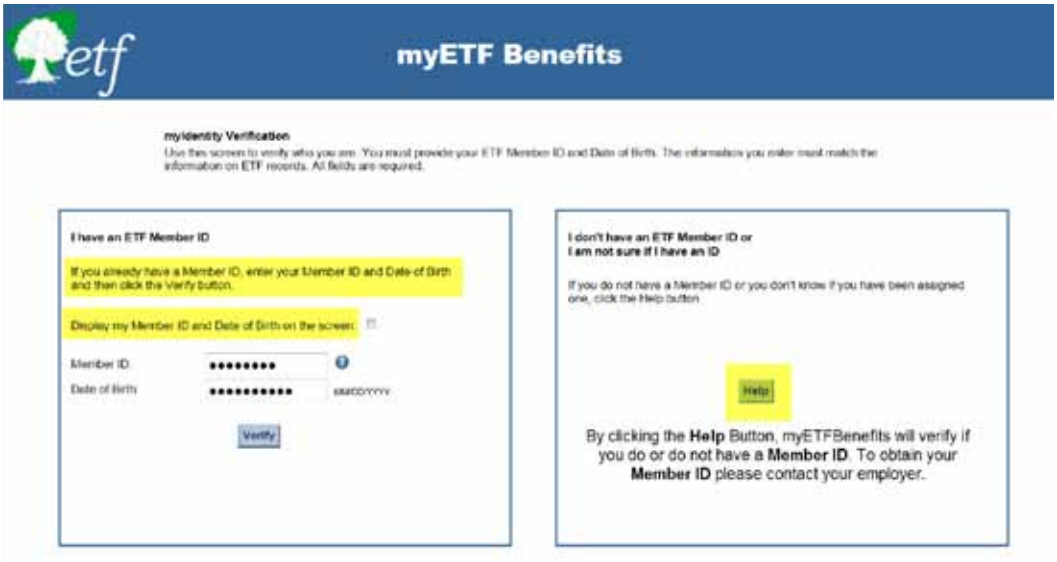
Type your WAMS ID and password. Click **Login**. If you don't have a WAMS ID, click **Register Now**. You will be taken through the process to get one. If you need assistance registering please view the instructional webcast on the myETF Benefits home page at **myETF.wi.gov/ONM.html**. Keep track of 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.



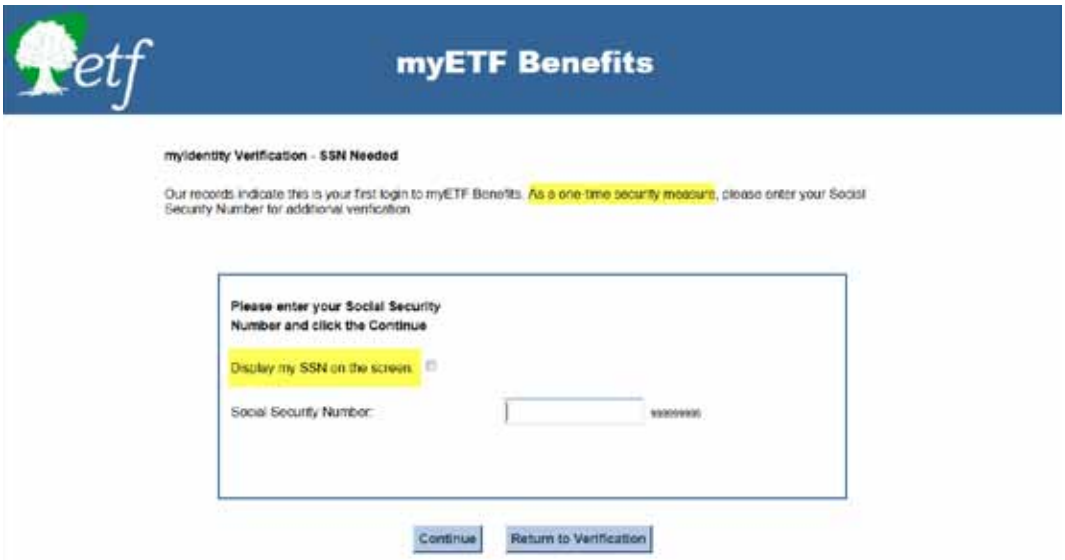
Step 3—myIdentity Verification (ETF Member ID)

Type your ETF Member ID (Employees: available on your Navitus Prescription Drug ID card, ETF Statement of Benefits or from your employer. Annuitants: find your Member ID on your ETF Annuity Payment Statement or from ETF) and birth date. Your birth date should 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.



Step 5—myInfo

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

To make an 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.

To log off of myETF Benefits click the **Log Off** tab.

Employees with questions should contact their employers. Annuitants and continuants should contact ETF at 1-877-533-5020.

FREQUENTLY ASKED QUESTIONS

IT'S YOUR CHOICE OPEN ENROLLMENT PERIOD

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

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

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, enroll if you had previously deferred coverage, change your coverage, or cancel the coverage for your adult dependent child. It is offered only to employees and insured annuitants who are eligible under the Wisconsin Public Employers Group Health Insurance Program. Changes made become effective January first of the following year.

NEW BENEFITS AND ELIGIBILITY CHANGES

2. Are dental benefits changing in 2014?

Yes. Starting January 1, 2014 the Wisconsin Public Employers Group Health Insurance Program is offering an optional uniform dental benefit. Health plans will still have the option of whether to offer dental benefits or not. However, in 2014, dental benefits will be the same across all health plans, similar to the current uniform medical benefits. The new uniform dental benefit will be substantially similar to the dental benefits that most plans currently offer.

3. How do I find out if my health plan offers uniform dental benefits in 2014?

To find out if your health plan offers uniform dental benefits, go to the *Health Plan Description* pages in the *Choose Your Health Plan* section of this guide.

4. How do I find out which specific benefits and services are covered under the 2014 uniform dental plan?

To find out what is covered under the uniform dental plan, go to the *Uniform Dental Plan Design* in the 2014 *It's Your Choice Reference Guide.*

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

The *Uniform Dental Plan Design* is your certificate of coverage. The benefits and services listed in the certificate will be covered by your health plan if your health plan offers dental coverage. No payment will be made for a benefit that is not listed in the certificate of coverage. The certificate of dental coverage also contains a number of specific exclusions and limitations. Exclusions are benefits or services that are not covered. Limitations are benefits and services that are covered but subject to specific limitations, such as visit limits or age requirements.

5. How do I find a list of dental providers offered by my health plan in 2014?

To find a list of dental providers by health plan, go to the *Health Plan Description* pages in the *Choose Your Health Plan* section of this guide.

6. Will the dental services that I started in 2013 and that extend into 2014 be covered under my 2013 dental plan or the new 2014 uniform dental plan?

Dental services that you start in 2013 but do not complete before December 31, 2013 will be covered under the terms of your 2013 dental plan. Contact your dental provider and health plan if you have questions about whether specific dental services are considered part of a dental procedure that you start in 2013 or if they are considered part of a new dental procedure that you start in 2014.

7. What are the main dental services that are covered under the uniform dental benefit?

- Diagnostic/Preventive services (e.g., routine evaluations and X-rays) are covered at 100% when provided by an in-network dental provider; 75% coverage when provided by a designated out-of-network provider.
- Restorative services (e.g., fillings) are covered at 100% when provided by an in-network dental provider; 50% coverage when provided by a designated out-of-network provider.
- Periodontic services (e.g., periodontal maintenance) are covered at 80% when provided by an in-network dental provider; 50% coverage when provided by a designated out-of-network provider.
- Adjunctive services (e.g. local anesthesia) are covered at 80% when provided by an in-network dental provider; 50% coverage when provided by a designated out-of-network provider.
- Orthodontic services are covered for children up to age 19 at 50%.

8. What is the health insurance Marketplace, and is it an option for me?

The Marketplace, established under the Patient Protection and Affordable Care Act (PPACA), allows individuals to shop for health insurance outside of our program. Open enrollment begins

in October of 2013 for coverage effective January 1, 2014. This may be of interest to annuitants who are paying premiums out-of-pocket. Note, premiums for Marketplace insurance cannot be paid with any employer contribution. Marketplace premiums are the responsibility of the individual and are made on an after-tax basis. Note, however, tax credits and cost-sharing subsidies for expenses like deductibles may be available to you.

Premium Assistance Tax Credits: Marketplace premium assistance tax credits vary by income, and may be available for earners up to 400% of the federal poverty limit (FPL). The following chart illustrates the values in 2013 for 400% of the FPL for families of one through four people (as of the printing of this guide, 2014 FPL amounts were not available):

Household size	2013: 400% FPL
1	$45,960
2	$62,040
3	$78,120
4	$94,200

Cost-sharing subsidies: People with incomes up to 250% of the FPL may also be eligible for cost-sharing subsidies to reduce out-of-pocket costs such as deductible and copays. The subsidies likewise vary by income. There are limits on what insurers can charge in premiums for older insureds relative to younger ones.

Health insurance plans offered through the Marketplace are described as being 1 of 4 "metal" levels of coverage for Wisconsin's Essential Health Benefits (EHB). They are platinum (expected to cover about 90% of eligible costs), gold (80%), silver (70%) and bronze (60%). Various insurers across the state applied for and were accepted into the Marketplaces in order to offer coverage.

All plans offered under the Wisconsin Public Employers Health Insurance Program exceed the federal Minimum Value Standard.

Visit **HealthCare.gov** for detailed information about the Marketplace. ETF does not have the information necessary for you to evaluate the effect of the Marketplace on you. The federally required Marketplace Notice appears in the *It's Your Choice Reference Guide* in the **State and Federal Notifications** section.

THINGS TO CONSIDER DURING IT'S YOUR CHOICE OPEN ENROLLMENT

9. 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/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 10 and 11*.

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

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

Domestic Partners: The fair market value for insurance coverage provided for a domestic partner and his or her children, if elected, must also be calculated and added to your income unless the domestic partner and his/her children qualify as the employee's tax dependents.

The fair market value of the health insurance benefits will be calculated and added to your earnings as imputed income (see *Question 11* 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 Internal Revenue Code Section 152 during the plan year. The additional premium attributable to the non-qualified dependent will be taxable.

Adult Children: The Patient Protection and Affordable Care Act (PPACA) and 2011 Wisconsin Act 49 eliminated tax liability for the fair market value of elected health coverage for these dependents through the month in which they turn 26 if eligible.

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

11. What is imputed income?

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

Note: See *Question 10* to learn when imputed income applies. For more information, employees should contact their employer and annuitants should contact ETF.

12. 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 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* (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, 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, 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 on the date of birth with a birth certificate listing the father's name. The effective date of coverage will be the date of birth, if a statement of paternity is filed within 60 days of the birth. If filed more than 60 days after the birth, coverage will be effective on the first of the month following receipt of application.
3. If an application is received by your benefits/payroll/personnel office for active employees or ETF for annuitants/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.

13. 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 yourself and/or your adult dependent children or do a spouse/domestic

partner to spouse/domestic partner transfer of your health insurance coverage.

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

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

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

15. What if my spouse or domestic partner is a State of Wisconsin employee or annuitant?

You may each retain or select single coverage, family coverage or you may select one family plan. See *Frequently Asked Question 12* in the *It's Your Choice Reference Guide* for details.

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

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

If you decide to change to a different plan, you are encouraged to make changes online using the myETF Benefits website (see Pages 5 through 8 of this guide), or you may submit a paper application per 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 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 be not be accepted.

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

17. How do I use the myETF Benefits website?

Refer to Pages 5 through 8 in this guide.

18. What happens if I enter my changes online, but I 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.

19. 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.

20. 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 anytime 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

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

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

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

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

- If you are covered through an HMO, you are required to obtain allowable 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 Organization (PPO) such as WPS Metro Choice, WEA Trust PPO 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 Standard 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.

23. 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. Neither ETF nor your benefits/payroll/personnel office maintains a current list of this information.

OTHER ITEMS OF NOTE

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

Most people become eligible for Medicare at age 65, 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 *It's Your Choice Reference Guide* for full details.)

25. 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. However, when you use out-of-network providers 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.

26. 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.)

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INTRODUCTION TO HEALTH PLAN OPTIONS

As a participant in the Wisconsin Public Employers Group Health Insurance Program, all of the health plans listed in this guide are available to you. This includes 18 different private insurers (also called the Alternate Plans), the Standard Plan, and State Maintenance Plan (SMP). All of these options are described in more detail below. Definitions of terms also appear in the *Glossary* 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 100% of current local employees choose coverage through the Alternate Health Plans. These include 16 Health Maintenance Organizations (HMOs) and two Preferred Provider Organizations (PPOs). These health plans all administer a "Uniform Benefits" package, meaning you will receive the same package of covered benefits and services, regardless of your health plan selection. *Uniform Benefits* is described in detail in the *It's Your Choice Reference Guide*.

You should be aware that there are some differences 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. Your employer will provide information about each plan's cost to you.
- ***Provider Network:*** The location, quantity, quality and availability of the doctors, clinics, hospitals and emergency/urgent care centers differ for each health plan.
- ***Dental Benefits (if offered):*** Plans that choose to offer dental benefits provide a uniform package of covered dental benefits and services. Note, however, that dental 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:*** The health plans may require you to select a primary care provider (PCP), get a referral from your PCP before seeing a specialist or get a

prior authorization before obtaining certain services such as for high-tech radiology (for example: MRI, PET, and CT scans) and low back surgeries.

State Maintenance Plan (SMP)

The SMP is available only in counties that lack a Tier 1 qualified Alternate Plan HMO or PPO. It offers the same Uniform Benefits package as the Alternate Plans.

The Standard Plan

The Standard Plan is a PPO administered by WPS. The Standard Plan provides you with comprehensive freedom of choice among hospitals and physicians throughout Wisconsin and nationwide. You can compare the Standard Plan to the Uniform Benefits package on Pages 26 through 29.

Health Plans For Annuitants

Medicare Coordinated Plans

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

1. Members enrolled in Humana will be enrolled in Humana's Medicare Advantage Preferred Provider Organization (MA-PPO) plan after they enroll in Medicare Parts A and B.
2. Members enrolled in the Standard Plan or 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 26 for more information.

The **Medicare Advantage Preferred Provider Organization** (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.

Medicare Plus is a fee-for-service Medicare supplement 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.

HEALTH PLAN 2014 PREMIUM RATES

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

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

1. Your employer pays between 50% and 88% of the premium rate of the average Tier 1 qualified plan in the employer's service area for either single or family coverage for employees who are participants under the Wisconsin Retirement System (WRS).
   - **Note**: Your employer may pay as little as 25% of the premium for either single or family coverage for an employee appointed to a position working fewer than 1,044 hours per year and who is a WRS participating employee.
2. A Three-Tier health insurance premium option is also available to employers. 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. The 2014 health plan Tiers appear on Page 23.

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

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

Annuitants and their 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.

