



It's Your Choice: 2011 Decision Guide

Group Health Insurance Plans

Participating Local Government
Employees and Annuitants



ET-2128d-11 (11/10)

Enrollment Period: October 4-29, 2010



STATE OF WISCONSIN
Department of Employee Trust Funds

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Fall 2010

Dear Members:

I am pleased to announce exciting changes for the 2011 It's Your Choice health insurance enrollment period. This fall, the Department of Employee Trust Funds (ETF) is unveiling our new online **myETF Benefits** system. **MyETF Benefits** allows our members to review and make changes to their health insurance enrollment information online. You can learn more about the system and how you can access your information on page 4 of this book, the *It's Your Choice: 2011 Decision Guide*. In the future, this feature will be enhanced to allow greater online access to other benefit information. You can learn about other exciting changes for 2011, such as the addition of a new health plan in eastern Wisconsin, in the *Important Changes* section of the book.

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

The *Choose Wisely* section of this book highlights important changes to your health benefits and health plans for 2011. The *Choose Your Health Plan* section provides information about premium rates, your benefits package and health plan options. The *Choose Quality* section provides the quality score of each health plan to help you compare how each plan ranks on care delivery and customer service. Finally, the *Glossary* section clarifies and explains common health care terminology.

This Decision Guide is paired with a reference booklet that contains more technical information, such as your *Certificate of Coverage*, and important state and federal notifications. Please keep the reference booklet for future use since we will only publish a new reference booklet during the years when there are major changes in health insurance law, coverage and plans.

Our mission at ETF is to provide high quality, affordable benefits for you and your family. We will continue to work with the Group Insurance Board to be a leader in improving the quality of our health care delivery system in a cost effective way.

Sincerely,

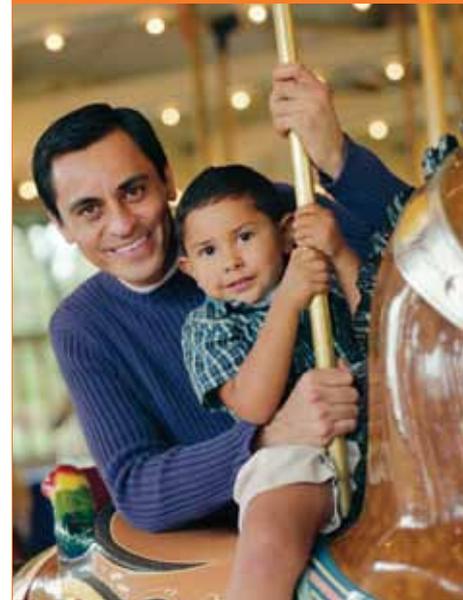
David A. Stella

Secretary, Department of Employee Trust Funds

Every effort has been made to ensure that the information in this booklet is accurate. In the event of conflicting information, state statute, state health contracts, and/or policies and provisions established by the State of Wisconsin Group Insurance Board shall be followed.

Table of Contents

Choose Wisely	3
Important Changes	4
Frequently Asked Questions	10
Choose Your Health Plan	21
Introduction to Health Plan Options	22
Health Plan Map	24
Health Plan Premium Rates.....	25
Local Health Plan Tiers.....	28
Comparison of Benefit Options	29
Health Plan Features - At A Glance.....	32
Health Plan Descriptions	36
Choose Quality	61
Health Plan Report Card	62
Grievances and Complaints Information	69
Other Quality Information Resources	72
Other Benefits and Information	73
Pharmacy Benefits	74
Life Insurance	76
Health Insurance Applications	79
Glossary	89
Health Plan Contact Information ... Inside Back Cover	



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Important Changes for 2011
Frequently Asked Questions



Important Changes

E-Health Insurance Application Submission

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

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

All changes must be entered on-line, submitted, faxed or postmarked no later than October 29, 2010.

Step 1

Home Page - Online Network for Members

Go to <http://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 below). Click on the "myETF Benefits" link to begin the login steps.

Step 2

myIdentity Verification (WAMS ID)

Type your WAMS ID and Password. Click "Login."

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

Step 3

myIdentity Verification (ETF Member ID)

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

Step 4

myIdentity Verification (Social Security Number)

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

After you are logged in, the myInfo page will appear which



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

Step 5 myETF Benefits – It’s Your Choice Change

To make your It’s Your Choice enrollment change, click the “Edit” button on the left toward the middle of the screen and complete the fields that appear. When complete, click the “Submit” button.

OR

Step 5 myETF Benefits - New Hire Enrollment

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

Step 6 myETF Benefits - Finale

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

Note: If you have questions, employees should contact your employer, annuitants/continuant should contact ETF at 1-877-533-5020.

Important Changes



EFFECTIVE JANUARY 1, 2011

The following plan and coverage changes take effect on January 1, 2011. If you have questions or concerns about any of these changes, contact your health plan using the information listed in the back of this booklet.

Types of Changes	Plan Name	Change
<p>New federal mandates are effective January 1, 2011.</p>	<p>All Plans</p> <p>For more information, see the <i>Frequently Asked Questions</i> section and the <i>It's Your Choice: Reference Guide</i> section, State And Federal Notifications.</p>	<p>Federal law:</p> <ul style="list-style-type: none"> • Eliminates health plan lifetime dollar maximum amounts. • Allows for an open enrollment period this October for your child who previously was not eligible for coverage up to the end of the month in which your child turns 26 (for example, if your child is married). • Requires coverage for certain preventive care services. • Eliminates preexisting condition waiting period for members who are late entrants and are younger than age 19. <p>See <i>Frequently Asked Question 12</i> in this book.</p>

Important Changes

Types of Changes	Plan Name	Change
Administrative rule/ contract change	All Plans	Annually, during the It's Your Choice Enrollment period, you may elect to enroll or drop coverage for your domestic partner, similar to your existing opportunity for adult dependents. See <i>Frequently Asked Questions 2</i> and <i>14</i> for more information.
New health plans	WEA Trust PPP	WEA Trust PPP is offered in 24 eastern Wisconsin counties.
Significant Health Plan Provider Network Changes	Some health plans have made significant changes by adding or terminating contracts with provider groups. Refer to the map on page 24 , and call the health plan for more details. For examples, see below:	
	Anthem Blue Northeast	Added Affinity providers in the Northeast.
	GHC of Eau Claire	Will no longer offer providers in the following counties: Buffalo, Clark, Jackson, Pierce, St. Croix and Trempealeau.
	Health Tradition Health Plan	Will no longer offer Luther Midelfort and Red Cedar providers. This impacts Barron, Chippewa, Dunn, Eau Claire, Pepin and St. Croix counties.
	Network Health Plan	Added Thedacare providers. This impacts Calumet, Outagamie, Shawano, Waupaca and Winnebago counties.

Important Changes

Types of Changes	Plan Name	Change
Significant Health Plan Provider Network Changes	Some health plans have made significant changes by adding or terminating contracts with provider groups. Refer to the map on page 24 , and call the health plan for more details. For examples, see below.	
	State Maintenance Plan (SMP)	<p>SMP will no longer be available in Crawford County. Subscribers using providers in this county must consider selecting another plan or will be limited to the SMP providers remaining in other areas.</p> <p>SMP will be newly available in Buffalo and Vilas counties.</p>
	UnitedHealthcare SE	Added providers in Dodge, Jefferson and Rock counties.
Health Plan Changes	Humana Eastern and Western	Medicare eligible members will be enrolled in Humana’s Medicare Advantage Preferred Provider Organization (MA-PPO) rather than the current Medicare Advantage Private-Fee-For-Service plan. See Frequently Asked Question 19 and the plan description pages for more information.

Important Changes

Types of Changes	Plan Name	Change
Changes to Dental Coverage	For more information, see the Health Plan Description pages in the <i>Choose Your Health Plan</i> section.	
	WEA Trust PPP	Newly offered benefits.
Other Information on ETF's website	All	The <i>It's Your Choice: Decision Guide</i> and <i>Reference Guide</i> are available at ef.wi.gov . Any known printing discrepancies will be clarified on this site. Additional information about insurance programs, including the complete Report Card on health plans, is available.
Online help	All	Are you unsure where to start with the <i>It's Your Choice: Decision Guide</i> and <i>Reference Guide</i> ? Review ETF's newest online tutorial, <i>It's Your Choice: Your Health Insurance Benefits for 2011</i> . The program explains how the books are organized, where to find specific information and highlights important factors to consider when choosing a health plan for 2011. Find it on ETF's Internet site under the Group Health Insurance menu, at ef.wi.gov
	Navitus Health Solutions	Also at http://ef.wi.gov , in ETF's Online Video Library, is a new pharmacy benefit presentation from Navitus. Find it in the Participant Catalog under <i>Other Benefits</i> .

Note: If you plan to stay with your current plan for next year and you are not changing your coverage, you do not need to take any action during the It's Your Choice Enrollment period.

Frequently Asked Questions

The “It’s Your Choice” enrollment period is the annual opportunity for our insured subscribers to select one of the many health plans offered by the Wisconsin Public Employers Group Health Insurance program. Today, eligible subscribers have more than 18 health plans to choose from. In previous years, we have referred to this enrollment opportunity by its more technical name, “Dual-Choice.” 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](#) section at the back of this booklet.

IT’S YOUR
CHOICE
ENROLLMENT
PERIOD

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

1. **Is the It’s Your Choice enrollment available to everyone?**

No, the It’s Your Choice enrollment period is offered only to subscribers presently insured under the Wisconsin Public Employers Group Health Insurance program.

2. **May I change from single to family coverage during the It’s Your Choice 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 14](#).

For information on changing from family to single coverage, see the [Frequently Asked Question](#) section of the It’s Your Choice: Reference Guide.

3. **How do I change health plans during the It’s Your Choice enrollment period?**

If you decide to change to a different plan, you are encouraged to make changes online using the my ETF Benefits website (see [Frequently Asked Questions 4](#) and [5](#)), or you may submit a paper application per the following instructions:

- Active employees may use the application in the back of this book, or receive blank applications from your benefits/payroll/personnel office to complete and return to that office.

Frequently Asked Questions

- Annuitants and continuants should complete the application in the back of this booklet 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.

4. How do I make changes to my benefits on the myETF Benefits website?

- a. Log onto myETF Benefits located at <http://myETF.wi.gov/ONM.html>. Review the quick and easy myETF Benefits instructions for how to log on and use the benefits web application.
- b. Obtain a WAMS (Wisconsin Web Access Management System) ID. Keep a record of your ID and password for the future.
- c. You will need your eight-digit ETF Member ID number, which can be obtained from your Navitus ID Card, your Wisconsin Retirement System Statement of Benefits or your employer.
- d. Click the "Health" Tab to view your health insurance coverage level.
- e. Edit your benefit selections for each plan by clicking the "Edit" button.
- f. Click "Submit" after making all applicable changes to your health insurance benefits.

Note: All changes will need to be verified by your benefits/payroll/personnel office (ETF for annuitants) prior to becoming effective.

- g. When you finish making your changes make sure you "Log Out" of the myETF Benefits to protect your personal information.
- h. Check your e-mail account (associated with WAMS ID) for confirmation of your changes.

Frequently Asked Questions

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

Your changes will not be stored unless you click on the "Submit" button. You will need to log back in, and make the changes again (see [Question 4 above](#)). To view what you submitted, click the "myRequests" button on the bottom of the "myInfo" page.

6. What is the effective date of changes made during the It's Your Choice enrollment period?

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

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

You may submit or make changes at any time during the It's Your Choice enrollment period, either online using the myETF Benefits website or by filing 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.

- Withdraw your application on myETF Benefits by clicking the button on the "Health" page; or
- active employees should inform your 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

8. How do I select a health plan?

You will want to do the following:

- Determine which plans have providers in your area by reviewing the [Health Plan map on page 24](#).
- Contact the health plans directly for information regarding available physicians, medical facilities and services.
- Review the Health Plan Report Card in the *Choose Quality* section in the book and at etf.wi.gov.

Frequently Asked Questions

- Review the [Plan Descriptions](#) in the *Choose Your Health Plan* section.
- Compare the premium rates and contributions beginning on [page 25](#).
- Compare the health plan features grid.

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

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



10. 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 routine care 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.
- If you are covered through a Preferred Provider Plan (PPP) such as WPS Metro Choice, WEA Trust PPP or the Standard Plan, you have the flexibility to seek care outside a particular service area. However, out-of-network care is subject to higher deductible and coinsurance amounts.
- Annuitants only: If you or your dependents are covered through the 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.

Frequently Asked Questions



11. 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.

NEW BENEFITS AND ELIGIBILITY CHANGES

12. What changes have been made to my health insurance, effective January 1, 2011, due to federal health care reform from the Patient Protection and Affordable Care Act (PPACA)?

- Lifetime dollar maximums have been eliminated. This includes \$2,000,000 for Uniform Benefits with a \$1,000,000 transplant maximum, and the \$250,000 major medical lifetime maximum for the Standard Plan and SMP.
- Certain children described in [Frequently Asked Question 13](#) are newly eligible dependents that can be added to your policy this October.
- Preexisting waiting periods on late entrants younger than age 19 no longer apply.
- Certain preventive care services are being newly included and will be paid in-network, without PPP deductible or coinsurance. However, some HMOs have been allowing these federally recommended services, so members may see no change in benefit payments.

13. What are the new Dependent Eligibility changes?

Effective January 1, 2011, the following children are newly eligible for coverage through the end of the month in which they turn 26 years old:

- Married children. His or her spouse and children are not eligible.
- Children who previously were not eligible because they were eligible for other employer group coverage, unless they are enrolled in other coverage.

For detailed information on which dependents are eligible, see the It's Your Choice: Reference Guide, *Frequently Asked Question* section on Dependent Eligibility.

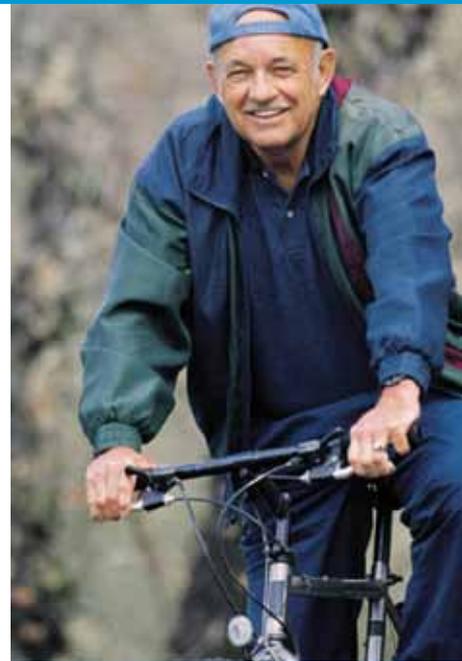
14. What are the tax implications for covering non-tax dependents?

Adult Children: The Patient Protection and Affordable Care Act (PPACA) eliminates federal tax liability for the Fair Market Value (FMV) of elected health coverage for an employee's dependent through the year in which they turn 26. This age standard replaces the lower age limits that applied under prior tax law, as well as requirements that a child generally qualify as a tax dependent. If an insured adult child turns 27 in any month of 2011, the FMV of health coverage provided for that child must be added as taxable income for the period of time that the dependent is covered in that year.

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

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

The FMV of the health insurance benefits will be calculated and added to an employee's earnings as imputed income (see [Question 15 for definition](#)). The monthly imputed



Frequently Asked Questions



income amounts vary by health plan and are provided for either one non-tax dependent, or two or more non-tax dependents. These dollar amounts will be adjusted annually and are available from your employer (affected annuitants may contact ETF). Employees who are unsure if a person can be claimed as a dependent should consult IRS Publication 501 or a tax advisor.

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

As more information becomes available, ETF will post it on its website and payroll/benefits/personnel offices will provide it to affected employees.

15. 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 (FMV) of the health care coverage

Frequently Asked Questions

extended to their dependents who do not qualify as dependents for tax purposes.

Note: See [Question 14](#) for the exception for health coverage for adult children younger than age 27.

16. If I do not change from single to family coverage during the It's Your Choice 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/continuant 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/continuant, 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 or on the date the acknowledgement of paternity is filed with the Department of Health Services (or equivalent, if the

THINGS TO
CONSIDER
DURING THE
IT'S YOUR
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ENROLLMENT
PERIOD

Frequently Asked Questions

birth was outside of the state of Wisconsin) or date of birth with a birth certificate listing the father's name. The effective date of coverage will be the 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 child(ren) who are not currently covered.

17. 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 elect single or family coverage, or if they are eligible only for family coverage through one of the spouses/domestic partners.

Note: For domestic partners, further information is available on our website at etf.wi.gov.

18. 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. For some, it 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.)

Active Employees and their dependents may wish to enroll in Medicare Part A when you first become eligible. However, the requirement to enroll for Medicare Part B coverage is deferred until the subscriber's termination of the WRS-covered employment through which active employee coverage is provided. Medicare Part D coverage is voluntary and enrollment can also be deferred without penalty, as with

Frequently Asked Questions

Part B, until the subscriber's termination.

Subscribers and their dependents with End Stage Renal Disease (ESRD) will want to contact your local Social Security office, health plan, provider, and Medicare to make sure you enroll in Medicare parts A and B at the appropriate time. The Wisconsin Public Employers group health insurance program will provide primary coverage during the 30-month coordination period for members with ESRD. You will want to decide if it would be beneficial to enroll in Medicare Part B during your initial or general enrollment opportunities to avoid delayed Medicare enrollment and potential premium penalties after your 30-month coordination period ends.

Retired Wisconsin public employers, employees (annuitants) and their dependents who are eligible for coverage under the federal Medicare program must immediately enroll in both Medicare parts A and B. If you do not enroll for all available portions of Medicare upon retirement, you may be liable for the portion of your claims that Medicare would have paid on the date Medicare coverage would have become effective. For pharmacy benefit coverage—if you are eligible for Medicare when you retire or obtain Medicare eligibility after retiring—you will be enrolled in the State's preferred Medicare Part D prescription drug plan (PDP). Your prescription drug coverage will no longer be managed by the state's PBM. It is important to provide ETF with a copy of your, and/or your dependents', Medicare card as soon as possible after receiving it. If you or your insured spouse or domestic partner is also insured as an active employee under a non-Wisconsin Public Employers group plan, however, enrollment in Medicare may be deferred until retirement from that job.

Important Caution: All health plans have coverage options that coordinate with Medicare, and you will remain covered by the plan you selected after you are enrolled in Medicare parts A and/or B.

For those annuitants enrolled in both Medicare parts A and B, the following exception applies:

- Members enrolled in the SMP Plan will be changed to the Standard Plan on the member's Medicare effective date.

