Dunn County, WI Municipal Health Plan

The information contained in this packet is the product of Open Records requests filed by the Partnership for Safe Medicines. For additional information, contact PSM at editors@safemedicines.org

IMPORTANT NOTE: The following information is a general description of a covered person's benefits arranged by type of coverage (example: medical, dental, vision). It is not intended to be an all-inclusive benefit description and cannot be considered a guarantee of benefits. Please note any limitations that apply to specific benefits or diagnoses. Not all restrictions or limitations are listed.

The benefits available are conditional on the patient's employment status, plan eligibility, payment of contributions, and amount of benefits remaining, plan provisions, and plan exclusions. The benefits quoted are not guaranteed. Final determination as to benefits payable will be made at the time a claim is submitted for payment, and subject to review of the necessary medical records and other information.

INFORMATION LISTED IS IN EFFECT AS OF 01/01/2023

COUNTY of DUNN

Network Information:
The Alliance/Trilogy – 800-223-4139 www.the-alliance.org
Out of Area – FHN- www.myfirsthealth.com

Non Grandfathered * Embedded deductibles *****IN NETWORK*** MAJOR MEDICAL BENEFITS**	
Group / Plan:	DUN / 100DUNHDB
Individual Deductible:	$5,000
Family Deductible:	$10,000
Maximum Individual Out-of-Pocket	$7,500 – Includes Deductible
Maximum Family Out- of- Pocket	$15,000 – includes deductible

OUT OF NETWORK MAJOR MEDICAL BENEFITS	
Group / Plan:	DUN / 100DUNHDB
Individual Deductible:	$10,000
Family Deductible:	$20,000
Maximum Individual Out of Pocket	$15,000 – Includes Deductible
Maximum Family Out of Pocket	$30,000 – Includes Deductible

Required Pre-Certification/Utilization

Please call Prairie States at 1-800-615-7020 for the following: 7 days in advance for scheduled or 48 hours after, for emergency procedures/admissions.

All Inpatient Hospitalization >24 hours
All Surgical Procedures – Inpatient & Outpatient
Chemotherapy-All Types including Oral Medications
Clinical Trials
Cochlear Implants
CT/MRI/PET Scans
Dialysis
Durable Medical Equipment (DME)-all new DME > $500 & all rentals
Epidural Steroid & Facet Injections
Home Health Care/Home Infusion Services
Hospice Care Services
Mental Health/Substance Abuse – Inpatient and Transitional Treatment
Radiation Therapy
Skilled Nursing Facility
Testing or Services for Rare or Genetic Diseases
Therapies (Occupational, Physical, Speech)
Therapies (Rehab: Cardiac, Pulmonary)
Transplant Evaluations – All Types

CODES: 'A'nnual, 'L'ifetime, 'W'eekly, "D'aily, 'O'ccurrence, '$' Dollars, 'U'nits, 'C'opay, 'V'isits, 'M'ax Charge;
*After Deductible Met; + Does not apply to out-of-pocket, P = pre-certification or authorization required; S = Continued Stay Certification.

Service	Benefit IN-WORK	Benefit OUT-NETWORK	Limits
Acupuncture	80%*	50%*	15 visits calendar year
Ambulance	80%*	80%*	In-network deductible and out of pocket applies
Ambulatory Surgical Center	80%*	50%*	Pre-Cert Required
Anesthesia	80%*	50%*	
Birth Control	100%*	50%*	
Cardiac Rehabilitation	80%*	50%*	Pre-Cert Required
Chemotherapy	80%*	50%*	Pre-Cert Required
Chiropractic	80%*	50%*	15 visits calendar year
Colonoscopy – Routine Cologuard	100%*	50%*	Starting at age 45 1 every 10 years Cologuard will be paid at 100% deductible waived. If the Cologuard comes back requiring the member to have a colonoscopy the plan will pay for one follow up colonoscopy at 100% deductible waived
Colonoscopy – Non–routine	80%*	50%*	Pre-Cert Required
Dialysis	80%*	50%*	Pre-cert Require
Doctor Office Visit PCP Specialist	80%*	50%*	
Durable Medical Equipment (DME)	80%*	50%*	Pre-Cert Required Purchase >$500 & all rental
Eye Exam - Routine	100%*	50%*	Limited to 1 per year
Eyeglasses/contact lenses	100% Deductible waived	50%*	Max of $200 every 2 consecutive years Frames are not covered
Emergency Room	80%*	80%*	In-network deductible and out of pocket applies
Extended Care Facility/Skilled Nursing	80%*	50%*	Pre-Cert Required Limited to 30 days
Hearing Aids	80%*	50%*	Dependent child <18yrs old 1 per 3 years
Home Health Care	80%*	50%*	Pre-Cert Required
Hospital Diagnostic	80%*	50%*	Pre-cert required for CT/MRI/PET SCANS
Hospital Outpatient Surgery	80%*	50%*	Pre-Cert Required
Hospital Observation	80%*	50%*	23-hrs or less
Hospital Inpatient (semi-private room)	80%*	50%*	Pre-Cert Required
Hospital Inpatient Mental Nervous	80%*	50%*	Pre-Cert Required
Hospital Inpatient Substance Abuse	80%*	50%*	Pre-Cert Required
Hospice Care	80%*	50%*	Pre-Cert Required
Injections	80%*	50%*	Pre-Cert Required
Infertility treatment	NOT COVERED	NOT COVERED	
IV Therapy	80%*	50%*	Pre-Cert Required
Laboratory	80%*	50%*	Genetic testing-pre-cert required
Maternity	80%*	50%*	Pre-cert Required

