

# Deductible HMO — Standard PPO Addendum



CONTENTS for program option 4:

- Rates
- Comparison of Benefit Options
- Questions & Answers
- Standard Plan and SMP Description Pages

## 2014 Wisconsin Public Employers Group Health Insurance Program



Participating Local Government  
Employees & Annuitants

Keep this as a reference throughout the year with the *It's Your Choice* guides.



## 2014 Monthly Local Rates: Deductible HMO Option — Standard PPO

Plan Name	Tier	Non-Medicare Rates*		Medicare Rates		
		Single	Family	Single	Medicare 1 Eligible**	Medicare 2 Eligible***
Anthem Blue Northeast	1	671.90	1,673.20	473.30	1,140.80	942.20
Anthem Blue Southeast	1	720.10	1,793.70	496.80	1,212.50	989.20
Arise Health Plan	1	917.70	2,287.70	596.20	1,509.50	1,188.00
Dean Health Plan	1	623.60	1,552.50	442.60	1,061.80	880.80
Dean Health Insurance Prevea360	1	761.30	1,896.70	509.80	1,266.70	1,015.20
GHC of Eau Claire	1	1,035.20	2,581.50	540.30	1,571.10	1,076.20
GHC of South Central Wisconsin	1	557.60	1,387.50	416.20	969.40	828.00
Gundersen Health Plan	1	707.90	1,763.20	371.40	1,074.90	738.40
HealthPartners	1	826.60	2,060.00	530.90	1,353.10	1,057.40
Health Tradition Health Plan	1	652.30	1,624.20	461.60	1,109.50	918.80
Humana Eastern	3	1,043.10	2,601.20	343.30	1,382.00	682.20
Humana Western	1	1,043.10	2,601.20	343.30	1,382.00	682.20
Medical Associates Health Plan	1	629.10	1,566.20	370.00	994.70	735.60
Medicare Plus****	N/A****	N/A****	N/A****	414.30	N/A****	825.10
MercyCare Health Plan	1	526.00	1,308.50	382.50	904.10	760.60
Network Health Plan	1	721.70	1,797.70	498.20	1,215.50	992.00
Physicians Plus	1	605.90	1,508.20	413.70	1,015.20	823.00
Security Health Plan	3	1,020.60	2,545.00	508.30	1,524.50	1,012.20
Standard Plan - Balance of State****	3	980.50	2,446.10	N/A	1,394.80****	N/A
Standard Plan - Dane****	3	911.20	2,271.80	N/A	1,325.50****	N/A
Standard Plan - Milwaukee****	3	1,057.70	2,637.60	N/A	1,472.00****	N/A
Standard Plan - Waukesha****	3	980.50	2,446.10	N/A	1,394.80****	N/A
State Maintenance Plan (SMP)	1	708.20	1,765.40	N/A	1,122.50****	N/A
UnitedHealthCare	1	773.10	1,926.20	521.80	1,290.50	1,039.20
Unity Community	1	575.60	1,432.50	410.30	981.50	816.20
Unity UW Health	1	528.60	1,315.00	388.20	912.40	772.00
WEA Trust PPO East	1	739.60	1,842.50	507.20	1,242.40	1,010.00
WEA Trust PPO Northwest	1	864.90	2,155.70	569.80	1,430.30	1,135.20
WEA Trust PPO South Central	1	721.40	1,797.00	498.00	1,215.00	991.60
WPS Metro Choice Northwest	1	1,049.20	2,616.50	662.00	1,706.80	1,319.60
WPS Metro Choice Southeast	3	1,272.40	3,174.50	773.60	2,041.60	1,542.80

**Standard Plan Area Includes The Following:**

- <sup>1</sup> BALANCE OF STATE: All other Wisconsin counties
- <sup>2</sup> DANE: Dane, Grant, Jefferson, LaCrosse, Polk, St. Croix
- <sup>3</sup> MILWAUKEE: Milwaukee County, also applies to retirees and continuants living out of state
- <sup>4</sup> WAUKESHA: Kenosha, Ozaukee, Racine, Washington, Waukesha

N/A= "not applicable."

