Group Health Insurance Program for Members in the

Local Traditional Access Plan

- Employees
- Non-Medicare Retirees and
- COBRA Continuants

Schedule of Benefits

Effective January 1, 2024

The Schedule of Benefits explains what medical services the Group Health Insurance Program (GHIP) covers and what you pay for covered services. See your Uniform Benefits Certificate of Coverage (ET-2180) for complete coverage details. The Schedule of Benefits is divided into the following sections:

Annual Limits

In-Network and Out-of-Network Out-of-Pocket limits accumulate separately.

Annual Medical Deductible		
The amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all Out-of-Network covered items and services.		
	In-Network	**Out-of-Network**
Individual:	$0	$500
Family:	$0	$1,000 The family deductible is embedded – no one family member will contribute more than the individual amount to the family deductible. ✓ Applies to Out-of-Pocket Limit (OOPL) ✗ Does not apply to Prescription drugs

Annual Medical Coinsurance		
The percentage of costs for a covered service you pay after meeting your deductible.		
	In-Network	**Out-of-Network**
You pay:	0%	20%
Plan Pays:	100% Does not apply to: ✗ Durable Medical Equipment & Medical Supplies where you pay 20% coinsurance, up to $500 per person ✗ Prescription drugs	80% ✓ Applies to Out-of-Pocket Limit (OOPL) ✗ Does not apply to Prescription drugs

Annual Medical Out-of-Pocket Limit (OOPL)		
The most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.		
	In-Network	**Out-of-Network**
Individual:	$500 per person for Durable Medical Equipment & Medical Supplies	$2,000
Family:	(see above)	$4,000
This Plan uses a provider network. You pay less if you use the plan's provider network. Check your provider directory before you receive services.		
The OOPL is for Durable Medical Equipment & Medical Supplies only and applies per person enrolled in the plan.		The OOPL is embedded for family plans – no one family member will contribute more than the individual amount to the family OOPL.
Applies to: ✓ Maximum Out-of-Pocket Limit (MOOP) Does not apply to: × Prescription drugs		Does not apply to: × Prescription drugs

Annual Maximum Out-of-Pocket Limit (MOOP)		
This is the yearly amount set by the federal government as the most an Individual or Family is required to pay in cost sharing during the plan year for covered, in-network services.		
	In-Network	**Out-of-Network**
Individual:	$9,450	None
Family:	$18,900	
• The most you could pay for services you receive from in-network providers. Your out-of-pocket costs for services received from in-network providers will count toward this limit. • The MOOP is embedded for family plans – no one family member will contribute more than the individual amount to the family MOOP.		

Covered Services

Commonly used services appear below. This is not a complete list. If you have questions about other specific benefits, contact your health plan. Some services may be paid as In-Network as required by law. *See your Uniform Benefits Certificate of Coverage (ET-2180)*.

Ambulance	
Also known as paramedic services, these are emergency services that provide urgent pre-hospital treatment and stabilization for serious illness, injuries, and transport to definitive care.	
You pay:	$0

Chiropractic Care		
Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position). This also includes Occupational therapy (helping with daily living tasks caused from illnesses and injuries to your brain and body).		
	In-Network	**Out-of-Network**
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance
× Maintenance visits are not covered.		

Cochlear Implant Devices – Under Age 18

An electronic device that partially restores hearing. For coverage for participants over the age of 18, see Cochlear Implant Devices – Over Age 18 in the Additional Covered Services section.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance × Does not apply to OOPL

- Includes all charges related to implantation surgery and follow-up training sessions.

Diagnostic Services and Labs

Tests to figure out what your health problem is. Make sure to verify anticipated costs with your provider prior to receiving services. Note: some advanced imaging like MRI or CT scans may require prior authorization.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance

Covered diagnostic services include:

- ✓ Diagnostic radiology (x-rays, PET, MRI, MRA, and CT scans)
- ✓ Lab tests

Durable Medical Equipment and Medical Supplies

Equipment and supplies ordered by a health care provider for everyday or extended use.

	In-Network	Out-of-Network
You pay:	20% coinsurance, up to $500 per person	Out-of-Network Deductible, then Medical Coinsurance ✓ Applies to OOPL

- ✓ Includes Durable Diabetic Equipment and related supplies.

Does not apply to the following. See Additional Covered Services.

- × Adult hearing aids
- × Adult cochlear implant devices
- × Dental implants

Emergency and Urgent Care

Certain medical conditions require expedited medical care. You can work with your provider to determine the best level of care to meet your urgent or emergent needs.

Emergency Care

Care for a life-threatening illness, injury, or condition that requires immediate attention. You should seek care at an in-network Emergency Room whenever possible.

