State of Wisconsin Group Health Insurance
for Local Employees with the IYC Local Health Plan

Schedule of Benefits

Effective January 1, 2022

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

Annual Limits

Annual Medical Deductible

The amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services.

Individual: $250

Family: $500

- The family deductible is embedded – no one family member will contribute more than the individual amount ($250) to the family deductible ($500).

Applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)
- ✓ Maximum Out-of-Pocket Limit (MOOP)

Does not apply to:

- × Preventive services
- × Prescription drugs

Annual Medical Coinsurance

The percentage of costs for a covered service you pay after meeting your deductible.

You pay: 10% after deductible is met

Plan pays: 90% after deductible is met

Applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)
- ✓ Maximum Out-of-Pocket Limit (MOOP)

Does not apply to:

- × Preventive services
- × Prescription drugs
- × Durable Medical Equipment & Supplies

Annual Medical Out-of-Pocket Limit (OOPL)

The most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

Individual: $1,250

Family: $2,500

- This Plan uses a provider network. You pay less if you use the plan's provider network. Check with your plan before you receive services.

Annual Medical Out-of-Pocket Limit (OOPL), Continued

- The OOPL is embedded for family plans – no one family member will contribute more than the individual amount ($1,250) to the family OOPL ($2,500).

Applies to:

- ✓ Maximum Out-of-Pocket Limit (MOOP)

Does not apply to:

- × Prescription drugs

Annual Maximum Out-of-Pocket Limit (MOOP)

This is the yearly amount set as the most a Single or Family is required to pay in cost sharing during the plan year for covered, in-network services.

Individual: $8,700

Family: $17,400

- The most you could pay for services you receive from in-network providers. Your out-of-pocket costs for services received from in-network providers will count toward this limit.
- The MOOP is embedded for family plans – no one family member will contribute more than the individual amount ($8,700) to the family MOOP ($17,400).

Covered Services

Ambulance

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

You pay: 10% coinsurance per trip after deductible is met

- Coinsurance is for each one-way trip.

Chiropractic Care

Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position). This also includes Occupational therapy (helping with daily living tasks caused from illnesses and injuries to our brain and body).

You pay: $15 copayment per visit

- Maintenance visits are not covered.

Cochlear Implant Devices – Under Age 18

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

You pay: Full allowed cost until deductible is met

10% coinsurance after deductible is met

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

Coinsurance applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)
- ✓ Maximum Out-of-Pocket Limit (MOOP)

Diagnostic Services and Labs

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

You pay: Full allowed cost until deductible is met

10% coinsurance after deductible is met

Covered diagnostic services include:

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

Durable Medical Equipment and Supplies

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

You pay: Full allowed cost until deductible is met

20% coinsurance after deductible is met

- Includes Durable Diabetic Equipment and related supplies.

Coinsurance applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)
- ✓ Maximum Out-of-Pocket Limit (MOOP)

Emergency and Urgent Care

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

Emergency Care

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

You pay: $75 copayment per visit

- The copayment is waived if you are admitted as an inpatient or for observation for 24 hours or more.
- You may be responsible for other charges in addition to the visit copayment. See Illness or Injury Treatment Services for more details.

Copayment applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)
- ✓ Maximum Out-of-Pocket Limit (MOOP)

Copayment does not apply to:

- × Deductible

Urgent Care Visit

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

You pay: $25 copayment per visit

- Deductible need not be met first.

Copayment applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)
- ✓ Maximum Out-of-Pocket Limit (MOOP)

Copayment does not apply to:

- × Deductible

Hearing Aids – Under Age 18

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

You pay: Full allowed cost until deductible is met

10% coinsurance after deductible is met

Coinsurance applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)
- ✓ Maximum Out-of-Pocket Limit (MOOP)

Home Care Benefits

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

You pay: Full allowed cost until deductible is met

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

Inpatient Hospital Services

Services necessary for your admission to a hospital, as well as diagnosis and treatment, are covered when they are provided by an in-network provider.

You pay: Full allowed cost until deductible is met

10% coinsurance after deductible is met

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

Outpatient Hospital & Ambulatory Surgery Center Services

Services necessary for your admission to an outpatient hospital or Ambulatory Surgery Center, as well as diagnosis and treatment, are covered when they are provided by an in-network provider.

You pay: Full allowed cost until deductible is met

10% coinsurance after deductible is met

- You may receive other services while in an outpatient hospital facility, which could be billed separately and subject to other copayments or coinsurance.

Skilled Nursing Facility

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

You pay: Full allowed cost until deductible is met

10% coinsurance after deductible is met

- Up to 120 calendar days per benefit period

Illness or Injury Treatment Services

Services related to an illness/injury beyond an office visit or Emergency Room visit.