Medicare premium rates apply only to subscribers who have terminated employment.

\*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 Eligible= One family member enrolled in Medicare Parts A, B & D.

\*\*\*Medicare 2 Eligible= Family coverage with all insured members enrolled in Medicare Parts A, B & D.

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

# Comparison of Benefit Options

This chart is designed to compare Uniform Benefits, the Standard PPO Plan and Medicare Plus. It is not intended to be a complete description of coverage. Differences might exist among the health plans in the administration of the Uniform Benefits package.

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN		MEDICARE PLUS and Medicare Parts A, B and D <sup>8</sup>
		Preferred Provider	Non-Preferred Provider	
Annual Deductible <sup>1</sup>	\$500 individual/ \$1,000 family <sup>2</sup>	\$500 individual/ \$1,000 family.	\$1,000 individual/ \$2,000 family.	No deductibles
Annual Co-insurance <sup>3</sup>	As described below <sup>4</sup>	80%/20% Annual OOP (includes deductible): \$2,000 individual/\$4,000 family.	70%/30% Annual OOP (includes deductible): \$4,000 individual/\$8,000 family.	100%
Routine Preventive <sup>5</sup>	100% <sup>5</sup>	100% <sup>5</sup>	Deductible and coinsurance	100% Covered by Medicare only.
Hospital Days	As medically necessary, plan providers only	Deductible and coinsurance as medically necessary, no day limit	Deductible and coinsurance as medically necessary, no day limit	100% 120 days; semi-private room
Emergency Room	\$60 copay per visit	\$75 copay per visit, deductible and coinsurance thereafter.	\$75 copay per visit, Preferred Provider deductible and coinsurance thereafter.	100% no copay
Ambulance	100%	Deductible and coinsurance	Deductible and coinsurance	100%
Transplants (May cover these and others listed)	Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung	Deductible and coinsurance Bone marrow, parathyroid, musculoskeletal, corneal, and kidney	Deductible and coinsurance Bone marrow, parathyroid, musculoskeletal, corneal, and kidney	100% for Medicare approved heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver transplants in a Medicare-certified facility
Mental Health/ Alcohol & Drug Abuse	Inpatient, Outpatient, and Transitional, 100%	Deductible and coinsurance	Deductible and coinsurance	Inpatient 100%, up to 120 days Outpatient & Transitional 100%
Hearing Exam	100%	Benefit for illness or disease to deductible and coinsurance	Benefit for illness or disease to deductible and coinsurance	Benefit for illness or disease, 100%
Hearing Aid (per ear)	Every 3 years: Adults, 80%/20%, up to \$1,000; dependents younger than 18 years, 100%, maximum does not apply.	For dependents younger than 18 years only, every 3 years. - deductible and coinsurance	For dependents younger than 18 years only, every 3 years. - deductible and coinsurance	For dependents younger than 18 years only, every three years—100%

Footnotes appear on Page 4.