You pay:	$60 copayment per visit

- The copayment is waived if you are admitted as an inpatient or for observation for 24 hours or more.
- You may be responsible for other charges in addition to the visit copayment. See Durable Medical Equipment and Medical Supplies for more details on items that may be prescribed for you to take home.

Urgent Care Visit

Care for an illness, injury, or condition serious enough that it requires attention within 24 hours but is not life-threatening. You should seek care at an in-network Urgent Care whenever possible.

You pay:	$0

Hearing Aids – Under Age 18

Electronic amplifying devices designed to bring sound more effectively into the ear. For coverage for participants over the age of 18, see Hearing Aids – Over Age 18 in the Additional Covered Services section

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance × Does not apply to Annual OOPL

Home Care Benefits

Medically necessary nursing care, home health aide services, and other home care benefits provided by a medical professional at home as part of a care plan.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance

- Up to 50 visits per participant per calendar year
- Your plan may review your first 50 visits to verify progress is being made
- Up to a maximum of 50 additional visits per participant, per calendar year may be available with prior authorization from your health plan

Inpatient Hospital Services

Services necessary for your admission to a hospital, as well as diagnosis and treatment.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance

- Your health plan may require prior authorization for hospital and/or inpatient services.
- This includes inpatient hospitalization for medical and/or mental health needs.
- Your plan covers a semi-private room, ward, or intensive care unit, as well as any medically necessary miscellaneous hospital expenses, including prescription drugs given during confinement.
- Private rooms are only covered if medically necessary, as determined by your health plan.

Mental Health Counseling Visits

These services include behavioral health, psychiatric counseling, and substance use disorder services.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance

Applies to:

- ✓ Individual therapy office visits
- ✓ Outpatient groups
- ✓ Telehealth visits

Occupational, Physical, and Speech Therapy

Physical therapy (PT) involves treatments for the prevention and management of injuries or disabilities. PT helps to relieve pain, promote health, and restore function/movement. This includes Occupational therapy (OT), which helps with daily living tasks caused from illnesses and injuries to the brain and body; and Speech/Language therapy (ST), which helps to relearn how to communicate and swallow to prevent aspiration.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance

- Up to 50 visits per participant for all therapies combined per calendar year.
- Up to a maximum of 50 additional visits per therapy, per participant, per calendar year may be available with prior authorization from your health plan.

Applies to:

- ✓ Comprehensive outpatient rehabilitation facility visits
- ✓ Hospital outpatient department visits
- ✓ Independent therapist office visits

Outpatient Cardiac Rehabilitation

Rehabilitation following an inpatient hospital stay for a heart attack, bypass surgery, angina, heart valve surgery, angioplasty, or heart transplant.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance

Outpatient Hospital & Ambulatory Surgery Center Services

Services necessary for your admission to an outpatient hospital or Ambulatory Surgery Center, as well as diagnosis and treatment.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance
	• You may be prescribed DME and Medical Supplies to be taken home during an outpatient hospital facility visit, which could be billed separately and subject to coinsurance.	

Preventive Care Services

Routine health care, including screening, check-ups, and patient counseling to prevent or discover illness, disease, or other health problems – as required by federal law. Federal law specifies at what age and how frequently a service can be paid with no cost to you. See healthcare.gov/preventive-care-benefits for more details.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance

- Services for specific conditions found during a preventive exam may be subject to cost sharing.
- Your preventive check-up can be used to fulfill activities for the annual Well Wisconsin incentive program. See https://etf.wi.gov/well-wisconsin-members for more details.

The plan covers the following federally required preventive services including but not limited to:

- ✓ Alcohol misuse counseling
- ✓ Breast cancer screening (mammogram)
- ✓ Cholesterol screening
- ✓ Depression screening
- ✓ Diabetes screening
- ✓ HIV screening
- ✓ Immunizations, including flu, hepatitis A & B, pneumococcal and other shots
- ✓ Obesity screening and counseling
- ✓ Blood pressure screening
- ✓ Cervical cancer screening
- ✓ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- ✓ Hepatitis C screening
- ✓ Lung cancer screening
- ✓ Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
- ✓ Well child exam

Primary Care

Primary care includes preventive health care, treatment of illness and injuries, and the coordination of access to needed specialty providers or other services. Your primary care provider (PCP) or primary care clinic (PCC) will provide or arrange for most of your health care needs, including well check-ups, office visits, referrals, out-patient surgeries, hospitalizations, and health-related services.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance

- You must select a PCP or PCC at the time or enrollment or when you change health plans; your PCP may be a physician, physician assistant, nurse practitioner, or any other provider that manages your primary care services.
- If you do not choose a PCP or PCC, or your selection is no longer available, your health plan will assign a PCP or PCC for you.
- Contact your health plan directly to change your current PCP or PCC selection.