Frequently Asked Questions

19. What changes were made to Humana's Medicare Advantage Plan for 2011?

Humana is replacing its Medicare Advantage Private Fee-For-Service (MA-PFFS) plan with a Medicare Advantage Preferred Provider Organization (MA-PPO) for members who have Medicare parts A and B as their primary coverage. Currently enrolled members will receive information in the mail from Humana regarding the change, including how to identify in-network providers. Contact Humana for further information.

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 \$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.

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

You should consider that each health plan has the right to determine whether or not a newly enrolled disabled dependent meets the (new) plan's definition of disabled dependent. (See the Dependent Information contained in the *Reference Guide* for full details.)

Choose Your Health Plan

Introduction to Health Plan Options

Health Plan Map

Health Plan Premium Rates

Comparison of Benefit Options

Health Plan Features At a Glance

Health Plan Descriptions



Introduction to Health Plan Options

As a participant in the Wisconsin Public Employers Group Health Insurance program, all the health plans listed in this booklet 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. 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 chose coverage through the Alternate Health Plans. These include 16 Health Maintenance Organizations (HMOs)* and two Preferred Provider Plans (PPP)**. These health plans all administer a “Uniform Benefits” package, meaning you will receive the same package of covered benefits and services, regardless of your health plan selection. *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 from these health plans, 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.

*An **HMO** is an entity that provides health care through a group of hospitals, physicians and other health professionals who contract or collectively agree to provide all medically necessary covered services to the HMO’s participants in return for a pre-paid fee. Each HMO offers service only in specific areas of the State.

All insured members of an HMO are expected to receive their health care only through physicians, health professionals and hospitals affiliated with that HMO. 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.

A **PPP allows you to see any provider of your choice, but there are differences in reimbursements depending on whether you go to an in-network or an out-of-network provider. If you receive services from an in-network provider, you will have lower out-of-pocket costs. If you choose an out-of-network provider, you will contribute more toward your health care costs. This arrangement can be attractive to our participants who are generally satisfied with the health plan’s providers, but who may occasionally need to use a particular specialist or need additional options while traveling. Currently, the only available Alternate Health Plans that offer a PPP are WPS Metro Choice and WEA Trust PPP.

Introduction to Health Plan Options

- **Dental Benefits (if offered):** The location and availability of dental benefits and providers differ for each plan.
- **Benefit Determinations:** While all plans cover the Uniform Benefits package, this does not mean that all health plans will treat all illnesses or injuries in an identical manner. Treatment will vary depending on the 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.

State Maintenance Plan (SMP)

The SMP is available only in counties that lack a qualified HMO. You can compare SMP to the Uniform Benefits package on pages [29 through 31](#).

The Standard Plan

The Standard Plan is 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 [29 through 31](#).

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 the SMP Plan will be moved to the Standard Plan on the member's Medicare effective date.
2. 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.

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

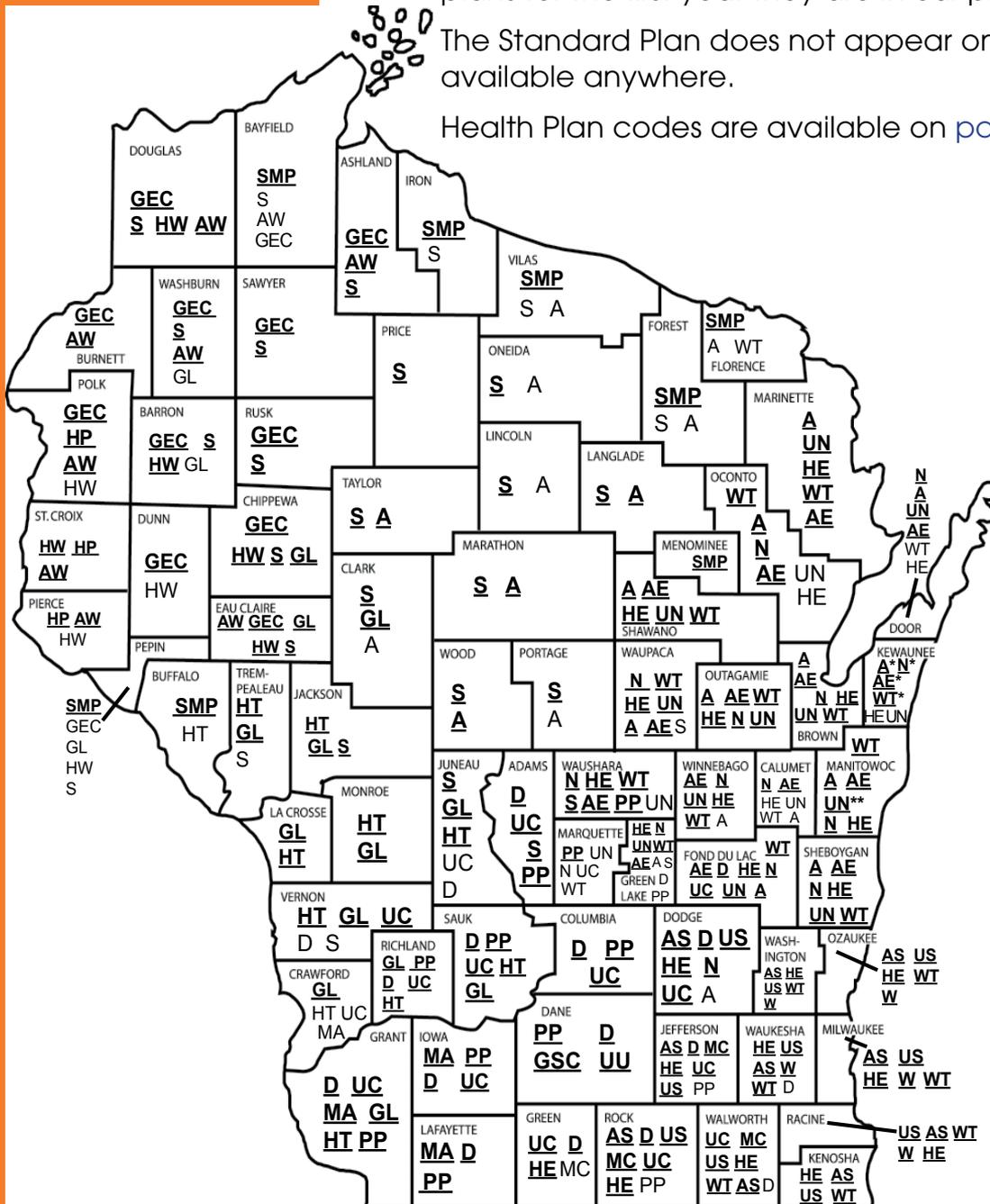
Health Plan Map 2011

This map shows which health plan is available in each county for 2011. *Qualified* plans are highlighted in underlined, bold text. If a plan is *non-qualified*, it has limited provider availability in that area.

Note: WEA Trust PPP cannot be used to set the employer contribution. This is a special provision applied to new plans for the first year they are in our program.

The Standard Plan does not appear on this map since it is available anywhere.

Health Plan codes are available on [page 26](#).



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

Health Plan 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 105% of the premium rate of the lowest cost 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 plan to one of three Tier categories, based its efficiency and quality of care. Your premium contribution is determined by the Tier ranking of your health plan. The 2011 [Health Plan Tiers appear on page 28](#).

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.

Local Government Employees and Annuitant Rates

2011 Traditional HMO Option - Classic Standard Plan

Plan Name	Plan code	Local Employees & Non-Medicare Annuitants*		Local Medicare Annuitants		
		Single	Family	Single	Medicare 1**	Medicare 2***
Anthem Blue Northeast	AE	930.70	2,322.90	635.80	1,563.90	1,269.00
Anthem Blue Northwest	AW	948.90	2,368.40	644.90	1,591.20	1,287.20
Anthem Blue Southeast	AS	1,101.10	2,748.90	721.00	1,819.50	1,439.40
Arise Health Plan	A	769.20	1,919.20	555.00	1,321.60	1,107.40
Dean Health Plan	D	538.20	1,341.70	434.10	969.70	865.60
GHC of Eau Claire	GEC	841.00	2,098.70	574.20	1,412.60	1,145.80
GHC of South Central Wisconsin	GSC	545.80	1,360.70	443.40	986.60	884.20
Gundersen Lutheran Health Plan	GL	810.20	2,021.70	507.10	1,314.70	1,011.60
HealthPartners	HP	864.90	2,158.40	582.20	1,444.50	1,161.80
Health Tradition Health Plan	HT	723.50	1,804.90	532.10	1,253.00	1,061.60
Humana Eastern	HE	1,114.10	2,781.40	432.70	1,544.20	862.80
Humana Western	HW	1,114.10	2,781.40	432.70	1,544.20	862.80
Medical Associates Health Plan	MA	597.90	1,490.90	396.40	991.70	790.20
MercyCare Health Plan	MC	512.10	1,276.40	426.50	936.00	850.40
Network Health Plan	N	649.90	1,620.90	495.40	1,142.70	988.20
Physicians Plus--Meriter & UW Health	PP	529.10	1,318.90	406.00	932.50	809.40
Security Health Plan	S	978.10	2,441.40	557.20	1,532.70	1,111.80
Standard Plan: Balance of State ¹	NA	1,071.90	2,675.80	382.60	1,454.40	762.50
Standard Plan: Dane ²	NA	993.30	2,479.40	382.60	1,375.90	762.50
Standard Plan: Milwaukee ³	NA	1,159.30	2,894.40	382.60	1,541.90	762.50
Standard Plan: Waukesha ⁴	NA	1,071.90	2,675.80	382.60	1,454.40	762.50
State Maintenance Plan	SMP	712.90	1,778.60	NA	NA	NA
UnitedHealthCare NE	UN	725.00	1,808.70	533.00	1,255.40	1,063.40
UnitedHealthCare SE	US	760.30	1,896.90	550.60	1,308.30	1,098.60
Unity Community	UC	514.00	1,281.20	405.90	917.30	809.20
Unity UW Health	UU	514.50	1,282.40	406.10	918.00	809.60
WEA Trust PPP	WT	769.50	1,919.90	555.20	1,322.10	1,107.80
WPS Metro Choice	W	1,043.20	2,604.20	692.10	1,732.70	1,381.60

Please refer to page 27 for footnoted information.

Local Premium Rate Notes

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 Medicare in order for the Medicare rates to apply. And Medicare premium rates apply only to subscribers who have terminated employment.



Footnotes from page 26:

NA = "not applicable". Medicare eligible participants automatically receive Standard Plan benefits.

*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, & D.

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

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.
2. DANE: Dane, Grant, Jefferson, La Crosse, Polk and St. Croix.
3. MILWAUKEE: Milwaukee County, and retirees and continuants living out of state.
4. WAUKESHA: Kenosha, Ozaukee, Racine, Washington and Waukesha.

Local Health Plan Tiers

2011 Health Plans by Tier for Local Employees
TIER 1
ANTHEM BLUE NORTHEAST
ANTHEM BLUE NORTHWEST
ANTHEM BLUE SOUTHEAST
ARISE HEALTH PLAN
DEAN HEALTH PLAN
GHC OF EAU CLAIRE
GHC OF SOUTH CENTRAL WISCONSIN
GUNDERSEN LUTHERAN HEALTH PLAN
HEALTHPARTNERS
HEALTH TRADITION HEALTH PLAN
HUMANA EASTERN
HUMANA WESTERN
MEDICAL ASSOCIATES HEALTH PLAN
MERCYCARE HEALTH PLAN
NETWORK HEALTH PLAN
PHYSICIANS PLUS - MERITER & UW HEALTH
SECURITY HEALTH PLAN
STATE MAINTENANCE PLAN (SMP)
UNITEDHEALTHCARE NE
UNITEDHEALTHCARE SE
UNITY COMMUNITY
UNITY UW HEALTH
WEA TRUST PPP
WPS METRO CHOICE
TIER 2
NO TIER 2 HEALTH PLANS
TIER 3
STANDARD PLAN

Comparison of Benefit Options

The chart on the following pages is designed to compare Uniform Benefits, the Standard Plan and the State Maintenance Plan (SMP).

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 Plans (ET-2131)*, and the *State Maintenance Plan (ET-2165)* benefit booklets.

All of the plans listed are substantially equivalent in the value of their benefits. However, there may be differences among the health plans in the administration of the benefits package. Health plans may have slight differences in benefits such as dental or wellness programs. Treatment may vary depending on patient needs, the physicians' preferred practices, and the health plan's managed care policies and procedures.



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 only major medical* Standard Plan and SMP services. Deductible does not apply to certain preventive services and prescription drugs.

² PPPs have out-of-network deductibles. See PPP Plan Descriptions for detail.

³ Coinsurance out-of-pocket maximum (OOPM) does not include deductible.

⁴ PPPs have out-of-network coinsurance. See PPP Plan Descriptions for details.

⁵ This is separate from other out-of-pocket maximums, such as the medical.

⁶ Level 3 co-pays don't apply to the OOPM.

Comparison of Benefit Options

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN	STATE MAINTENANCE PLAN (SMP)
Annual Deductible ¹	No deductible ² (or option of \$500 single/\$1000 family).	Major Medical* only Non-Medicare: \$250 single, \$500 family. Medicare: \$150 single, \$300 family.	Major Medical* only \$200 single, \$400 family.
Annual Co-insurance ³	As described below ⁴	Major Medical*, only 80%/20% to out-of-pocket maximum \$1,000 single/\$2,000 family.	Major Medical*, only 80%/20%, to out-of-pocket maximum \$1,000 single/\$2,000 family.
Hospital Days	As medically necessary, plan providers only.	100%, up to 365 per admission, then Major Medical*.	100%, up to 365 days per admission, then Major Medical*.
Emergency Room	\$60 copay per visit.	100%, no copay on Base** Major Medical* deductible/coinsurance, as applicable.	100%, no copay on Base** Major Medical* deductible/coinsurance, as applicable.
Ambulance	100%.	Plan pays first \$50 per trip, then applies Major Medical* deductible/coinsurance.	Plan pays first \$50 per trip, then applies Major Medical* deductible/coinsurance.
Transplants (may cover these and others listed)	<i>Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung.</i>	100% <i>Bone marrow, parathyroid, musculoskeletal, corneal, and kidney</i>	100% <i>Bone marrow, parathyroid, musculoskeletal, corneal, and kidney</i>
Mental Health/ Alcohol & Drug Abuse	Inpatient, Outpatient, and Transitional 100%.	Inpatient 100% 120 days; Outpatient and Transitional portions can be covered under base** and/or major medical* deductible/ coinsurance.	Inpatient, 100%, 120 days; Outpatient and Transitional portions can be covered under base** and/or major medical* deductible/ coinsurance.
Routine Physical	One per year.	Major Medical* deductible/ coinsurance applies to the office visit, except as required by federal law.	100%
Hearing Exam	100%	Benefit for illness or disease, Major Medical* deductible/ coinsurance applies.	100% Benefit for illness or disease.
Hearing Aid (per ear)	Every three years: Adults, 80%/20%, up to \$1,000; Dependents under 18, 100%, maximum does not apply.	For dependents younger than 18 years only, every three years- 100%-subject to major medical* deductible/ coinsurance.	For dependents younger than 18 years only, every three years-subject to major medical* deductible/ coinsurance.

Comparison of Benefit Options

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN	STATE MAINTENANCE PLAN (SMP)
Cochlear Implants	Adults 80%/20% for device, surgery, follow-up sessions; 100% hospital charge for surgery. Dependents younger than 18 years, 100%.	Dependents younger than 18 years, portions can be covered under base** and/or major medical* deductible/ coinsurance.	Dependents younger than 18 years, portions can be covered under base** &/or major medical* deductible/ coinsurance.
Routine Vision Exam	One per year.	No Benefit for routine. Illness or disease only, Major Medical* deductible/coinsurance applies.	Preventative up to age 18, 100% one per year. Age 18 and older, illness or disease only, 100%.
Skilled Nursing Facility (non custodial care)	120 days per benefit period.	100%, up to a max of 120 days per confinement, less hospital days used.	100%, up to a max of 120 days per admission, less hospital days used.
Home Health (non custodial)	50 visits per year. Plan may add 50 visits.	100%, up to 365 days less hospital days used	100%, up to 365 days, less hospital days used.
Physical/Speech /Occupational Therapy	50 visits per year; Plan may prior authorize an additional 50 visits.	Major Medical* deductible/ coinsurance, no limit on visits or days.	Major Medical* deductible/ coinsurance, no limit on visits or days.
Durable Medical Equipment	20% co-insurance, \$500 OOP maximum.	Major Medical* deductible/coinsurance	Major Medical* deductible/coinsurance
Referrals	In network varies by plan. Out of network required.	Not required.	In network none required. Out of network required.
Primary Care Provider/Clinic	Varies by plan.	Not required.	Any provider in network.
Surgical Treatment for Morbid Obesity	Excluded.	100% Base** benefits, Major Medical* services to deductible/coinsurance.	Excluded.
Oral Surgery	11 procedures.	23 procedures. 100%.	23 procedures. 100%.
Dental Care	Varies by plan.	No benefit.	Preventative up to age 12, 100%.
Drug Copays and out-of-pocket maximum OOPM ⁵	Level 1=\$5; 2=\$15; 3=\$35 ⁶ . OOPM \$410 individual / \$820 family.	Level 1=\$5; 2=\$15; 3=\$35 ⁶ . No limit.	Level 1=\$5; 2=\$15; 3=\$35 ⁶ . No limit.

Superscripts 1 through 6 are explained on page 29.

*Common Major Medical services comprise durable medical equipment, physical/speech/occupational therapy, medical services and supplies, cardiac rehabilitation, and total extraction and replacement of teeth.

**Base benefits are hospital inpatient services and most professional services such as surgery and anesthesia. Note that professional services have an aggregate maximum payment of \$10,000 per participant per illness or injury. Professional charges after \$10,000 may be payable under major medical services.

Health Plan Features - At a Glance



Evaluate Your Health Plan Features and Take Charge of Your Health

On the surface, you may think that there is not much difference among the available health plan options. However, benefits and services can vary from plan to plan. The chart on the following pages was developed to assist you in comparing the health plans on key benefits and services.

Dental Benefits

The Uniform Benefits package does not include coverage for routine dental care, but the health plans have the option to offer dental coverage to members. The comparison chart highlights the plans that have elected to provide some level of dental coverage. Members who place a high value on dental services should refer to the additional information in the Plan Descriptions that appear later in this section, or contact the health plan directly if you have specific questions regarding dental coverage or dental provider availability.

Quality

Each year, participating health plans are evaluated based on care delivery in areas such as wellness and prevention, disease management, and consumer satisfaction. The chart lists how the various health plans rated on overall quality and how many of our members would recommend their plan to family and friends. We encourage you to also look at the more comprehensive quality ratings in the [Choose Quality](#) section of this book.

Health and Wellness Plan Services

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.