# Comparison of Benefit Options

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN		MEDICARE PLUS and Medicare Parts A, B and D <sup>8</sup>
		Preferred Provider	Non-Preferred Provider	
Cochlear Implants	Adults, 80%/20% for device, surgery, follow-up sessions; 100% hospital charge for surgery. Dependents under 18, 100%.	Dependents under 18, deductible and coinsurance device, surgery, follow-up sessions.	Dependents under 18, deductible and coinsurance device, surgery, follow-up sessions.	Dependents under 18, 100% device, surgery, follow-up sessions
Routine Vision Exam <sup>5</sup>	One per year	100% for children under age 5 <sup>5</sup> . Illness or disease only, deductible and coinsurance.	No benefit for routine. Illness or disease only, deductible and coinsurance.	No benefit for routine. Illness or disease only, 100%
Skilled Nursing Facility (non custodial care)	120 days per benefit period	Deductible and coinsurance, as medically necessary, 120 days per benefit period.	Deductible and coinsurance, as medically necessary, 120 days per benefit period.	Medicare approved facility: 100% 120 days/benefit period. Non-Medicare approved facility, if transferred within 24 hours of hospital release, benefits payable up to 30 days/confinement
Home Health (non custodial)	50 visits per year; Plan may add 50 visits.	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50.	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50.	100%
Physical/Speech /Occupational Therapy	50 visits per year; Plan may prior authorize an additional 50 visits.	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50.	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50.	100%
Durable Medical Equipment	80%/20% co-insurance, \$500 OOPL	Deductible and coinsurance	Deductible and coinsurance	100%
Hospital Pre-Certification	Varies by plan	WPS Medical Management Program for inpatient stays.	WPS Medical Management Program for inpatient stays.	None required
Referrals	In-network varies by plan. Out-of-network required.	None required	None required	None required
Treatment for Morbid Obesity	Excluded	Preferred provider deductible and coinsurance at Centers of Excellence (COE) provider	Non-preferred provider deductible and coinsurance outside COE provider	100% for Medicare covered service
Oral Surgery	11 procedures	23 procedures. -deductible and coinsurance	23 procedures. -deductible and coinsurance	100%
Dental Care	Uniform Dental Benefit, if offered	No benefit	No benefit	No benefit
Drug Copays and OOPL <sup>6</sup> (Non Specialty)	Level 1=\$5; 2=\$15; 3=\$35 <sup>7</sup> . OOPM \$410 individual/\$820 family.	Level 1=\$5; 2=\$15; 3=\$35 <sup>7</sup> . OOPL \$1,000 individual/ \$2,000 family.	Level 1=\$5; 2=\$15; 3=\$35 <sup>7</sup> . OOPL \$1,000 individual/ \$2,000 family.	Level 1=\$5; 2=\$15; 3=\$35 <sup>8</sup> . OOPL \$410 individual/\$820 family
Specialty Drug Copays and OOPL <sup>6</sup> Preferred Pharmacy	Formulary drugs \$15 to OOPL \$1,000 individual/\$2,000 family; Non-formulary drugs \$50, no OOPL	Formulary drugs \$15 to OOPL \$1,000 individual/\$2,000 family; Non-formulary drugs \$50, no OOPL	Not applicable	Formulary drugs \$15 to OOPL \$1,000 individual/\$2,000 family; Non-formulary drugs \$50, no OOPL
Specialty Drug Copays and OOPL <sup>6</sup> Non-Preferred Pharmacy	Formulary drugs \$50 to OOPL \$1,000 individual/\$2,000 family; Non-formulary drugs \$50, no OOPL	Not applicable	Formulary drugs \$50 to OOPL \$1,000 individual/\$2,000 family; Non-formulary drugs \$50, no OOPL	Formulary drugs \$50 to OOPL \$1,000 individual/\$2,000 family; Non-formulary drugs \$50, no OOPL

Footnotes appear on Page 4.

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

## Comparison of Benefit Options Footnotes

- <sup>1</sup> Deductible applies to all services, except certain preventive services and prescription drugs.
- <sup>2</sup> PPOs like WEA Trust PPO and WPS Metro Choice have out-of-network deductibles. See PPO Plan Descriptions in *It's Your Choice: Decision Guide* for details.
- <sup>3</sup> Coinsurance applies to all services up to the listed out-of-pocket limit, then all services are covered at 100%.
- <sup>4</sup> PPOs like WEA Trust PPO and WPS Metro Choice have out-of-network coinsurance. See PPO Plan Descriptions in *It's Your Choice: Decision Guide* for details.
- <sup>5</sup> As required by federal law: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>. Note: coinsurance may vary by age.
- <sup>6</sup> This is separate from other out-of-pocket limits, such as the medical.
- <sup>7</sup> Level 3 copays don't apply to the OOPL.
- <sup>8</sup> Medicare Plus supplements Medicare's payment up to 100% coverage. If Medicare denies, this plan also denies except as stated.