Skilled Nursing Facility

Admission to a licensed Skilled Nursing Facility for continued treatment after a hospital stay.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance

- × Up to 120 calendar days per benefit period

Telemedicine and Remote Care

Certain telehealth and remote care services are covered. These remote services should maintain the quality, safety, and effectiveness of an in-person visit. You should work with your provider to determine the best technology solution(s) to meet your care needs.

E-Visit

An evaluation and treatment by a provider using a patient portal, preferred or vended portal, email, or secure messaging which can include text, images, or videos. Services must address an issue that would typically require an office visit and be patient-initiated. An E-Visit is also called a digital visit or a virtual visit.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance

- Must be initiated by the member seeking services, not the provider, in order to be covered.
- E-Visits are covered when the same service would be covered if provided in person when performed by one of the following provider types:
  - Doctor
  - Nurse practitioner
  - Physician assistant
  - Licensed clinical social worker
  - Clinical psychologist or psychiatrist
  - Occupational therapist
  - Speech language pathologist

Telehealth

Telehealth is a service delivered via real-time audio and video. Telehealth may also be called telemedicine, online or virtual evaluation and management, or a video visit. Telehealth services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by a doctor or other health care provider who is located elsewhere using interactive two-way, real-time audio and video technology. Telehealth can be provided in your home, as well as at a health care facility.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance

- Telehealth will be covered by your health plan if those services are delivered:
  - Outside of your physical presence (e.g., remotely),
  - When both audio and video elements are present, and
  - When there is no reduction in the quality, safety, or effectiveness of the service.
- If you and your provider determine that you cannot successfully complete a Telehealth visit with full audio and video, you may opt to change to a Telephone Visit.

Telephone Visit

Telephone Visit is an evaluation and treatment by a provider using audio-only. Services must address an issue that would typically require an office visit and be patient-initiated.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance

- Telephone visits will be covered if the provider can successfully provide the service without a reduction in quality, safety, or effectiveness.

Remote Patient Monitoring

Remote Patient Monitoring is a series of services whereby a provider collects and interprets a person's physiologic data that is sent digitally to support treatment and management of medical conditions.

	In-Network	Out-of-Network
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance

- Device must meet home-use medical device as defined by the Food and Drug Administration and be provided as part of the monitoring service.
- Devices are provided as a lease; they cannot be lease-to-own, purchased to own, or already owned.

Virtual Check-In		
A brief discussion either by telephone or real-time audio and video between a provider and an established patient to manage a medical condition. These are services separate from and less intensive than Telehealth, Telephone Visits, or E-Visits.		
	In-Network	**Out-of-Network**
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance
• Covered as a Virtual Check-In as long as the check-in is not related to another medical visit within the past 7 days, and as long as the check-in does not lead to a medical visit within the next 24 hours or the next available appointment.		
Vision Services		
Yearly eye exam to diagnose and treat diseases and conditions of the eye. Does not include frames or any other vision related expenses. For supplemental vision coverage, including prescription glasses and contacts, see the Supplemental Vision Benefit.		
	In-Network	**Out-of-Network**
You pay:	$0	Out-of-Network Deductible, then Medical Coinsurance
• Coverage is limited to one eye exam per participant per calendar year • Non-routine eye exams are covered if considered medically necessary by your health plan		

Additional Covered Services

Cochlear Implant Devices – Over Age 18		
An electronic device that partially restores hearing. For coverage for participants under the age of 18, see Cochlear Implant Devices – Under Age 18 in the Covered Services section.		
	In-Network	**Out-of-Network**
You pay:	20% coinsurance for implant devices, professional surgery for implantation, and follow-up device training • Includes all charges related to professional surgical implantation and follow-up training sessions Applies to: ✓ Maximum Out-of-Pocket Limit (MOOP) Does not apply to: × Annual Out-of-Pocket Limit (OOPL)	Out-of-Network Deductible, then Medical Coinsurance Does not apply to: × Annual Out-of-Network OOPL

Dental Implants		
Dental implants are artificial tooth roots placed in the jaw to hold a replacement tooth or bridge after the loss of a tooth or teeth.		
	In-Network	**Out-of-Network**
You pay:	$0 Applies to: ✓ Maximum Out-of-Pocket Limit (MOOP) Does not apply to: × Annual Out-of-Pocket Limit (OOPL)	Out-of-Network Deductible, then Medical Coinsurance Does not apply to: × Annual Out-of-Network OOPL
× Dental implants are only covered following accident or injury. × Maximum benefit plan payment of $1,000 per tooth.		