Selecting a Primary Care Physician (PCP) or clinic location is required by some health plans.

Health Risk Assessments (HRA) are a great tool to help you assess your health history and lifestyle choices in order to identify certain characteristics that may, over time, develop into diseases such as cancer, diabetes, heart disease and osteoporosis. Once you have completed your questionnaire,

Health Plan Features - At a Glance



the health plan will provide you with personalized information to help you take charge of your health.

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

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.

Online Services

If you have Internet access, some health plans offer online information and services on their websites. Some areas of the website may require members to enroll to gain access using a specified login identification and password. The chart lists some of the services various plans offer, such as searchable provider directories and access to your medical information.

Health Plan Features – At a Glance

Stars: ★ 1-4, 1 being lowest

• Indicates a “Yes” response. This means the Health Plan either offers the service or has a requirement that applies.	Quality Information			Dental Benefits			
	Overall Quality Score	Plan to Family or Friends Recommend % Would	Accreditation NQQA	Deductible Applies Co-pay/	Orthodontic Benefits	Annual Benefit Maximum per Member	Dental ID Card Required Separate
Anthem BCBS**	★	89%	●	No dental coverage available.			
Arise Health Plan	★★★	96%	●	●	●	●	●
Dean Health Plan	★★	95%	●	No dental coverage available.			
GHC of Eau Claire	★★★	98%		No dental coverage available.			
GHC of South Central Wisconsin	★★★★★	97%	●		●		
Gundersen Lutheran Health Plan	★★★★★	97%		●		●	
HealthPartners	Not Available		●	No dental coverage available.			
Health Tradition Health Plan	★★★	97%				●	
Humana Eastern	★	94%	●	●	●		●
Humana Western	★	77%	●	●	●		●
Medical Associates	★★★★★	96%	●	●	●	●	
MercyCare	★★	90%	●	No dental coverage available.			
Network Health Plan	★★★	96%	●	●	●	●	●
Physicians Plus--Meriter & UW Health	★★★	96%		No dental coverage available.			
Security Health Plan	★★★	98%	●	No dental coverage available.			
UnitedHealthCare NE	★★	93%	●	●	●	●	●
UnitedHealthCare SE	★★	91%	●	●	●	●	●
Unity Community	★★★	94%	●	No dental coverage available.			
Unity UW Health	★★★	97%	●	No dental coverage available.			
WEA TRUST PPP	Not available				●	●	
WPS Metro Choice	Not available	85%		No dental coverage available.			

**Anthem Blue Northeast, Anthem Blue Northwest and Anthem Blue Southeast were combined into Anthem BCBS for the purpose of calculating the composite scores.

Health Plan Features - At a Glance

Health Plan Services				Online Services			
Primary Care Physician or Clinic Required	Health Risk Assessments (HRA)	Wellness Classes and Education	24-hour Nurseline	Searchable Provider Directory	Member Service Message Center Available	Review and View Appointments	Review Preventive Test Results and/or e-Health Records
	•		•	•	•		
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				•	•		

Health Plans

Anthem Blue Preferred Northeast Network

(800) 553-5240 from Oct. 1 to 31, 2010

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

www.anthem.com



Overall Quality Rating

See Report Card section

What's New for 2011

Affinity Health System has joined the Anthem Blue Cross and Blue Shield network. Members in Wisconsin have access to care from the award-winning health system at in-network rates and benefit levels. With the addition of Affinity, Anthem now offers one of the broadest networks of doctors, hospitals and specialists in the Fox Valley. The agreement adds more than 200 Affinity Medical Group physicians and comprehensive services at St. Elizabeth Hospital, Mercy Medical Center, Calumet Medical Center, and 22 clinics to Anthem's provider network.

Provider Directory

Go to www.anthem.com/shared/wi/f4/s1/t0/pw_ad093378.pdf. To search for a provider, go to www.anthem.com and enter the site by selecting *Wisconsin*. Click *Find a Doctor*, select *Wisconsin* and click *Next*. Under the "Plan Information" pull down menu, select *Blue Preferred HMO Northeast - State of Wisconsin*. Or call Anthem Customer Service to request a paper copy of the directory. Coming later in 2010, the way you search for provider's may change as the member website is being updated.

Referrals and Prior Authorizations

You do not need a referral from your primary care physician (PCP) to see any Northeast Network specialists. You need a written referral from your PCP and authorization from Anthem to obtain services from a specialist who is not participating in the Northeast Network. Certain health care procedures require pre-authorization as initiated by your PCP or specialist. Pre-certification is required for non-emergency hospital stays. Contact Anthem for more information. Anthem will provide a written response to requests to both you and your PCP.

Care Outside Service Area

Emergency Care: Go to the nearest health care facility for treatment, and contact your primary care physician (PCP) and Anthem within 24 hours or as soon as reasonably possible.

Urgent Care: Call your primary care physician (PCP) for advice about appropriate treatment.

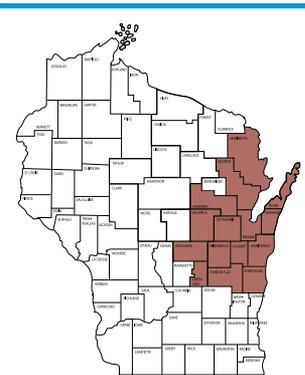
All Other Care: You must receive prior authorization from Anthem for all other care outside the Northeast Network as explained above.

Mental and Behavioral Health Services

You do not need a referral to see a Northeast Network mental health provider. Precertification is required for inpatient care.

Dental Benefits

No routine dental coverage provided.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Anthem Blue Preferred Northwest Network

(800) 553-5240 from Oct. 1 to 31, 2010

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

www.anthem.com



Overall Quality Rating

See Report Card section

What's New for 2011

We're helping to improve our members' health with innovative tools and resources. And when you are looking for a trusted resource for health and wellness information, you can go to MyHealth@Anthem at anthem.com to check your health status, learn what you can do to improve it, calculate your body mass index, find the most up-to-date information on health topics and treatments, take advantage of discounts and special offers, and call the AudioHealth Library to hear confidential, educational recordings that cover nearly 500 health topics in both English and Spanish.

Provider Directory

Go to www.anthem.com/shared/noapplication/f4/s2/t0/pw_ad088213.pdf.

To search for a provider, go to www.anthem.com and enter the site by selecting *Wisconsin*. Click *Find a Doctor*, select *Wisconsin* and click *Next*. Under the "Plan Information" pull down menu, select *Blue Preferred HMO Northwest - State of Wisconsin*. Or call Anthem Customer Service to request a paper copy of the directory. Coming later in 2010, the way you search for provider's may change as the member website is being updated.

Referrals and Prior Authorizations

You do not need a referral from your primary care physician (PCP) to see any of the Northwest Network specialists. You need a written referral from your PCP and authorization from Anthem to obtain services from a specialist who is not participating in the Northwest Network. Certain health care procedures require pre-authorization as initiated by your PCP or specialist. Pre-certification is required for non-emergency hospital stays. Contact Anthem for more information. Anthem will provide a written response to requests to both you and your PCP.

Care Outside Service Area

Emergency Care: Go to the nearest health care facility for treatment, and contact your primary care physician (PCP) and Anthem within 24 hours or as soon as reasonably possible.

Urgent Care: Call your primary care physician (PCP) for advice about appropriate treatment.

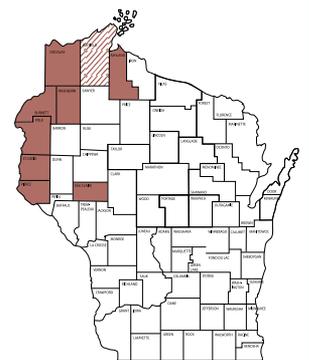
All Other Care: You must receive prior authorization from Anthem for all other care outside the Northwest Network as explained above.

Mental and Behavioral Health Services

You do not need a referral to see a Northwest Network mental health provider. Precertification is required for inpatient care.

Dental Benefits

No routine dental coverage provided.



■ Qualified Plan

▨ Non-Qualified Plan

See Glossary for definitions

Health Plans

Anthem Blue Preferred Southeast Network

(800) 553-5240 from Oct. 1 to 31, 2010

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

www.anthem.com



What's New for 2011

We're helping to improve our members' health with innovative tools and resources. And when you are looking for a trusted resource for health and wellness information, you can go to MyHealth@Anthem at anthem.com to check your health status, learn what you can do to improve it, calculate your body mass index, find the most up-to-date information on health topics and treatments, take advantage of discounts and special offers and call the AudioHealth Library to hear confidential, educational recordings that cover nearly 500 health topics in both English and Spanish.

Provider Directory

Go to www.anthem.com/shared/noapplication/f4/s2/t0/pw_ad088214.pdf.

To search for a provider, go to www.anthem.com and enter the site by selecting *Wisconsin*. Click *Find a Doctor*, select *Wisconsin* and click *Next*. Under the "Plan Information" pull down menu, select *Blue Preferred HMO Southeast – State of Wisconsin*. Or call Anthem Customer Service to request a paper copy of the directory. Coming later in 2010 the way you search for provider's may change as the member website is being updated.

Referrals and Prior Authorizations

You do not need a referral from your primary care physician (PCP) to see any of the Southeast Network specialists. You need a written referral from your PCP and authorization from Anthem to obtain services from a specialist who is not participating in the Southeast Network. Certain health care procedures require pre-authorization as initiated by your PCP or specialist. Pre-certification is required for non-emergency hospital stays. Contact Anthem for more information. Anthem will provide a written response to requests to both you and your PCP.

Care Outside Service Area

Emergency Care: Go to the nearest health care facility for treatment, and contact your primary care physician (PCP) and Anthem within 24 hours or as soon as reasonably possible.

Urgent Care: Call your primary care physician (PCP) for advice about appropriate treatment.

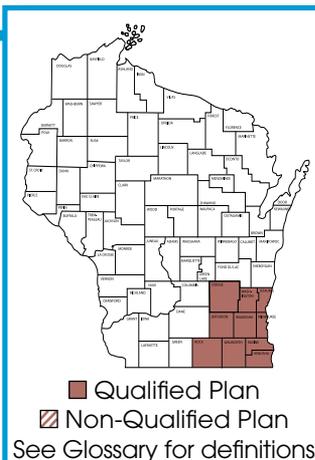
All Other Care: You must receive prior authorization from Anthem for all other care outside the Southeast Network as explained above.

Mental and Behavioral Health Services

You do not need a referral to see a Southeast Network mental health provider. Precertification is required for inpatient care.

Dental Benefits

No routine dental coverage provided.



Arise Health Plan

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

www.WeCareForWisconsin.com



Overall Quality Rating
See Report Card section

What's New for 2011

Arise Health Plan's provider network has been enhanced to include more providers in our service areas. These providers can be viewed at our newly designed website, www.WeCareForWisconsin.com.

Provider Directory

Go to www.WeCareForWisconsin.com, select *Members* and then **Find A Doc**. 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 1-888-711-1444 to request a directory.

Referrals and Prior Authorizations

No written referrals are required when receiving necessary care from participating providers. Pre-service authorization is required for all non-participating providers and tertiary care specialists. We will send written notification of approval or denial to you and your provider requesting the pre-service authorization. Please refer to your Arise handbook (*When Do I need a Pre-Service Authorization?*).

Care Outside Service Area

Emergency care is covered. If you are admitted to the hospital, you must notify us within 48 hours. If you are out of area and need urgent care, go to the nearest appropriate facility, unless you can safely return to the service area to receive care from a participating provider. For follow-up care, contact your PCP for instructions. Please refer to your Arise handbook (*Emergency, Urgent, Out Of Area Care*).

Mental and Behavioral Health Services

Participating providers must be used for all mental health, alcohol and other drug abuse (AODA) services. Pre-service authorization is required for inpatient services and transitional care; however, it is not required for outpatient care.

Dental Benefits *(This is a brief summary. Contact plan for details.)*

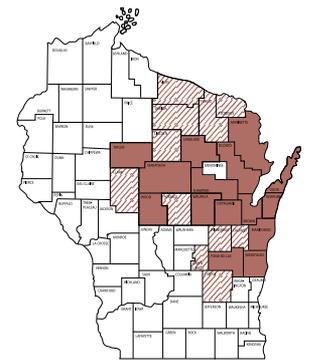
Preventive Services: Covered at 100%: Exams, cleanings, fluoride treatments, X-rays, space maintainers. Limited to six-month intervals. Full mouth X-rays.

Restorative Services: Covered at 80%, subject to deductible (\$25 individual / \$75 family): Sealants (up to age 14, one per tooth per lifetime), fillings and emergency treatment to relieve pain.

Annual Benefit Maximum: Individual maximum is \$1,000.

Orthodontics: 50% for eligible dependent children, up to a lifetime maximum of \$1,500.

Dental Network: Go to www.deltadentalwi.com. Select Premier or PPO as your dental plan. Call 1-800-236-3712 with questions.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Plans

Dean Health Plan, Inc.

(800) 279-1301

deancare.com



Overall Quality Rating

See Report Card section

What's New for 2011

Tobacco Cessation Help from Dean Health Plan – The Quit For Life® Program. See deancare.com/quitforlife for complete details.

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 paper copy.

Referrals and Prior Authorizations

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

Care Outside Service Area

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

Mental and Behavioral Health Services

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

Dental Benefits

No routine 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 2011

Group Health Cooperative (GHC) of Eau Claire will no longer have providers in the following counties: Buffalo, Clark, Jackson, Pierce, St. Croix and Trempealeau. In the remaining counties, GHC has added more medical and chiropractic providers.

Provider Directory

Go to group-health.com/docs/GHCStateProviderDirectory.pdf. For any questions regarding the GHC provider network, please contact a Member Services Advocate at (888) 203-7770.

Referrals and Prior Authorizations

Referrals are not required for in-network providers. Prior to receiving care from an out-of-network provider, you must get a referral event authorization. Event authorization is required for all admissions, selected outpatient services and all out-of-network care. **For certain procedures, members will be required to participate in a patient decision aid program to review information on options, outcomes and to clarify personal values.** GHC will send written notification to you and the ordering physician of approval or denial of the event authorization request. For further information regarding Authorization Guidelines, please contact a Member Services Advocate at (888) 203-7770.

Care Outside Service Area

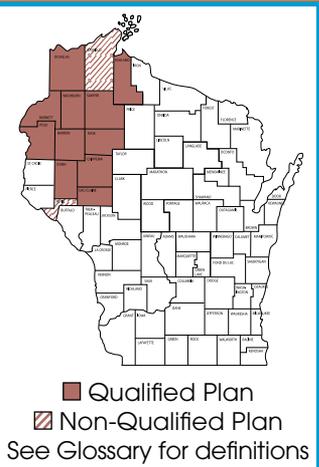
Emergency and urgent care do not require a referral. The FirstCare Nurseline, listed on your ID card, can help you determine the appropriate level of care. GHC has the right to review for medical necessity. Follow up care must be received by an in-network provider.

Mental and Behavioral Health Services

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

Dental Benefits

No routine dental coverage provided.





What's New for 2011

- Learn about our pediatric medical home program at ghcscw.com.
- Check out our new Complementary Medicine classes and services including Zumba, Integrative Counseling and Naturopathy.

Provider Directory

Visit https://ghcscw.com/page_flip_prod/Default.htm. To search for providers and to view their professional qualifications, go to ghcscw.com and click on *Find a Provider*. Members may request a Provider Directory by contacting GHC-SCW Member Services at (800) 605-4327.

Referrals and Prior Authorizations

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

Care Outside Service Area

Call us at (800) 605-4327, ext. 4504 within 48 hours after receiving emergency or urgent care outside the GHC-SCW network. All other care requires a referral as described above. This phone number is also located on the member ID card.

Mental and Behavioral Health Services

When you need mental health services, contact a GHC-SCW staff outpatient mental health provider directly. Please refer to the GHC-SCW Provider Directory. A referral is *not* required for services provided in a GHC-SCW Clinic. A referral *is* needed for transitional and/or inpatient care.

Dental Benefits *(This is a brief summary. See plan for details.)*

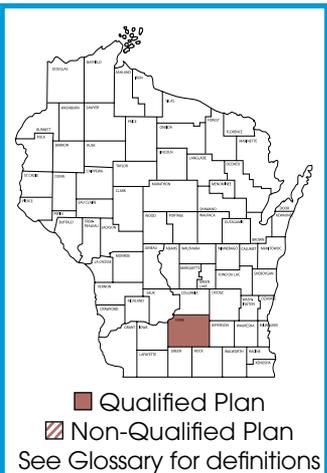
Preventive Services: Covered at 100%: Exams, X-rays, cleanings, every six months.

Restorative Services: Covered at 100%: Amalgam fillings, composite fillings for anterior teeth, stainless steel crowns for primary teeth and simple and surgical extractions.

Annual Benefit Maximum: None

Orthodontics: 50% of the first \$3,500 in billed charges for dependent children through age 18.

Dental Network: All dental services must be obtained from Dental Health Associates in Madison.



Gundersen Lutheran Health Plan

(800) 897-1923 or (608)775-8007

www.glhealthplan.org



Overall Quality Rating
See Report Card section

What's New for 2011

There are no significant changes to the 2011 Gundersen Lutheran Health Plan (GLHP) offering.

Provider Directory

To view or print a copy of the provider directory, go to www.glhealthplan.org. Under the "Find a Doctor" tab, select *Provider Directory - State of Wisconsin Employees*. To view or print a hard copy of the Provider Directory, click on *2011 Provider Directory*. To access a current searchable directory, click *Online Directory*. Under the Network tab, select "Gundersen Lutheran Health Plan Employer Group." Select the fields that you would like to include in your search criteria. You may also call Customer Service at 800-897-1923 to request a Provider Directory.



Referrals and Prior Authorizations

A member may seek services from any GLHP network provider without a referral. If your GLHP provider feels that you require specialty care outside of the network, he/she will complete a referral request form and submit it to GLHP for review. Selected medical procedures and services covered by GLHP require prior authorization. Your provider should submit a written prior authorization request to GLHP for review. GLHP will respond in writing to you and your provider after reviewing the referral or prior authorization request.

Care Outside Service Area

In the case of an emergency or urgent medical condition, you should seek care from the nearest provider equipped to handle your condition. You must receive urgent care from a plan provider if you are in the plan service area, unless it is not reasonably possible. Please notify GLHP within 24 hours if admitted to a hospital. All other care must be with a plan provider, unless GLHP has approved a referral as described above.

Mental and Behavioral Health Services

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

Dental Benefits *(This is a brief summary. See plan for details.)*

Preventive Services: Covered at 100%: Exams, prophylaxis, fluoride (to age 18), sealants (to age 18) and X-rays, two per year.

Restorative Services: Covered at 80%: Bridgework, implants, dentures, crowns and root canals.