Local Government Employee and Annuitant Rates

2014 Monthly Full Pay HMO Option - Standard PPO

	Local Employees & Non-Medicare Annuitants*		Local Medicare Annuitants		
Plan Name	Single	Family	Single	Medicare 1**	Medicare 2***
Anthem Blue-Northeast	752.60	1,875.00	513.70	1,261.90	1,023.00
Anthem Blue-Southeast	807.40	2,012.00	540.80	1,343.80	1,077.20
Arise Health Plan	980.80	2,445.50	627.70	1,604.10	1,251.00
Dean Health Insurance	690.00	1,718.50	475.00	1,160.60	945.60
Dean Health Insurance-Prevea360	844.60	2,105.00	550.50	1,390.70	1,096.60
Group Health Cooperative of Eau Claire	1,129.80	2,818.00	576.30	1,701.70	1,148.20
GHC of South Central Wisconsin	593.50	1,477.20	434.10	1,023.20	863.80
Gundersen Health Plan	755.10	1,881.20	386.00	1,136.70	767.60
Health Tradition Health Plan	695.30	1,731.70	484.90	1,175.80	965.40
HealthPartners	882.80	2,200.50	557.50	1,435.90	1,110.60
Humana-Eastern	1,148.30	2,864.20	402.90	1,546.80	801.40
Humana-Western	1,148.30	2,864.20	402.90	1,546.80	801.40
Medical Associates Health Plans	701.80	1,748.00	402.60	1,100.00	800.80
Medicare Plus****	NA****	NA****	414.30	NA****	825.10
MercyCare Health Plans	570.10	1,418.70	385.70	951.40	767.00
Network Health	809.20	2,016.50	542.00	1,346.80	1,079.60
Physicians Plus	664.30	1,654.20	430.20	1,090.10	856.00
Security Health Plan	1,125.10	2,806.20	525.70	1,646.40	1,047.00
Standard Plan: Balance of State[1]	1,164.70	2,905.10	NA****	1,579.10	NA****
Standard Plan: Dane[2]	1,079.40	2,691.90	NA****	1,493.70	NA****
Standard Plan: Milwaukee[3]	1,259.60	3,142.50	NA****	1,674.00	NA****
Standard Plan: Waukesha[4]	1,164.70	2,905.10	NA****	1,579.10	NA****
State Maintenance Plan	774.40	1,931.10	NA****	1,188.70	NA****
UnitedHealthcare	852.70	2,125.20	563.70	1,412.00	1,123.00
Unity-Community	612.80	1,525.50	427.80	1,036.20	851.20
Unity-UW Health	562.30	1,399.20	404.00	961.90	803.60
WEA Trust PPO-East	796.90	1,985.70	535.80	1,328.30	1,067.20
WEA Trust PPO-Northwest	933.20	2,326.50	603.90	1,532.70	1,203.40
WEA Trust PPO-South Central	777.20	1,936.50	525.90	1,298.70	1,047.40
WPS Metro Choice Northwest	1,122.10	2,798.70	698.40	1,816.10	1,392.40
WPS Metro Choice Southeast	1,362.10	3,398.70	818.40	2,176.10	1,632.40

Please refer to the following page for footnoted information.

LOCAL PREMIUM RATE FOOTNOTES

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

Footnotes from preceding page:

NA = "not applicable."

*Members of new participating employers may have a surcharge added to their rates. Your employer will inform you. Contact your payroll office with questions.

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

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

**** 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.

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

1. BALANCE OF STATE: All other Wisconsin counties not listed below. (Code A4)
2. DANE: Dane, Grant, Jefferson, La Crosse, Polk and St. Croix. (A1)
3. MILWAUKEE: Milwaukee County. Also applies to retirees and continuants living out of state. (A2)
4. WAUKESHA: Kenosha, Ozaukee, Racine, Washington and Waukesha. (A3)

LOCAL HEALTH PLAN TIERS

2014 Health Plans
TIER 1
ANTHEM BLUE-NORTHEAST
ANTHEM BLUE-SOUTHEAST
ARISE HEALTH PLAN
DEAN HEALTH INSURANCE
DEAN HEALTH INSURANCE-PREVEA360
GROUP HEALTH COOPERATIVE OF EAU CLAIRE
GHC OF SOUTH CENTRAL WISCONSIN
GUNDERSEN HEALTH PLAN
HEALTH TRADITION HEALTH PLAN
HEALTHPARTNERS
HUMANA-WESTERN
MEDICAL ASSOCIATES HEALTH PLANS
MERCYCARE HEALTH PLANS
NETWORK HEALTH PLAN
PHYSICIANS PLUS
STATE MAINTENANCE PLAN (SMP)
UNITEDHEALTHCARE
UNITY-COMMUNITY
UNITY-UW HEALTH
WEA TRUST PPO-EAST
WEA TRUST PPO-NORTHWEST
WEA TRUST PPO-SOUTH CENTRAL
WPS METRO CHOICE NORTHWEST
TIER 2
NO TIER 2 HEALTH PLANS
TIER 3
HUMANA-EASTERN
SECURITY HEALTH PLAN
STANDARD PLAN
WPS METRO CHOICE SOUTHEAST

HEALTH PLAN MAP 2014

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.

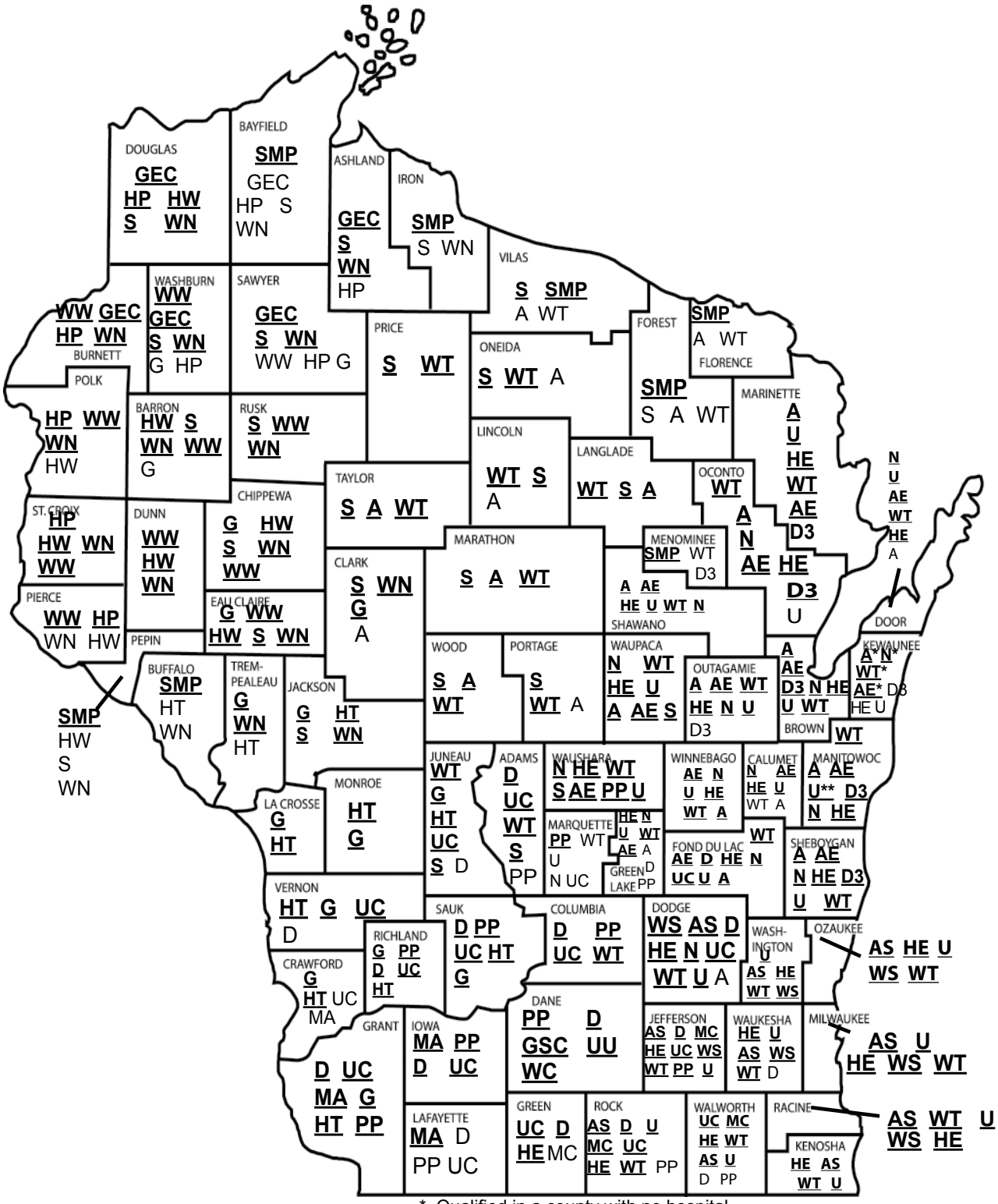
The Standard Plan and Medicare Plus do not appear on this map since they are available everywhere.

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

Plan specific information is available on the *Health Plan Description* pages later in this guide.

Plan Name	Plan code
Anthem Blue-Northeast	AE
Anthem Blue-Southeast	AS
Arise Health Plan	A
Dean Health Insurance	D
Dean Health Insurance-Prevea360	D3
Group Health Cooperative of Eau Claire	GEC
GHC of South Central Wisconsin	GSC
Gundersen Health Plan	G
Health Tradition Health Plan	HT
HealthPartners	HP
Humana-Eastern	HE
Humana-Western	HW
Medical Associates Health Plans	MA
Medicare Plus	N/A
MercyCare Health Plans	MC
Network Health	N
Physicians Plus	PP
Security Health Plan	S
Standard Plan: Balance of State[1]	N/A
Standard Plan: Dane[2]	N/A
Standard Plan: Milwaukee[3]	N/A
Standard Plan: Waukesha[4]	N/A
State Maintenance Plan	SMP
UnitedHealthcare of Wisconsin	U
Unity-Community	UC
Unity-UW Health	UU
WEA Trust PPO-East	WT
WEA Trust PPO-Northwest	WN
WEA Trust PPO-South Central	WC
WPS Metro Choice Northwest	WW
WPS Metro Choice Southeast	WS

HEALTH PLAN MAP 2014



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

COMPARISON OF BENEFIT OPTIONS

The chart on the following pages is designed to compare Uniform Benefits, the Standard Plan and the Medicare Plus Plan.

This outline is not intended to be a complete description of coverage. The Uniform Benefits package is described in detail in your *It's Your Choice Reference Guide*. Details for the other plans are found in the *Standard Plan* (ET-2131), and the *Medicare Plus* (ET-4113) benefit booklets.

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

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

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

[1] Deductible applies to all Uniform Benefits medical services when employer selects deductible option. Deductible applies to Standard Plan services. Deductible does not apply to certain preventive services and prescription drugs.

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

[3] Coinsurance out-of-pocket limit (OOPL) does not include deductible.

[4] PPOs have out-of-network coinsurance. See *Health Plan Descriptions* for details.

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

[6] This is separate from other out-of-pocket limit (OOPL), such as the medical.

[7] Level 3 copays do not apply to the OOPL.

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

Comparison of Benefit Options

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN (If under Medicare Age)		MEDICARE Plus (and Medicare Part A, B and D[8])
		Preferred Provider	Non-Preferred Provider	
Annual Deductible[1]	No deductible[2]	$100 individual/ $200 family	$500 individual/ $1,000 family	No deductible
Annual Coinsurance & OOPL[3]	As described below[4]	None	80%/20% Annual OOPL *(includes deductible)*: $2,000 individual/$4,000 family	100%
Routine Preventive	One per year	100%[5]	Deductible and coinsurance	100% covered by Medicare only
Hospital Days	As medically necessary, plan providers only. No day limit.	Deductible, as medically necessary. No day limit.	Deductible and coinsurance, as medically necessary. No day limit.	100% 120 days; semi-private room
Emergency Room	$60 copay per visit	$75 copay per visit, deductible thereafter	$75 copay per visit, preferred provider deductible and coinsurance thereafter	100%, no copay
Ambulance	100%	Deductible	Deductible and coinsurance	100%
Transplants *(May cover these and others listed)*	*Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung*	Deductible *bone marrow, musculoskeletal, corneal, and kidney*	Deductible and coinsurance *bone marrow, musculoskeletal, corneal, and kidney*	100% *for Medicare approved heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver transplants in a Medicare-certified facility*
Mental Health/ Alcohol & Drug Abuse	Inpatient, outpatient, and transitional, 100%	Deductible	Deductible and coinsurance	Inpatient 100%, up to 120 days. Outpatient and transitional 100%
Hearing Exam	100%	Benefit for illness or disease to deductible	Benefit for illness or disease to deductible and coinsurance	Benefit for illness or disease 100%

Footnotes are explained on the preceding page.

Comparison of Benefit Options

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN (If under Medicare Age)		MEDICARE Plus (and Medicare Part A, B and D[8])
		Preferred Provider	Non-Preferred Provider	
Hearing Aid (per ear)	Every 3 years: Adults, 80%/20%, up to $1,000 (not to OOPL). Dependents younger than 18 years, 100%, maximum does not apply.	For dependents younger than 18 years only, every 3 years—deductible	For dependents younger than 18 years only, every 3 years—deductible and coinsurance	For dependents younger than 18 years only, every 3 years—100%
Cochlear Implants	Adults, 80%/20% for device, surgery, follow-up sessions (not to OOPL); 100% hospital charge for surgery. Dependents under 18, 100%.	Dependents under 18, deductible for device, surgery, follow-up sessions	Dependents under 18, deductible and coinsurance for device, surgery, follow-up sessions	Dependents under 18, 100% for device, surgery, follow-up sessions
Routine Vision Exam	One per year	100% for children under age 5[6]; illness or disease only, deductible	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)	120 days per benefit period	Deductible, as medically necessary, 120 days per benefit period	Deductible and coinsurance, as medically necessary, 120 days per benefit period	100% 120 days/ benefit period at Medicare-approved facility. At non-Medicare-approved facility, if transferred within 24 hours of hospital release, benefits payable up to 30 days/confinement
Home Health (non custodial)	50 visits per year; plan may approve an additional 50	Deductible, 50 visits per plan year; plan may approve an additional 50	Deductible and coinsurance, 50 visits per plan year; plan may approve an additional 50	100%
Physical/ Speech/ Occupational Therapy	50 visits per year; plan may approve an additional 50	Deductible, 50 visits per plan year; plan may approve an additional 50	Deductible, 50 visits per plan year; plan may approve an additional 50	100%
Durable Medical Equipment	80%/20% coinsurance, $500 OOPL	Deductible	Deductible and coinsurance	100%

Footnotes are explained on Page 26.

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN (If under Medicare Age)		MEDICARE Plus (and Medicare Part A, B and D[8])
		Preferred Provider	Non-Preferred Provider	
Hospital Pre-Certification	Varies by plan	WPS Medical Management for inpatient stays	WPS Medical Management for inpatient stays	Not required
Referrals	In-network varies by plan; out-of-network required.	None required	Not required	Not required
Treatment for Morbid Obesity	Excluded	Deductible at Center of Excellence in-network provider	Non-preferred provider deductible and coinsurance outside Center of Excellence provider	100% for Medicare-covered service
Oral Surgery	11 procedures	23 procedures—deductible	23 procedures—deductible and coinsurance	100%
Dental Care (if offered)	Uniform Dental Benefit	No benefit	No benefit	No benefit
Drug Copays and OOPL[6] (non-specialty)	Level 1=$5; 2=$15; 3=$35[7] OOPL $410 individual/$820 family	Level 1=$5; 2=$15; 3=$35[7] OOPL $1,000 individual/$2,000 family	Level 1=$5; 2=$15; 3=$35[7] OOPL $1,000 individual/$2,000 family	Level 1=$5; 2=$15; 3=$35[7] OOPL $410 individual/$820 family
Specialty Drug Copays and OOPL[6] **Preferred Pharmacy**	Formulary drugs $15 to OOPL $1,000 individual/$2,000 family; Non-formulary drugs $50, no OOPL	Formulary drugs $15 to OOPL $1,000 individual/$2,000 family; Non-formulary drugs $50, no OOPL	Not applicable	Formulary drugs $15 to OOPL $1,000 individual/$2,000 family; Non-formulary drugs $50, no OOPL
Specialty Drug Copays and OOPL[6] **Non-Preferred Pharmacy**	Formulary drugs $50 to OOPL $1,000 individual/$2,000 family; Non-formulary drugs $50, no OOPL	Not applicable	Formulary drugs $50 to OOPL $1,000 individual/$2,000 family; Non-formulary drugs $50, no OOPL	Formulary drugs $50 to OOPL $1,000 individual/$2,000 family; Non-formulary drugs $50, no OOPL

Footnotes are explained on Page 26.

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.

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. 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 strongly encouraged to provide you with coordinated care and 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.

Wellness Programs may be offered by the health plans. These services may be in the form of online educational 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 and are designed to provide education and enhance treatment.

