

## GUNDERSEN LUTHERAN HEALTH PLAN

2008 - 2009

### Summary of BadgerCare Plus Benchmark Plan Covered Services

<b>BENEFIT AND POLICY MAXIMUMS</b>	<b>MEMBER RESPONSIBILITY</b>
<p><i>Gundersen Lutheran Health Plan covers all medically necessary services as required by the Wisconsin Department of Health and Family Services Administrative Code, HFS 107.</i></p>	
<b>HOSPITAL SERVICES</b>	
<ul style="list-style-type: none"> <li>• Inpatient Hospital Services (except MH/AODA, refer to MH/AODA section)</li> </ul> <p>Unlimited days when medically necessary, semi-private room.</p>	<p>\$100 Copay per hospital stay (medical/ surgical)</p> <p>\$50 Copayment per stay for psychiatric treatment</p>
<ul style="list-style-type: none"> <li>• Maternity</li> </ul>	<p>No copayments apply for prenatal/maternity care</p>
<ul style="list-style-type: none"> <li>• Outpatient medical services, including diagnostic tests</li> </ul> <p>Multiple visits to the same provider on the same day will be treated as a single visit.</p>	<p>\$15 Copay per visit</p>
<ul style="list-style-type: none"> <li>• Outpatient Surgery</li> </ul>	<p>\$15 Copay per visit</p>
<ul style="list-style-type: none"> <li>• Emergency Room Services (Facility Charges)</li> </ul> <p>Copay waived if immediately admitted to inpatient status.</p>	<p>\$60 Copay</p>
<b>PHYSICIAN/CLINICIAN SERVICES</b>	
<ul style="list-style-type: none"> <li>• Physician Office Visits or Consultation</li> </ul> <p>Additional visits to more than one physician may result in more than one copayment per day.</p>	<p>\$15 Copay per visit</p>
<ul style="list-style-type: none"> <li>• Urgent Care</li> </ul>	<p>\$15 Copay per visit</p>
<ul style="list-style-type: none"> <li>• Vision Exams</li> </ul>	<p>\$15 Copay per visit</p>
<ul style="list-style-type: none"> <li>• Physical therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP)</li> </ul> <p>Limited to 20 visits for each type of therapy per enrollment year.</p>	<p>\$15 Copay per visit</p>

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<b>PHYSICIAN/CLINICIAN SERVICES (continued)</b>	<b>MEMBER RESPONSIBILITY</b>
<ul style="list-style-type: none"> <li>• Cardiac Rehabilitation Limited to 36 visits per enrollment year.</li> </ul>	\$15 Copay per visit
<ul style="list-style-type: none"> <li>• Podiatric Coverage for medically necessary services. Routine foot care is not covered. Orthopedic shoes, supportive devices and treatment of flat feet are not covered.</li> </ul>	\$15 Copay per visit
<ul style="list-style-type: none"> <li>• Prenatal Care/Maternity Coverage includes Prenatal Care Coordination for high-risk pregnancies.</li> </ul>	No copayments
<b>WELLNESS BENEFITS</b>	
<ul style="list-style-type: none"> <li>• HealthCheck HealthCheck for individuals under 21 years old.</li> </ul>	No Copay
<ul style="list-style-type: none"> <li>• Reproductive Health Family planning services are covered without a copayment.</li> </ul>	No Copay
<ul style="list-style-type: none"> <li>• Vision Exams, including refraction Limited to one routine eye exam each year. Additional visits payable under Physician/Clinician Services. Eyeglasses and contact lenses are not covered.</li> </ul>	\$15 Copay
<ul style="list-style-type: none"> <li>• Hearing Exams No coverage for hearing instruments and related services.</li> </ul>	\$15 Copay
<ul style="list-style-type: none"> <li>• Tobacco/Smoking Cessation Coverage includes prescription and over the counter (OTC) tobacco cessation products. Services covered under the Pharmacy benefit.</li> </ul>	\$15 Copay per visit