Service	Benefit IN-WORK	Benefit OUT-NETWORK	Limits
			Dependent children are eligible
Morbid Obesity	NOT COVERED	NOT COVERED	Including bariatric surgery
MRI	80%*	50%*	Pre-Cert Required
Occupational Therapy	80%*	50%*	Pre-Cert Required
Oral Surgery	80%*	50%*	Partial or completely impacted teeth
Orthotics (foot) DME Provider	80%*	50%*	1 every 5 years
Prescription Drugs	ScoutRx	ScoutRX	1-833-233-1818
Physical Therapy	80%*	50%*	Pre-Cert Required
Physician Visit inpatient or consultation	80%*	50%*	
Physician Surgery Inpatient outpatient	80%*	50%*	
Podiatry Services Routine foot care	80%* Not covered	50%* Not covered	
Psychiatric/Mental Health Office Visit	80%*	50%*	
Radiation Therapy	80%*	50%*	Pre-Cert Required
Radiology	80%*	50%*	
Routine Preventative Office Visit Well Baby Visit Pap PSA- age 40 Mammogram, etc. Immunizations (includes flu shots)	100%*	50%*	Based on ACA Guidelines/Frequency/Age https://healthcare.gov/preventive-care-benefits https://healthcare.gov/preventive-care-children https://healthcare.gove/preventive-care-women (School, Sports and Camp Exams are not covered)
Second Surgical Opinion	80%*	50%*	
Sleep Studies	80%*	50%*	
Speech Therapy	80%*	50%*	Pre-Cert Required
Sterilization -male	80%*	50%*	Reversal of sterilization not covered
Sterilization – Female	100%	50%	ACA guidelines Reversal of sterilization not covered
Substance abuse office / outpatient visit	80%*	50%*	
TMJ	80%*	50%*	Limited to $1500 per year
Urgent Care	80%*	80%*	In-network deductible and out of pocket applies

- Benefit year January 1 thru December 31
- Timely Filing One year from date of occurrence of services

Claims Submission Information:

Prairie States Enterprises, Inc. • P.O. Box 23 • Sheboygan, WI 53082-0023
Voice (920) 451-7020 • Toll-Free (800) 615-7020 • Fax (920) 451-7023

The Alliance
P.O. Box 44365 Madison, WI 53744
www.the-alliance.org Change Healthcare: 88461
Relay Health 1500-2712
Relay Health UB -1935

Group Health Insurance Program for Members in the
High Deductible Health Plan (HDHP)

Schedule of Benefits

Effective January 1, 2024

State of Wisconsin HDHP	Local HDHP (PO7/17)

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

Annual Deductible and Limits

Annual Medical Deductible

The amount you would 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: $1,600

Family: $3,200

- There are NO services covered before you meet your deductible except for covered preventive services.
- The family deductible is aggregate for family plans – all family members must meet the full family deductible ($3,200) before coverage begins.

Applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)
- ✓ Prescription drugs

Does not apply to:

- × Preventive services

Annual Medical Out-of-Pocket Limit (OOPL)

The most you would 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: $2,500

Family: $5,000

- This Plan uses a provider network. You may have no coverage or have greater out-of-pocket costs if you get care outside of the plan's provider network. Check your provider directory before you receive services.
- The OOPL is aggregate for family plans – all family members must meet the full family deductible before coverage begins.