Online Services

If you have Internet access, some health plans offer online information and services on their websites. Some areas of those 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.

Stars: ★ 1-4, 1 being lowest

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.	Quality Information	Dental Benefits		Health Plan Services	
	Overall Quality Score	Uniform Dental Benefit Offered	Separate Dental ID Card Required	Primary Care Physician or Clinic Required	24-Hour Nurseline Offered
Anthem Blues*	★★	No dental coverage.			•
Arise Health Plan	★★★	•	•	•	
Dean Health Insurance**	★★★	No dental coverage.		•	•
GHC of Eau Claire	★★★	No dental coverage.		•	•
GHC of South Central Wisconsin	★★★★	•		•	•
Gundersen Health Plan	★★★	•	•		•
Health Tradition Health Plan	★★★	•		•	•
HealthPartners	★★★	No dental coverage.			•
Humana-Eastern	★	•	•	•	•
Humana-Western	★★	•	•	•	•
Medical Associates	★★★★	•			•
MercyCare Health Plans	★	No dental coverage.		•	•
Network Health	★★★	•	•	•	•
Physicians Plus	★★★	No dental coverage.		•	•
Security Health Plan	★★★	No dental coverage.		•	•
State Maintenance Plan	Not available	No dental coverage.			
UnitedHealthcare	★	•	•		•
Unity-Community	★★★	No dental coverage.		•	
Unity-UW Health	★★★★	No dental coverage.		•	
WEA Trust PPO***	★	•			
WPS Metro Choice - Northwest & Southeast	Not available	No dental coverage.			

*Anthem health plans (Northeast, Northwest and Southeast) were combined into Anthem Blues to produce an "Overall Quality" score. Anthem Northwest is not offered in 2014.

**Dean Health Insurance does not include Dean Health Insurance-Prevea360 in the Overall Quality Score. It is included in the other columns.

***WEA Trust PPO includes two of the three health plans offered by this entity in the Overall Quality Score. WEA Trust PPO-South Central is not included in that column, but is in the other columns.

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.	Online Services			
	Searchable Provider Directory	Member Service Messaging Center	View and Review Appointments	View Electronic Health Records
Anthem Blues*	•	•		•
Arise Health Plan	•	•		
Dean Health Insurance**	•	•	•	•
GHC of Eau Claire				
GHC of South Central Wisconsin	•	•	•	•
Gundersen Health Plan	•	•		•
Health Tradition Health Plan	•			
HealthPartners	•	•	•	•
Humana-Eastern	•	•		•
Humana-Western	•	•		•
Medical Associates	•	•		
MercyCare Health Plans	•	•	•	•
Network Health	•	•		
Physicians Plus	•	•	•	•
Security Health Plan	•			
State Maintenance Plan	•	•		
UnitedHealthcare			•	•
Unity-Community	•	•	•	•
Unity-UW Health	•	•	•	•
WEA Trust PPO***	•			
WPS Metro Choice - Northwest & Southeast	•	•		

Footnotes explained on Page 31.

Health Plan Features–At a Glance

• Indicates a "Yes" response. This means the health plan offers the service.	Wellness Programs****		Disease Management Programs			
	Smoking Cessation	Weight Management	Asthma Management	Lower Back Care Management	Diabetes Care Management	Prenatal and Postnatal Programs
Anthem Blues*	●	●	●		●	●
Arise Health Plan	●				●	●
Dean Health Insurance**	●	●	●		●	●
GHC of Eau Claire	●		●	●	●	●
GHC of South Central Wisconsin	●	●	●	●	●	●
Gundersen Health Plan	●	●	●	●	●	
Health Tradition Health Plan	●		●	●	●	●
HealthPartners	●	●	●	●	●	●
Humana-Eastern	●	●	●	●	●	●
Humana-Western	●	●	●	●	●	●
Medical Associates	●	●	●	●	●	●
MercyCare Health Plans	●	●	●	●	●	●
Network Health	●	●	●		●	●
Physicians Plus	●	●		●	●	●
Security Health Plan	●	●	●	●	●	●
State Maintenance Plan			●		●	●
UnitedHealthcare	●	●	●		●	●
Unity-Community	●	●	●	●	●	●
Unity-UW Health	●	●	●	●	●	●
WEA Trust PPO***	●	●	●	●	●	●
WPS Metro Choice-Northwest & Southeast			●		●	●

Footnotes *, ** and *** explained on Page 31.
****Plans may offer incentives, discounts and/or reimbursements for participation. Check with the health plan for details.

Anthem Blue Preferred – Northeast Network

(800) 843-6447
anthem.com

Overall Quality Rating
See *Report Card* section

What's New for 2014

The redesigned explanation of benefits includes:

- A simpler explanation of what was paid and what is owed.
- Answers to most questions about the claim, including a simple explanation if a service isn't covered.
- Less health care jargon. We explain terms in plain language and made the design easier to follow.
- Information on how much you saved by going to in-network doctors and care centers.

Exclusive Member Savings on Contacts and Glasses

We've teamed up with 1-800 CONTACTS and Glasses.com to give you exclusive savings on contact lenses and eyeglasses - $20 off a $100 purchase and free shipping.

Estimate your Cost

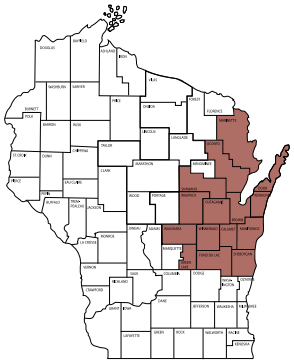
Compare quality and costs at hospitals and other facilities on anthem.com. Did you know that different facilities may charge different amounts for the same service? Estimate your share of the costs before you get your care.

Provider Directory

To access a copy of the directory, go to anthem.com/stateofwisconsin. You may also call Anthem's customer service area at 800-843-6447 to request a paper copy.

Referrals and Prior Authorizations

You don't need a referral when you see a specialist in the Northeast Network. If the specialist isn't in the network, you'll need a written referral from your primary care physician (PCP) and authorization from Anthem. This plan will pay some or all of the costs to see a specialist for covered services only if you have the plan's permission before you see the specialist. You will need prior authorization for some medical procedures. Your PCP or specialist will initiate this. You also need precertification for non-emergency hospital stays.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Service Area

Marinette, Oconto, Outgamie, Brown, Shawano, Door, Waupaca, Winnebago, Calumet, Manitowoc, Green Lake, Fond du Lac, Waushara, Kewaunee and Sheboygan counties.

Care Outside Service Area

For emergency care, go to the nearest health care facility. Contact your PCP and Anthem within 24 hours or as soon as possible. For urgent care, call your PCP for advice on the right treatment. All other services must be received within your service area.

Mental and Behavioral Health Services

You don't need a referral to see a Northeast Network mental health provider. You will need precertification for inpatient care.

Dental Network

No dental coverage provided.

Anthem Blue Preferred – Southeast Network

(800) 843-6447
anthem.com

Overall Quality Rating
See *Report Card* section

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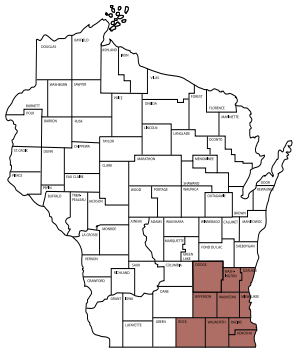
To access a copy of the directory, go to anthem.com/stateofwisconsin. You may also call Anthem's customer service area at 800-847-6447 to request a paper copy.

Referrals and Prior Authorizations

You don't need a referral when you see a specialist in the Southeast Network. If the specialist isn't in the network, you'll need a written referral from your primary care physician (PCP) and authorization from Anthem. This plan will pay some or all of the costs to see a specialist for covered services only if you have the plan's permission before you see the specialist. You will need prior authorization for some medical procedures. Your PCP or specialist will initiate this. You also need precertification for non-emergency hospital stays.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Service Area

Dodge, Jefferson, Rock, Washington, Waukesha, Walworth, Ozaukee, Milwaukee, Racine and Kenosha counties.

Care Outside Service Area

For emergency care, go to the nearest health care facility. Contact your PCP and Anthem within 24 hours or as soon as possible. For urgent care, call your PCP for advice on the right treatment. All other services must be received within your service area.

Mental and Behavioral Health Services

You don't need a referral to see a Southeast Network mental health provider. You will need precertification for inpatient care.

Dental Network

No dental coverage provided.

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 2014

Arise Health Plan is excited to announce new additions to its comprehensive provider network. Aurora Health Care and Bay Care Clinic join the Arise family of quality health care providers for 2014. With these new additions, the Arise Health Plan network now consists of 36 hospitals and over 4,000 doctors.

Shared Decision Making

Shared decision making is a collaborative process which involves patients and their providers making health care decisions together. Your participating orthopedic surgeon or neurosurgeon will be required to submit a pre-service authorization for low back surgery. A determination of benefits will be made using evidence-based guidelines.

Provider Directory

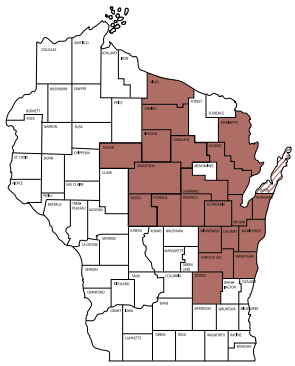
Go to wecareforwisconsin.com, select **Members** and then **Find A Doctor**. Enter group number "087889." To print a provider directory, scroll to the bottom of the **Find A Doctor** page and **select the link below the search options**, or call (888) 711-1444 to request a directory.

Referrals and Prior Authorizations

No written referrals are required when receiving necessary care from participating providers. Pre-service authorization is required for certain procedures and 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.

Service Area

Brown, Calumet, Clark, Dodge, Door, Florence, Forest, Fond du Lac, Green Lake, Langlade, Lincoln, Kewaunee, Manitowoc, Marathon, Marinette, Oconto, Oneida, Outagamie, Portage, Shawano, Sheboygan, Taylor, Vilas, Waupaca, Winnebago and Wood counties.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

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.

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.

Dental Network

Dental benefits are administered by Delta Dental. Go to deltadentalwi.com and select **Premier** or **PPO** as your dental plan. Call (800) 236-3712 with questions.

Dean Health Insurance

(800) 279-1301

deancare.com/wi-employees

Overall Quality Rating

See *Report Card* section

What's New for 2014

Integrated health systems like Dean's, that bring together all key players of the health care system—insurance providers, hospital partners and health care experts—are the models that federal health care reform is attempting to replicate. This partnership allows more focus on managed and preventive care through strong provider-patient relationships, wellness programs and incentives, and an on-site team of nurses monitoring and measuring the care you receive to ensure its quality.

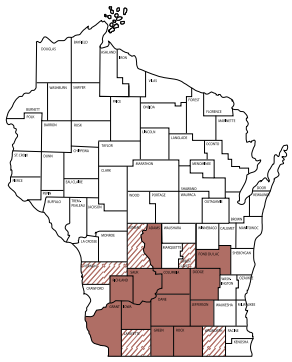
This commitment to your well-being is demonstrated through initiatives such as the popular Healthy Partners program, which offers discounts at several local health clubs, Quit for Life tobacco cessation and Strong Beginnings for expectant mothers. It's always been our quality care that ensures you receive the right preventive screenings and treatment that you need.

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 at (800) 279-1301.

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 tell your provider to contact Dean Health Insurance for an approved prior authorization before receiving care. Dean Health Insurance will notify you and your provider in writing of the decision.



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

Service Area

Adams, Columbia, Dane, Dodge, Fond du Lac, Grant, Green, Green Lake, Iowa, Jefferson, Juneau, Lafayette, Richland, Rock, Sauk, Vernon and Walworth counties.

Care Outside Service Area

When you receive emergency or urgent care outside the Dean network, call the number on your ID card by the next business day or as soon as possible. Non-emergency/non-urgent care is not covered unless 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.

Dental Network

No dental coverage provided.

Dean Health Insurance - Prevea360 Health Plan

(800) 230-7555

prevea360.com/wi-employees

Not Available
Overall Quality Rating
See *Report Card* section

What's New for 2014

Prevea360 Health Plan is now available to Wisconsin Public Employees living in northeastern Wisconsin. It is underwritten by Dean Health Insurance, so you know it's a plan Wisconsinites have come to know and trust.

What makes Prevea360 so special is its proprietary network of hospitals, physicians and ancillary providers that is based on Prevea Health's multi-specialty physician group and Hospital Sisters Health System (HSHS) partner hospitals. These include St. Mary's and St. Vincent's Hospitals in Green Bay, and St. Nicholas Hospital in Sheboygan, and other in-network hospitals in Oconto, Manitowoc and Door County.

Provider Directory

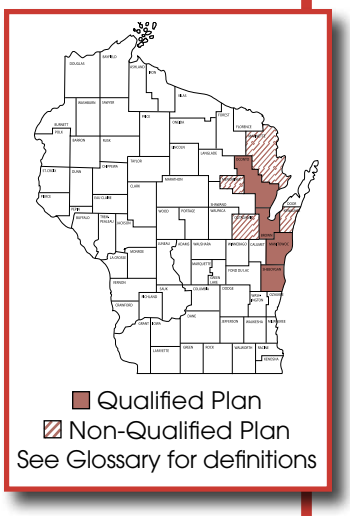
Go to prevea360.com/wi-employees. For a searchable directory, select Find a Provider. A printable version of the directory is also available on this page. If you prefer, you may call the customer care center at (877) 230-7555 to request a copy.

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 at (877) 230-7555. You must tell your provider to contact Prevea360 for an approved prior authorization before receiving care. Prevea360 will notify you and your provider in writing of the decision.

Service Area

Brown, Manitowoc, Marinette, Kewaunee, Oconto, Outagamie, Marinette, Menominee and Sheboygan counties.



Care Outside Service Area

When you receive emergency or urgent care outside the Prevea360 network, call the number on your ID card by the next business day or as soon as possible. Non-emergency/non-urgent care is not covered unless 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.

Dental Network

No dental coverage provided.

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 2014

Group Health Cooperative of Eau Claire has rolled out a health and wellness blog authored by its own Health Promotion Coaches. Weekly posts feature tips on leading a healthy lifestyle, motivation and healthy recipes! Visit Coaches' Corner at group-health.com to read, comment and learn.

In addition, Wiser Health, Group Health Cooperative's online tool featuring detailed health information on more than 200 health conditions, has introduced new interactive features. Learn more about what actions other people with the same health condition have taken at group-health.com.

Provider Directory

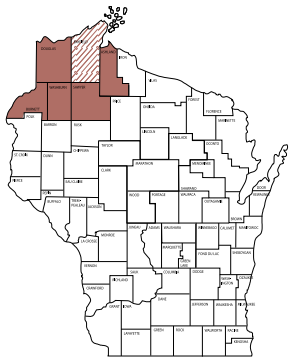
Refer to our website group-health.com and choose **Find a Provider** to access the 2014 **State of WI** provider listing.

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.** Group Health Cooperative 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 group-health.com or call (888) 203-7770 to speak with member services.

Service Area

Ashland, Bayfield, Burnett, Douglas, Sawyer and Washburn counties.



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

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. Group Health Cooperative has the right to review for medical necessity. Follow-up care must be received by an in-network provider.

Mental and Behavioral Health Services

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

Dental Network

No routine dental coverage provided.

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 2014

- Madison College Community Clinic located at 1705 Hoffman Street, Madison 53704
- Check out our new complementary medicine classes and services, including Healing Yoga for Post Traumatic Stress Disorder (PTSD), Oncology Care, Sports Massage and Trager Approach.