Annual Benefit Maximum: \$500 per person per calendar year.

Orthodontics: None

Dental Network: You can go to any dental provider and the services are not subject to a Usual and Customary fee schedule.

Health Plans

HealthPartners Health Plan

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

www.healthpartners.com/stateofwis

Not Available
Overall Quality Rating
See Report Card section

What's New for 2011

HealthPartners has a new look to our website. Our online tools make it easy to find health information and resources, learn how to save money on your care and get tips on living a healthier life with our new Virtual Coaching. Members can also register to view claims, explanation of benefits and other personal health information. This year we released a new mobile application to access your Member ID card on your smart phone. Our network has made some change to specialty behavioral health and chiropractic providers.

Provider Directory

Go to www.healthpartners.com/stateofwis and click on the search for providers link. Click on the PDF listing or search our online directory for providers. (For help registering, please call our Web support team at 1-877-726-0203.) Call 1-800-883-2177 to request a directory or for assistance in finding a provider.

Referrals and Prior Authorizations

No referrals are necessary to see in-network providers. Certain services will require a prior authorization. Call Member Services at (800) 883-2177 for more information or see complete listing at www.healthpartners.com/stateofwis. Your doctor will request the authorization and HealthPartners will notify you in writing of the coverage decision.

Care Outside Service Area

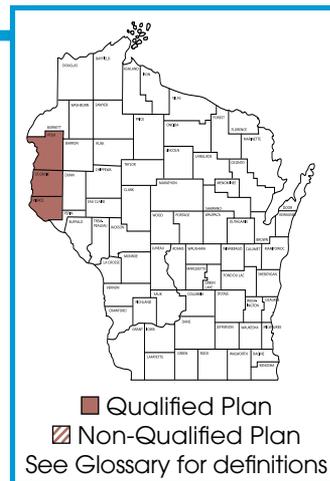
Members are covered for emergency and urgently needed care outside of the HealthPartners plan service area when medically necessary. Call 1-800-316-9807 within 48 hours if an admission occurs.

Mental and Behavioral Health Services

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

Dental Benefits

No routine dental coverage provided.



Health Tradition Health Plan

(877) 832-1823 or (888) 459-3020

www.healthtradition.com



Overall Quality Rating
See Report Card section

What's New for 2011

Health Tradition Health Plan (HTHP) will no longer be available in the following counties: Barron, Chippewa, Dunn, Eau Claire and Pepin. Subscribers using providers in these counties, which includes any of the providers within the Luther Midelfort and Red Cedar systems, must consider selecting another plan or will be limited to the HTHP providers remaining in other areas.

Provider Directory

Go to www.healthtradition.com. Under "Quick Links" select *Choosing a Provider*. Scroll down to "State of Wisconsin Members" and select the directory. You can also contact us at (888) 459-3020 to request one.

Referrals and Prior Authorizations

You can see any provider in the HTHP network (primary care or specialist) without a referral. You must get a referral approved by HTHP before you see providers outside the HTHP network (including Mayo Clinic). 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 our website or call us at (877) 832-1823.

Care Outside Service Area

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

Mental and Behavioral Health Services

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

Dental Benefits *(This is a brief summary. Contact plan for details.)*

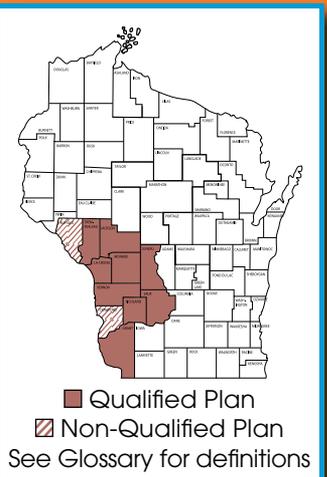
Preventive Services: Covered at 100% up to annual benefit maximum: exams, cleanings, fluoride treatments, X-rays and sealants.

Restorative Services: Covered at 80%, up to annual benefit maximum: services such as fillings, bridges, crowns and root canals.

Annual Benefit Maximum: \$500 per person per year on all services.

Orthodontics: None

Dental Network: You can see any dentist. Benefits subject to Usual and Customary charges unless you use the Health Tradition Preferred Dental Network. See instructions above to view the dental directory.



Health Plans

Humana – Eastern

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

www.humana.com



What's New for 2011

Members on Medicare: In 2011, Humana's Medicare Advantage plan will be a Preferred Provider Organization (PPO) with a network. See details below.

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

Provider Directory

Go to <http://apps.humana.com/egroups/Wisconsin/home.asp>. Or go to www.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 1-800-4humana to request an HMO directory. HMO Premier is a national network, but you **must** select a Wisconsin based PCP, regardless of your address. Providers outside of Wisconsin may require a referral in addition to those required by Humana. Referrals are not required in the Medicare PPO plan.

How Humana is Unique for Members on Medicare

If you are retired and enrolled in Medicare parts A and B, Humana will automatically enroll you in a Humana Medicare Advantage PPO plan. You will still have the Uniform Benefits coverage, plus more. You have flexibility to see virtually any provider in the country, but will pay 10% coinsurance, up to an annual \$500 out-of-pocket maximum when seeing providers out of the network. For enrollment questions or to request an enrollment kit with area PPO directory, call Humana Group Medicare Enrollment at 1-866-396-8810.

Referrals and Prior Authorizations

Referrals are required to see some network providers and all providers outside the HMO Premier network. Prior authorizations are required for certain services. See your Humana handbook. Your PCP must contact Humana at 1-800-626-2698 to make the request. Verify the status of the request by logging on to your MyHumana Web page or calling 1-800-4humana.

Care Outside Service Area

Call Humana at 1-888-555-1234 within 48 hours after receiving emergency or urgent care outside our network.

Mental and Behavioral Health Services

Before seeking any mental or behavioral health services, call 1-800-4humana between 8:00 a.m. and 5:30 p.m., and follow the prompts. A behavioral health specialist will assist you.

Dental Benefits *(This is a brief summary. Contact plan for details.)*

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

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

Annual Benefit Maximum: None

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

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



Humana – Western

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

www.humana.com



Overall Quality Rating
See Report Card section

What's New for 2011

Members on Medicare: In 2011, Humana's Medicare Advantage plan will be a Preferred Provider Organization (PPO) with a network. See details below.

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

Provider Directory

Go to <http://apps.humana.com/egroups/Wisconsin/home.asp>. Or go to www.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 1-800-4humana to request an HMO directory. HMO Premier is a national network, but you **must** select a Wisconsin based PCP, regardless of your address. Providers outside of Wisconsin may require a referral in addition to those required by Humana. Referrals are not required in the Medicare PPO plan.

How Humana is Unique for Members on Medicare

If you are retired and enrolled in Medicare parts A and B, Humana will automatically enroll you in a Humana Medicare Advantage PPO plan. You will still have the Uniform Benefits coverage, plus more. You have flexibility to see virtually any provider in the country, but will pay 10% coinsurance, up to an annual \$500 out-of-pocket maximum when seeing providers out of the network. For enrollment questions or to request an enrollment kit with area PPO directory, call Humana Group Medicare Enrollment at 1-866-396-8810.

Referrals and Prior Authorizations

Referrals are required to see some network providers and all providers outside the HMO Premier network. Prior authorizations are required for certain services. See your Humana handbook. Your PCP must contact Humana at 1-800-626-2698 to make the request. Verify the status of the request by logging on to your MyHumana Web page or calling 1-800-4humana.

Care Outside Service Area

Call Humana at 1-888-555-1234 within 48 hours after receiving emergency or urgent care outside our network.

Mental and Behavioral Health Services

Before seeking any mental or behavioral health services, call 1-800-4humana between 8:00 a.m. and 5:30 p.m., and follow the prompts. A behavioral health specialist will assist you.

Dental Benefits *(This is a brief summary. Contact plan for details.)*

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

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

Annual Benefit Maximum: None

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

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



Medical Associates Health Plans

1 (800) 747-8900

www.mahealthcare.com



Overall Quality Rating
See Report Card section

What's New for 2011

Medical Associates Health Plans is pleased to announce the addition of the University of Wisconsin Hospital and Clinics as a Preferred Tertiary Referral Facility for MAHP enrollees. To arrange care at either of our Preferred Tertiary Referral Facilities, UW or University of Iowa Hospitals and Clinics, please contact our Health Care Services Dept. at 1-800-325-7442. You may continue to see any primary care doctor and/or specialist within the Medical Associates Health Plan (MAHP) network without a referral. You may continue to see the dental provider of your choice.

Provider Directory

Go to www.mahealthcare.com/OnlineDirectories/EmpGroup.aspx or visit MAHP's website at www.mahealthcare.com to view an online provider directory. Call MAHP at 800-747-8900 to request a directory.

Referrals and Prior Authorization

Members do not need to obtain referrals to get care within the MAHP network. However, members must obtain written authorization from the MAHP Medical Director prior to receiving services from a provider outside of the MAHP network. If services cannot be provided by a physician within the MAHP network, your physician will initiate the request for prior authorization. MAHP will review the request and respond in writing to you and your physician. Call MAHP to confirm the status of your authorization request before receiving services.

Care Outside Service Area

If you need urgent or emergent care when you are outside of the MAHP service area, contact MAHP Health Care Services at 800-325-7442 (number shown on the back of your MAHP ID card) prior to receiving care or as soon as reasonably possible. Present your MAHP ID card to the facility for proper billing. All other care should be obtained from a MAHP participating physician or provider unless it is prior authorized as explained above.

Mental and Behavioral Health Services

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

Dental Benefits *(This is a brief summary. Contact plan for details.)*

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

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

Annual Benefit Maximum: \$1,000 per member

Orthodontics: 50% coverage, up to \$1,500 lifetime maximum (up to age 19).

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



MercyCare Health Plans

800-895-2421

www.mercycarehealthplans.com



Overall Quality Rating
See *Report Card* section

What's New for 2011

Our new web portal not only allows members to access claims and communicate with customer service, but they can also establish their own personal health record to include such information as immunizations and physician visits.

Provider Directory

Go to www.mercycarehealthplans.com. Under "For Members," click on *State of Wisconsin Members* and click on the link to the provider directory in blue area on right. To search for a provider, from our home page click on *Find a Provider* and select *State of Wisconsin Employees*. You may search by provider type or facility type. Contact Customer Service at 800-895-2421 to request a paper copy.

Referrals and Prior Authorizations

You have open access to providers and specialists in MercyCare's network. If the care is not available in our network, your PCP must request a prior authorization from MercyCare. MercyCare will notify you in writing if authorization is approved or denied. Prior authorization is also required for specific services. If you have questions, contact Customer Service at 800-895-2421.

Care Outside Service Area

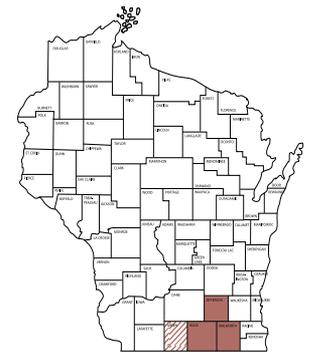
If you require emergency care, you should seek care from the nearest physician, hospital or clinic. Contact Customer Service at 800-895-2421 for all emergency or out-of-state inpatient admissions within 48 hours or as soon as reasonably possible.

Mental and Behavioral Health Services

Mental health and substance abuse services must be provided by a provider in MercyCare's network. Outpatient visits do not require prior authorization. Patient and transitional care require prior authorization. Contact Customer Service at 800-895-2421 with any questions.

Dental Benefits

No routine dental coverage provided.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Plans

Network Health Plan

(800) 826-0940

www.networkhealth.com



Overall Quality Rating
See Report Card section

What's New for 2011

Network Health Plan (NHP) has added the THEDACARE, INC. providers in Calumet, Outagamie, Shawano, Waupaca and Winnebago counties.

Provider Directory

Go to <http://www.networkhealth.com/page/network-members-doctors>. Then scroll down and click on *State of Wisconsin Fox Valley Network Provider Director*. Or call 1-800-826-0940 to request a copy.

Referrals and Prior Authorizations

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

Care Outside Service Area

Emergency and urgent care outside the service area is covered when medically necessary. Call us at 1-800-236-0208 within 48 hours of going to an emergency room or a non-participating hospital. All other care, including follow-up care, must be obtained from participating providers unless it is authorized by NHP as explained above.

Mental and Behavioral Health Services

Prior authorization is required for all behavioral health services. For assistance, please contact NHP's Care Management Behavioral Health Department at 1-800-555-3616. After hours, call your provider or *NurseDirect* at 1-800-362-9900.

Dental Benefits (*This is a brief summary. Contact plan for details.*)

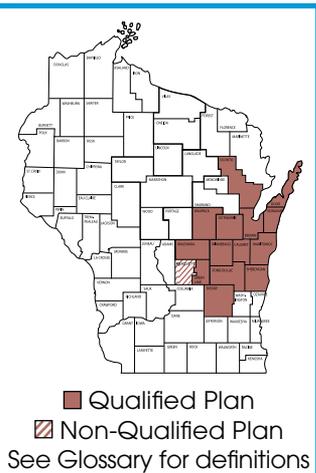
Preventive Services: Covered at 100%: exams, cleanings, fluoride treatments, x-rays, and space maintainers.

Restorative Services: Covered at 80%, subject to deductible: sealants, emergency treatment to relieve pain, and fillings.

Annual Benefit Max: \$1,000/ind Deductible: \$25 ind/\$75 fam

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

Dental Network: Go to www.deltadentalwi.com and choose Delta Dental Premier or Delta Dental PPO as your Dental Plan. Or call Delta Dental at 1-800-236-3712.



Physicians Plus – Meriter & UW Health

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

www.pplusic.com



Overall Quality Rating
See Report Card section

What's New for 2011

Meriter's new Pediatric Center, located in Meriter Hospital at 202 S. Park Street, provides 24/7 medical care for children with emergencies, as well as patients requiring observation and hospitalization.

Physicians Plus encourages members (18 or older) to complete a personalized Succeed health risk assessment (HRA) and lifestyle improvement/coaching sessions through our GO-TO Healthy Choices program to improve overall health and well-being.

Provider Directory

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

Referrals and Prior Authorizations

Written referrals are not required to visit most network specialty care providers. Before receiving care from non-network providers, members must have their primary care physician submit a referral to Physicians Plus. Prior authorizations are required for certain services; consult the member handbook. Your doctor must submit the request, and we will notify you in writing of our decision on all requests.

Care Outside Service Area

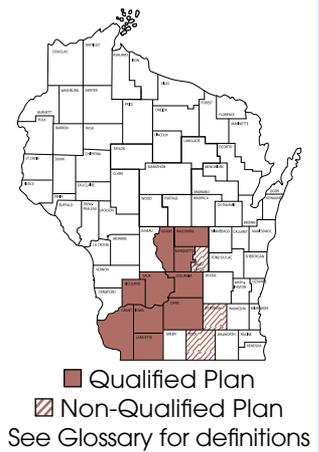
Emergency and urgent care outside the service area is covered when medically necessary. Call Physicians Plus at (800) 545-5015 within 72 hours after receiving emergency or urgent care outside our network. All other care, including follow-up care, should be obtained from network providers unless approved by Physicians Plus, as described above.

Mental and Behavioral Health Services

Contact UWMF Behavioral Health Consultation System at (608) 282-8960 or (800) 683-2300 for prior authorization Monday through Friday, 8:00 a.m. to 5:00 p.m. For emergencies, please contact your therapist. If you do not currently have a therapist, call a Physicians Plus participating emergency room. A mental health professional will assess your situation and refer you to the appropriate provider.

Dental Benefits

No routine dental coverage provided.



Health Plans

Security Health Plan

(800) 472-2363 or (715) 221-9555

www.securityhealth.org/state



Overall Quality Rating
See *Report Card* section

What's New for 2011

Security Health Plan's Tobacco Free Program connects members with trained health coaches who will help them develop a personalized plan and provide support to quit tobacco use--at no additional charge.

Provider Directory

Visit www.securityhealth.org/state and click on *Provider Directory*. For a printed copy, contact Customer Service at 1-800-472-2363.

Referrals and Prior Authorizations

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

Prior authorizations: Required for certain services. See our Member Handbook or call Customer Service for more information. You or your doctor must submit the request; Security Health Plan will notify you in writing of our decision.

Care Outside Service Area

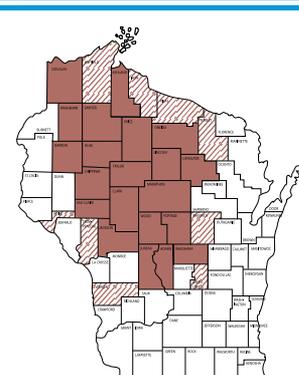
For emergency and urgent care outside of the network, you must notify Security Health Plan by the next business day or as soon as possible to ensure appropriate claim payment. All other care provided by providers outside of the network will not be covered unless a referral has been approved by Security Health Plan, as explained above.

Mental and Behavioral Health Services

You may see any provider in the network for mental/behavioral health care. You do not need a referral or authorization.

Dental Benefits

No routine dental coverage provided.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Standard Plan

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

Not Available
Overall Quality Rating
See Report Card section

What's New for 2011

Visit the Health Center at www.wpsic.com/healthcenter, an online resource designed to help you make good health decisions, whether you're looking for advice on treating a chronic condition or for tips on leading a healthy lifestyle.

General Information

The Standard Plan is a 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 starting on page 29 for more information and view the Health Care Benefit Plan booklet for more complete details at <http://etf.wi.gov/publications/et2131.pdf>

Provider Directory

You may see any provider, but if you see providers from the participating directory, they will accept WPS's fee schedule and not balance bill you for Usual Customary & Reasonable (UCR) disputed charges. Go to www.wpsic.com/state/pdf/dir2011_par.pdf to search for a provider or contact WPS member services to request a copy.

Referrals and Prior Authorizations

Referrals are not needed.

WPS recommends that members or providers request prior authorization for services when you are concerned if they will be payable and at what cost. Without an approved prior authorization, WPS may deny payment. Please visit www.wpsic.com/state and follow the *Member Materials* link to obtain a copy of a Medical Preauthorization Request Form or 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 Benefits

No dental coverage provided.

Health Plans

SMP - State Maintenance Plan

Administered by WPS Health Insurance
(800) 634.6448 www.wpsic.com/state

Not Available
Overall Quality Rating
See Report Card section

What's New for 2011

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

SMP will be newly available in Buffalo and Vilas counties.

General Information

The SMP program provides maximum health care coverage over a broad range of benefits in a managed care environment. See the Comparison of Benefit Options section starting on page 29 for more information and view the Health Care Benefit Plan booklet for more complete details at <http://efw.wi.gov/publications/et2165.pdf>.

Provider Directory

Please visit www.wpsic.com/state/pdf/dir2011_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.