You pay: Full allowed cost until deductible is met

10% coinsurance after deductible is met

Coinsurance applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)
- ✓ Maximum Out-of-Pocket Limit (MOOP)

Mental Health Counseling Visits

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

You pay: $15 copayment per visit

Applies to:

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

Occupational, Physical, and Speech Therapy

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

You pay: $15 copayment per visit

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

Applies to:

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

Outpatient Cardiac Rehabilitation

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

You pay: Full allowed cost until deductible is met

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

Preventive Care Services

Routine health care, including screening, check-ups, and patient counseling to prevent or discover illness, disease, or other health problems – as required by federal law. See healthcare.gov/preventive-care-benefits for more details.

You pay: $0

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

Preventive Care Services, Continued

The plan covers many preventive services including:

- Alcohol misuse counseling
- Annual physical exam
- Annual wellness visit
- Breast cancer screening (mammogram)
- Cardiovascular disease risk reduction visit
- Glaucoma screening
- HIV screening
- Immunizations, including flu shots, hepatitis B shots, pneumococcal shots
- Medical nutrition therapy services
- Obesity screening and counseling
- Cardiovascular disease testing
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screening
- Diabetes screening Prostate cancer screening (PSA)
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)

Primary Care

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

You pay: $15 copayment per visit

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

Telemedicine and Remote Care

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

E-Visit

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

You pay: $0

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

Telehealth

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

You pay: $15/$25, depending upon provider specialty

- Telehealth will be covered by your health plan if those services are delivered:
  - Outside of your physical presence (e.g., remotely),
  - When both audio and video elements are present, and
  - When there is no reduction in the quality, safety, or effectiveness of the service.

If you and your provider determine that you cannot successfully complete a Telehealth visit with full audio and video, you may opt to change to a Telephone Visit.

Telephone Visit

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

You pay: $15/$25, depending upon provider specialty

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

Remote Patient Monitoring

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

You pay: $15 for initial setup of device including patient education

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

Virtual Check-In

A brief discussion either by telephone or real-time audio and video between a provider and an established patient to manage a medical condition. These are services separate from and less intensive than Telehealth, Telephone Visits, or E-Visits.

You pay: $0/$15/$25, depending upon vendor and provider specialty

- Covered as a Virtual Check-In as long as the check-in is not related to another medical visit within the past 7 days, and as long as the check-in does not lead to a medical visit within the next 24 hours or the next available appointment.

Vision Services

Yearly eye exam to diagnose and treat diseases and conditions of the eye. Does not include frames or any other vision related expenses. For supplemental vision coverage, including prescription glasses and contacts, see the Supplemental Vision Benefit.

You pay: $25 per visit

- Coverage is limited to one eye exam per participant per calendar year
- Non-routine eye exams are covered if considered medically necessary by your health plan
- Child vision screenings:
  - Under age 5 – Considered preventive and are not subject to deductible or copayment
- Age 6 or older – Not considered preventive, subject to provider and specialist provider office visit copayment

Additional Covered Services

Cochlear Implant Devices – Over Age 18

An electronic device that partially restores healing. For coverage for participants under the age of 18, see Cochlear Implant Devices – Under Age 18 in the Covered Services section.

You pay: Full allowed cost until deductible is met

20% coinsurance after deductible is met for implant devices, professional surgery for implantation, and follow-up device training

10% coinsurance after deductible is met for hospital charges

Dental Implants

Dental implants are artificial tooth roots placed in the jaw to hold a replacement tooth or bridge after the loss of a tooth or teeth.

You pay: Full allowed cost until deductible is met

10% coinsurance after deductible is met

- Dental implants are only covered following accident or injury.
- Maximum benefit plan payment of $1,000 per tooth.

Hearing Aids – Over Age 18

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

You pay: Full allowed cost until deductible is met

20% coinsurance after deductible is met

- One hearing aid per ear, no more than once every 3 years.
- Maximum benefit plan payment of $1,000 per hearing aid.

Temporomandibular Joint Disorders – Diagnosis and Non-Surgical Treatment	
Coverage for diagnostic procedures and medically necessary surgical or non-surgical for the correction of temporomandibular disorders, provided all coverage criteria are met.	
You pay:	Full allowed cost until deductible is met 10% coinsurance after deductible is met • Maximum benefit plan payment of $1,250 per participant per plan year

Dental, Pharmacy, and Supplemental Plans

Uniform Dental Benefit (Program Option 06 Only)
The Uniform Dental Benefit provides coverage for basic procedures such as cleanings, fluoride treatments, fillings, and orthodontia. This benefit is offered through Delta Dental. Learn more at deltadentalwi.com/state-of-wi.
Uniform Pharmacy Benefit
Your coverage for most medications is provided by Navitus Health Solutions, a Pharmacy Benefit Manager (PBM). You must obtain pharmacy benefits at a participating Navitus pharmacy, except when not reasonably possible because of Emergency or Urgent Care. For full detail on services covered by the PBM, please see the Uniform Pharmacy Benefits Certificate of Coverage.
Supplemental Vision Benefit
The supplemental DeltaVision Plan provides coverage for eye exams, prescription glasses, contacts, and more. This benefit is offered through Delta Dental, in partnership with EyeMed Vision Care. Learn more at visiting deltadentalwi.com/state-of-wi-vision.