Provider Directory

Visit https://ghcscw.com, click on "Find a Provider" 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

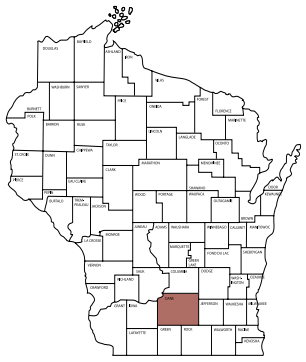
Your primary care physician will submit a referral request to a certified GHC-SCW case manager when you need to receive services outside of a GHC-SCW clinic or through a specialty care area. Certain procedures or tests also require a prior authorization. You will receive a letter from GHC-SCW, as well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

Service Area

Dane County

Care Outside Service Area

The GHC-SCW service area is Dane County, Wisconsin. 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.



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

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.

Dental Network

Dental benefits are offered by GHC-SCW. All dental services must be obtained from Dental Health Associates in Madison.

Gundersen Health Plan

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

Overall Quality Rating
See *Report Card* section

What's New for 2014

In 2013, Gundersen Lutheran Health Plan changed its name to Gundersen Health Plan.

Our name may have changed, but we continue to provide the same great local service, coverage and providers. Gundersen Health Plan (GHP) has a fresh new logo and developed new ID cards, explanation of benefits (EOB), and newsletters. Our website is also at a new address: www.gundersen-healthplan.org. The website (new in 2014) has a responsive web design, allowing for access to our website from your computer, tablet or phone.

Provider Directory

To view or print a copy of the provider directory, go to www.gundersenhealthplan.org/etf and click on **2014 Provider Directory**. To access the most current practitioners and facilities, a searchable online directory is also available at www.gundersenhealthplan.org/providerdirectory. You may also call customer service at (800) 897-1923 or (608) 775-8007 to request a provider directory or to find a provider in your network.

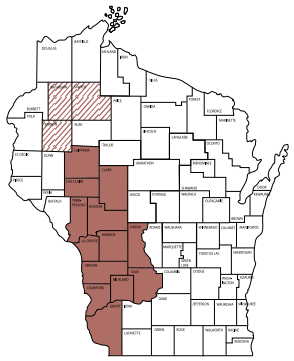
Referrals and Prior Authorizations

A member may seek services from any GHP network provider without a referral.

If your GHP provider feels that you require specialty care outside of the network, the provider must complete a referral request form and submit it to GHP. Selected medical procedures and services, including high-tech radiology and low back surgery, require prior authorization. Your provider should submit a written prior authorization request to GHP. GHP will respond in writing to you and your provider after reviewing the referral or prior authorization request.

Service Area

Barron, Chippewa, Clark, Crawford, Eau Claire, Grant, Jackson, Juneau, La Crosse, Monroe, Richland, Sauk, Sawyer, Trempealeau, Vernon and Washburn counties.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

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 GHP within 24 hours if admitted to a hospital. All other care must be with a plan provider, unless GHP has approved a referral as previously described.

Mental and Behavioral Health Services

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

Dental Network

You can go to any dental provider, and the services are not subject to a usual and customary fee schedule.

Health Tradition Health Plan

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

Overall Quality Rating
See *Report Card* section

What's New for 2014

There are no significant plan-specific changes to the Health Tradition Health Plan (HTHP) offering from last year. Please check the website periodically for additional details regarding health and wellness initiatives through Health Tradition. 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

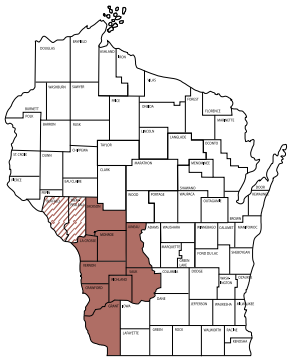
Go to **healthtradition.com**. You can select **MMSI Service Center** in the bottom right section of the home page. Once you log in, click on **Find a Doctor** across the top tool bar. Select **MMSI** as your network and then you can do a provider search by provider name, specialty, location, etc. You can also contact HTHP at (888) 459-3020 to request a paper copy.

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.

Service Area

Buffalo, Crawford, Grant, Jackson, Juneau, La Crosse, Monroe, Richland, Sauk, Trempealeau and Vernon counties.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

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 Network

You can see any dentist. Benefits subject to usual and customary charges unless you use the Health Tradition Preferred Dental Network. To view our dental providers, go to healthtradition.com and click on **Provider Directory** across the top toolbar. Scroll down to the heading titled **State of Wisconsin Members** and select **Dental Provider Directory**.

HealthPartners Health Plan

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

healthpartners.com/stateofwis

Overall Quality Rating

See *Report Card* section

What's New for 2014

Virtuwell is our 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. As always, members can also register online to view claims, explanations of benefits and other personal health information.

Provider Directory

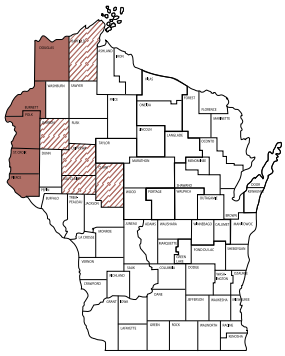
Go to healthpartners.com/stateofwis and click on the **find a doctor or specialist** link. Click on the **PDF listing** or search our online directory for providers. No registration is necessary. Search providers as well as facilities to make sure they are in our network. Call (800) 883-2177 to request 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 see healthpartners.com/stateofwis. Your doctor will request the authorization, and HealthPartners will notify you in writing of the coverage decision.

Service Area

Ashland, Bayfield, Douglas, Burnett, Polk, St. Croix, Sawyer, Washburn and Pierce counties.



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

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.

Mental and Behavioral Health Services

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

Dental Network

No dental coverage provided.

Humana – Eastern

(855) STOFWIH or (855) 786-3944
humana.com

Overall Quality Rating
See *Report Card* section

What's New for 2014

Humana offers HumanaVitality, a health and wellness program that rewards healthy lifestyle choices for members and their families. Visit humana.com/Vitality for more information. Humana's robust online tools help you choose a provider, see claim status and more. For more information go to humana.com/custom_clients/stateofwi.

Provider Directory

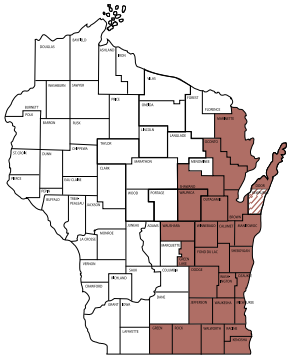
Go to apps.humana.com/egroups/Wisconsin/home.asp. Or go to **humana.com** to search for a provider. Select **Find a Doctor**, enter your member ID or select **Employer Group Plan** (if on Medicare, select **Medicare**). Enter your zip code. Select **HMO Premier** (if on Medicare, select **Medicare PPO**). **HMO Premier** (or **Medicare PPO**) will not appear in the list if no providers are found in the area. Call (855) STOFWIH or (855) 786-3944 to request an HMO directory. HMO Premier is a national network, but you **must** select a Wisconsin-based primary care physician, 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 limit 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 (855) STOFWIH or (855) 786-3944.

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 primary care physician must call (800) 523-0023 to make the request. Verify the status of the request by logging on to your MyHumana web page or call (855) STOFWIH or (855) 786-3944.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Service Area

Kenosha, Racine, Milwaukee, Ozaukee, Sheboygan, Manitowoc, Kewaunee, Door, Marinette, Oconto, Shawano, Waupaca, Outagamie, Brown, Calumet, Winnebago, Waushara, Green Lake, Fond du Lac, Dodge, Washington, Jefferson, Waukesha, Walworth, Rock and Green counties.

Care Outside Service Area

Call Humana at (800) 523-0023 within 48 hours after receiving emergency or urgent care outside Humana's network.

Mental and Behavioral Health Services

Before seeking any mental or behavioral health services, call (855) STOFWIH or (855) 786-3944 between 8:00 a.m. and 5:30 p.m., and follow the prompts. A behavioral health specialist will assist you.

Dental Network

Go to humanadental.com Follow the **Provider Directory** directions and select **Dentists** as the type of provider.

Humana – Western

(855) STOFWIH or (855) 786-3944

humana.com

Overall Quality Rating

See *Report Card* section

What's New for 2014

Humana offers HumanaVitality, a health and wellness program that rewards healthy lifestyle choices for members and their families. Visit humana.com/Vitality for more information. Humana's robust online tools help you choose a provider, see claim status and more. For more information go to humana.com/custom_clients/stateofwi.

Provider Directory

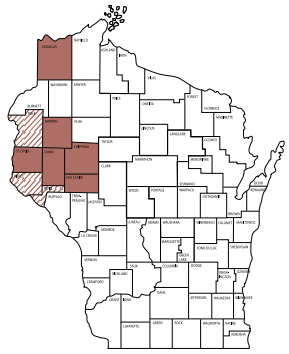
Go to apps.humana.com/egroups/Wisconsin/home.asp. Or go to humana.com to search for a provider. Select **Find a Doctor**, enter your member ID or select **Employer Group Plan** (if on Medicare, select **Medicare**). Enter your zip code. Select **HMO Premier** (if on Medicare, select **Medicare PPO**). HMO Premier (or Medicare PPO) will not appear in the list if no providers are found in the area. Call (855) STOFWIH or (855) 786-3944 to request an HMO directory. HMO Premier is a national network, but you **must** select a Wisconsin based primary care physician, 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 limit 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 (855) STOFWIH or (855) 786-3944.

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 primary care physician must call (800) 523-0023 to make the request. Verify the status of the request by logging on to your MyHumana web page or calling (855) STOFWIH or (855) 786-3944.



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

Service Area

Douglas, Polk, Barron, St. Croix, Dunn, Chippewa, Eau Claire, Pierce and Pepin counties.

Care Outside Service Area

Call Humana at (800) 523-0023 within 48 hours after receiving emergency or urgent care outside Humana's network.

Mental and Behavioral Health Services

Before seeking any mental or behavioral health services, call (855) STOFWIH or (855) 786-3944 between 8:00 a.m. and 5:30 p.m., and follow the prompts. A behavioral health specialist will assist you.

Dental Benefit

Go to humanadental.com. Follow the **Provider Directory** directions and select **Dentists** as the type of provider.

Medical Associates Health Plans

(800) 747-8900

mahealthcare.com

Overall Quality Rating

See *Report Card* section

What's New for 2014

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

Provider Directory

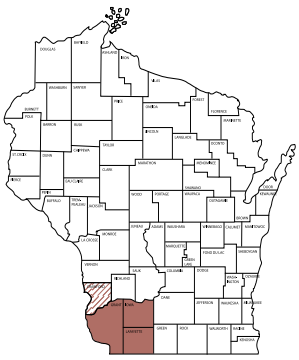
Go to mahealthcare.com/OnlineDirectories/EmpGroup.aspx or visit the MAHP's website at **mahealthcare.com** to view an online provider directory. You may also call MAHP at (800) 747-8900 to request a directory.

Referrals and Prior Authorizations

Members do not need to obtain referrals to receive 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. Prior authorizations are required for certain services. 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 request before receiving services.

Service Area

Iowa, Grant, Lafayette and Crawford counties.



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

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 an MAHP participating physician or provider unless it is prior authorized as previously explained.

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.

Dental Network

You may see the dentist of your choice. Benefits are not subject to usual and customary charges. Present your medical ID card at the time of dental services.

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 2014

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

Medicare Plus will continue to be a Medicare supplement plan for eligible annuitants and their dependents who select the Standard Plan. Medicare Plus will pay your Medicare Part A and B deductibles and coinsurance. This group plan is superior to individual Medicare supplements as it provides protections from fees that exceed usual, customary and reasonable amounts if members use a provider who is not affiliated with Medicare. It also offers coverage during foreign travel. Note, however in cases where Medicare excludes coverage for a service, this plan will also deny coverage.

The Medicare Plus plan is designed to supplement, not duplicate, the benefits available under Medicare for State of Wisconsin Group Health Insurance Program annuitants.

For benefit differences, see the Comparison of Benefit Options section in 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 and prior authorizations are not necessary under this plan as benefits are only supplemental to approved Medicare benefits.

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 Network

No dental coverage provided.

MercyCare Health Plans

(800) 895-2421

mercycarehealthplans.com

Overall Quality Rating

See *Report Card* section

What's New for 2014

MercyCare's network has expanded to include a new primary care clinic in Elkhorn. You can now hold your place in line at a Mercy emergency room or urgent care facility by using Mercy Health System's new website. Choose the facility you want, select a projected treatment time, fill out a form, then relax from the comfort of your home until it's time to go. Visit the mercyinquicker.org website.

Provider Directory

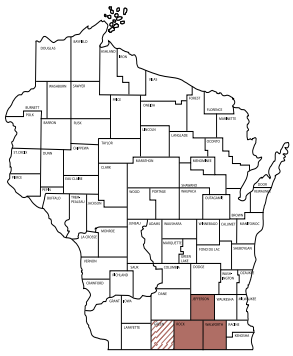
Go to mercycarehealthplans.com, click on **State of Wisconsin Members**, click on **Provider Directory**.

Referrals and Prior Authorizations

You have open access to your primary care provider. A referral from your primary care provider is required to see a specialist in MercyCare's network. If the care is not available in MercyCare's network, your primary care physician 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.

The following services do not need a referral from a PCP or Prior Authorization when performed by a network provider at a network facility:

- OB/GYN consults
- Ophthalmology consults and diagnostic eye exams and testing
- Optometry consult and one vision screening per contract year
- Physical, Occupational, and Speech Therapy
- Clinic Mental Health and Addiction Consults
- Chiropractic Treatment
- Audiology testing and consults
- Dietician and Diabetic Counseling



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

Service Area

Rock, Walworth, Jefferson and Green counties.

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.

Dental Network

No dental coverage provided.

Network Health

(800) 826-0940

networkhealth.com

Overall Quality Rating

See *Report Card* section

What's New for 2014

Make sure to visit Network Health's website, networkhealth.com, to find the answers you need to better manage your health. You can access tools and information to search for health care providers, enroll in disease management programs, and check out upcoming health and wellness classes. It's Network Health's way of helping you stay healthier.

Provider Directory

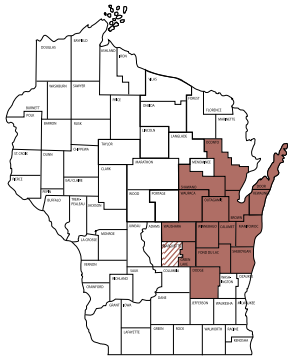
Go to networkhealth.com, under **Find a Doctor**, choose State of Wisconsin Employee as your plan or call (800) 826-0940 to request a copy.

Referrals and Prior Authorizations

You do not need a referral to see providers participating in Network Health's network. However, prior authorization is required to see a provider that is not in network. Prior authorizations are also required for certain services. Members should contact Network Health Customer Service at (800) 826-0940 for information on specific health care services that require prior authorization. Your doctor must submit the prior authorization request, and Network Health will notify you of the approval or denial.

Service Area

Brown, Calumet, Dodge, Door, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marquette, Oconto, Outagamie, Shawano, Sheboygan, Waupaca, Waushara and Winnebago counties.



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

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 Network Health as explained above.

Mental and Behavioral Health Services

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

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.

Physicians Plus

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

pplus.com

Overall Quality Rating

See *Report Card* section

What's New for 2014

Physicians Plus MyChart replaces GO-TO as our online health plan management tool, making member insurance and medical information available from a single point-of-entry. For more information, **visit** pplus.com.

Physicians Plus will be adding Jefferson County (which includes Whitewater) to its Service Area in 2014.

Meriter Pediatric After-Hours Clinic in Meriter Hospital is available to all Physicians Plus members. If your child needs doctors' care beyond regular business hours, call the After-Hours Clinic at (608) 417-6868 to make an appointment.

Provider Directory

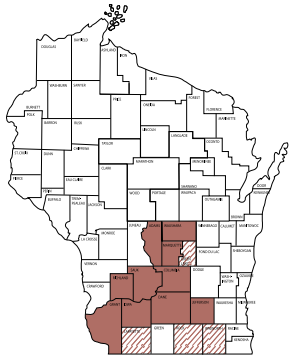
Go to pplus.com and click on **Find a Provider**. To print the provider listing, select **State of Wisconsin Employees/WPE Directory**. To search for a provider, select **State of Wisconsin/Wisconsin Public Employee** (State/WPE) under the network drop-down menu. Call member service at (608) 282-8900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

Referrals and Prior Authorizations

Prior authorization is not required for most covered services delivered by Physicians Plus network providers. Prior authorization will be required for out-of-network specialty services. Members must have their provider submit a prior authorization request to Physicians Plus before receiving care from out-of-network providers. Written decisions will be provided to members and providers for all requests.