WPS recommends that members or providers request prior authorization for services when you are concerned if they will be payable and at what cost. Without an approved prior authorization, WPS may deny payment. Please visit www.wpsic.com/state and follow the Member Materials link to obtain a copy of a Medical Preauthorization Request Form or call Member Services.

Mental and Behavioral Health Services

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

Dental Benefits

Members younger than age 12 are eligible to receive preventive care limited to routine exam, prophylaxis and topical fluoride, but not more than once in any 180 consecutive day period.



UnitedHealthcare of Wisconsin Northeast

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

www.myuhc.com



Overall Quality Rating
See Report Card section

What's New for 2011

There are no significant network changes for 2011.

Provider Directory

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

Referrals and Prior Authorizations

You do not need a referral to see a physician/hospital in the network. If a specific covered health service is not available from a network physician/hospital, your network physician must notify UnitedHealthcare (UHC) Care Coordination to request a "Network Gap Exception". In addition, you are responsible for notifying UHC's Care Coordination before obtaining services for dental/oral surgery or within 24 hours (or as soon as possible) of an emergency admission to a non-network hospital. You and your physician will be notified in writing of UHC's decision and coverage determination.

Care Outside Service Area

For emergency or urgent care, please contact UHC's customer service at 800-357-0974 as soon as possible. Care other than emergency or urgent care is not covered outside of the service area. Follow-up care will need to be completed back in the service area (see map above).

Mental and Behavioral Health Services

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

Dental Benefits (This is a brief summary. Contact plan for details.)

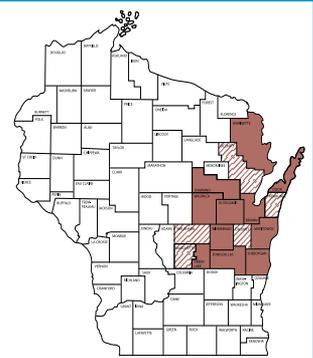
Preventive Services: Covered at 100%: exams two times per calendar year, bitewing X-rays, cleanings, fluoride treatments and sealants, complete series or panorex X-rays.

Restorative Services: Covered at 50% after deductible (\$50 per individual / \$100 per family, per calendar year): amalgam and composite resin restorations, general anesthesia and space retainers. No coverage for major restorative services.

Annual Benefit Maximum: \$1,000 per person per calendar year.

Orthodontics: Covered at 50% for dependents younger than age 19; up to an individual ortho lifetime maximum of \$1,200.

Dental Network: Open dental network to allow members to go to a dentist of their choice. Charges are payable up to UHC's maximum allowable fee schedule.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Plans

UnitedHealthcare of Wisconsin Southeast

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

www.myuhc.com



Overall Quality Rating
See Report Card section

What's New for 2011

We have added three additional counties to our Southeast service area: Dodge, Jefferson and Rock counties.

Provider Directory

Go to www.myuhc.com/groups/state and click on *Find Physicians & Facilities* and then click on *Wisconsin Southeast*. To request a directory, call customer service at 800-357-0974 and request directory #FWOAH20WI-606.

Referrals and Prior Authorizations

You do not need a referral to see a physician/hospital in the network. If a specific covered health service is not available from a network physician/hospital, your network physician must notify UnitedHealthcare (UHC) Care Coordination to request a "Network Gap Exception." In addition, you are responsible for notifying UHC's Care Coordination before obtaining services for dental/oral surgery or within 24 hours (or as soon as possible) of an emergency admission to a non-network hospital. You and your physician will be notified in writing of UHC's decision and coverage determination.

Care Outside Service Area

For emergency or urgent care, please contact UHC's customer service at 800-357-0974 as soon as possible. Care other than emergency or urgent care is not covered outside of the service area. Follow-up care will need to be completed back in the service area (see map above).

Mental and Behavioral Health Services

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

Dental Benefits (This is a brief summary. Contact plan for details.)

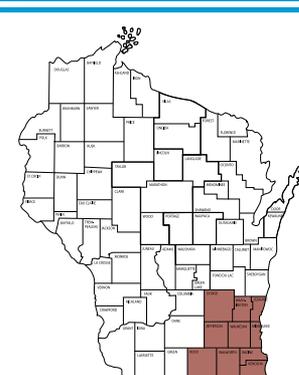
Preventive Services: Covered at 100%: exams two times per calendar year, bitewing X-rays, cleanings, fluoride treatments and sealants, complete series or panorex X-rays.

Restorative Services: Covered at 50% after deductible (\$50 per individual / \$100 per family, per calendar year): amalgam and composite resin restorations, general anesthesia and space retainers. No coverage for major restorative services.

Annual Benefit Maximum: \$1,000 per person per calendar year.

Orthodontics: Covered at 50% for dependents younger than age 19; up to an individual ortho lifetime maximum of \$1,200.

Dental Network: Open dental network to allow members to go to a dentist of their choice. Charges are payable up to UHC's maximum allowable fee schedule.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Unity Health Insurance-Community

(800) 362-3310

chooseunityhealth.com



Overall Quality Rating

See *Report Card* section

What's New for 2011

Unity is making some enhancements and changes to its wellness programs. To learn about Fitness First & More, visit chooseunityhealth.com and click *Health and Wellness* and then *Rewards*.

Provider Directory

Go to chooseunityhealth.com and click *Find A Doctor*. Here you will find links to the 2011 Community Directory (PDF) and the Community Network provider search function. Or call 800-548-6489 to request a copy of the Community Provider Directory.

Referrals and Prior Authorizations

Written referral requests are required to see providers outside of the Community Network. Prior authorizations are required for certain services. See the Community Network Provider Directory for more information. Your doctor must submit the request and we will notify you in writing of our decision.

Care Outside Service Area

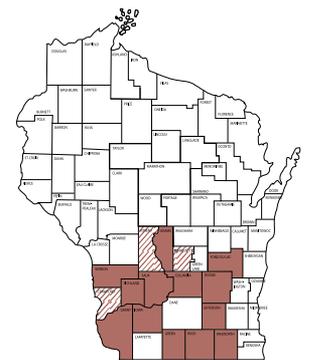
Call us at 800-362-3310 within three (3) business days after receiving emergency or urgent care services from a non-participating provider. All other care from non-participating providers requires a written referral request as described above.

Mental and Behavioral Health Services

Before getting services, you must call UW Behavioral Health at 800-683-2300. Assistance is available 24 hours a day.

Dental Benefits

No routine dental coverage provided.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Plans

Unity Health Insurance – UW Health

(800) 362-3310

chooseunityhealth.com



Overall Quality Rating
See Report Card section

What's New for 2011

Unity is making some enhancements and changes to its wellness programs. To learn about Fitness First & More, visit chooseunityhealth.com and click *Health and Wellness* and then *Rewards*.

Provider Directory

Go to chooseunityhealth.com and click *Find A Doctor*. Here you will find links to the 2011 UW Health Directory (PDF) and the UW Health Network provider search function. Or call 800-548-6489 to request a copy of the UW Health Provider Directory.

Referrals and Prior Authorizations

Written referral requests are required to see providers outside of the UW Health Network. Prior Authorizations are required for certain services. See the UW Health Network Provider Directory for more information. Your doctor must submit the request and we will notify you in writing of our decision.

Care Outside Service Area

Call us at 800-362-3310 within three (3) business days after receiving emergency or urgent care services from a non-participating provider. All other care from non-participating providers requires a written referral request as described above.

Mental and Behavioral Health Services

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

Dental Benefits

No routine dental coverage provided.



WEA Trust PPP

(800) 279.4000 or (608) 276.4000

www.weatrust.com/state

Not Available
Overall Quality Rating
See *Report Card* section

What's New for 2011

The WEA Trust PPP is a new option for state and local government employees in eastern Wisconsin. For 40 years, the Trust has provided a top-rated health plan and superior customer service to Wisconsin public school employees. The WEA Trust PPP offers more than 24,000 providers, meaning if you switch to our plan, you likely won't have to switch doctors.

Provider Directory

You can search for a doctor or print from a PDF directory by going to www.weatrust.com/state and click the *Find a Doctor* link under Health Plan. You may also call Customer Service at (800) 279-4000 for assistance.

How WEA Trust PPP is Unique

The WEA Trust PPP is a preferred provider plan with access to providers throughout Wisconsin and nationwide—a broader alternative to HMOs that limit choices. In rare cases where you need to see a non-network provider, we'll still pay for covered services, subject to a deductible of \$1,000 individual/\$2,000 family and then payable at 70%. (Also see Care Outside Service Area section below.)

Referrals and Prior Authorizations

Referrals are not necessary. Some services require prior authorization. See a complete listing at www.weatrust.com/state or call Customer Service at (800) 279-4000.

Care Outside Service Area

We have a statewide and national network outside the WEA Trust PPP service area (see map above for service area). To receive in-network benefits outside the PPP service area, call Customer Service at (800) 279-4000 before your appointment to find a network provider. For emergency and urgent care, use network providers wherever possible.

Mental and Behavioral Health Services

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

Dental Benefits *(This is a brief summary. Contact plan for details.)*

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

Restorative Services: Covered at 80%: Fillings, extractions and periodontal services. Covered at 50%: Crowns and onlays.

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

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

Dental network: Go to www.weatrust.com/state and under Dental Plan, click *Find a Dentist* or call Customer Service at (800) 279-4000. You may see any dentist but reimbursement for non-network providers is limited by our reasonable and customary fee schedule.



Health Plans

WPS Metro Choice

(800) 634-6448

www.wpsic.com/state

Not Available
Overall Quality Rating
See Report Card section

What's New for 2011

Visit the Health Center at www.wpsic.com/healthcenter, an online resource designed to help you make good health decisions, whether you're looking for advice on treating a chronic condition, or for tips on leading a healthy lifestyle.

Provider Directory

Go to www.wpsic.com/state/pdf/dir2011_metro_choice.pdf to search for a provider, or contact WPS member services at 1-800-634-6448 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 below 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

Members may also request prior authorization for any service to ensure coverage. WPS will notify you and your provider in writing of its decision on the authorization request.

Care Outside Service Area

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

Mental and Behavioral Health Services

Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their license.

Note: If you use providers that are not in the WPS Metro Choice network, services are subject to the deductible, then payable at 70%.

Dental Benefits

No routine dental coverage provided.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Plan Report Card

Grievances and Complaints Information

Other Quality Information Resources



Health Plan Report Card

PLEASE NOTE:
ETF'S WEBSITE AT
ETF.WI.GOV
CONTAINS
MORE DETAILED
INFORMATION.



Health Plan Report Card

This section provides the results of two important annual evaluations of our health plans—the member satisfaction survey and quality performance measures. We encourage you to review this information and see how your health plan compares with other available plans.

- The **Quality Composite** provides a summary of the health plans' quality scores in an overall composite and in the following four areas of care: Wellness and Prevention, Behavioral and Mental Health, Disease Management and Consumer Satisfaction and Experiences.
- The Consumer Assessment of Healthcare Providers and Systems (**CAHPS®**) is our annual member survey. The survey reveals how members rate their health plan and the health care services they receive. The survey focuses on areas where the people enrolled in the health plans are really the experts about how well their plan is working. *The Department of Employee Trust Funds (ETF) would like to thank the 6,786 members who participated in this year's successful survey.* This important study was administered by Synovate, an independent research firm on the behalf of ETF.
- The Healthcare Effectiveness Data and Information Set (**HEDIS®**) demonstrates health plan performance from a clinical perspective. The measures evaluate whether the health plan delivers the recommended care based on medical evidence to prevent or manage illness. HEDIS measures address health care issues that are meaningful to consumers and purchasers. They measure performance in areas of care where improvements can make a meaningful difference in member's lives and areas that health care systems can take action to improve.

Example of information types gathered:

CAHPS: How often did you get care as soon as you thought you needed it?

HEDIS: What percentage of women age 42 to 69 had a mammogram within the last two years?

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.

Health Plans Included in this Report Card

Note the following about the health plans that were included in this report card:

- CAHPS results were collected by health plan for active state and retiree membership. The survey only includes health plans that were available to state employees and retirees starting on January 1, 2009, no data were therefore collected for HealthPartners—a new health plan that became available January 1, 2010. 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.
- HEDIS scores include all the HMO insurers that were available to ETF members in 2010. HEDIS data are collected by each insurer for its entire commercial population and is not reported separately by service area or for state employee and retiree membership. No HEDIS data are available for SMP, the Standard Plan or WPS Metro Choice. HEDIS data for WEA Trust PPP were not included in this report card but scores by measure are available on ETF's website.
- The Quality Composite Rating Chart includes all HMO health plans that were available in 2010 and for which HEDIS and CAHPS data were available. Anthem Blue Northeast, Anthem Blue Northwest and Anthem Blue Southeast were combined into Anthem Blue for the purpose of calculating the composite scores.



Quality Composite Rating Chart



Quality Composite

The following are descriptions of the rankings displayed in the [chart on page 65](#).

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 questions surveying our members about whether wellness information is provided by their doctor.

Behavioral and Mental Health

This score includes HEDIS measures for the treatment of depression and follow-up after a hospitalization for mental illness. This composite also includes survey questions on whether members could obtain needed treatment or counseling for a personal or family problem.

Disease Management

This score includes HEDIS measures that address treatment and screenings for members with acute cardiovascular conditions, hypertension, diabetes, chronic obstructive pulmonary disease and asthma. This composite also includes a measure that addresses monitoring members who are on persistent medications of interest.

Consumer Satisfaction and Experiences

This composite includes CAHPS scores that measure member satisfaction with their health plan and the health care they receive 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.

Quality Composite Rating Chart

Understanding the Scores for the Health Plans:

- ★★★★★ 4 stars: **well above** the average of all health plans (by **more than** one standard deviation)*
- ★★★★ 3 stars: **above** the average of all health plans (by **less than** one standard deviation)*
- ★★★ 2 stars: **below** the average of all health plans (by **less than** one standard deviation)*
- ★ 1 star: **well below** the average of all health plans (by **more than** one standard deviation)*

Please see previous page for descriptions of the Quality Composite Ratings.

Plan Name	Overall Quality	Wellness & Prevention	Behavioral & Mental Health	Disease Management	Consumer Satisfaction and Experiences
Anthem BCBS	★	★	★★	★★	★
Arise Health Plan	★★★	★★	★★★★	★★	★★★
Dean Health Plan	★★	★★★★	★★	★★★★	★★
GHC of Eau Claire	★★★	★★★★	★★	★**	★★★★
GHC of SCW	★★★★★	★★★★★	★★★★	★★★★	★★★★★
Gundersen Lutheran	★★★★★	★★★★★	★★★★	★★★★★	★★★
HealthPartners	Not Available	Not Available	Not Available	Not Available	Not Available
Health Tradition	★★★	★★★★	★	★★★★	★★★
Humana Eastern	★	★★	★★★★	★	★
Humana Western	★	★★	★★	★	★
Medical Associates	★★★★★	★★	★★	★★★★★	★★★
MERCYCARE	★★	★★★★	★★★★	★★★★	★★
Network Health Plan	★★★	★★★★	★★	★★★★	★★★
Physicians Plus	★★★	★★★★	★★★★	★★★★	★★★
Security Health Plan	★★★	★★★★	★★★★	★★★★	★★★
UnitedHealthCare NE	★★	★	★★	★★★★	★
UnitedHealthCare SE	★★	★	★★	★★★★	★
Unity Community	★★★	★★★★	★★★★	★★★★	★★★
Unity UW Health	★★★	★★★★	★★★★	★★★★	★★★

*The standard deviation measures the difference between an individual health plan's score and the average score of all health plans. We are more certain that health plans with four stars have performed better than average and health plans with one star have performed worse than average. We cannot conclude that health plans with three stars or two stars have performed differently from the average.

**Data discrepancies were identified when reporting this measure.

CAHPS Overall Rating Chart

Understanding the Scores for the Health Plans:

- ★★★★★ 4 stars: **well above** the average of all health plans (by **more than** 1.96 standard deviations)*
- ★★★★ 3 stars: **above** the average of all health plans (by **less than** 1.96 standard deviations)*
- ★★★ 2 stars: **below** the average of all health plans (by **less than** 1.96 standard deviations)*
- ★ 1 star: **well below** the average of all health plans (by **more than** 1.96 standard deviations)*

This chart shows results for individual survey questions for which members were asked to rate their health plan, health care, primary doctor and specialists. 10 is the “best possible” rating and 0 is the “worst possible” rating. Health plan scores were adjusted for age, education level, and self-reported health status.

↗ means that a health plan had a statistically significant improvement in their score from 2008 to 2009.

↘ means that a health plan had a statistically significant decline in their score from 2008 to 2009.

Plan Name	How people rated their HEALTH PLAN	How people rated their HEALTH CARE	How people rated their PRIMARY DOCTOR	How people rated their SPECIALIST
AVERAGE - All Health Plans	8.23	8.44	8.69	8.47
Anthem BCBS	★	★	★★	★★↗
Arise Health Plan	★★★★↗	★★★★	★★★	★★★
Dean Health Plan	★★★	★★	★★	★★
GHC of Eau Claire	★★★★↗	★★★★	★★★	★★★
GHC of SCW	★★★★	★★★★	★★	★★★
Gundersen Lutheran	★★★★	★★★★	★★★★	★★★
Health Tradition	★★★★	★★★★↗	★★★★↗	★★★
Humana Eastern	★	★★★	★★★	★★★★↗
Humana Western	★↗	★	★★	★★
Medical Associates	★★★★	★★★★	★★★★	★★★
MercyCare	★★	★★	★★	★★
Network Health Plan	★★★★	★★	★	★★★
Physicians Plus	★★★★	★★★	★★	★★★
Security Health Plan	★★★★↗	★★★	★★★	★★★★↗
Standard Plan	★★★★	★★	★	★★↗
UnitedHealthCare NE	★	★★	★★	★★★★↗
UnitedHealthCare SE	★	★★	★★	★
Unity Community	★★★★	★★★	★★	★★↗
Unity UW Health	★★★★	★★★	★★	★★
WPS Metro Choice	★	★★	★★	★★★★↗

*The standard deviation measures the difference between an individual health plan’s score and the average score of all health plans. We are more certain that health plans with four stars have performed better than average and health plans with one star have performed worse than average. We cannot conclude that health plans with three stars or two stars have performed differently from the average.

CAHPS Composite Rating Chart

Understanding the Scores for the Health Plans:

- ★★★★★ 4 stars: **well above** the average of all health plans (by **more than** 1.96 standard deviations)*
- ★★★★ 3 stars: **above** the average of all health plans (by **less than** 1.96 standard deviations)*
- ★★★ 2 stars: **below** the average of all health plans (by **less than** 1.96 standard deviations)*
- ★ 1 star: **well below** the average of all health plans (by **more than** 1.96 standard deviations)*

This chart shows results for a composite of survey questions that asked members how often something occurred (“Always”, “Sometimes”, “Usually” or “Never”) regarding Customer Service, Claims Processing, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Shared Decision Making (between the member and the doctor). Health plan scores were adjusted for age, education level, and self reported health status.