Hearing Aids – Over Age 18		
Electronic amplifying devices designed to bring sound more effectively into the ear. For coverage for participants under the age of 18, see Hearing Aids – Under Age 18 in the Covered Services section.		
	In-Network	**Out-of-Network**
You pay:	20% coinsurance Applies to: ✓ Maximum Out-of-Pocket Limit (MOOP) Does not apply to: × Annual Out-of-Pocket Limit (OOPL)	Out-of-Network Deductible, then Medical Coinsurance Does not apply to: × Annual Out-of-Network OOPL
• One hearing aid per ear, no more than once every 3 years. • Maximum benefit plan payment of $1,000 per hearing aid.		

Temporomandibular Joint Disorders – Diagnosis and Non-Surgical Treatment		
Coverage for diagnostic procedures and medically necessary surgical or non-surgical for the correction of temporomandibular disorders, provided all coverage criteria are met.		
	In-Network	**Out-of-Network**
You pay:	$0 Applies to: ✓ Maximum Out-of-Pocket Limit (MOOP) Does not apply to: × Annual Out-of-Pocket Limit (OOPL)	Out-of-Network Deductible, then Medical Coinsurance Does not apply to: × Annual Out-of-Network OOPL
• Maximum benefit plan payment of $1,250 per participant per plan year		

Dental, Pharmacy, and Supplemental Plans

Dental Benefit
The Uniform and Preventive Dental Benefit provides coverage for basic procedures such as cleanings, fluoride treatments, fillings, and orthodontia. This benefit is offered through Delta Dental. Learn more at deltadentalwi.com/state-of-wi.
Uniform Dental Benefit
If your employer offers this benefit as part of your health insurance, you may enroll in the Uniform Dental Benefit (UDB). Premiums are included in your health insurance rates. If you have individual health insurance coverage, you will have individual UDB coverage. If you have family, you will have family.

Preventive Dental Benefit
If your employer offers this Delta Dental benefit you are solely responsible for premiums in this plan; your employer will not provide any contribution. You may select any level of coverage that is individual or family, regardless of your health insurance coverage (individual or family) or if you did not enroll in health insurance coverage.
If your employer offers these Delta Dental benefits, you can enhance your UDB or Preventive plan with supplemental dental. You can enroll in a supplemental dental benefit without enrolling in UDB or Preventive. You are solely responsible for premiums in this plan. Your employer will not provide any contribution. You may select any level of coverage, that is individual, individual plus spouse, individual plus child(ren) or family, regardless of your health insurance coverage (individual or family) or if you did not enroll in health insurance coverage. You may only enroll in either the Select Plan or Select Plus Plan, not both.
Select Plan
Covers dental services considered Major and Restorative Dental Services. Examples of this are crowns, bridges, dentures, and implants. This plan does not cover orthodontia services. Your employer must opt-in with Delta Dental in order for you to enroll in this benefit.
Select Plus Plan
In addition to coverage of dental services considered Major and Restorative Dental Services like crowns, bridges, dentures and implants, this plan also covers orthodontia services. Your employer must opt-in with Delta Dental in order for you to enroll in this benefit.
Uniform Pharmacy Benefit
Your coverage for most medications is provided by Navitus Health Solutions, a Pharmacy Benefit Manager (PBM). You must obtain pharmacy benefits at a participating Navitus pharmacy, except when not reasonably possible because of Emergency or Urgent Care. For full detail on services covered by the PBM, please see the Uniform Pharmacy Benefits Certificate of Coverage.
Supplemental Vision Benefit
The supplemental DeltaVision Plan provides coverage for eye exams, prescription glasses, contacts, and more. This benefit is offered through Delta Dental, in partnership with EyeMed Vision Care. Learn more at visiting deltadentalwi.com/state-of-wi-vision.
Accident Plan
Provides employees and their dependents with a cash payment to help cover out-of-pocket expenses regardless of any other insurance coverage. Your employer has to opt-in to offer this to you. This plan does not disqualify you for medical coverage. Learn more at Accident Plan.

Wellness and Chronic Condition Management

Uniform Wellness Benefits
The Uniform Wellness Benefit is available to Subscribers and Spouses. Services, provided by WebMD, include a health assessment, health screenings, flu vaccines, unlimited health coaching (weight management, nutrition, exercise, tobacco cessation, stress resiliency, sleep hygiene, alcohol use), digital well-being education, challenges, and learning modules. Participants can earn an annual incentive. For more details on services included in the program, please see the Well Wisconsin for Members webpage.
Uniform Chronic Condition Management Benefits
The Uniform Chronic Condition Management Benefit is available to Subscribers and Spouses. Services, provided by WebMD, include unlimited coaching for asthma, diabetes, chronic obstructive pulmonary disease, congestive heart failure, and coronary artery disease. A diabetes prevention program, and resources for chronic pain management are also available. For more details on services included in the program, please see the Well Wisconsin for Members webpage.