Service Area

Adams, Columbia, Dane, Grant, Green Lake, Iowa, Jefferson, LaFayette, Marquette, Richland, Rock, Sauk, Walworth and Waushara counties.



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

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 48 hours after receiving emergency or urgent care outside of the Physicians Plus network. All other care, including follow-up care, should be obtained from network providers unless approved by Physicians Plus, as previously described.

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 Network

No dental coverage provided.

Security Health Plan

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

Overall Quality Rating
See *Report Card* section

What's New for 2014

Security Health Plan is adding a new level of services to our popular Nurse Line. We'll have licensed nurse practitioners on duty from 7 a.m. to 9 p.m. who can offer telephone-based care for some common medical issues. They can even prescribe medications. That's putting quality health care at your convenience. Find out more at securityhealth.org/state.

Provider Directory

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

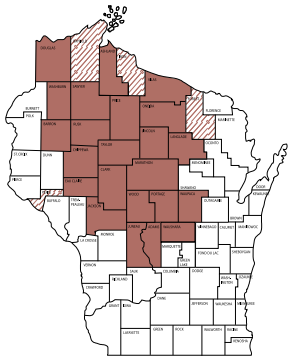
Referrals and Prior Authorizations

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

Prior authorizations: Required for certain services. See Security Health Plan's 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.

Service Area

Adams, Ashland, Barron, Bayfield, Chippewa, Clark, Douglas, Eau Claire, Forest, Iron, Jackson, Juneau, Langlade, Lincoln, Marathon, Oneida, Pepin, Portage, Price, Rusk, Sawyer, Taylor, Vilas, Washburn, Waupaca, Waushara and Wood counties.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

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 from providers outside of the network will not be covered unless a referral has been approved by Security Health Plan.

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 Network

No dental coverage provided.

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 2014

WPS Health Insurance has reached an agreement with Aurora Health Care to offer Aurora providers through our WPS Network. Our new relationship with Aurora improves our already exceptional list of provider collaborations.

Aurora offers 15 hospitals, 172 clinics and more than 1,500 employed physicians, as well as affiliations with 3,000 independent physicians.

General Information

This Standard Plan is a comprehensive health plan that provides you with freedom of choice among hospitals and physicians in Wisconsin and across the nation. See the Comparison of Benefit Options section in this guide for more information or for greater detail on modernized benefits, contact WPS.

Provider Directory

Go to wpsic.com/state/pdf/dir2014_statewide_eastern.pdf or wpsic.com/state/pdf/dir2014_statewide_western.pdf to search for a provider within Wisconsin and bordering areas. You can also visit wpsic.com/state/fad2014-state-national.shtml to search for providers in Wisconsin, as well as nationwide. You may also contact member services at (800) 634-6448 to request a copy.

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 necessary.
- Members or providers may request prior authorization for services when concerned if WPS will pay and at what rate. Without an approved prior authorization, WPS may deny payment. Prior authorization is required for low back surgery and high-tech radiology services. 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 365 days.

Dental Network

No dental coverage provided.

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 2014

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.

SMP is no longer available in Oneida and Price Counties.

Provider Directory

Please visit wpsic.com/state/pdf/dir2014_state_smp.pdf to search for a provider or contact WPS member services.

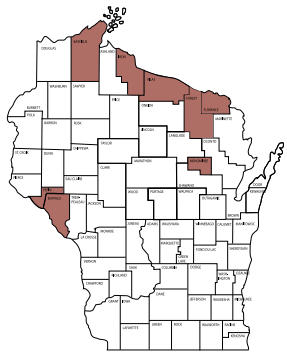
Referrals and Prior Authorizations

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 may request prior authorization for services when concerned if WPS will pay and at what rate. Without an approved prior authorization, WPS may deny payment. Prior authorization is required for low back surgery and high-tech radiology services. 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 at (800) 634-6448.

Service Area

Bayfield, Buffalo, Florence, Forest, Iron, Menominee, Oneida, Pepin and Vilas counties.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Care Outside Service Area

For 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 licensed mental health professionals practicing within the scope of their license. Inpatient services will be limited to 365 days.

Dental Network

No dental benefits available.

UnitedHealthcare of Wisconsin

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

Overall Quality Rating
See *Report Card* section

What's New for 2014

The UHC service area will be expanding. You will no longer need to choose between northeast or southeast regions. There will be one health plan offering with the same provider access. For members traveling out of the service area, including students, please contact customer service at 800-357-0974 (current members) or 866-873-3903 (non current member) for our available national providers.

Provider Directory

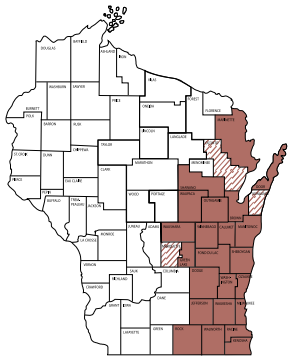
Go to state.welcometouhc.com, click on **Find a Doctor/Hospital** and then select the **State of WI employee Provider Directory** link. For a print version, call Customer Service at 800-357-0974 (current member) or 866-873-3903 (non current member). A full directory or zip code search may be requested. If you are currently enrolled, you will be able to register on **myuhc.com** for your personal search criteria.

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 certain specific procedures, and 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.

Service Area

Brown, Calumet, Dodge, Door, Fond du Lac, Green Lake, Jefferson, Kenosha, Kewaunee, Manitowoc, Marinette, Marquette, Milwaukee, Oconto, Outagamie, Ozaukee, Racine, Rock, Shawano, Sheboygan, Walworth, Washington, Waukesha, Waupaca, Waushara, Winnebago counties.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Care Outside Service Area

If you are out of the service area and need urgent or emergency care, go to the nearest appropriate facility, unless you can safely return to the service area or receive care from one of our nationally contracted providers. See Provider Directory section.

Mental and Behavioral Health Services

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

Dental Network

UHC will be participating in the new uniform dental offering. To obtain the highest benefit level, please find a participating dentist by logging onto www.myuhcdental.com or by calling 877-816-3596. If you use a non-participating dentist of your choice, you will be subject to the lower benefit level. Please see your dental benefits summary.

Our dental network is National Options PPO 30 at www.myuhcdental.com.

Unity Health Insurance – Community

(800) 362-3310

ChooseUnityHealth.com

Overall Quality Rating

See *Report Card* section

What's New for 2014

Want to learn more about how health insurance works? Check out Unity's online Resource Center at www.unityhealth.com/resource-center where you will find educational videos, interactive tools and other information to help you better understand health insurance.

You continue to have guaranteed access to UW Health specialists.

Provider Directory

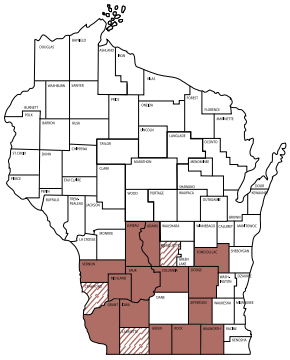
Go to ChooseUnityHealth.com and select **Find A Doctor**. Here you will find the Community Network provider search function and a link to the 2014 Community Network Provider Directory (PDF). You may also call (800) 548-6489 to request a copy of the Community Network Provider Directory.

Referrals and Prior Authorizations

Written referral requests are *not* required to see providers in the Community Network. You will need a written referral request, approved by Unity, to see out-of-network providers. Prior authorizations are required for certain services. See the Community Network Provider Directory for more information or call Unity Customer Service at (800) 362-3310. Your doctor must submit the request, and Unity will notify you in writing of the decision.

Service Area

Adams, Columbia, Crawford, Dodge, Fond du Lac, Grant, Green, Iowa, Jefferson, Juneau, Lafayette, Marquette, Richland, Rock, Sauk, Vernon and Walworth counties, as well as providers located in Black Earth and Cambridge.



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

Care Outside Service Area

All care from out-of-network providers, except emergency care or urgent care, requires a written referral request as previously described.

Mental and Behavioral Health Services

For assistance in accessing Behavioral Health Services, please call UW Behavioral Health at (800) 683-2300. Assistance is available 24 hours a day. You can see any in-network provider for mental and behavioral health services.

Dental Network

No dental coverage provided.

Unity Health Insurance – UW Health

(800) 362-3310

ChooseUnityHealth.com

Overall Quality Rating

See *Report Card* section

What's New for 2014

Unity-UW Health has no in-network hospital or clinic changes in 2014. You continue to have guaranteed access to UW Health providers.

Want to learn more about how health insurance works? Check out Unity's online Resource Center at www.unityhealth.com/resource-center where you will find educational videos, interactive tools and other information to help you better understand health insurance.

Provider Directory

Go to ChooseUnityHealth.com and select **Find A Doctor**. Here you will find the UW Health Network provider search function and a link to the 2014 UW Health Network Provider Directory (PDF). You may also call (800) 548-6489 to request a copy of the UW Health Network Provider Directory.

Referrals and Prior Authorizations

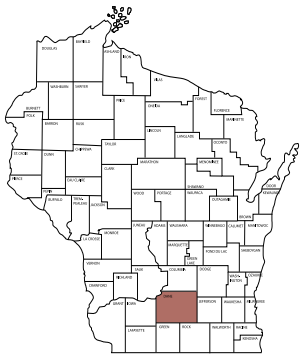
Written referral requests are *not* required to see providers in the UW Health Network. You will need a written referral request, approved by Unity, to see out-of-network providers. Prior authorizations are required for certain services. See the UW Health Network Provider Directory for more information or call Unity customer service at (800) 362-3310. Your doctor must submit the request, and Unity will notify you in writing of the decision.

Service Area

Dane County, except providers located in Black Earth and Cambridge.

Care Outside Service Area

All care from out-of-network providers, except emergency care or urgent care, requires a written referral request as previously described.



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

Mental and Behavioral Health Services

For assistance in accessing Behavioral Health Services, please 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. You can see any in-network provider for mental and behavioral health services.

Dental Network

No dental coverage provided.

WEA Trust PPO – East

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

Overall Quality Rating
See *Report Card* section

What's New for 2014

We are pleased to add four more counties to WEA Trust PPO East—Forest, Oneida, Price and Vilas. This service area now totals 41 counties and thousands of health and dental providers covering the entire eastern half of the state.

To learn more about our expansion and other exciting changes for 2014, go to weatruststatehealthplan.com.

Provider Directory

Go to weatruststatehealthplan.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.

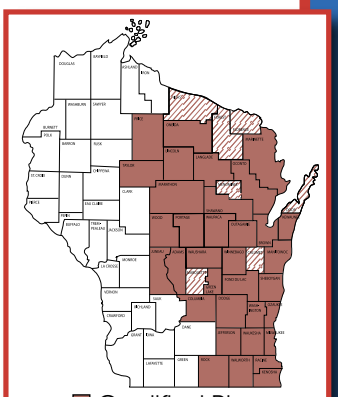
How WEA Trust PPO East is Unique

WEA Trust PPO East is a preferred provider plan that allows you to see any provider and receive benefits. Services received from non-network providers are 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 weatrust.com/preauthorization or call customer service at (800) 279-4000.

Service Area



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Adams, Brown, Calumet, Columbia, Dodge, Door, Florence, Fond du Lac, Forest*, Green Lake, Jefferson, Juneau, Kenosha, Kewaunee, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Marquette, Menominee, Milwaukee, Oconto, Oneida*, Outagamie, Ozaukee, Portage, Price*, Racine, Rock, Shawano, Sheboygan, Taylor, Vilas*, Walworth, Washington, Waukesha, Waupaca, Waushara, Winnebago and Wood counties.

*New for 2014

Care Outside Service Area

If you see a non-network provider, WEA Trust will pay for covered services at 70% of our maximum allowable fee, subject to an annual deductible of $1,000 individual/$2,000 family. For emergency and urgent care, use WEA Trust PPO 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 are needed.

Dental Network

Click **Find a Dentist** at weatruststatehealthplan.com or call customer service at (800) 279-4000.

WEA Trust PPO – Northwest

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

Overall Quality Rating
See *Report Card* section

What's New for 2014

WEA Trust PPO Northwest members will choose from two separate provider networks—the Chippewa Valley or the Mayo Health System. Each network gives you a choice of hundreds of providers. These networks will help organize your care and enhance communication between providers.

When you join our plan, you will need to select one of the two networks. In order to receive in-network reimbursement for your care, you must see health care providers from your chosen network. Each family member may see a different provider but all providers must be in the same network.

If you or your family members see providers outside your chosen network, you will receive the lesser reimbursement levels the plan provides for non-network providers. For additional details of 2014 changes, go to weatruststatehealthplan.com and click on the Northwest service area. If you are a current subscriber who has not chosen a network by 1/1/14, we will assign one based on past use of care. Contact WEA directly to choose a network.

Provider Directory

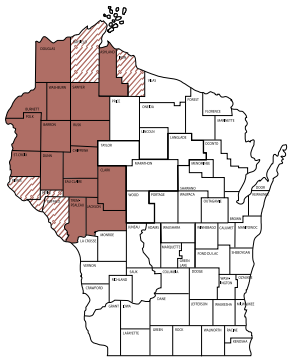
Go to weatruststatehealthplan.com. From there, you may search for a doctor or print from a PDF. You may also call customer service at (800) 279-4000 for assistance.

How WEA Trust PPO Northwest is Unique

WEA Trust PPO Northwest is a preferred provider plan that allows you to see any provider and receive benefits. Services received from non-network providers are covered 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 weatrust.com/preauthorization or call customer service at (800) 279-4000.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Service Area

Ashland, Barron, Bayfield, Buffalo, Burnett, Chippewa, Clark, Douglas, Dunn, Eau Claire, Iron*, Jackson, Pepin, Pierce, Polk, Rusk, Sawyer, St. Croix, Trempealeau and Washburn counties.

*New for 2014

Care Outside Service Area

If you see a non-network provider, WEA Trust will reimburse for covered services at 70% of our maximum allowable fee, 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 are needed.

Dental Network

Click **Find a Dentist** at weatruststatehealthplan.com or call customer service at (800) 279-4000.

WEA Trust PPO – South Central

(800) 279-4000 or (608) 276-4000

weatruststatehealthplan.com

Not Available
Overall Quality Rating
See *Report Card* section

What's New for 2014

WEA Trust is excited to be a new option in Dane County. Our South Central Service Area features Meriter Hospital, the physicians of the growing Meriter Medical Group, and other independent providers in the area. Since 1970, the WEA Trust has provided a top-rated health plan and superior customer service to public employees, including state and local government employees the past three years.

To learn more about our plan offerings, go to weatruststatehealthplan.com and click on the South Central Service Area.

Provider Directory

Go to weatruststatehealthplan.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 PPO South Central is Unique

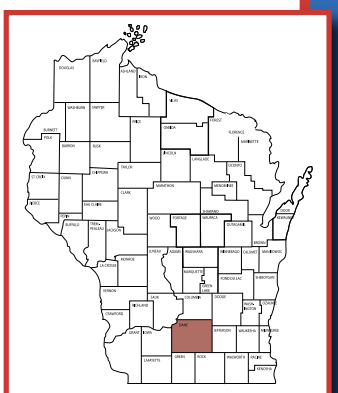
WEA Trust PPO South Central is a preferred provider plan that allows you to see any provider and receive benefits. Services received from non-network providers are covered at a lesser benefit level. (Also see Care Outside Service Area section.)

Referrals and Prior Authorizations

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

Service Area

Dane County



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Care Outside Service Area

If you see a non-network provider, WEA Trust will reimburse for covered services at 70% of our maximum allowable fee, 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 are needed.