↗ means that a health plan had a statistically significant improvement in their score from 2008 to 2009.

↘ means that a health plan had a statistically significant decline in their score from 2008 to 2009.

Plan Name	Customer Service	Claims Processing	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Shared Decision Making
AVERAGE - All Health Plans	3.47	3.45	3.37	3.49	3.66	3.51
Anthem BCBS	★↗	★↗	★★★★	★★	★	★
Arise Health Plan	★★★★	★★★★	★★★★★	★★★★	★★★★	★★★★
Dean Health Plan	★★	★★★★	★	★	★★	★★
GHC of Eau Claire	★★★★★	★★★★★	★★★★★	★★★★	★★★★	★★
GHC of SCW	★★★★★↗	★★★★★	★★★★	★★★★★	★★★★	★★★★★
Gundersen Lutheran	★★★★	★★★★★	★★★★	★★	★★★★★	★★★★
Health Tradition	★★★★	★★★★	★★★★	★★★★★	★★★★★↗	★★★★
Humana Eastern	★	★	★★★★★	★★★★	★★★★	★
Humana Western	★	★	★↗	★★★★	★	★★
Medical Associates	★★★★	★★★★★↗	★★★★★	★★★★★	★★★★★	★★
MercyCare	★★	★★	★★	★★	★★	★★★★
Network Health Plan	★★★★★	★★★★★	★★★★	★	★★	★★
Physicians Plus	★★★★	★★★★	★	★★	★★	★★★★
Security Health Plan	★★★★★	★★★★★	★★★★★	★★★★	★★★★	★★
Standard Plan	★★	★★	★★★★	★★	★	★★
UnitedHealthCare NE	★↗	★	★★★★★	★★★★	★★★★	★★★★
UnitedHealthCare SE	★	★★	★★★★	★★★★	★★★★	★★★★
Unity Community	★★★★★	★★★★★↗	★★	★★★★	★★	★★★★
Unity UW Health	★★★★★	★★★★	★↘	★	★★	★★★★
WPS Metro Choice	★★	★	★★	★★★★	★★	★★

*The standard deviation measures the difference between an individual health plan’s score and the average score of all health plans. We are more certain that health plans with four stars have performed better than average and health plans with one star have performed worse than average. We cannot conclude that health plans with three stars or two stars have performed differently from the average.

HEDIS Composite Chart

This chart displays the following quality measures:

- * **Cancer Screenings:** This score includes the following HEDIS measures: Colorectal, Breast and Cervical Cancer Screenings.
- * **Appropriate Use of Antibiotics:** This score includes the following HEDIS measures: Appropriate Treatment for Children with upper respiratory infection, appropriate testing for children with Pharyngitis, avoidance of antibiotic treatment in adults with acute bronchitis.
- * **Diabetes Care:** This score includes the following HEDIS measures: HbA1c control, cholesterol screening and control, medical attention for kidney disease, eye exam, and blood pressure control.
- * **Controlling High Blood Pressure:** This score examines the percentage of eligible members with high blood pressure who had their blood pressure controlled.
- * **Cholesterol Management for Patients with Cardiovascular Conditions:** This score includes the following HEDIS measures: Cholesterol screening and control.
- * **Annual Monitoring for Patients with Persistent Medications:** This single score examines monitoring for the following drugs of interest: Angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), Digoxins, Diuretics, Anticonvulsants.

Plan Name	Cancer Screenings	Appropriate Use of Antibiotics	Diabetes Care	Controlling High Blood Pressure	Cholesterol Management for Patients with Cardiovascular Conditions	Annual Monitoring for Patient with Persistent Medications
Anthem BCBS	★	★★	★	★	★	★★
Arise Health Care	★★★	★★	★★★★	★★★★★	★★	★★★★
Dean Health Care	★★	★★	★★	★★	★★	★★★★
GHC of Eau Claire	★★★	★★★★	★★*	★★	★★★★★	★★
GHC of SCW	★★★★★	★★★★★	★★★★	★★	★★	★★★★★
Gundersen Lutherran	★★★	★★★★★	★★★★★	★★★★	★★	★
HealthPartners	★★★	★★	★★★★	★★★★★	★★★★★	★★★★
Health Tradition	★★	★★★★	★★★★	★★★★	★★	NA*
Humana	★★	★★	★	★★	★	★★★★
Medical Associates	★★★	★	★★★★★	★★★★★	★★★★	★★★★
MercyCare Health Plan	★	★★★★	★★	★★	★★	★★
Network Health Plan	★★★	★★	★★★★	★★	★★★★★	★★★★
Physicians Plus	★★★	★★	★★	★★	★★★★	★
Security Health Plan	★★★	★★	★★★★	★★★★	★★★★★	★★★★★
UnitedHealthCare	★★	★★	★★	★★★★	★★	★★★★
Unity Health Insurance	★★★	★★	★★	★★★★	★★★★	★★

*Data discrepancies were identified when reporting this measure.

Please see page 65 for a description of the star rating system that was used for this chart.

Grievances and Complaints Information

The grievance process is a health plan's internal process for resolving member complaints. Each health plan is required to have a grievance process in place for members to seek a change to an unfavorable decision.

A complaint occurs when a member contacts ETF about an issue for input or investigation. The complaint process is the initial, optional step involved in the administrative review process, which allows members to appeal a health plan decision to ETF and subsequently to the Group Insurance Board.

The most frequent complaints types filed by members in 2009 were related to the following:

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

The most frequent types of grievances filed by members in 2009 were related to:

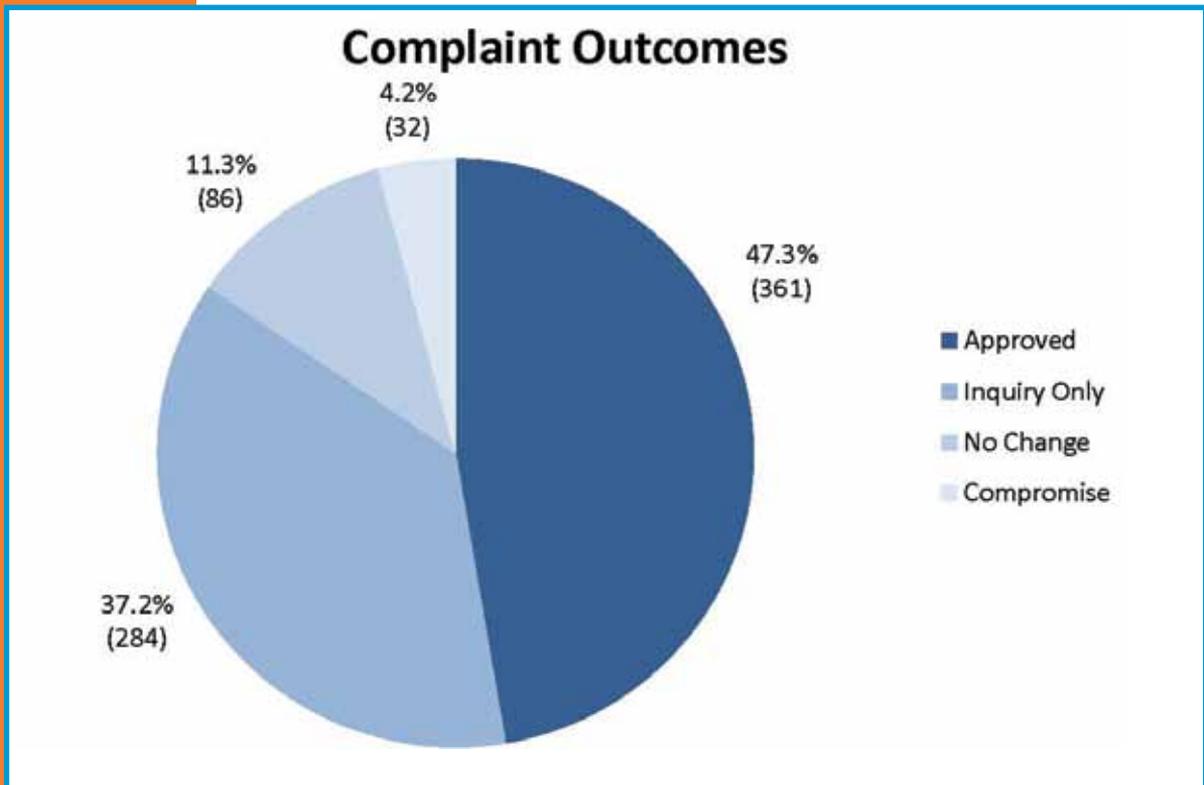
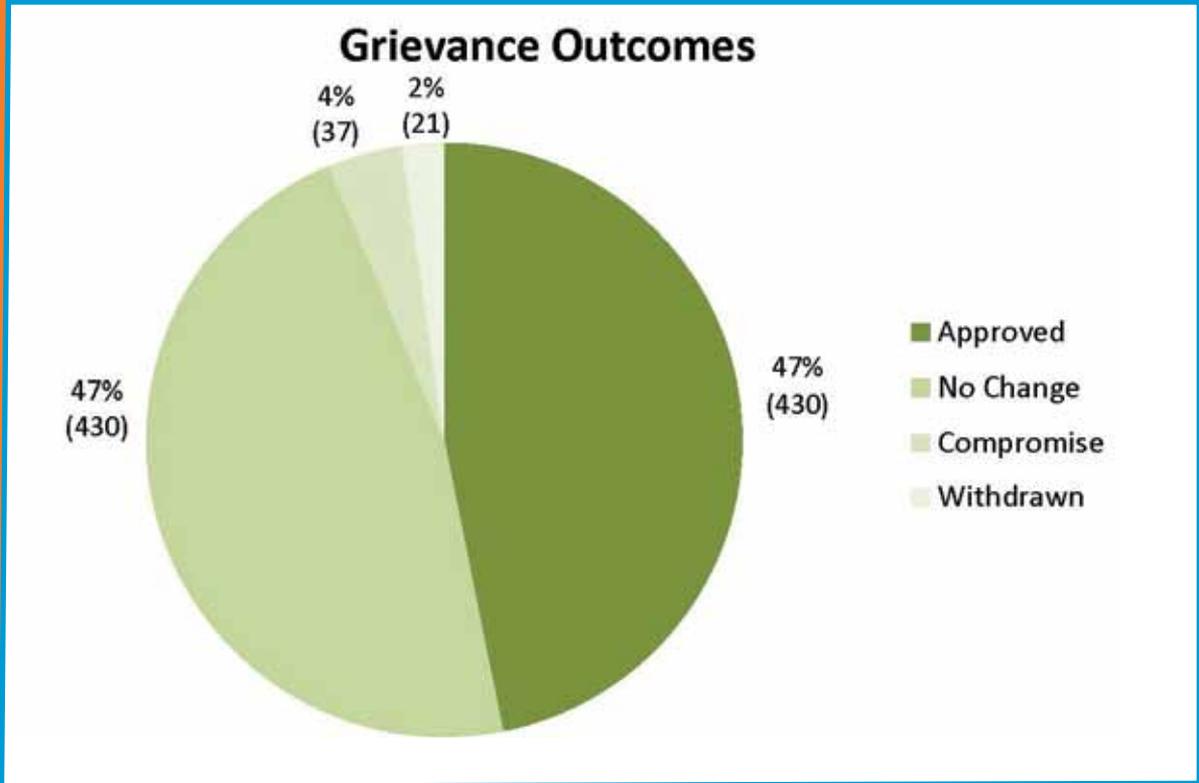
- Non-covered or excluded benefits
- Plan administration
- Prior authorizations

In 2009, 918 members filed grievances with their health plan and 1,304 filed complaints with ETF.

The following pie charts show how often complaints and grievances were resolved in favor of the member. Approximately one half of complaints and grievances filed by members were ultimately approved (the health plan's original decision was overturned).



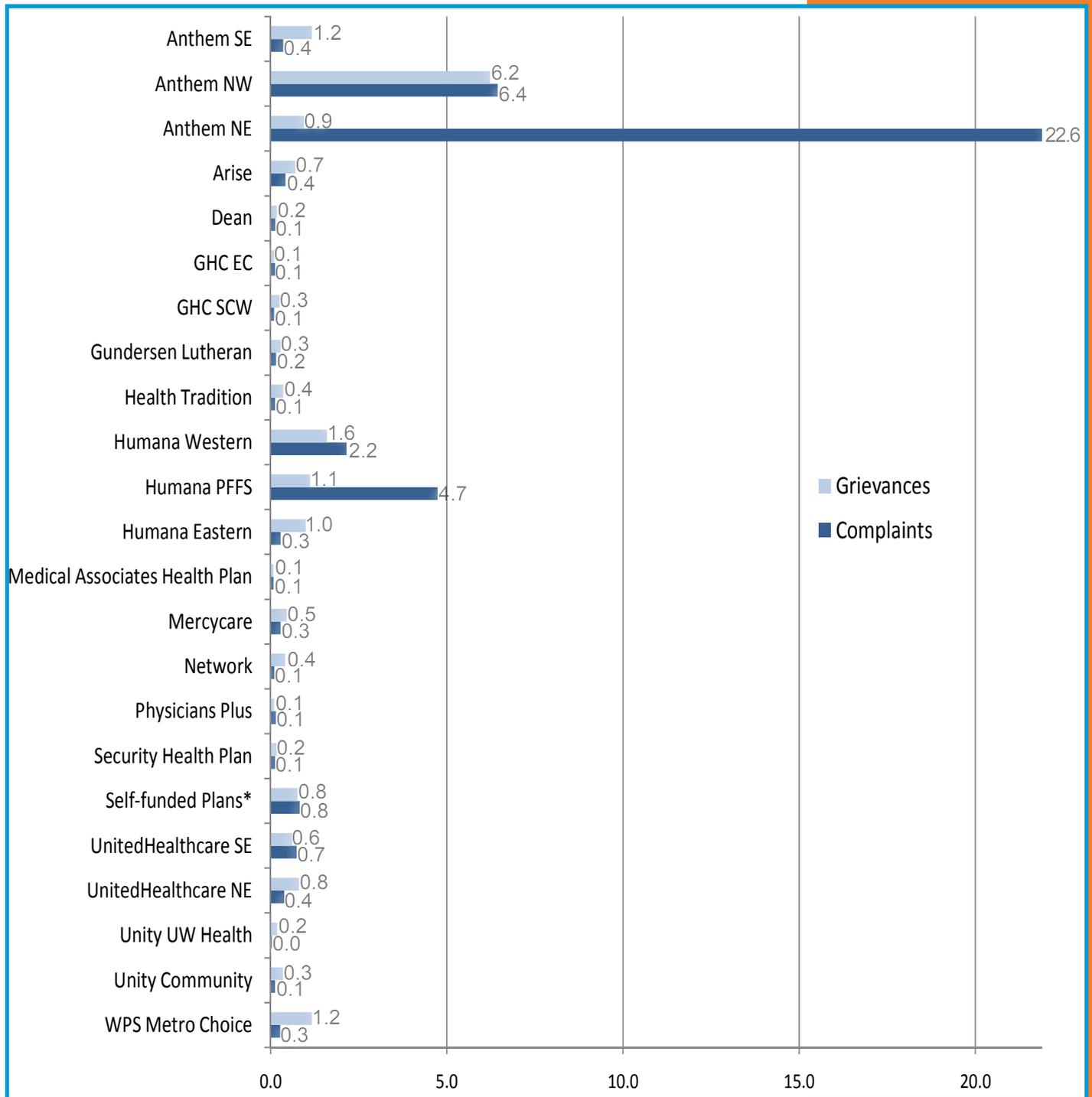
Grievances and Complaints Charts



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

Grievances and Complaints by Health Plan

This chart shows the total number of complaints and grievances per 100 members for each health plan during the 2009 calendar year.



*Includes the Standard Plan, SMP and Medicare Plus \$1,000,000

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 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.

www.leapfroggroup.org

Checkpoint is a program sponsored by the Wisconsin Hospital Association. It provides a snapshot of hospital performance, and information may be used to compare how well hospitals administer recommended care. The 128 hospitals that currently participate in Checkpoint provide care to 99% of Wisconsin's patient population.

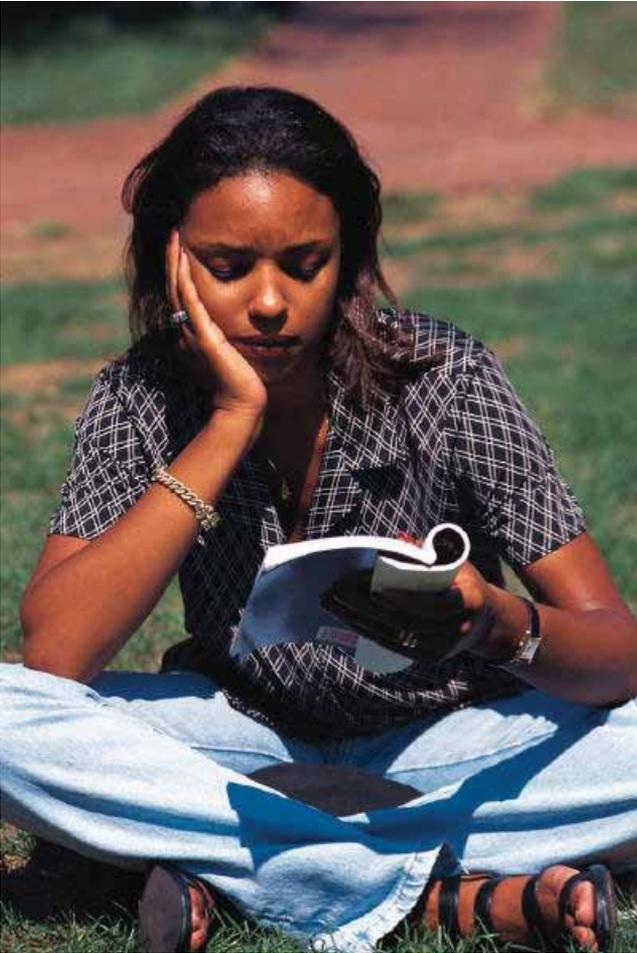
www.wicheckpoint.org

The Wisconsin Collaborative for Healthcare Quality (WCHQ) provides links to a variety of performance measures that compare information from participating physician groups, hospitals and health plans. Consumers can view reports comparing the performance of providers on measures such as diabetes management, heart care, women's health, cancer screenings, access to care, critical care, surgery, health information technology, patient safety, patient satisfaction, appointment wait times and more.

www.wchq.org

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

www.hospitalcompare.hhs.gov



Pharmacy Benefits

Life Insurance

NAVITUS HEALTH SOLUTIONS™

(866) 333.2757 - Toll-Free Customer Care

www.navitus.com

What's New for 2011

There is no change in the out-of-pocket maximum for 2011. It will remain at \$410 per individual and \$820 per family for all participants. EXCEPTION: There is no out-of-pocket maximum for Wisconsin Public Employer participants enrolled in the Standard Plan or State Maintenance Plan (SMP), effective January 1, 2011.