# FREQUENTLY ASKED QUESTIONS AND THEIR ANSWERS

## General Information

### **CAN MY EMPLOYER PAY FOR MY OUT-OF-POCKET COSTS FOR MEDICAL SERVICES AND PRESCRIPTION DRUG COPAYS, DEDUCTIBLES AND/OR COINSURANCE?**

---

No, however, if your employer offers you a medical Flexible Spending Account (FSA), you may be able to lower the amount you pay for certain medical out-of-pocket costs.

A medical FSA program allows you to reduce your taxable income by an agreed-upon amount each pay period and to have these amounts set aside to pay certain medical expenses. Contributions are made on a pre-tax basis to your account as established by you annually. These contributions are returned to you by submitting receipts and other required documentation to your employer's FSA administrator.

A medical reimbursement account is used to pay medical expenses for you, your spouse and dependents that are not paid by insurance. This would include deductibles and coinsurance amounts; drugs; dental, vision and hearing care; orthodontia; and other uncovered medical procedures or supplies.

## **Deductible HMO (for the Alternate Plans)**

### **HOW IS THE DEDUCTIBLE HMO OPTION DIFFERENT FROM UNIFORM BENEFITS, THE TRADITIONAL OR FULL PAY HMO OPTION?**

---

Under the Deductible HMO option, you have an upfront deductible per calendar year of \$500 per individual, \$1,000 per family for medical services with the exception of federally mandated preventive care services, that are paid for in full. That is, you usually pay the first \$500 in services per individual or \$1,000 per family. Once the deductible is met, you receive benefits as described in Uniform Benefits, for example, copayment on emergency room visits, coinsurance on durable medical equipment (DME), etc.

### **ARE THERE ANY SERVICES THAT DO NOT APPLY TO THE UPFRONT DEDUCTIBLE?**

---

The deductible does not apply to federally mandated preventive care services. In addition, pharmacy claims do not apply and continue to be subject to existing prescription drug copays.

### **WHAT ARE ROUTINE OR PREVENTIVE SERVICES, AND WHY ARE THEY TREATED DIFFERENTLY THAN TREATMENT OF AN ILLNESS OR INJURY?**

---

Routine, preventive care is care that is designed to help prevent disease, or to diagnose it in the early stages. Federal health care reform requires first dollar coverage of preventive care services when grandfathering is lost as a result of significant benefit and/or premium changes. The list of federally required preventive services is available at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>. Your provider uses standardized codes to bill your insurer for services. These codes require providers, when performing a non-trivial treatment of an illness or injury, to separate the claim from the preventive service. In general, don't expect to have the evaluation or treatment of an illness or injury paid as preventive when it occurs during a preventive exam.

## **HOW WILL I KNOW WHEN MY DEDUCTIBLE IS MET?**

---

Until you meet your deductible, your HMO will send you an Explanation of Benefits (EOB) each time it processes a claim. The EOB will identify information about the claim, including the provider name, the amount billed, and the amount applying to your deductible, which you are responsible for paying the provider. Typically you would pay your provider after you receive the EOB from your health plan. The EOB will allow you to track when your deductible is met.

## **Standard Preferred Provider Organization (PPO)**

### **WHAT IS THIS CHANGE TO THE PPP ALL ABOUT?**

---

The redesign of the Wisconsin Public Employer's Standard Plan into a preferred provider organization (PPO) with a network will be effective on January 1, 2013, or the date selected by your employer. The PPO network offers participants the choice to see any provider, but there are differences in reimbursements depending on whether you go to an in-network provider or an out-of-network provider. When you receive services from providers, you will need to meet up-front deductible and coinsurance amounts with the exception of in-network federally mandated preventive care services, that are paid for in full. If you receive services from an in-network provider, you contribute more toward your health care costs by incurring additional deductible and coinsurance costs.