Dental Network

Click **Find a Dentist** at weatruststatehealthplan.com or call customer service at (800) 279-4000.

WPS Metro Choice Northwest

(800) 634-6448

wpsic.com/state

Not Available
Overall Quality Rating
See *Report Card* section

What's New for 2014

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

Go to wpsic.com/state and choose "Find a Doctor" to search for a provider. You may also contact WPS at (800) 634-6448 to request a copy.

How Metro Choice is Unique

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

Referrals and Prior Authorizations

Referrals are not necessary under this plan. If you use providers outside the WPS Metro Choice network, you do not need a referral but the services are subject to a deductible of $1,000 individual/$2,000 family and then payable at 70%.

Prior authorization is recommended for any of the following services:

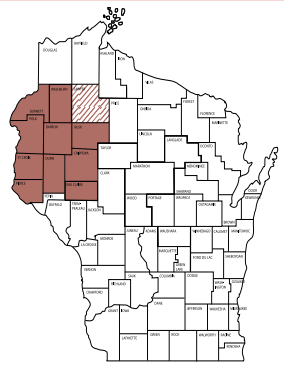
- New medical or biomedical technology;
- Methods of treatment by diet or exercise;
- New surgical methods or techniques;
- Organ transplants;
- Durable medical equipment over $500;
- Pain management injections.

Prior authorization is required for low back surgery and high-tech radiology services.

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.

Service Area

Barron, Burnett, Chippewa, Dunn, Eau Claire, Pierce, Polk, Rusk, Sawyer, St Croix and Washburn counties.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Care Outside Service Area

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

Mental and Behavioral Health Services

Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their licenses and processed based on the provider's network status.

Dental Network

No dental coverage is provided.

WPS Metro Choice Southeast

(800) 634-6448

wpsic.com/state

Not Available
Overall Quality Rating
See *Report Card* section

What's New for 2014

WPS Health Insurance has reached an agreement with Aurora Health Care to offer Aurora providers through our WPS Network. Our new relationship with Aurora improves our already exceptional list of provider collaborations.

Provider Directory

Go to wpsic.com/state and choose "Find a Doctor" to search for a provider. You may also contact WPS at (800) 634-6448 to request a copy.

How Metro Choice is Unique

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

Referrals and Prior Authorizations

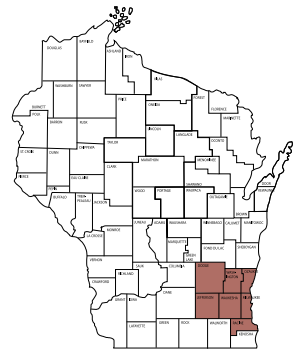
Referrals are not necessary under this plan. If you use providers outside the WPS Metro Choice network, you do not need a referral but the services are subject to a deductible of $1,000 individual/$2,000 family and then payable at 70%.

Prior authorization is recommended for any of the following services:

- New medical or biomedical technology;
- Methods of treatment by diet or exercise;
- New surgical methods or techniques;
- Organ transplants;
- Durable medical equipment over $500;
- Pain management injections.

Prior authorization is required for lower back surgery and high-tech radiology services.

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.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Service Area

Dodge, Jefferson, Milwaukee, Ozaukee, Racine, Washington and Waukesha counties.

Care Outside Service Area

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

Mental and Behavioral Health Services

Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their licenses and processed based on the provider's network status.

Dental Network

No dental coverage is provided.

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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®. We encourage you to review this information and evaluate 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 2013 and for which HEDIS® and CAHPS® data were available. Anthem Blue Northeast, Northwest and Southeast were combined into Anthem Blues 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 & Clinics and University of Wisconsin employees, including graduate assistants and state retirees. The survey only includes health plans that were available starting on January 1, 2012. Data were not collected for WPS Metro Choice Northwest, Dean Health Insurance-Prevea360 and WEA Trust PPO-South Central. Although data were 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. This important survey was administered by Morpace, an independent research firm, on the behalf of ETF.
- The **HEDIS®** measures how the health plan performs from a clinical perspective. The measures 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® data were collected by each health plan for its membership for the 2012 calendar year. No HEDIS® data are available for SMP, the Standard Plan or WPS Metro Choice.

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.

QUALITY COMPOSITE RATING CHART

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 a CAHPS® question surveying our members about whether wellness information is provided by their health plan.

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 a CAHPS® survey question 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®: When you needed care right away, how often did you get care as soon as you needed?

HEDIS®: What percent of eligible women 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 participating health plans
★★★ 3 stars: **above** the average of all participating health plans
★★ 2 stars: **below** the average of all participating health plans
★ 1 star: **well below** the average of all participating health plans

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 Blues*	★★	★★	★★	★★★	★
Arise Health Plan	★★★	★★★	★★★	★★	★★★
Dean Health Insurance**	★★★	★★★	★★★★	★★★	★★★
GHC of Eau Claire	★★★	★★★	★	★★★	★★★
GHC of SCW	★★★★	★★★★	★★★	★★★	★★★★
Gundersen Health Plan	★★★	★★	★	★★★★	★★
Health Tradition	★★★	★★★	★★	★★★	★★
HealthPartners	★★★	★★★	★★	★★★	★★
Humana-Eastern	★	★★★	★★	★	★
Humana-Western	★★	★★★★	★★	★	★
Medical Associates	★★★★	★★★	★	★★★★	★★★
MercyCare Health Plans	★	★★	★	★★	★
Network Health	★★★	★★★	★	★★★	★★★
Physicians Plus	★★★	★★★	★★★★	★★★	★★
Security Health Plan	★★★	★★	★★	★★★	★★★★
UnitedHealthcare NE*	★	★	★★★★	★	★
UnitedHealthcare SE*	★	★	★★★★	★	★★
Unity-Community	★★★	★★★	★★★★	★★★	★★★
Unity-UW Health	★★★★	★★★	★★★★	★★★	★★★★
WEA Trust PPO-East	★	★	★★	★	★★★★
WEA Trust PPO-Northwest	★	★	★★	★	★★

*Three Anthem health plans (Northeast, Northwest, Southeast) were combined into Anthem Blues to produce ratings. Anthem Northwest is not offered in 2014. Note that United Healthcare NE and SE combined into UnitedHealthcare of Wisconsin for 2014.

** This is a name change for 2014 from Dean Health Plan. The results reported here do not include Dean Health Insurance-Prevea360.

CAHPS® Overall Rating Chart

Understanding the scores for the health plans:

★★★★ 4 stars: **well above** the average of all participating health plans
★★★ 3 stars: **above** the average of all participating health plans
★★ 2 stars: **below** the average of all participating health plans
★ 1 star: **well below** the average of all participating health plans

This chart shows results for individual survey questions for which members were asked to rate their health plan, health care, primary doctor and specialists. Health plan scores were adjusted for age, education level and self-reported health status.

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**
Anthem Blues*	★	★	★★★	★★
Arise Health Plan	★★★★	★★★	★★★	★★★
Dean Health Insurance**	★★★	★★★★	★★★★	★★★
GHC of Eau Claire	★★★	★★	★★	★★
GHC of SCW	★★★★	★★★	★★	★
Gundersen Health Plan	★★★	★★★	★★★	★★★
Health Tradition	★★★	★★★	★★★★	★★★
HealthPartners	★★	★	★★	★★
Humana-Eastern	★	★★	★★	★★
Humana-Western	★	★★★	★★	★★★★
Medical Associates	★★★	★★★	★★★★	★★
MercyCare Health Plans	★	★	★★	★★
Network Health	★★★	★★	★★	★★★
Physicians Plus	★★	★★★	★★★	★★★
Security Health Plan	★★★★	★★★	★★	★★
Standard Plan	★★★★	★★★	★★	★★★★
UnitedHealthcare NE*	★	★★	★★★	★★
UnitedHealthcare SE*	★★	★★	★★★	★★★★
Unity-Community	★★★	★★	★★	★
Unity-UW Health	★★★★	★★★★	★	★★★
WEA Trust PPO-East	★★★★	★★	★★	★★
WEA Trust PPO-Northwest	★	★★★	★★★	★★★
WPS Metro Choice Southeast	NR	NR	NR	NR

*Three Anthem health plans (Northeast, Northwest, Southeast) were combined into Anthem Blues to produce ratings. Anthem Northwest is not offered in 2014. Note that United Healthcare NE and SE combined into UnitedHealthcare of Wisconsin for 2014.

** This is a name change for 2014 from Dean Health Plan. The results reported here do not include Dean Health Insurance-Prevea360.

"NR" Not reported due to too few cases to produce a rating.

CAHPS® Composite Rating Chart

Understanding the scores for the health plans:

★★★★ 4 stars: **well above** the average of all participating health plans
★★★ 3 stars: **above** the average of all participating health plans
★★ 2 stars: **below** the average of all participating health plans
★ 1 star: **well below** the average of all participating health plans

This chart shows results for a composite of survey questions that asked members how often something occurred 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.

Plan Name	Customer Service	Claims Processing	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Shared Decision Making
Anthem Blues*	★	★★	★★	★★	★★★	★★
Arise Health Plan	★★★	★★	★★★★	★★★	★★	★★★
Dean Health Insurance**	★★	★★	★★★	★★	★★★★	★★★
GHC of Eau Claire	★★★★	★★★★	★★	★★★	★★	★★★
GHC of SCW	★★★★	★★★	★	★★	★★★	★★★
Gundersen Health Plan	★★	★	★★	★★	★★★	★★★★
Health Tradition	★★	★★	★★★	★★	★★★	★★★
HealthPartners	★★	★★★	★★	★★★	★★	★★★
Humana-Eastern	★	★	★★★	★★	★★★	★★
Humana-Western	★	★	★★★★	★★★	★★★	★★★
Medical Associates	★★★	★★★	★★★	★★★	★★★★	★★★
MercyCare Health Plans	★★★	★★	★★	★★★	★★	★★
Network Health	★★★★	★★★	★★	★★	★★★	★★
Physicians Plus	★★	★★★	★★	★★	★★★	★★
Security Health Plan	★★★★	★★★	★★★★	★★★	★★	★★★
Standard Plan	★★★	★★★	★★★	★★★★	★★	★★
UnitedHealthcare NE*	★	★	★★★	★★★	★★	★★
UnitedHealthcare SE*	★	★★	★★★	★★	★★	★★
Unity-Community	★★★★	★★★★	★	★★	★	★★
Unity-UW Health	★★★★	★★★	★★	★★	★	★★★
WEA Trust PPO-East	★★★★	★★★	★★★	★★★	★★★	★★
WEA Trust PPO-Northwest	★★★	★★★★	★★	★★	★★★★	★★★
WPS Metro Choice Southeast	NR	NR	NR	NR	NR	NR

*Three Anthem health plans (Northeast, Northwest, Southeast) were combined into Anthem Blues to produce ratings. Anthem Northwest is not offered in 2014. Note that United Healthcare NE and SE combined into UnitedHealthcare of Wisconsin for 2014.

** This is a name change for 2014 from Dean Health Plan. The results reported here do not include Dean Health Insurance-Prevea360.

"NR" Not reported due to too few cases to produce a rating.

HEDIS® Composite Rating 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 Blues*	★	★★	★★	★★★	★★★	★★★
Arise Health Plan	★★	★★★	★	★	★★	★
Dean Health Insurance**	★★	★★	★★★	★★★	★★★	★★★
GHC of Eau Claire	★★★	★★★	★★★	★	★★★	★★
GHC of SCW	★★★★	★★★★	★★	★★★	★★★	★★★★
Gundersen Health Plan	★★★	★★	★★★	★★★★	★★★	★★
Health Tradition	★★	★★★	★★★	★★★	★★★	★★★
HealthPartners	★★	★★★	★★★	★★★★	★★★	★★★
Humana	★	★★★★	★	★	★★	★★★
Medical Associates	★★	★★	★★★★	★★★★	★★★	★★★
MercyCare Health Plans	★	★	★★★	★★★	★★★	★
Network Health	★★★★	★★★	★★★	★★	★★★	★★
Physicians Plus	★★★	★★	★★	★★	★★★	★★★
Security Health Plan	★★★★	★★	★★★	★★★	★★★	★★★★
UnitedHealthcare	★★★	★	★	★★★	★	★★
Unity Health Insurance	★★★	★★	★★	★★	★★★	★★★
WEA Trust PPO	★★★	★	★	★	★★	★★★

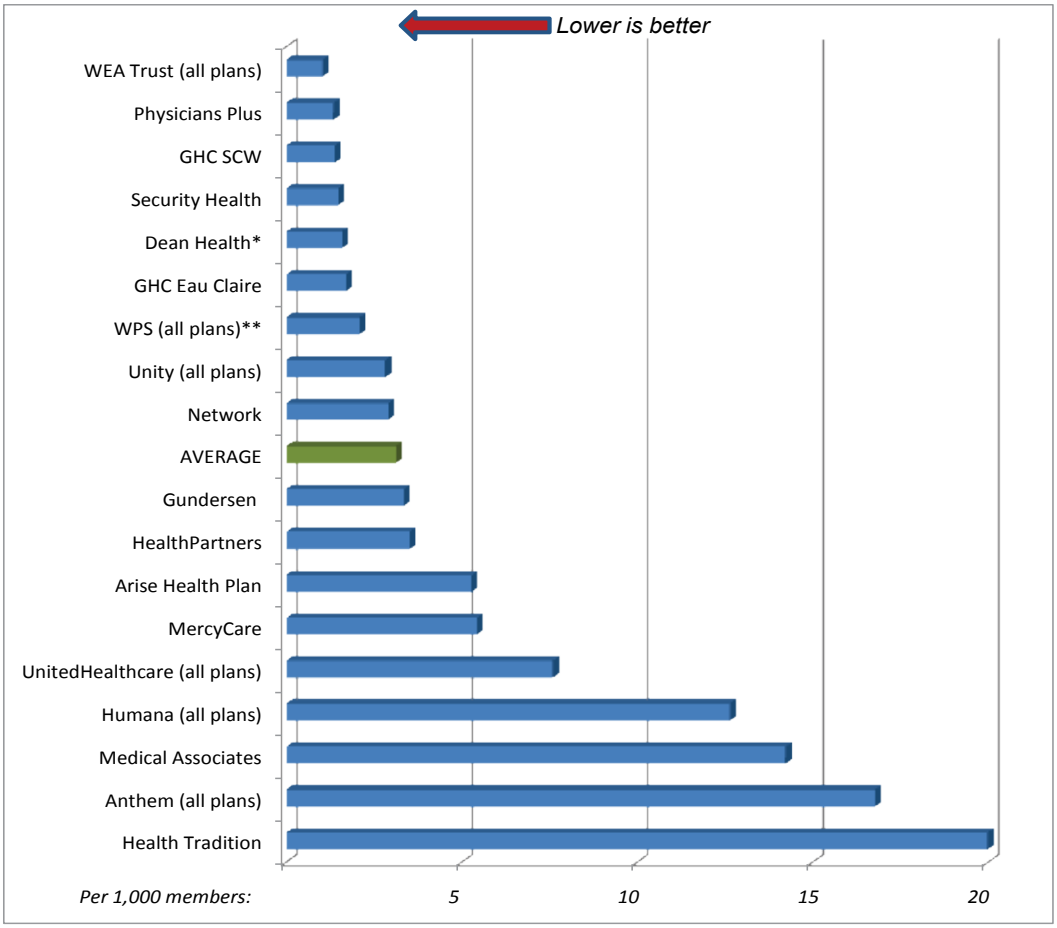
See previous page for footnote explanations and description of the star rating system that was used for this chart.

Grievance Information

The health plan's grievance process is the first step in resolving member complaints. The most frequent types of grievances filed by members in 2012 were related to:

- health plan service and administration;
- non-covered or excluded benefits; and
- prior authorizations.

The 2012 rate of grievances for each health plan appears below. Lower rates may be more desirable when selecting a health plan.



* This is a name change for 2014 from Dean Health Plan. The results reported here do not include Dean Health Insurance-Prevea360.

