



Wisconsin Public Employees (WPE)
WEA Trust 2012 Deductible Preferred Provider Plan (PPP)
Outline of Coverage

Network services must be provided by a WEA Trust PPP participating provider. The Network deductible applies to all services except Preventive Services. This Outline of Coverage is only a summary of benefits under this plan.

	NETWORK	NON-NETWORK
Annual deductible	\$500 Individual/\$1,000 Family	\$1,000 Individual/ \$2,000 Family
Coinsurance (excluding durable medical equipment)	None	**70%
Coinsurance—Durable Medical Equipment	80%	**70%
Maximum Durable Medical Equipment Out of Pocket Per Member	\$500 annually, in addition to policy deductible, per member for medical supplies (including durable medical equipment and related supplies and durable equipment, but excluding hearing aids), after which reimbursement is at 100%.	Unlimited

PREVENTIVE SERVICES (non-network is subject to deductible and coinsurance amounts previously described)		
Services that follow federal guidelines in the Patient Protection and Affordable Care Act, such as screenings, vaccinations, and counseling.	Covered in full	**70%

OUTPATIENT SERVICES (subject to the Network and non-network deductible and coinsurance amounts previously described)		
Adult Office Visits	Covered in full	**70%
Child Office Visits (0–17)	Covered in full	**70%
Adult Chiropractic Visits	Covered in full	**70%
Child Chiropractic Visits	Covered in full	**70%
Adult vision exam	Covered in full. One routine exam (does not include contact lens fitting) per contract year.	**70%
Hearing Aids	*Covered at 80%. One hearing aid per ear no more than once every three years up to a maximum payment of \$1,000 per hearing aid. Hearing aids for participants under age 18 are covered at 100% (\$1,000 limit does not apply).	**70%
Allergy Injections	Covered in full	**70%
Routine Pre- and Postnatal Maternity Office Visits	Covered in full	**70%
Medical Imaging and Laboratory Tests	Covered in full	**70%
Mental Health and Substance Abuse Services	Covered in full	**70%
Outpatient Surgery	Covered in full	**70%
Immediate/Urgent Care Services	Covered in full	**70%
Radiation Therapy	Covered in full	**70%

* Requires prior authorization. All benefits are paid according to terms of the Master Contract between the WEA Trust and the Group Insurance Board. Uniform Benefits, including a Schedule of Benefits, are wholly incorporated in the Master Contract. The Schedule of Benefits describes certain essential dollar or visit limits of your coverage and certain rules, if any, you must follow to obtain covered services.

** After annual deductible is met.

INPATIENT SERVICES (subject to the Network and non-network deductible and coinsurance amounts previously described)		
Hospitalization (Semi-Private Room)	*Covered in full	**70%
Inpatient, Physician, and Nursing Care	*Covered in full	**70%
Surgery, Anesthesia, and Related Supplies	*Covered in full	**70%
Maternity	*Covered in full	**70%
Medical Imaging and Laboratory Tests	*Covered in full	**70%
Mental Health and Substance Abuse Services	*Covered in full	**70%
Inpatient Medications	*Covered in full	**70%

EMERGENCY SERVICES (subject to the Network and non-network deductible and coinsurance amounts previously described)	
Ambulance Service (Air/Ground)	Covered in full as is medically necessary.
Emergency Room	\$60 copayment per visit. Copayment waived if held for observation for 24 hours or more or admitted as an inpatient directly from the emergency room.

OTHER SERVICES (subject to the Network and non-network deductible and coinsurance amounts previously described)	
Home Care	*50 visits per member per contract year; 50 additional medically necessary visits per contract year may be authorized by WEA Trust.
Outpatient Physical, Speech, and Occupational Therapy	*Covered in full up to 50 visits for all therapies combined per contract year. Additional medically necessary visits may be available when authorized by WEA Trust, up to a maximum of 50 additional visits per therapy per contract year.
Hospice Care	*Covered in full when the member's life expectancy is six months or less and when authorized in advance by WEA Trust.
Licensed Skilled Nursing Home	*Covered in full for 120 days per benefit period. Skilled care only.
Accidental Dental	*Covered in full. Treatment must commence within 18 months of accident-related injury to natural teeth.
Cardiac Rehabilitation	*Covered in full for specific diagnoses.
Temporomandibular Disorder (TMD)	The maximum benefit for diagnostic procedures and non-surgical treatment is \$1,250 per member per contract year.
Transplants	*Limited to transplants listed in the Benefits and Services section of the "It's Your Choice Reference Guide" booklet.
Kidney Disease/Transplant	*Covered for inpatient and outpatient kidney disease treatment.
Cochlear Implants	*Covered at 80% when medically necessary and prior authorized by WEA Trust. Cochlear implants for participants under age 18 are covered at 100%.

PREVENTIVE DENTAL SERVICES
Please refer to the Dental Outline of Coverage for more information about the WEA Trust PPP preventive dental benefits.

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** After annual deductible is met.

