Benefit Highlights

Wisconsin Department of Employee Trust Funds 13889
Effective January 1, 2021 to December 31, 2021
This is a short description of your plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

Plan Costs

	In-Network	Out-of-Network
Annual medical deductible	Your plan has an annual combined in-network and out-of-network medical deductible of $500 each plan year.	
Annual out-of-pocket maximum (The most you pay in a plan year for covered medical care)	Your plan has an annual combined in-network and out-of-network Part A and Part B maximum out-of-pocket amount of $6,700. † Your plan has an annual combined in-network and out-of-network maximum out-of-pocket amount of $500 per participant for durable medical equipment and supplies you receive from any provider.	

Medical Benefits

Benefits covered by Original Medicare and your plan

	In-Network	Out-of-Network
Doctor's office visit	Primary Care Provider: $0 copay	Primary Care Provider: $0 copay
	Specialist: $0 copay	Specialist: $0 copay
	Virtual Doctor Visits: $0 copay	Virtual Doctor Visits: $0 copay
Preventive services	$0 copay for Medicare-covered preventive services. Refer to the Evidence of Coverage for additional information.	
Inpatient hospital care	$0 copay per stay	$0 copay per stay
Skilled nursing facility (SNF)	$0 copay per day up to 120 days	$0 copay per day up to 120 days
	Our plan covers up to 120 days in a SNF per benefit period.	
Outpatient surgery	$0 copay	$0 copay
Outpatient rehabilitation (physical, occupational, or speech/language therapy)	$0 copay	$0 copay
Mental health (outpatient and virtual)	Group therapy: $0 copay	Group therapy: $0 copay
	Individual therapy: $0 copay	Individual therapy: $0 copay
	Virtual visits: $0 copay	Virtual visits: $0 copay

Medical Benefits

Benefits covered by Original Medicare and your plan

	In-Network	Out-of-Network
Diagnostic radiology services (such as MRIs, CT scans)	$0 copay	$0 copay
Durable medical equipment	20% coinsurance up to $500 annual maximum out-of-pocket per participant. Once you have met the $500 annual maximum out-of-pocket, it is covered at 100%.	20% coinsurance up to $500 annual maximum out-of-pocket per participant. Once you have met the $500 annual maximum out-of-pocket, it is covered at 100%.
Lab services	$0 copay	$0 copay
Outpatient x-rays	$0 copay	$0 copay
Therapeutic radiology services (such as radiation treatment for cancer)	$0 copay	$0 copay
Ambulance	$0 copay	$0 copay
Emergency care	$60 copay (worldwide)	
Urgently needed services	$0 copay (worldwide)	$0 copay (worldwide)

Additional benefits and programs not covered by Original Medicare

	In-Network	Out-of-Network
Annual routine physical exam	$0 copay; 1 per plan year*	$0 copay; 1 per plan year*
Chiropractic care	$0 copay*	$0 copay*
Foot care - routine	$0 copay (Up to 6 visits per plan year)*	$0 copay (Up to 6 visits per plan year)*
Hearing - routine exam	$0 copay (1 exam per plan year)*	$0 copay (1 exam per plan year)*
Hearing aids	20% coinsurance applies, the plan pays up to a $1,000 allowance for one hearing aid per ear every 3 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing.	Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered.
Vision - routine eye exams	$0 copay (1 exam every 12 months)*	$0 copay (1 exam every 12 months)*

	In-Network	Out-of-Network
Fitness program through SilverSneakers®	You have access to SilverSneakers®, a Medicare fitness program. SilverSneakers inludes a $0 membership fee for a standard, monthly membership at a participating fitness center. To get your SilverSneakers ID number or learn more about this benefit, visit SilverSneakers.com or call 1-888-423-4632, TTY 711, 8 a.m. – 8 p.m. ET, Monday – Friday.	
NurseLine	Receive access to nurse consultations and additional clinical resources at no additional cost.	

†Refer to your Prescription Drug Plan benefit details at etf.wi.gov for more information on your annual maximum out-of-pocket amount.
*Benefits are combined in and out-of-network

Retiree plan prospects must meet the eligibility requirements to enroll for group coverage. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or copayments/coinsurance may change each plan year.
The maximum out-of-pocket displayed in this document only includes out-of-pocket medical costs. It does not include your prescription drug out-of-pocket costs. Please contact Navitus Health Solutions to confirm how much you have accumulated in your prescription drug out-of-pocket costs.