** Includes the Standard Plan and SMP.

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 the majority of Wisconsin's patient population.

www.wicheckpoint.org

Wisconsin Collaborative for Healthcare Quality

The Wisconsin Collaborative for Healthcare Quality (WCHQ) provides a variety of performance measures that compare information from participating medical groups and hospitals. 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.

www.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 and the U.S. Department of Health and Human Services.

www.medicare.gov/hospitalcompare/

Other Benefits

Pharmacy—*NAVITUS HEALTH SOLUTIONS™*

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

Formulary Information

The four-level formulary requires copayments of $5 (Level 1), $15 (Level 2), $35 (Level 3) and $50 (Level 4). Copayments for non-formulary drugs (all Level 3 and some Level 4 drugs) are not applied against the prescription drug or specialty medication out-of-pocket limit (OOPL). The most up-to-date formulary information is available on the Navitus website through Navi-Gate for Members. Under **Quick Links** click on **Members - Your Formulary** to log in, and 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 1-866-333-2757, with questions about the formulary.

Level 4 Copayments for Specialty Medications

A $50, Level 4 copayment applies to covered, formulary and non-formulary prescription drugs classified as specialty medications. A reduced, $15 copayment applies when a covered, **formulary** specialty medication is filled at **Diplomat Specialty Pharmacy**. These formulary specialty medications are marked with "ESP" on the formulary. Please see additional information in the Specialty Medications Program section on the next page.

Level 4 Out-of-Pocket Limits (OOPL)

A separate Level 4 OOPL applies to covered, formulary specialty medications: $1,000 individual/$2,000 family. This OOPL will accumulate separately from the Level 1/ Level 2 OOPL for non-specialty, formulary drugs. Copayments for formulary specialty medications accumulate to the Level 4 OOPL; however, copayments for non-formulary drugs do not apply to any OOPL.

Medicare Prescription Drug Coverage

All Medicare-eligible retirees, as well as Medicare-eligible dependents of retirees, will be automatically enrolled in the Navitus MedicareRx (PDP), underwritten by Sterling Life Insurance Company, a Federally-Qualified Medicare Contracting Prescription Drug Plan. This is Medicare Part D coverage through an employer group waiver plan.

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 all necessary information from your physician. Medications that require prior authorization for coverage are marked with "PA" on the formulary.

Diabetic Supply Coverage

Diabetic supplies and glucometers are covered with a 20% coinsurance. In most cases this coinsurance applies to your

prescription drug OOPL. Contact Navitus Customer Care if you have questions about your copayment applying to the OOPL.

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. Three copayments are still required. More information can be found on Navitus' website or by calling Navitus Customer Care.

Mail Order Program

Up to a 90-day supply of Level 1 and Level 2 medications can be purchased for only two copayments through our mail order service. Level 3 medications may also be available for up to a 90-day supply, but three copayments will apply. More detailed information can be found on the Navitus website; the WellDyneRx website (welldynerx.com) or by calling Navitus Customer Care. To register for mail order service, call WellDyneRx Customer Care toll free at 1-866-490-3326, 24 hours a day, seven days a week.

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 "¢" on 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" on 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 Medication Program (Self-Injectables and Specialty Medications)

If you are on a specialty medication, the Navitus SpecialtyRx Program is offered through a partnership with Diplomat Specialty Pharmacy to help coordinate members' specialty pharmacy needs. Prescriptions for formulary specialty medications, marked with "ESP" in the formulary, that are filled at Diplopmat receive a reduced $15 copayment. The reduced copayment does not apply to covered, non-formulary specialty medications. To begin receiving your self-injectable and other specialty medications from the specialty pharmacy, please call Navitus SpecialtyRx Customer Care at 1-877-651-4943 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 Wisconsin Public Employers plan. 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

Each January 1st all Medicare-eligible participants covered under an annuitant contract will be automatically enrolled in the Medicare Part D prescription drug program called Navitus MedicareRx (PDP), underwritten by Sterling Life Insurance Company, a Federally-Qualified Medicare Contracting Prescription Drug Plan. Eligible individuals enrolled as members in the Wisconsin Public Employers Group Health Insurance Program were covered by creditable coverage through Navitus Health Solutions prior to being enrolled in Navitus MedicareRx (PDP).

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 benefit 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 supplemental wrap benefit is also included to provide full coverage to program members when they reach the Medicare coverage gap, also known as the "donut hole." You will be automatically enrolled in this supplemental wrap coverage. Your formulary will include a four-level copayment structure which includes: $5 (Level 1), $15 (Level 2), $35 (Level 3) and $50/$15 (Level 4). Information regarding your Medicare Part D benefit will be mailed to you by Navitus MedicareRx (PDP) upon confirmed enrollment from Medicare.

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 program for people with Medicare.

By completing your enrollment application or maintaining your enrollment with the Wisconsin Public Employers 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 obtain 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 Medicare Part D 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 program coverage changes. For more information please contact either ETF or Navitus MedicareRx (PDP).

Navitus MedicareRx (PDP) Customer Care

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.

WRITE: Navitus MedicareRx (PDP) Customer Care, P.O. Box 1039, Appleton, WI 54912-1039

WEBSITE: medicarerx.navitus.com

STATE OF WISCONSIN Department of Employee Trust Funds Robert J. Conlin
SECRETARY

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax (608) 267-4549
http://etf.wi.gov

Important Notice About Your Prescription Drug Coverage and Medicare

2014 Notice of Creditable Coverage for Medicare Part D

KEEP THIS NOTICE – DO NOT DISCARD

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State of Wisconsin (State) or Wisconsin Public Employers (WPE) Group Health Insurance Program and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan under an individual policy. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering individual Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **The Department of Employee Trust Funds (ETF) has determined that the prescription drug coverage offered by the State and WPE programs, and administered by Navitus Health Solutions is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year after that from October 15th through December 7th. If you lose your State or WPE prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

For Medicare eligible, active working individuals enrolled in the State or WPE group health insurance program, if you decide to join a Medicare drug plan, your current State or WPE prescription drug coverage will not be affected. You can remain enrolled in the State's or WPE's plan and prescription drug coverage through the State or WPE will be primary to Medicare Part D. However, there will be no reduction in your monthly premium. If you do decide to drop your current State or WPE coverage, be aware that you and your dependents may not be able to get this coverage back. The State and WPE benefit plan design doesn't allow you to drop prescription drug coverage and maintain health benefit coverage separately. Refer to the 2014 Reference Guide (ET-2107r-14 for State or ET-2128r-14 for WPE) for more information on reenrolling in the State or WPE plan and the impact Medicare Part D has on your State coverage.

For Medicare eligible, retired, disabled and COBRA individuals who are not actively working, prescription drug coverage is provided through a Medicare Part D employer group waiver plan, Navitus MedicareRx (PDP), underwritten by Sterling Life Insurance Company, which is considered creditable coverage.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

If you drop or lose your current coverage with the State or WPE program and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join another Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join a Medicare drug plan.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact either Navitus or ETF.

Navitus Health Solutions
Phone toll free: 1-866-333-2757

Navitus MedicareRx (PDP)
Phone toll free: 1-866-270-3877

Hours: 24 hours a day, 7 days a week (Closed Thanksgiving and Christmas Day)

Department of Employee Trust Funds
Phone toll free..... 1-877-533-5020
Local to Madison..... (608) 266-3285
FAX..... (608) 267-4549
Web site..... http:\\etf.wi.gov

Mailing Address:
P.O. Box 7931
Madison, WI 53707-7931

Wisconsin Relay Service (*for hearing & speech impaired*)
7-1-1 or 1-800-947-3529 (*English*) or 1-800-833-7813 (*Spanish*)

This notice is provided each year, prior to the next Medicare prescription drug coverage enrollment period or whenever State or WPE coverage changes. You may also request a copy of this notice from ETF at any time.

For More Information About This Notice or Your Current Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is available in the annual "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. While you may also be contacted directly by Medicare PDP providers, you can get more information about Medicare prescription drug coverage from the following sources:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program for personalized help
  (see the inside back cover of the "Medicare & You" handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: KEEP THIS CREDITABLE COVERAGE NOTICE.
If you decide to join one of the Medicare prescription drug plans approved by Medicare you may need to provide a copy of this notice when you join to show that you have maintained creditable coverage and, therefore, are not required to pay a higher premium (a penalty)

Wisconsin Public Employers (WPE) Life Insurance—*Minnesota Life Insurance Company*

(866) 295-8690 etf.wi.gov

The life insurance program offers local government employees coverage of up to five times annual earnings—the Basic, Supplemental, and Additional plan each base earnings on your highest prior calendar year's earnings with your current employer, rounded up to the next thousand. The amount of coverage available depends on which plans are offered by your employer.

- **Basic Plan** coverage will continue in a reduced amount for your lifetime, without cost, for eligible retirees over age 65 and for active employees over age 70.
- **Supplemental Plan** provides coverage up to age 65, if retired, or age 70 if an active employee.
- **Additional Plan** provides up to three units of coverage. Depending on how many levels of coverage are offered by your employer, you may choose one, two or three units of Additional coverage. Coverage may continue until you terminate employment or cancel coverage.
- **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.
- **Conversion of Life Insurance to Pay Health Insurance Premiums**
  Retirees who have WPE life insurance and reached age 66 or 67—depending on the post-retirement benefit selected by your employer—may be eligible to convert the present value of their life insurance to pay ETF-administered health insurance premiums. See *Converting Your Group Life Insurance to Pay Health or Long-Term Care Insurance Premiums* (ET-2325).
- **Living Benefits**
  Insured persons may apply to receive all or part of the value of their life insurance while still living, if they are diagnosed with a terminal condition caused by illness or injury and have a life expectancy of 12 months or less. See the *Living Benefits* (ET-2327) brochure for more information.
- **Eligibility and Enrollment**
  You have an open enrollment opportunity for life insurance coverage if you:
  - are under age 70, and
  - have worked six or more months in service covered by the WRS, and
  - apply within 30 days of your first eligibility.

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

You may also enroll for one level of employee coverage or increase your coverage by one level if have a qualifying family status change event: marriage, domestic partnership as defined in Wis. Stat. 40.02(21d) or the birth, adoption, placement for adoption, or award of legal guardianship of a dependent child.

For Spouse and Dependent coverage only, you may apply when you first have a spouse or domestic partner or dependent to insure. 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 , including current premium costs.

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Group Health Insurance Application

Submit your completed application and retain one for your records if, for next year, you want to:

- change health plans
- change to family or single coverage
- drop your adult dependent child
- enroll (if you previously deferred coverage and are an eligible employee, annuitant or surviving spouse/dependent)

Copies of the Group Health Insurance Application/Change Form (ET-2301) are also available at **etf.wi.gov/publications/et2301.pdf**.

Your application must be submitted electronically (see Pages 5 through 8), handed in, faxed or postmarked by the last day of the It's Your Choice Open Enrollment period (November 1, 2013). 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 enroll online through myETF Benefits or submit this application to your employer, if you are actively employed, or to the Department of Employee Trust Funds (ETF) 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 (DP) Status: Check the box that indicates your current marital status. If you are Married, in a DP, Divorced or Widowed, provide the applicable marital status date.
   - The effective date of a DP is the date that ETF receives the Affidavit of Domestic Partnership form (ET-2371); your health application must be received within 30 days of this date.
   - The entry of judgment of divorce is typically when the judge signs the divorce decree and the clerk of courts date stamps the document.
3. If married or in a DP, you must provide your spouse/DP's name, prior name if any, SSN and birth date; even if you are applying for single coverage. If applying for family coverage also include gender, tax dependent status and physician.
4. Indicate your Eligibility Status based on your employee type by checking a box.
5. For initial enrollment only, indicate when you want coverage to start: 1) immediately (as soon as possible) or 2) when you become eligible for the employer contribution toward the health insurance premium.
6. Coverage Desired: Indicate level of coverage desired by checking either single or family.
7. Health Plan Selected: Indicate the name of the health plan that you want to provide your health insurance.

SECTION 2 – REASON FOR APPLICATION

1. Indicate the reason for submitting this application by checking the box(es) that apply under subsections A, B, C, D, E or F. If you are adding or removing a dependent due to marriage/DP, birth, adoption, placement for adoption, divorce/termination of DP, or changing from family to single coverage and also wish to change health plans, a second application must be completed.
2. Subsection A — If declining coverage, check a box and go to Section 6 to date and sign your application.
3. Subsection B — Indicate an enrollment reason and select an event from the listing. Indicate the date of the event on the line titled "Event Date." If removing a spouse due to divorce, the entry of judgment of divorce is typically when the judge signs the divorce decree and the clerk of courts date stamps the document.

   Dependent Information - If you select an enrollment reason in section 2(B) or are updating personal data for a dependent in section 2(D), provide all information requested in this Section for any eligible dependents, excluding spouse/DP. Spouse or DP information is to be provided in Section 1.

   For "Rel. Code" use the following codes to describe the relationship of dependents to you:

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

   03=Minor 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 or your spouse/DP's grandchildren listed as an eligible dependent on this application. 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 or dependent of domestic partner is considered a "tax dependent" under federal law.

   Physician/clinic information is required for yourself and all dependents, unless you have elected the Standard Plan.
4. Subsection C — If changing health plan, please indicate the reason and provide the name of your current health plan as well as the date of the qualifying event. A qualifying Section 125 Status Change is marriage/DP, birth, adoption, divorce/termination of DP or a move from service area.
5. Subsection D—When updating spouse/DP/dependent personal data, this can be done on the same application when selecting a reason under subsections B, C, E or F, or on a separate application. Complete spouse/DP changes in Section 1 and update Dependent Information in Section 2 for other dependent updates.
6. Subsections E and F — If canceling coverage or electing a Change from Family to Single 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. If electing single coverage due to your spouse and all dependents, or your last covered dependent, becoming eligible for and enrolling in other group coverage, an application must be received by your employer or a myETF Benefits request submitted within 30 days of their enrollment in the other group coverage. You may also cancel coverage or change to single due to a qualifying Section 125 Status Change such as a marriage/DP, divorce/termination of DP, birth, adoption or move from service area.
7. Removing Adult Dependents - Dependents under the age of 19 cannot be dropped from coverage when family coverage is in place. Once the dependent turns age 19, that adult dependent can be dropped at the end of the calendar year they turned 19 during the It's Your Choice Open Enrollment period. An adult dependent can be dropped or added during any It's Your Choice period.

SECTION 3 – ADDITIONAL INFORMATION

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

SECTION 4 – MEDICARE INFORMATION

Indicate "Yes" or "No" if you or any of your dependents (including your spouse/DP) 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 5 – OTHER COVERAGE

Provide information regarding any other group health insurance under which you or your dependents (including your spouse/ DP) are covered. NOTE: "Other coverage" does not include supplemental insurance (examples, EPIC or DentalBlue).

SECTION 6 – 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 and sign the application. By signing the application, you are acknowledging that you have read and agree to the TERMS AND CONDITIONS.
2. Make a copy of the application for your records, and submit the application to your payroll representative. If you are an annuitant or continuant, please submit your application to ETF directly.
3. Your employer will complete Section 7 and provide a copy of the application to you. For annuitants/continuants, ETF will complete Section 7 and provide a copy of the application to you.