Applies to:

- ✓ Prescription drugs

Annual Maximum Out-of-Pocket Limit (MOOP)

This is the yearly amount set by the federal government as the most an Individual or Family is required to pay in cost sharing during the plan year for covered, in-network services.

Individual: Not Applicable

Family: Not Applicable

- The most you would pay for services you receive from in-network providers is the OOPL. For the HDHP plan, there is no MOOP beyond the OOPL.

Copayments and Coinsurance

Medical Copayments

Additional costs for coinsurance may apply after you pay the deductible and copay, based on the services your provider orders during your visit.

You pay: $0 copayment per certain telehealth visits

$15 copayment per primary care visit

$25 copayment per specialty or urgent care visit

$75 copayment per emergency room visit

- See Covered Services below for additional information.

Does not apply to:

- Deductible

Medical Coinsurance

The percentage of costs for a covered service you pay after meeting your deductible except for Durable Medical Equipment and Medical Supplies.

You pay: 10% after deductible is met

Plan pays: 90% after deductible is met

- See Covered Services below for additional information.

Applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)

Does not apply to:

- × Prescription drugs
- × Preventive services
- × DME & Medical Supplies

Durable Medical Equipment (DME) and Medical Supplies Coinsurance

The percentage of costs you pay after meeting your deductible for equipment or supplies ordered by your provider. DME Coinsurance applies to the Covered Services listed below as indicated in each section.

You pay: 20% after deductible is met

Plan pays: 80% after deductible is met

- See DME below for additional information. May include oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Applies to:

- Annual Out-of-Pocket Limit (OOPL)

Covered Services

Commonly used services appear below. This is not a complete list. If you have questions about other specific benefits, contact your health plan.

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: Deductible, then Medical Coinsurance

- Applies to 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 your brain and body).

You pay: Deductible, then $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: Deductible, then Medical Coinsurance

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

Diagnostic Services and Labs

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

You pay: Deductible, then Medical Coinsurance

Covered diagnostic services include:

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

Durable Medical Equipment and Medical Supplies

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

You pay: Deductible, then Durable Medical Equipment and Medical Supplies Coinsurance

- ✓ Includes Durable Diabetic Equipment and related Medical Supplies.

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

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

Emergency and Urgent Care

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

Emergency Care

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

You pay: Deductible, then $75 copayment per visit, then

Medical coinsurance

- 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.

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: Deductible, then $25 copayment per visit

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: Deductible, then Medical Coinsurance

Home Care Benefits

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

You pay: Deductible, then Medical Coinsurance

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

Inpatient Hospital Services

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

You pay: Deductible, then Medical Coinsurance

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

Mental Health Counseling Visits

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

You pay: Deductible, then $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 (ST), which helps to relearn how to communicate and swallow to prevent aspiration.

You pay: Deductible, then $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: Deductible, then Medical Coinsurance

Outpatient Hospital & Ambulatory Surgery Center Services

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

You pay: Deductible, then Medical Coinsurance

Preventive Care Services

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

You pay: $0

- 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.

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

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

Primary Care

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

You pay: Deductible, then $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.

Skilled Nursing Facility

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

You pay: Deductible, then Medical Coinsurance

- Up to 120 calendar days per benefit period

Telemedicine and Remote Care

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

E-Visit

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

You pay: Deductible, then $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: Deductible, then $15/$25 copayment per visit, 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: Deductible, then $15/$25 copayment per visit, 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: Deductible, then $15 copayment per visit 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: Deductible, then $0/$15/$25 copayment per visit, 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: Deductible, then $25 copayment 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 – Federally covered and considered preventive 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 hearing. For coverage for participants under the age of 18, see Cochlear Implant Devices – Under Age 18 in the Covered Services section.

You pay: Deductible, then
20% coinsurance for implant devices, professional surgery for implantation, and follow-up device training

10% coinsurance after deductible is met for hospital charges

Applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)

Dental Implants

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

You pay: Deductible, then Medical Coinsurance

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

Applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)

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: Deductible, then 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: Deductible, then Medical Coinsurance

- Maximum benefit plan payment of $1,250 per participant per plan year

Applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)

Dental, Pharmacy, and Supplemental Plans

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

Wellness and Chronic Condition Management

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