A hospital pre-certification program is included. This program requires at least 48 hours prior notice of non-emergency hospital admissions, or notice with 48 hours after an emergency admission or as soon as reasonably possible. If you do not notify WPS, their payment for your claim will be reduced by \$100. You will be responsible to pay that amount in addition to your deductible.

Refer to the plan description page for more details. This arrangement can be attractive to members who, for the most part, are comfortable with the plan's providers but occasionally feel the need to utilize a particular specialist or desire coverage for routine care while traveling. In addition, members who have students away at college may choose the plan to offer comprehensive coverage to all family members, regardless of where they live. The provider network is nationwide, so covered members who receive care out of state will have improved access to providers.

Note that the Standard PPO is separate from Uniform Benefits offered by the alternate plans (HMOs, WPS Metro Choice and WEA Trust PPOs). All eligible employees and annuitants have the option to enroll in this plan.

### **HOW DO I KNOW WHICH PROVIDERS ARE IN-NETWORK PROVIDERS?**

---

You get this information from WPS Health Insurance (WPS) over the Internet at [www.wpsic.com/state](http://www.wpsic.com/state). See the plan description page for more information. Or you can call WPS at (800) 634-6448 for information or to request a printed provider directory.

### **HOW DOES THE APPLICATION OF THE PREFERRED PROVIDER NETWORK INTO THE STANDARD PLAN SAVE MONEY AND IMPROVE SERVICES?**

---

When using a preferred provider network, claim charges are discounted by in-network providers to a greater extent than those of out-of-network providers. As members utilize in-network service, the plan saves money and future increases would reflect the savings.

With this change in applying a preferred provider network, we hope our plan will become easier to understand and use, for members and providers, as it becomes more similar to other plans in the marketplace. Also, this change helps to keep the cost of administration down.

## **WHY IS THE STANDARD PLAN WITH THE PREFERRED PROVIDER NETWORK BEING IMPLEMENTED NOW?**

---

Over the past few years, the Group Insurance Board has studied alternatives for our plans. One of the goals was to make the plan more cost-effective and affordable. Your employer is also concerned about this and has selected this option to meet these goals.

## **IF I WANT THE FREEDOM OF PROVIDER CHOICE OF THE STANDARD PPO AND AM RETIRED WHERE MY DEPENDENTS OR I HAVE MEDICARE, WHAT IS MY BENEFIT PLAN?**

---

Insured Retirees and their dependents who are eligible for Medicare Parts A & B and choose the Standard Plan will be automatically enrolled in Medicare Plus. Medicare Plus is a Medicare supplement plan. An insured retiree and his/her dependents who are not eligible for Medicare will remain in the Standard Plan.

Refer to the Comparison of Benefit Options in this addendum and the Medicare Plus plan description page in the It's Your Choice: Decision Guide for more details.

## **Standard Maintenance Plan (SMP)**

### **HOW ARE SMP BENEFITS DIFFERENT FROM THE OLD SMP?**

---

SMP benefits have been changed to match those of the Uniform Benefits plan offered to you and explained in the Comparison of Benefits Options listed in this addendum. This benefit change does not impact the network in place.

A hospital pre-certification program is included. This program requires at least 48 hours prior notice of non-emergency hospital admissions, or notice with 48 hours or as soon as reasonably possible after an emergency admission. If you do not notify WPS Health Insurance (WPS), their payment for your claim will be reduced by \$100.

## **State Maintenance Plan (SMP)**

### **HOW ARE SMP BENEFITS DIFFERENT FROM THE OLD SMP?**

---

Effective January 1, 2013, SMP benefits have been changed to match those of the Uniform Benefits plan offered to you and explained in the Comparison of Benefits Options listed in this addendum. This benefit change does not impact the network in place.

A hospital pre-certification program is included. This program requires at least 48 hours or as soon as reasonably possible prior notice of non-emergency hospital admissions, or notice with 48 hours after an emergency admission. If you do not notify WPS Health Insurance (WPS), their payment for your claim will be reduced by \$100.