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<b>DURABLE MEDICAL EQUIPMENT, PROSTHETICS AND SUPPLIES</b>	<b>MEMBER RESPONSIBILITY</b>
<ul style="list-style-type: none"> <li>Durable Medical equipment, prosthetics, supplies Limited to \$2,500 per enrollment year.</li> </ul>	\$5 Copay per purchased item
<ul style="list-style-type: none"> <li>Disposable Medical Supplies (DMS) Limited to syringes, diabetic pens and DMS that is required with use of a DME item.</li> </ul>	No Copay
<b>MENTAL HEALTH, ALCOHOL AND OTHER DRUG ADDICTIONS (MH/AODA)</b>	
<p>Coverage and coverage limitations for these services are based upon the Wisconsin State Employees' Health Plan. Covered services include outpatient mental health, outpatient substance abuse (including narcotic treatment, mental health day treatment for adults, child/adolescent mental health day treatment, and substance abuse day treatment for adults and children.</p> <p>Non-covered services include Crisis Intervention, Community Support Program (CSP), Comprehensive Community Services (CCS), outpatient mental health and substance abuse services in the home and community for adults, and substance abuse residential treatment.</p> <p>Substance abuse services will be subject to specified dollar limits established under the Wisconsin State Employees' Health Plan, which are as follows:</p> <ul style="list-style-type: none"> <li>\$4,500.00 for outpatient substance abuse services. Of the total \$4,500.00 outpatient limit, only \$2,700.00 can be used for substance abuse day treatment services.</li> <li>\$6,300 for inpatient acute general care hospital stays for substance abuse treatment.</li> <li>\$7,000.00 OVERALL LIMIT. The paid amount for all substance abuse and mental health services count toward the overall limit. Once the overall limit is reached, <b>no</b> substance abuse services will be covered.</li> </ul> <p>Coverage of mental health services are not subject to any dollar limits.</p>	\$10 copay
<ul style="list-style-type: none"> <li>Inpatient Care Limited to 30 days per enrollment year for mental health or substance abuse. This limit applies to general acute care and institution for mental disease (IMD) hospital stays.</li> </ul>	\$50 Copay
<ul style="list-style-type: none"> <li>Prenatal coverage of mental health and substance abuse counseling, and substance abuse intervention services for pregnant women at risk of mental health or substance abuse problems.</li> </ul>	No Copay

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<b>AMBULANCE SERVICES</b>	<b>MEMBER RESPONSIBILITY</b>
<ul style="list-style-type: none"><li>Emergency Ambulance Services</li></ul> Non-emergent ambulance services are not covered.	\$50 Copay
<b>HOME CARE</b>	
<ul style="list-style-type: none"><li>Home Health</li></ul> Coverage of in-home skilled nursing services, home health aide services and therapies (PT, OT, Speech Language Pathology).  Limited to 60 visits per enrollment year.	\$15 Copay per visit
<b>HOSPICE SERVICES</b>	
<ul style="list-style-type: none"><li>Hospice Services</li></ul> Limited to 360 days per lifetime.	\$2 Copay per day
<b>SKILLED NURSING FACILITY/SWING BED</b>	
<ul style="list-style-type: none"><li>Skilled Nursing Facility</li><li>Swing Bed</li></ul> Limited to 30 days per enrollment year	10% of the BadgerCare Plus allowed amount

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NON-COVERED	MEMBER RESPONSIBILITY
<p>Services covered by the <u>Standard Plan</u> that are not covered by the <u>Benchmark Plan</u> include:</p> <ul style="list-style-type: none"> <li>• Non-emergent transportation, including Specialized Medical Vehicle (SMV) transport</li> <li>• Case Management services</li> <li>• Crisis Intervention</li> <li>• Community Support Programs</li> <li>• Comprehensive Community Services</li> <li>• Private Duty Nursing</li> <li>• Personal Care</li> <li>• Outpatient mental health and substance abuse treatment in the home and the community for adults</li> <li>• Eyeglasses and contact lenses</li> <li>• Hearing devices</li> <li>• Enteral Nutrition</li> </ul> <p>The Benchmark Plan has additional non-covered services that are not listed above.</p>	Not Covered

The following services do not have a copayment under the Benchmark Plan:

- All maternity related services, including prenatal, delivery and postpartum care.
- Anesthesia
- Family planning services
- Routine immunizations
- Lab, X-ray and diagnostic tests
- Preventive visits
- Provider administered drugs

The following members are exempt from copayments under the Benchmark Plan:

- Pregnant women
- Members under 19 years of age who are members of a federally recognized tribe