Formulary Information

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

90-Day-At-Retail Program

A 90-day supply of most maintenance medications can be purchased at your retail pharmacy. Some restrictions do apply and three co-payments are still required. More information can be found on Navitus' web site or by calling Navitus Customer Care.

Mail Order Program

Up to a 90-day supply can be purchased for only two co-payments for Level 1 and Level 2 medications through our mail order service. To register for mail order service call Prescription Solutions Customer Service at 1-800-908-9097, 24 hours a day seven days a week. If you are hearing impaired, you can call 1-800-947-8642. More detailed information can be found on Navitus' web site; the Prescription Solutions Web site, www.rxsolutions.com; or by calling Navitus Customer Care.

RxCENTS Tablet-Splitting Program

By splitting a higher-strength tablet in half to provide the needed dose, you will receive the same medication and dosage while purchasing fewer tablets and saving on your copayment. Medications included in the program are marked with "¢" in the Navitus Formulary. Members may obtain tablet splitting devices at no cost by calling Navitus Customer Care.

Generic Copay Waiver Program

Your first fill of a sample medication through this program is free. Medications included in the Generic Copay Waiver Program are marked with "GW" in the Navitus Formulary. To use this program, your doctor needs to write a prescription for one of the program medications. If it is your first time filling this prescription, you get the medication at no cost.

Specialty Drug Program (Self-injectables & Specialty Medications)

If you are on a specialty medication, the Navitus SpecialtyRX Specialty Pharmacy Program is offered through a partnership with Diplomat Pharmacy to help members

continued on next page

continued

and their health care providers with specialty pharmacy needs. Medications available through this program are denoted with “SP” in the Navitus Formulary. To begin receiving your self-injectable and other specialty medications from the specialty pharmacy, please call Customer Care at 877-651-4943 or visit www.diplomatpharmacy.com.

Prior Authorization (PA) Requirements

A Prior Authorization is initiated by the prescribing physician on behalf of the member.

Navitus will review the prior authorization request within two business days of receiving complete information from your physician. Medications that require prior authorization for coverage can be identified on the Navitus Drug Formulary by a notation of “PA”.

Diabetic Supply Coverage

Diabetic supplies and glucometers are covered with a 20% coinsurance. This coinsurance applies to your out-of-pocket maximum, unless other coverage picks up the 20% coinsurance through coordination of benefits.

Medicare Part B

Claims for certain drugs/supplies such as test strips, lancets, inhalation drugs and IV drugs requiring a pump need to be submitted to Medicare Part B first for primary coverage. Navitus may cover the remaining cost up to the allowed amount under your policy as secondary coverage. In many instances your pharmacy will be able to submit the secondary claim to Navitus electronically. However, in cases where this is not possible you may submit a Direct Member Reimbursement Form, accompanied with your Medicare Summary Notice, to be reimbursed by your Navitus secondary coverage. This form is available on the Navitus Web site or by calling Navitus Customer Care.

Medicare Part D (This applies only to Local Government annuitants and continuants who are Medicare eligible.)

When you become eligible for coverage under Medicare Part D, you must voluntarily enroll in a Medicare Part D Prescription Drug Plan (PDP). Navitus will no longer provide coverage for you. If you take no action you will be automatically enrolled in the DeanCare Rx PDP, provided by Dean Health Insurance (DHI). You will need to complete enrollment information forms that DHI will send to you. In addition, you will also be automatically enrolled in secondary coverage with a “Wrap” product from DHI. This will ensure that you have coverage during the Medicare Part D coverage gap referred to as the “donut hole”. If you decide to enroll in a PDP other than the DeanCare Rx plan, you will still be covered by the Wrap benefit once you reach the “donut hole”.

Coordination of Benefits

Coordination of benefits applies when, as determined by the order of benefit determination rules, you have primary coverage under another policy and Navitus is your secondary coverage. All claims need to be submitted to your other policy first. Navitus covers the remaining cost of any covered prescriptions up to the allowed amount under your policies. COB does not guarantee that all of your out of pocket costs will be covered.

Minnesota Life Insurance Company

(866) 295-8690

etf.wi.gov

Wisconsin Public Employers (WPE) Group Life Insurance

The life insurance program offers employees coverage of up to five times annual earnings. The amount of coverage available to local government employees depends on which plans are offered by your employer. The program is administered by Minnesota Life Insurance Company (MLIC).

- The **Basic Plan** provides coverage equal to your previous year's earnings, rounded up to the next thousand. Basic coverage will continue in a reduced amount for life, without cost, for eligible retirees over age 65 and for active employees over age 70.
- The **Supplemental Plan** provides coverage equal to your previous year's earnings, rounded up to the next thousand. Coverage may continue up to age 65, if retired, or age 70 if an active employee.
- The **Additional Plan** provides up to three units of coverage. Each unit of coverage equals your previous year's earnings, rounded up to the next thousand. Depending on how many levels of coverage are offered by your employer, you may choose 1, 2, or 3 units of Additional coverage. Coverage may continue until you terminate employment, cancel coverage or stop paying premium.
- The **Spouse & Dependent Plan** provides up to two units of coverage for your spouse or domestic partner and all dependent(s). Each unit of coverage provides \$10,000 in spouse coverage and \$5,000 coverage for each dependent (regardless of the number).
- **Conversion of Life Insurance to Pay Health 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-sponsored health insurance premiums. See *Converting Your Group Life Insurance to Pay Health Insurance Premiums (ET-2325)* for more information.
- **Living Benefits**
Insured persons may apply to receive all or part of the value of their life insurance while still living, if they are diagnosed with a terminal condition caused by illness or injury and have a life expectancy of 12 months or less. See the *Living Benefits (ET-2327)* brochure for more information.
- **Eligibility and Enrollment**
You have an open enrollment opportunity for life insurance coverage if you:
 - are under age 70, and

continued on next page

Minnesota Life Insurance Company

(866) 295-8690
etf.wi.gov

continued

- have worked six or more months in service covered by the WRS, and
- you 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.

For Spouse and Dependent coverage only, you may apply when you have either a spouse or domestic partner or dependent to insure for the first time. If you do not enroll for all available coverage when you are first eligible, you may apply for future coverage only through *Evidence of Insurability (ET -2305)*.

See the *Wisconsin Public Employers Group Life Insurance Program (ET-2101)* brochure for complete program details.

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Group Health Insurance Applications



If you want to change health plans or change to family coverage for next year, submit one completed application and retain one for your records.

Your application must be submitted electronically, handed in, faxed or postmarked by the last day of the It's Your Choice enrollment period (October 29, 2010). Late applications will not be accepted.

GROUP HEALTH INSURANCE APPLICATION/CHANGE FORM

State of Wisconsin Employees and Annuitants

Wisconsin Public Employees and Annuitants

UW Graduate Assistants, Employees in Training, Short-Term Academic Staff, Fellows and Scholars

Wis. Stat. § 40.51

You must submit this application to your employer if you are actively employed, or to the Department of Employee Trust Funds if you are an annuitant or on continuation. Use this form when electing, declining, or canceling health insurance coverage; making changes; and adding or deleting a dependent. For complete enrollment and program information, read the *It's Your Choice* booklets. 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 state limited term employees or completion of 1000 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 without restriction or waiting periods for pre-existing medical conditions. 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 periods available to enroll without limitations or waiting periods. For complete enrollment and program information, read the *It's Your Choice* booklets.

There are no interim effective dates, except as required by Federal HIPAA law. If your application is submitted after these enrollment periods, you will be subject to waiting periods as described in the *It's Your Choice* booklets.

INSTRUCTIONS FOR COMPLETING HEALTH INSURANCE APPLICATION/CHANGE FORM

SECTION 1 – APPLICANT INFORMATION

1. *Print* your responses *clearly* and *legibly*.
 2. Enter your complete name (including your previous name, if applicable), your Social Security Number (SSN), your home address, including the county, and your home and daytime telephone numbers in the spaces provided.
- NOTE: If you choose not to enroll, go to Section 7.
3. Marital or Domestic Partnership Status: Check the box that applies to you. If you indicate that you are Married, Divorced, Widowed, or in a Domestic Partnership, list the date in the space provided. *Note the effective date of a Domestic Partnership is the date that ETF receives the Affidavit of Domestic Partnership form (ET-2371).* If married or in a domestic partnership, you must provide your spouse/domestic partner name, SSN and birth date, even if you are applying for single coverage.
 4. Eligibility Status: Check one box which describes your status as an applicant.
 5. For initial enrollment only, indicate if you want immediate health insurance coverage or coverage when you become eligible for the employer contribution toward the health insurance premium. Indicate It's Your Choice enrollment for coverage changes during the annual enrollment period.
 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

Subsections A and B

1. Indicate the reason for submitting this application by checking the box(es) that apply. If selecting Change To Single Coverage or Spouse To Spouse Transfer, you must also indicate the reason for your request.
2. If checking boxes in Subsection A only or both A and B, go to Section 3 and complete all enrollment information.
3. If checking boxes in Subsection B only, go to Section 7 to complete the application; except if you are updating Other Insurance Coverage, complete Section 6 & 7.

Changes To Dependent Coverage

Subsection C

Complete this Subsection when deleting a dependent. Check the reason and list all dependents to be deleted from your Health Insurance Contract. Use "Other" box, for example, to disenroll adult children during the annual It's Your Choice period.

Go to Section 7 to complete the application.

Subsection D

Complete this Subsection when adding a dependent. Check the reason for adding a dependent(s) and indicate the event date. Use the "Other" box to add eligible dependents for an unlisted reason. See Terms & Conditions #5 for more information. Go to Section 3 and list all family members who are being added to your Health Insurance Contract. Also, complete Sections 4, 5, 6 and 7.

SECTION 3 – ENROLLMENT INFORMATION

Provide all information requested in this Section for yourself, when applying for single coverage; when applying for family coverage, list yourself and all eligible dependents.

If the SSN is not known because it was just applied for, write "APPLIED FOR" in that field.

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

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

Completion of the Marital Status column is required. Indicate "Yes" for married or "No" for not married.

Indicate "Yes" or "No" if the dependent is disabled.

Indicate "Yes" or "No" if any dependent over age 27 is disabled.

Indicate "Yes" or "No" if your domestic partner and/or dependent child is considered a "tax dependent" under federal law. You do not need to complete this box for your spouse. *Note there may be tax consequences to you when you cover dependents (i.e., domestic partners and children) who are not dependent on you for at least 50% of their support.*

For yourself and all eligible dependents, provide the name of the physician or clinic. If selecting the Standard Plan, indicate "NONE."

SECTION 4 – ADDITIONAL INFORMATION

Indicate "Yes" or "No" for all three questions, and list names as applicable.

SECTION 5 – MEDICARE INFORMATION

Indicate whether any of your dependents (including your spouse/domestic partner) are covered by Medicare, and list the names of those covered. Provide the Health Insurance Claim number (HIC#) and effective date from the Medicare card for any individuals covered by Medicare.

SECTION 6 – "OTHER COVERAGE"

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

SECTION 7 – SIGNATURE

Read the **TERMS AND CONDITIONS** on the back of this page.

1. If applying for health insurance coverage, check the box that you are applying for coverage, sign and date the application, indicating agreement with the terms and conditions. Submit the application to your payroll representative or to ETF if you are an annuitant/continuant.
2. If declining health insurance coverage, check the box indicating you do not wish to enroll, sign and date the application, and submit to your payroll representative.
3. If cancelling current health insurance coverage, check the box indicating you wish to cancel coverage. Also, check one of the four boxes following that indicates if employee premiums are deducted pre-tax or post-tax and if you do or do not have comparable coverage or if your required contribution has significantly increased. The earliest your coverage will end when indicating if employee premiums are deducted pre-tax and you do not have comparable coverage is the end of the current year, 12/31/XXXX. Sign and date the application then submit it to your payroll representative.
4. Your employer will complete Section 8 and provide a copy of the application to you. For annuitants/continuant, ETF will complete section 8 and provide a copy of the application to you.
5. If submitting during the annual It's Your Choice enrollment period, make a copy for your records.

ETF Use Only

State of Wisconsin
Department of Employee Trust Funds
HEALTH INSURANCE APPLICATION/CHANGE FORM

Employer Notes

1. APPLICANT INFORMATION

Applicant – Last Name	First	Middle	Previous Name	Social Security Number
Address—Street and No.		City	State	Zip Code
County	Country (if not USA)	Home Telephone No.	Daytime Telephone No.	

MARITAL OR DOMESTIC PARTNERSHIP STATUS: Single Married (date) _____
 Divorced (date) _____ Widowed (date) _____ Domestic Partnership (date) _____
Spouse/Domestic Partner Name _____ SSN _____ Birth Date _____

ELIGIBILITY STATUS (check one) Employee Survivor
 Continuant (COBRA) Annuitant Graduate Assistant

I WANT MY COVERAGE TO BE EFFECTIVE: As soon as possible
 When employer contributes premium It's Your Choice (January 1)

COVERAGE DESIRED Single Family **HEALTH PLAN SELECTED** _____

2. REASON FOR APPLICATION

A. **Check all boxes that apply. Go to Section 3.**

Initial Enrollment – 02
 Moved from Service Area – 41 Date: _____
 Change to Family Coverage – 43
 Change to Single Coverage– 44 or 45
Reason¹: _____
 Spouse/DP to Spouse/DP Transfer -31
Reason²: _____
Spouse's/DP's State Agency _____
 Transfer from One State Agency to Another – 04
Name of previous State Agency _____
 COBRA (or continuation) – 63
 It's Your Choice – 40 Current Health Plan _____
 Other: _____

B. **Check all boxes that apply.**

Cancellation – 09
Desired Cancellation Effective Date _____
 Name Change, former name _____
 Address Change (indicate in Section 1)
 Telephone Number Change (indicate in Section 1)
 Social Security Number Correction to _____
for (name) _____

¹ If premiums are pre-tax, change to single coverage allowed only when your last dependent becomes ineligible for coverage.
² If premiums are pre-tax, mid-year transfer allowed only when spouse carrying coverage terminates employment, goes on unpaid LOA, or drops to less than half-time employment.

C. **Complete the following for deleting a dependent. List only dependents affected by this change below.**

Reason: Divorce/DP terminated Age* Dependent Married Other _____

**Dependent turned 27 or is over 18 and is eligible for health insurance through employer; grandchild of a dependent that turned 18.*

Last Name	First	Middle	Birthdate			Gender M/F	Social Security Number	Event Date	Dependent's Address (if different than subscriber's)	NOTE: THE DELETION OF A DEPENDENT DUE TO LOSS OF ELIGIBILITY PROVIDES AN OPPORTUNITY FOR CONTINUATION COVERAGE (COBRA) UP TO 36 MONTHS PROVIDED NOTICE IS GIVEN TO THE EMPLOYER WITHIN 60 DAYS OF EVENT
			Mo	Day	Yr					

D. **Complete the following when adding a dependent. List only dependents affected by this change in Section 3.**

Reason: Marriage Birth Legal Ward** Adoption** Domestic Partner**
 Disabled Other** _____ Event Date _____

***Please attach documentation for additions due to legal ward, adoption, paternity, National Medical Support Notice, or loss of coverage; acknowledgement to ETF affidavit required for domestic partnership.*

Dependents include spouse or domestic partner and children under age 27. Children include those who are your natural children, legal wards who become your permanent ward prior to age 19, adopted children, stepchildren, children of your domestic partner, or grandchildren until the grandchildren's parent (your child) reaches age 18.

Applicant Name Social Security Number

3. ENROLLMENT INFORMATION

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

4. ADDITIONAL INFORMATION

a. Are any of the dependents listed above your grandchild? Yes No If yes, name of parent _____

5. MEDICARE INFORMATION

Are you or any insured dependent covered under Medicare? Yes No If yes, list names of insured and Medicare dates.
 Name: _____ Dates: Part A _____ Part B _____ HIC # _____
 Name: _____ Dates: Part A _____ Part B _____ HIC # _____

6. OTHER COVERAGE

a. Other health insurance coverage? Yes No If yes, name of other insurance company _____
 Name(s) of Insured(s) _____
 b. Is your spouse/domestic partner a State of Wisconsin employee or annuitant (including University of Wisconsin)? Yes No

7. SIGNATURE (read the **Terms and Conditions** on the attached page, check one box and sign)

- I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and have read and agree to the **TERMS AND CONDITIONS**. A copy of this application is to be considered as valid as the original.
- I do not wish to enroll at this time.
- I wish to cancel my current coverage. My employee premium is deducted (Please check one box.):
 - pre-tax and I acknowledge that I have comparable coverage.
 - pre-tax and my required contributions has significantly increased.
 - pre-tax and I do not have comparable coverage. Coverage will end 12/31/XXXX.
 - post-tax.