# **Standard PPO Plan**

Administered by WPS Health Insurance

800-634-6448     [www.wpsic.com/state](http://www.wpsic.com/state)

## **What's New for 2014**

WPS Health Insurance has reached an agreement with Aurora Health Care to offer Aurora providers through our WPS Network. Our new relationship with Aurora improves our already exceptional list of provider collaborations. Aurora offers 15 hospitals, 172 clinics and more than 1,500 employed physicians, as well as affiliations with 3,000 independent physicians.

## **General Information**

The Standard Plan is a comprehensive health plan that provides you with freedom of choice among hospitals and physicians in Wisconsin and nationwide. A higher level of benefits is available by using a preferred or in-network provider which are available nationwide. For more information, see the booklet at <http://etf.wi.gov/publications/et2162.pdf>.

## **Provider Directory**

Go to [wpsic.com/state/pdf/dir2014\\_statewide\\_eastern.pdf](http://wpsic.com/state/pdf/dir2014_statewide_eastern.pdf) or [wpsic.com/state/pdf/dir2014\\_statewide\\_western.pdf](http://wpsic.com/state/pdf/dir2014_statewide_western.pdf) to search for a provider within Wisconsin and bordering areas. You can also visit [wpsic.com/state/fad2014-state-national.shtml](http://wpsic.com/state/fad2014-state-national.shtml) to search for providers within Wisconsin, as well as nationwide. You may also contact member services to request a copy.

## **Other: Pre-Certification**

To avoid a \$100 inpatient benefit reduction, you, a family member or a provider must notify WPS of *any* inpatient hospitalization to request pre-certification.

## **Referrals and Prior Authorizations**

Referrals are not needed.

Members or providers may request prior authorization for services when concerned if WPS will pay and at what rate. Without an approved prior authorization, WPS may deny payment.

**Prior Authorization is required for lower back surgery and high-tech radiology services.** Please visit [wpsic.com/state](http://wpsic.com/state) and follow the Member Materials link to obtain a copy of a Medical Preauthorization Request Form or call member services.

## **Mental & 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.

# Deductible SMP-State Maintenance Plan

Administered by WPS Health Insurance

800-634-6448 [www.wpsic.com/state](http://www.wpsic.com/state)

## What's New for 2014

SMP is no longer available in Oneida and Price counties.

Visit the Health Center at [wpsic.com/healthcenter](http://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 SMP program provides maximum health care coverage over a broad range of benefits in a managed care environment. See the Comparison of Benefit Options chart starting on Page 2 for more information and view the Health Care Benefit Plan booklet at <http://etf.wi.gov/publications/et2163.pdf>.

## Provider Directory

Please visit [wpsic.com/state/pdf/dir2014\\_state\\_smp.pdf](http://wpsic.com/state/pdf/dir2014_state_smp.pdf) to search for a provider or contact WPS member services.

## Other: Pre-Certification

To avoid a \$100 inpatient benefit reduction, you, a family member or a provider must notify WPS of *any* inpatient hospitalization to request pre-certification of services.

## Referrals and Prior Authorizations

You must get a referral approved by WPS before getting care outside the WPS SMP network.

**Your provider must request the referral.** Retroactive referrals **are not** allowed. It is ultimately the member's responsibility to make sure the referral is submitted and approved prior to receiving services.

Members or providers may request prior authorization for services when concerned if WPS will pay and at what rate. Without an approved prior authorization, WPS may deny payment.

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

Please visit [wpsic.com/state](http://wpsic.com/state) and follow the Member Materials link to obtain a copy of a Medical Preauthorization Request Form or call member services.

## Care Outside the Service Area

Emergency or Urgent Care: In-network hospital emergency rooms or urgent care facilities should be used whenever possible. Should you be unable to reach an in-network provider and cannot safely postpone the care, go to the nearest appropriate medical facility. Afterwards, contact member services by the next business day, or as soon as reasonably possible, and report where you received the care. Out-of-network care may be subject to Usual and Customary Charges. Non-urgent follow-up care must be received from an in-network provider.

## Mental & 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 benefits available.