Documentation Required by ETF for Health Insurance Coverage Changes (ET 2301)

Reason for Change	Type of Documentation
*Loss of Other Coverage	Certificate of Creditable Coverage from health plan; COBRA notice if coverage end date, covered individuals, and health plan are indicated; or letter from administrator if self-funded health plan. If loss of employer premium contributions, letter from employer indicating they no longer contribute towards their employee's premium.
Divorce Family to Single	No documents required but ETF may request per the Terms and Conditions on page 7 of this application, number 7.
*Divorce Family coverage remains in place when more dependents than spouse covered	Copy of Continuation/Conversion Notice (ET-2311) sent to ex-spouse of the subscriber (ETF may request copy of divorce decree from clerk of courts showing date of entry of divorce if needed per the Terms and Conditions on page 7 of this application, number 7.)
*Adoption	Recorded copy of court order granting adoption or letter of placement for adoption
*Legal Ward	Letter of guardianship/court order granting permanent guardianship of person
*National Medical Support Notice	Copy of National Medical Support Notice
*Paternity	Court order declaring paternity, or Voluntary Paternity Acknowledgement (HCF-5024) filed w/DHS, or birth certificate
*Affidavit of Domestic Partnership (ET-2371)	Copy of Acknowledgement letter indicating effective date of domestic partnership submitted to employer. Health application adding domestic partner should be submitted to employer when Affidavit of Domestic Partnership is submitted to ETF.
Cancel coverage due to enrollment in other health insurance coverage when premium contributions are deducted pre-tax	Copy of medical ID card or letter from health plan indicating effective date of other coverage**.
Family to Single because all dependents enrolled in other coverage	Same rules as Cancel above**.
Birth	Original birth certificate not required. ETF may request documentation per the Terms and Conditions on page 7 of this application, number 7. Do not wait for SSN before submitting health application to employer.
Marriage	Original marriage certificate is not required but ETF may request per the Terms and Conditions on page 7 of this application, number 7.
Termination of Domestic Partnership (ET-2371)	Affidavit of Termination of Domestic Partnership. (ETF may request copy of marriage certificate if marriage is reason for termination of domestic partnership per the Terms and Conditions on page 7 of this application, number 7.)
Change of Address/Telephone	None (ETF may request documentation per the Terms and Conditions on page 7 of this application, number 7.)
Eligible <u>and</u> enrolled in Medicare	Copy of Medicare card and Medicare Eligibility Statement (ET-4307). Only for retiree contracts If COBRA Continuation and subscriber becomes Medicare eligible after the COBRA effective date, subscriber is no longer eligible for COBRA Continuation
Death	Original death certificate
Legal Change of Name (other than due to marriage or divorce)	Copy of court order
Social Security Number Change	Copy of card or letter from Social Security Administration

*Documentation Required/Must Be Submitted To ETF.
**Does not apply to annuitants/retirees.

ETF Use Only

State of Wisconsin
Department of Employee Trust Funds (ETF)

Health Insurance Application/Change Form

Employer Notes

1. APPLICANT INFORMATION	ETF Member ID	SSN

Applicant Name – First	M.I.	Last	Previous Name	DOB	Gender	Physician/Clinic

Home Mailing Address—Street and No.	City	State	Zip Code	☐ Check here if updating address phone, email, or marital status.

Primary Telephone Number: ( )	Country (if not USA)	Applicant E-mail:

MARITAL OR DOMESTIC PARTNERSHIP STATUS:
☐ Single ☐ Married ☐ Domestic Partnership (DP) ☐ Divorced ☐ Widowed Date: _____

Spouse/DP: SSN _____ Name _____

Previous Name _____ Physician/Clinic _____

DOB: _____ Gender: _____ Tax Dep ☐ Yes ☐ No

ELIGIBILITY STATUS:
☐Employee ☐Graduate Assistant ☐Survivor
☐Continuant (COBRA) ☐Annuitant/Retiree

NEW HIRE — I WANT MY COVERAGE TO BE EFFECTIVE:
☐ As soon as possible (Employee will pay entire monthly premium until eligible for contribution)
☐ When employer contributes to premium

Coverage Desired ☐Single ☐ Family **Health Plan Selected:**

2. REASON FOR APPLICATION
Reasons marked with an * require supporting documentation. See page 4 of this application for specific documentation requirements.

A. Decline Coverage *(Check one box below and go to Section 6 to sign and date your application.)*
☐ I do not wish to enroll at this time. ☐ I do not wish to enroll at this time as I currently have other insurance coverage.

B. Enrollment (*Check a Reason* **and** *an Event below and indicate the date of event. Update Dependent Information below as appropriate)*
***Note**: Deletion of a Dependent due to loss of eligibility provides a COBRA enrollment opportunity. Notice must be provided to Employer within 60 days of event.*

Reason: ☐**Add Coverage (Add Cvg)** ☐**Add Dependent (Add Dep)** ☐**Remove Dependent (Rem Dep)**

Event:

☐New Hire (Add Cvg)
☐ Spouse/DP to Spouse/DP Transfer (Add Cvg)
☐ Transfer from One Employer to Another Employer (Add Cvg)
Name of Previous Employer _____
☐ Marriage/DP* (Add Cvg, Add Dep)
☐ Birth (Add Cvg, Add Dep)
☐ Adoption* (Add Cvg, Add Dep)
☐ National Medical Support Notice* (Add Dep)
☐ Paternity Acknowledgment* (Add Dep)
☐ Legal Ward/Guardianship* (Add Dep)
☐ Legal Ward/Guardianship Ends* (Rem Dep)
☐ Disabled, Age 26 or Older* (Add Dep)
☐ LTE New Hire - State Only (Add Cvg)

☐ State Annuitant/Retiree Re-enroll Effective Date _____ (Add Cvg)
☐ Eligible Dependent Not Included on Initial Enrollment (Excludes DP and Adult Dependents)
☐ Loss of other Coverage/Employer Contributions* (Add Cvg, Add Dep)
☐ Divorce*/DP Terminated* (Rem Dep)
☐ Death of Dependent (Rem Dep)
☐ Disabled Dependent: Disability Ends or Dependent Marries or Support less than 50% (Rem Dep)
☐ Grandchild's Parent Turns 18 (Rem Dep)
☐ Adult Dependent Eligible for other coverage (Rem Dep)
☐ Annual It's Your Choice (Jan. 1) (Add Cvg, Add Dep, Rem Dep)
☐ COBRA (Add Cvg)
☐ Other:_____

Event Date: (required)

DEPENDENT INFORMATION (excludes spouse/DP) — Complete all requested information.

Social Security Number	First Name	M.I.	Last	Previous	Birth Date (mm/dd/ccyy)	Gender (M/F)	Rel. Code	Tax Dep? (Y/N)	Disabled? (Y/N)	Enter Physician/ Clinic ***or*** Provide Dependent address for COBRA, if removing dependent.

Applicant Name	ETF Member ID	SSN

2. REASON FOR APPLICATION (continued)

Reasons marked with an * require supporting documentation. See page 4 of this application for specific documentation requirements.

C. Change Health Plan (Check one box below, Indicate Current Health plan, Provide date of event, Update Section 1 or 2 if applicable)

☐Move from Service Area ☐Eligible Section 125 Status Change (see Instructions, Section 2(4).)* ☐ Annual It's Your Choice (Jan. 1)

Current Health Plan: _____ **Event Date:** _____

D. Spouse/DP/Dependent Personal Data Update/Correction ☐Update Name/SSN/DOB (Complete Section 1 or 2)

Previous Name _____ Previous DOB _____ Previous SSN _____

E. Cancel Coverage: ☐**I wish to cancel coverage: Event Date** _____ (Check a post-tax or pre-tax box below.)

My Premiums are Deducted: ☐Post-tax, Coverage may be cancelled at any time ☐Pre-tax (If pre-tax check a box below.)

☐ I am terminating employment.
☐ I am going on unpaid leave of absence.
☐ Cancel current family coverage to perform a spouse to spouse transfer.
☐ Eligible Section 125 Status Change* (see Instructions, Section 2(4))*.
Event:_____

☐ My employee premium contribution has increased significantly.*
☐ I (and all dependents if applicable) became eligible for and enrolled in other group coverage.*
☐ Annual It's Your Choice Enrollment (Jan. 1).

Note: If pre-tax, coverage may only be cancelled due to a qualifying event or during the annual It's Your Choice period.

F. 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, indicate event date, and update Section 1*):

☐ Pre-tax and my employee premium contribution has increased significantly
☐ Pre-tax and all dependents became eligible for and enrolled in other group coverage.*
☐ Pre-tax, change to single during annual It's Your Choice (Jan. 1).
☐ Post-tax, midyear changes to coverage level can be made at any time.

☐ Pre-tax and my last dependent has become ineligible for this coverage.
☐ Pre-tax, eligible Section 125 Status Change (see Instructions, Section 2(4))*. Event:_____

Event Date: _____

3. ADDITIONAL INFORMATION Are any of the dependents listed under Dependent Information your or your spouse/DP's grandchild?

☐No ☐Yes If yes, name of parent _____

4.MEDICARE INFORMATION/UPDATE MEDICARE INFORMATION

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

Name: _____ Dates: Part A_____ Part B _____ HIC #_____

Name: _____ Dates: Part A_____ Part B _____ HIC #_____

5. OTHER HEALTH INSURANCE COVERAGE/UPDATE OTHER HEALTH INSURANCE (If yes, complete requested information)

Other coverage? ☐No ☐Yes Name of Company_____ Policy #:_____ Group #:_____

Name(s) of Insured:_____

6. SIGNATURE (Read the **TERMS AND CONDITIONS** on page 7 and sign the application.)

By signing this application, I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and I have read and agree to the TERMS AND CONDITIONS. A copy of this application is to be considered as valid as the original. In addition, 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/yy)

7. EMPLOYER COMPLETES (Coding instructions are in the Employer Health Insurance Administration Manual)

Employer Number 69-036-	Name of Employer	Payroll Representative E-mail

Group Number	Employee Type	Coverage Type Code	Health Plan Name or Suffix

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ LTE **Employee Deductions:** ☐ Pre-tax ☐ Post-tax

Previous Service - Complete Information	Date WRS Eligible Employment or Graduate Assistant Appointment Began or Hire Date	Employer Received Date
1. Are you a WRS participating employer? ☐YES ☐NO *If Yes, answer questions 2, 3, and 4.* 2. Did employee participate under WRS prior to being hired by you? ☐Yes ☐ No 3. Previous service check completed? ☐Yes ☐ No 4. Source of previous service check: ☐ Online Network for Employers (ONE) ☐ ETF		
Payroll Representative Signature/Phone Number (_____)_____	Event Date	Prospective Date of Coverage

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 , misrepresentation or fail to provide complete or timely information on this application, I may face action, including, but not limited to, loss of coverage, employment action, and/or 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. I agree to respond to questions from health plans and ETF, including, but not limited to, audits, in a timely manner.
5. I have reviewed and understand the eligibility criteria for dependents under this coverage and affirm that all listed dependents are eligible. I understand that children may be covered through the end of the month they turn 26. 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 of my insured domestic partner 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 domestic partner’s 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 domestic partner’s 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, acknowledgement of paternity, 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, acknowledgement of paternity, 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.

Glossary

This glossary has many commonly used terms, but it is not a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See the Uniform Benefits policy in the It's Your Choice Reference Guide or for the other plans, see the Medicare Plus (ET-4113) and Standard Plan (ET-2112) benefit booklets at ***etf.wi.gov/publications/insurance.htm****.)*

To view the federal Uniform Glossary, see: ***etf.wi.gov/members/health-plan-summaries.htm****. If you need a hard copy mailed to you, contact ETF at 1-877-533-5020.*

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

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

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

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

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

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

Coinsurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20% for durable medical equipment) of the allowed amount for the service. For example, if the health insurance or plan's allowed amount for crutches is $100, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

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

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency Caesarean section are not complications of pregnancy.

Continuant: A subscriber enrolled under the federal COBRA or state continuation provisions following loss of eligibility for coverage in certain circumstances.

Copayment: A fixed amount (for example, $5 for Level 1 prescription drugs) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $500, your plan won't pay anything until you've met your $500 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

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

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

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

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services you get in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Glossary

ETF: The Department of 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.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Formulary: A list of covered prescription drugs. The Wisconsin Public Employers Group Health Insurance Program's formulary is available on Navitus Health Solutions' website at **https://navitus.com/Home-Pages/welcome.aspx.**

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.

Habilitation Services: Excluded health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Also referred to as custodial care.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

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.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance: The percent (for example, 10%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance under a PPO.

In-network Copayment: A fixed amount (for example, $15) you pay for covered health care services such as specialty formulary prescription drugs to the provider who contracts with your PBM. In-network copayments usually are less than out-of-network co-payments.

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

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

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

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 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 enrolled in Medicare.

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.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. In a PPO, you'll pay more to see a non-preferred provider.

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

Out-of-Network Coinsurance: In a PPO, the percent (for example, 30%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-Network Copayment: A fixed amount (for example, $50) you pay for covered health care services such as specialty formulary prescription drugs from the provider who does not contract with your PBM. Out-of-network copayments usually are more than in-network copayments.

Out-of-Pocket Limit (OOPL): The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your copayments, out-of-network payments or other expenses toward this limit.

Glossary

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.

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

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 who has a contract with your health insurer or plan to provide services to you at a discount.

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

PPO (Preferred Provider Organization): 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 PPO are WPS Metro Choice and WEA Trust PPO.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium: The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage: Pharmacy benefits administered by the PBM that help pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Preventive Services: Routine, preventive care is designed to help prevent disease or to diagnose it in the early stages. Find the list of federally required preventive services at **http://www.healthcare.gov/what-are-my-preventive-care-benefits/**. Federal requirements may vary by age.

Primary Care Physician/Provider: See PCP.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

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.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

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.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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: An arrangement under which the State of Wisconsin funds the payment of claims and fees for a hired third-party administrator (TPA). The TPA creates networks and pays claims per the benefit contract. The Standard, SMP, Medicare Plus plans and Navitus Health Solutions are self-funded.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Subscriber: An eligible employee, annuitant or continuant who enrolled for single or family coverage and whose dependents are also eligible for benefits.

Glossary

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

Uniform Benefits: The standardized level of benefits offered to Wisconsin Public Employers Group Health Insurance Program members through the HMOs and as the in-network benefit for PPOs, such as WEA Trust PPO and WPS Metro Choice.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Wisconsin Public Employers (WPE): 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 Wisconsin Public Employers 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) 843-6447
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 Insurance
1277 Deming Way
Madison, WI 53717
Tele: (800) 279-1301
Fax: (608) 827-4212
Dean On Call: (800) 576-8773
Website: deancare.com/wi-employees

Dean Health Insurance-Prevea360 Health Plan
P.O. Box 28467
Green Bay, WI 54324-0467
Tele: (877) 230-7555
Prevea Care After Hours: (888) 277-3832
Website: prevea360.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 Nurse Connect: (855) 661-7350
Website: ghcscw.com

Gundersen Health Plan
1900 South Avenue
LaCrosse, WI 54601
Tele: (800) 897-1923 (608) 775-8007
Fax: (608) 775-8042
Nurse Advisor: (800) 362-9567
ext. 54454
Website: www.gundersenhealthplan.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
LaCrosse, WI 54602-0188
Tele: (888) 459-3020 (608) 781-9692
Fax: (608) 781-4620
Nurseline: (855) 392-4050
Website: healthtradition.com

Humana
N19 W24133 Riverwood Drive #300
Waukesha, WI 53188
Tele: (855) 786-3944
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
580 N. Washington Street
P.O. Box 550
Janesville, WI 53547-0550
Tele: (800) 895-2421 (608) 752-3431
Fax: (608) 752-3751
Nurse Line: (888) 756-6060
Website: mercycarehealthplans.com

Navitus Health Solutions
P.O. Box 999
Appleton, WI 54912-0999
Tele: (866) 333-2757
Website: www.navitus.com

Navitus MedicareRx (PDP) (Prescription drug coverage for Medicare eligible retirees)
P.O. Box 1039
Appleton, WI 54912-1039
Tele: (866) 270-3877
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) 327-0325
NursePlus: (866) 775-8776
Website: pplus.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
Care24: (888) 887-4114
Website: welcometouhc.com/state

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

Stay Informed

Get free ETF E-mail Updates

Look for the red envelope at etf.wi.gov

Wisconsin Department
of Employee Trust Funds

801 W. Badger Road (visitor address)

PO Box 7931 (mailing address)
Madison, WI 53707-7931

1-877-533-5020 (toll free)
(608) 266-3285 (local to Madison)
Fax (608) 267-4549

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