To the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395. Additional documentation may be required by ETF at any time to verify eligibility

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

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

Employer Number 69-036-	Name of Employer				Program Option Code	Surcharge Code
Group Number	Enrollment Type	Employee Type	Coverage Type Code	Carrier Suffix	Standard Plan Waiting Period	Participant County Code
Previous Service – Complete Information			Date Application Received by Employer (MM/DD/CCYY)		Date WRS Eligible Employment Began or Graduate Assistant Appointment Began (MM/DD/CCYY)	
1. Did employee participate under WRS prior to being hired by you? <input type="checkbox"/> Yes <input type="checkbox"/> No						
2. Previous service check completed? <input type="checkbox"/> Yes <input type="checkbox"/> No						
3. Source of previous service check: <input type="checkbox"/> Online Network for Employers(ONE) <input type="checkbox"/> ETF						
Monthly Employee Share \$	Monthly Employer Share \$		Event Date (MM/DD/CCYY)		Prospective Date of Coverage (MM/DD/CCYY)	
Payroll Representative Signature				Telephone ()		

COPY AND DISTRIBUTE: ETF EMPLOYEE EMPLOYER

ET-2301 (REV 07/2010)

HEALTH INSURANCE APPLICATION/CHANGE FORM TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information on this application, I may face criminal charges/sanctions under Wis. Stat. § 943.395.
2. I authorize the Department of Employee Trust Funds (ETF) to obtain any information from any source necessary to administer this insurance.
3. I agree to pay in advance the current premium for this insurance, and I authorize my employer (the remitting agent) to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to ETF.
4. I understand that eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting my health plan and/or ETF to obtain medical records from health care providers who have treated me or any dependents. If medical records are needed, my health plan and/or ETF will provide me with an authorization form.
5. Any children, as defined in the contract, listed on this application are not married during the year in which they turn 27 and not eligible for coverage under a group health insurance plan that is offered by their employer for which the amount of their premium contribution is not greater than the premium amount for their coverage under this program. Children may be covered through the end of the month in which they turn 27. Children may also be covered beyond age 27 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 and are not married; 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 and are not married.
6. I understand that if my insured domestic partner and/or dependent children are not considered “tax dependents” under federal law, my income will include the fair market value of the health insurance benefits provided to my domestic partner and/or dependent children. Furthermore, I understand this may affect my taxable income and increase my tax liability.
7. I understand that it is my responsibility to notify the employer, or if I am an annuitant or continuant to notify ETF, if there is a change affecting my coverage, including but not limited to, a change in eligibility due to divorce, marriage or domestic partnership, a change in the “tax dependent” status of my domestic partner and/or dependent children, or an address change due to a residential move. Furthermore, failure to provide timely notice may result in loss of coverage, delay in payment of claims, loss of continuation rights and/or liability for claims paid in error. Upon request, I agree to provide any documentation that ETF deems necessary to substantiate my eligibility or that of my dependents.
8. I understand that if there is a qualifying event in which a qualified beneficiary (me or any dependents) ceases to be covered under this program, the beneficiary(ies) may elect to continue group coverage as permitted by state or federal law for a maximum of 36 months 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 36 months of continuation coverage. I understand that notification of these events must be made to ETF in order to take advantage of the maximum 36 months.
9. I understand that if I am declining enrollment for myself or my dependents (including spouse or domestic partner) because of other health insurance coverage, I may be able to enroll myself and my dependents in this plan if I or my dependents lose eligibility for that other coverage (or if the employer stops contributing toward that other coverage). However, I must request enrollment within 30 days after my or my dependents’ other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if I have a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents if I request enrollment within 30 days after the marriage or effective date of the domestic partnership, or within 60 days after the birth, adoption, or placement for adoption. To request special enrollment or obtain more information, I should contact my employer (or ETF if I am an annuitant or continuant).
10. I agree to abide by the terms of my benefit plan, as explained in any written materials I receive from ETF or my health plan, including, without limitation, the ***It’s Your Choice*** booklets.

ETF Use Only

State of Wisconsin
 Department of Employee Trust Funds
HEALTH INSURANCE APPLICATION/CHANGE FORM
DUPLICATE APPLICATION FOR YOUR RECORDS

Employer Notes

1. APPLICANT INFORMATION

Applicant – Last Name	First	Middle	Previous Name	Social Security Number
Address—Street and No.		City	State	Zip Code
County	Country (if not USA)	Home Telephone No.	Daytime Telephone No.	

MARITAL OR DOMESTIC PARTNERSHIP STATUS: Single Married (date) _____
 Divorced (date) _____ Widowed (date) _____ Domestic Partnership (date) _____
 Spouse/Domestic Partner Name _____ SSN _____ Birth Date _____

ELIGIBILITY STATUS (check one) Employee Survivor
 Continuant (COBRA) Annuitant Graduate Assistant

I WANT MY COVERAGE TO BE EFFECTIVE: As soon as possible
 When employer contributes premium It's Your Choice (January 1)

COVERAGE DESIRED Single Family **HEALTH PLAN SELECTED** _____

2. REASON FOR APPLICATION

A. **Check all boxes that apply. Go to Section 3.**

Initial Enrollment – 02
 Moved from Service Area – 41 Date: _____
 Change to Family Coverage – 43
 Change to Single Coverage– 44 or 45
 Reason¹: _____
 Spouse/DP to Spouse/DP Transfer -31
 Reason²: _____
 Spouse's/DP's State Agency _____
 Transfer from One State Agency to Another – 04
 Name of previous State Agency _____
 COBRA (or continuation) – 63
 It's Your Choice – 40 Current Health Plan _____
 Other: _____

B. **Check all boxes that apply.**

Cancellation – 09
 Desired Cancellation Effective Date _____
 Name Change, former name _____
 Address Change (indicate in Section 1)
 Telephone Number Change (indicate in Section 1)
 Social Security Number Correction to _____
 for (name) _____

¹ If premiums are pre-tax, change to single coverage allowed only when your last dependent becomes ineligible for coverage.
² If premiums are pre-tax, mid-year transfer allowed only when spouse carrying coverage terminates employment, goes on unpaid LOA, or drops to less than half-time employment.

C. **Complete the following for deleting a dependent. List only dependents affected by this change below.**

Reason: Divorce/DP terminated Age* Dependent Married Other _____

**Dependent turned 27 or is over 18 and is eligible for health insurance through employer; grandchild of a dependent that turned 18.*

Last Name	First	Middle	Birthdate			Gender M/F	Social Security Number	Event Date	Dependent's Address (if different than subscriber's)	NOTE: THE DELETION OF A DEPENDENT DUE TO LOSS OF ELIGIBIL- ITY PROVIDES AN OPPORTUNITY FOR CONTINUATION COVERAGE (COBRA) UP TO 36 MONTHS PROVIDED NOTICE IS GIVEN TO THE EMPLOYER WITHIN 60 DAYS OF EVENT
			Mo	Day	Yr					

D. **Complete the following when adding a dependent. List only dependents affected by this change in Section 3.**

Reason: Marriage Birth Legal Ward** Adoption** Domestic Partner**
 Disabled Other** _____ Event Date _____

***Please attach documentation for additions due to legal ward, adoption, paternity, National Medical Support Notice, or loss of coverage; acknowledgement to ETF affidavit required for domestic partnership.*

Dependents include spouse or domestic partner and children under age 27. Children include those who are your natural children, legal wards who become your permanent ward prior to age 19, adopted children, stepchildren, children of your domestic partner, or grandchildren until the grandchildren's parent (your child) reaches age 18.

DUPLICATE APPLICATION FOR YOUR RECORDS

Applicant Name _____

Social Security Number _____

3. ENROLLMENT INFORMATION

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

4. ADDITIONAL INFORMATION

a. Are any of the dependents listed above your grandchild? Yes No If yes, name of parent _____

5. MEDICARE INFORMATION

Are you or any insured dependent covered under Medicare? Yes No If yes, list names of insured and Medicare dates.
 Name: _____ Dates: Part A _____ Part B _____ HIC # _____
 Name: _____ Dates: Part A _____ Part B _____ HIC # _____

6. OTHER COVERAGE

a. Other health insurance coverage? Yes No If yes, name of other insurance company _____
 Name(s) of Insured(s) _____
 b. Is your spouse/domestic partner a State of Wisconsin employee or annuitant (including University of Wisconsin)? Yes No

7. SIGNATURE (read the **Terms and Conditions** on the attached page, check one box and sign)

- I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and have read and agree to the **TERMS AND CONDITIONS**. A copy of this application is to be considered as valid as the original.
- I do not wish to enroll at this time.
- I wish to cancel my current coverage. My employee premium is deducted (Please check one box.):
 - pre-tax and I acknowledge that I have comparable coverage.
 - pre-tax and my required contributions has significantly increased.
 - pre-tax and I do not have comparable coverage. Coverage will end 12/31/XXXX.
 - post-tax.

To the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395. Additional documentation may be required by ETF at any time to verify eligibility

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

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

Employer Number 69-036-	Name of Employer				Program Option Code	Surcharge Code
Group Number	Enrollment Type	Employee Type	Coverage Type Code	Carrier Suffix	Standard Plan Waiting Period	Participant County Code
Previous Service – Complete Information			Date Application Received by Employer (MM/DD/CCYY)	Date WRS Eligible Employment Began or Graduate Assistant Appointment Began (MM/DD/CCYY)		
1. Did employee participate under WRS prior to being hired by you? <input type="checkbox"/> Yes <input type="checkbox"/> No			2. Previous service check completed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
3. Source of previous service check: <input type="checkbox"/> Online Network for Employers(ONE) <input type="checkbox"/> ETF			Event Date (MM/DD/CCYY)			Prospective Date of Coverage (MM/DD/CCYY)
Monthly Employee Share \$	Monthly Employer Share \$		Payroll Representative Signature			Telephone ()

COPY AND DISTRIBUTE: ETF EMPLOYEE EMPLOYER

ET-2301 (REV 07/2010)

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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 Plans (PPPs).

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

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

Checkpoint: A program that provides data from Wisconsin hospitals showing their performance on interventions that medical experts agree should be taken to treat major diseases.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986): An option that allows an insured member to continue 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.

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

Coinsurance: A specific percentage of the cost of an item or service that the member pays. For example, under Uniform Benefits, members pay 20% of the cost of purchasing most durable medical equipment (up to an out-of-pocket maximum cost of \$500 per member per year).

Co-payment: The set dollar amount a member pays when they receive a covered service or prescription. For example, emergency room visits and prescription drugs.

Deductible: The amount you pay for your health care before the health plan begins to pay claims.

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

Dual Choice (It's Your Choice enrollment period): The annual opportunity for currently insured members to change from one health plan to another, or to change from single to family coverage for the upcoming year without restrictions.

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

Emergency Care: Medical services to treat an injury or illness that could result in death or serious harm if not immediately treated.

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

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

Graduate Assistants: This group consists of graduate student assistants, employees-in-training, short-term academic staff and some visiting appointees. Members in this group are not enrolled in the Wisconsin Retirement System.

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.

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.



Leapfrog: A nationwide program that encourages easy access to health care information and places high importance on health care safety, quality and consumer value.

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

Medicare: The federal health insurance program for those who are eligible for coverage due to age, disability or blindness. The original federal Medicare program provides coverage under Medicare Part A and Part B.

Medicare Family 1 Premium Rate: The rate for a family plan where at least one member is enrolled in Medicare parts A and B (and Medicare is the primary (first) payer) and at least one family member is not.

Medicare Family 2 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: A grouping of doctors, clinics, hospitals and other health care providers who contract with a specific health plan to provide services under that plan's benefit package.

Non-Plan Provider: A provider who is not in a health plan's network.

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

Out-of-Pocket Maximum: The maximum amount of money a health plan member has to pay for services during a year.

PBM (Pharmacy Benefit Manager): The third part 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. The State Group Health Insurance Program's preferred PDP is DeanCare Rx.

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

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

PPP (Preferred Provider Plan): A health plan that uses a network of doctors, clinics, hospitals and other medical providers in a specific geographic area, and also provides coverage outside of that network (at a higher out-of-pocket cost to the member).

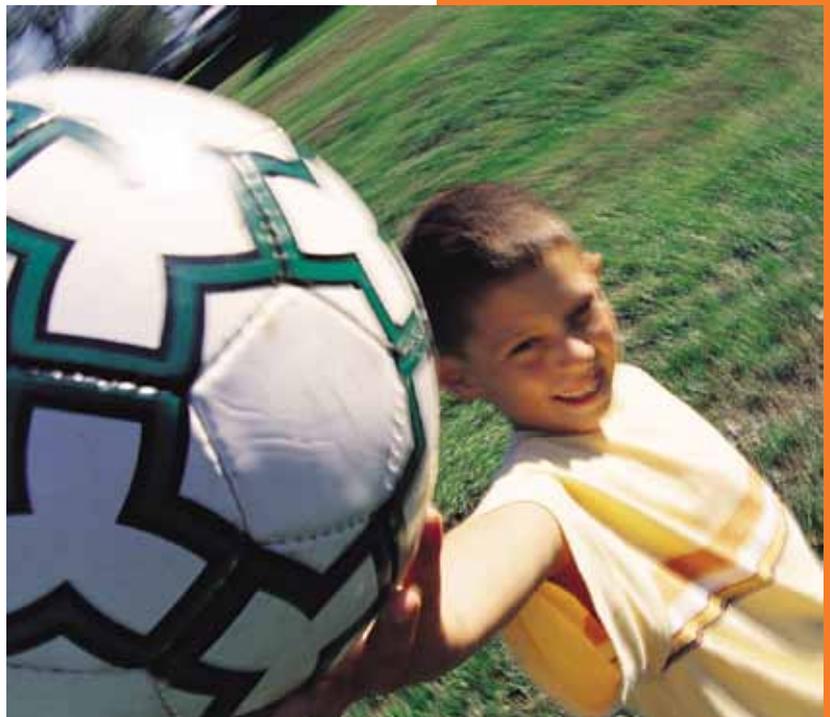
Prior Authorization: A process for requesting the health plan's approval before receiving certain medical services to determine if they are covered under the policy.

Qualified Plan: In order for a health plan to be called qualified in a county, it must meet minimum provider availability requirements. The minimum requirements are five primary care providers—a hospital, if one exists in the county; a chiropractor; and a dental provider, if the plan offers dental coverage. A health plan that is non-qualified is missing one or more of these types of providers, but is still an available option in the county.

Referral: When your doctor recommends that you see another provider or specialist for care. The process for approving referrals varies by health plan, so it is important to find out your health plan's requirements.

Schedule of Benefits: A document that details the specific benefits provided by your health plan including co-pays, deductibles and coinsurance, if any.

Self-Funded Plans: Where the State of Wisconsin is responsible for funding the payment of claims in addition to paying a hired third party administrator (TPA) that administers the plan. Administration by a TPA means that they create networks, pay claims, etc. The Standard and SMP plans, and Navitus Health Solutions are self-funded.



Glossary



Subscriber: The employee, annuitant or continuant who is eligible to participate in the Group Health Insurance Program and is allowed to select one of the available health plans for their coverage. This person's dependents are also eligible for coverage.

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

Uniform Benefits: The standardized level of benefits offered to State Group Health Insurance members through the HMOs and as the in-network benefit for PPPs such as WEA Trust PPP and WPS Metro Choice.

Urgent Care: Care given in a non-emergency situation due to an accident or illness when a member needs to see a doctor more quickly than a routine clinic visit.

Wisconsin Public Employer: Employers who have voluntarily chosen to participate in the Wisconsin Public Employers Group Health Insurance Program. This includes some villages, towns, cities, counties and school districts.

WRS: Wisconsin Retirement System

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It's Your Choice: 2011 Decision Guide

Group Health Insurance Plans

Participating Local Government
Employees and Annuitants



ET-2128d-11 (10/10)

Enrollment Period: October 4-29, 2010



STATE OF WISCONSIN
Department of Employee Trust Funds

David A. Stella
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>

Fall 2010

Dear Members:

I am pleased to announce exciting changes for the 2011 It's Your Choice health insurance enrollment period. This fall, the Department of Employee Trust Funds (ETF) is unveiling our new online **myETF Benefits** system. **MyETF Benefits** allows our members to review and make changes to their health insurance enrollment information online. You can learn more about the system and how you can access your information on page 4 of this book, the *It's Your Choice: 2011 Decision Guide*. In the future, this feature will be enhanced to allow greater online access to other benefit information. You can learn about other exciting changes for 2011, such as the addition of a new health plan in eastern Wisconsin, in the *Important Changes* section of the book.

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

The *Choose Wisely* section of this book highlights important changes to your health benefits and health plans for 2011. The *Choose Your Health Plan* section provides information about premium rates, your benefits package and health plan options. The *Choose Quality* section provides the quality score of each health plan to help you compare how each plan ranks on care delivery and customer service. Finally, the *Glossary* section clarifies and explains common health care terminology.

This Decision Guide is paired with a reference booklet that contains more technical information, such as your *Certificate of Coverage*, and important state and federal notifications. Please keep the reference booklet for future use since we will only publish a new reference booklet during the years when there are major changes in health insurance law, coverage and plans.

Our mission at ETF is to provide high quality, affordable benefits for you and your family. We will continue to work with the Group Insurance Board to be a leader in improving the quality of our health care delivery system in a cost effective way.

Sincerely,

David A. Stella

Secretary, Department of Employee Trust Funds

Every effort has been made to ensure that the information in this booklet is accurate. In the event of conflicting information, state statute, state health contracts, and/or policies and provisions established by the State of Wisconsin Group Insurance Board shall be followed.

Health Plan Contact Information

Anthem Blue

P.O. Box 34210
Louisville, KY 40233-4210
Tele: (800) 490-6201
NurseAssist: (888) 854-0618
Website: www.anthem.com

Arise Health Plan

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

Dean Health Insurance (DHI) (Prescription drug coverage for Medicare eligible retirees)

1277 Deming Way
Madison, WI 53717
Tele: (608) 827-4372
(888) 422-3326
Fax: (608) 827-4212
Website: www.deancare.com/deancarerx

Dean Health Plan

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

Group Health Cooperative of Eau Claire (GHC-EC)

P.O. Box 3217
Eau Claire, WI 54702
Tele: (715) 552-4300
(888) 203-7770
Fax: (715) 552-3500
FirstCare Nurseline: (800) 586-5473
Website: www.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: (608) 828-4853
(800) 605-4327
Fax: (608) 662-4186
GHC HealthLine: (888) 203-3504
Website: www.ghcscw.com

Gundersen Lutheran Health Plan

1836 South Ave.
LaCrosse, WI 54601
Tele: (608) 775-8007
(800) 897-1923
Fax: (608) 775-8042
Nurse Advisor: (800) 362-9567
ext. 54454
Website: www.glhealthplan.org

HealthPartners Health Plan

P.O. Box 1309
Minneapolis, MN 55440-1309
Tele: (800) 883-2177
(952) 883-5000
Fax: (952) 883-5666
Careline: (800) 551-0859
Website: www.healthpartners.com/stateofwis

Health Tradition Health Plan

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

Humana

N19 W24133 Riverwood Drive #300
Waukesha, WI 53188
Tele: (800) 448-6262
HumanaFirst Nurse Advice:
(800) 622-9529
Website: www.humana.com, or direct at
<http://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: (563) 556-8070
(800) 747-8900
Fax: (563) 556-5134
Nurse Line: (800) 325-7442
Website: www.mahealthcare.com

MercyCare Health Plans

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

Navitus Health Solutions

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

Network Health Plan

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

Physician Plus Insurance Corp.

22 E. Mifflin Street, Suite 200
P.O. Box 2078
Madison, WI 53701-2078
Tele: (608) 282-8900
(800) 545-5015
Fax: (608) 258-1902
NursePlus: (866) 775-8776
Website: www.pplusic.com

Security Health Plan

1515 Saint Joseph Ave.
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: www.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: www.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) 676-5637
Website: www.unitedhealthcare.com

Unity Health Insurance

840 Carolina Street
Sauk City, WI 53583-1374
Tele: (800) 362-3310
Fax: (608) 643-2564
Website: www.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: www.weatrust.com/state

WPS Metro Choice

1717 W Broadway
PO Box 8190
Madison, WI 53707-8190
Tele: (800) 634-6448
Fax: (608) 243-6139
Website: www.wpsic.com/state

