LOCAL ANNUITANT HEALTH PROGRAM

YOU ARE ONLY ELIGIBLE TO ENROLL IN THIS PROGRAM IF YOU RECEIVE MONTHLY ANNUITY PAYMENTS. ENROLLMENT IS COMPLETELY OPTIONAL.

Department of Employee Trust Funds
P. O. Box 7931
Madison, WI 53707-7931

ET-2156 (REV 01/2004)

Every effort has been made to ensure that the information in this booklet is accurate. In the event of conflicting information, state statute, state health contracts, and/or the policies and provisions established by the State of Wisconsin Group Insurance Board shall be followed.

The Department of Employee Trust Funds does not discriminate on the basis of disability in the provision of programs, services, or employment. If you need this printed material interpreted or in a different form or if you need assistance, call (608) 266-3285 or TTY (608) 267-0676. We will try to find another way to get the information to you in a usable form.

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OUTLINE OF COVERAGE

* This brochure describes eligibility, enrollment, and general provisions that apply to both health plans which are available to local annuitants. **Keep this brochure as a reference throughout the year.**

This brochure provides a very brief description of the important features of the plans. This is not a contract of insurance. A more detailed description of the LAHP Classic Blue (over age 65) and the LAHP Copay Plan (LCP) coverage is provided in the Booklet of Insurance which will be issued to each annuitant or beneficiary who becomes insured as a subscriber. **It is important that you read your booklet carefully!**

Coverage under either plan is subject to all terms, provisions and conditions of the Blue Cross & Blue Shield United of Wisconsin (BCBSUW) group master policy (the "policy") and of all its riders and endorsements, if any, issued to the Group Insurance Board.

The Wisconsin Retirement System (WRS)
Local Annuitant Health Insurance Program (LAHP)

On July 1, 1988 the Group Insurance Board, as authorized by Section 40.51 (10) of the Wisconsin Statutes, established a health insurance program for retired Wisconsin local government employees and their dependents. The program is designed to meet the needs of retiring local government employees whose health insurance needs are not met by group coverage through their former employer.

You may be interested in this program if you need health insurance and you are:

- A local government retiree,
- Preparing for retirement from a local government employer, or
- The beneficiary of a local government retiree or deceased active employee.

This program is entirely voluntary; you are not required to enroll. Your annuity will not be affected in any way if you do not choose this coverage. If you already have a different health insurance plan, you should compare the benefits of your current plan and this plan to make an informed decision regarding your health insurance needs.

AVAILABLE PLANS

There are two types of policies available: a group LAHP Classic Blue Medicare Supplement for individuals age 65 and over who are enrolled in Medicare, and the LAHP Copay Plan (LCP) for those under age 65. Both single and family coverages are available. Both policies are insured through Blue Cross & Blue Shield United of Wisconsin (BCBSUW) and are outlined in this brochure. The Group Insurance Board periodically reviews the plans offered through this program to ensure that they provide appropriate benefit levels at the minimum possible cost.

ELIGIBILITY

The Wisconsin Retirement System Local Annuitant Health Insurance Program (LAHP) is available to:

- Local government retirees (including their spouse and dependents) who are receiving a monthly annuity from the Wisconsin Retirement System (WRS).
- Local government retirees (including their spouse and dependents) at the time a lump sum annuity is taken.
- The insured surviving spouse and eligible dependent children of a deceased local government retiree.
- The surviving spouse and eligible dependent children of a deceased active local government employee.

Individuals who are receiving only a § 40.65 duty disability benefit are not eligible to apply.

Eligible dependents are the spouse and unmarried children of the retired or deceased employee. The child must be dependent upon you and/or the other parent for his/her financial support and must be your natural child, an adopted child, a legal ward who became your ward before age 19, or a stepchild. Your grandchild(ren) may also be covered but only until your insured dependent child turns 18. If coverage for your child ends before age 18, coverage will end for the grandchild as well. No other relatives are eligible. In case of divorce, a spouse's coverage under your plan terminates at the end of the month in which the divorce judgment is entered. You must notify the Department of Employee Trust Funds within 30 days of the divorce. Your ex-spouse will then be offered continuation of coverage.

Coverage for a dependent child who is not physically or mentally disabled terminates on the earliest of the following dates:

1. The last day of the month in which the child marries.
2. The last day of the calendar year in which the child:
    a. Reaches age 19 if not a full-time student.
    b. Ceases to be a full-time student and is age 19 or older.
    c. Reaches age 25 while still a full-time student.
    d. Ceases to be dependent for support and maintenance.
    e. Qualifies for group insurance coverage as an eligible annuitant or beneficiary.

If your unmarried child is physically or mentally handicapped and incapable of self-support, the child may remain insured as a dependent under the policy if he/she meets certain requirements. Coverage may continue as long as the child remains unmarried and incapable of self-support.

The LAHP Classic Blue coverage is available only to persons age 65 or above and eligible for Medicare. All applicants must be enrolled in both Parts A and B of Medicare on the date this coverage becomes effective.

The LAHP Classic Blue coverage is not available to those who are under age 65, disabled and on Medicare. If that is the case, you must apply for the LAHP Copay Plan and also continue the Medicare insurance. The premium for the LAHP Copay Plan will be reduced due to the Medicare coverage.

If coverage is in force when your monthly annuity ends, BCBSUW will bill you directly for the premiums.

Your eligibility to apply for LAHP coverage ceases when your monthly annuity ceases.

ENROLLMENT PERIOD

Open Enrollment: There are two open enrollment opportunities available to you:

1. You and your dependents may enroll without evidence of insurability if you apply within 60 days after the date you retire from local government employment (that is, cease to be an active employee participating in the Wisconsin Retirement System). Your annuity and health applications may be filed up to 90 days prior to the termination of your employment

but you cannot apply for this insurance before you apply for your annuity. To ensure that your coverage begins as soon as possible after retirement, it is best to file for your annuity and health insurance **before** you retire; or,

2. You may enroll without evidence of insurability when you become age 65 and/or first enroll in Medicare Part B if you are over age 65. This also applies to your dependents when they first turn age 65 and/or enroll in Medicare Part B if you are insured under this plan and the dependents are otherwise eligible. This open enrollment period extends for ten months:

   - The three calendar months before you enroll in Medicare Part B;
   - The calendar month in which you enroll in Medicare Part B; and
   - The six calendar months immediately following the month you enroll in Medicare Part B.

You may be subject to waiting periods for pre-existing conditions even if you first apply for coverage during the age 65 open enrollment period. See page 18 for further information on waiting periods for the LAHP Classic Blue or page 23 for the LAHP Copay policy.

Deferred Enrollment: If you do not apply within either of the open enrollment periods, you may file an application at any time; however, you will have to demonstrate good health by completing the health questions on the application. Applications may be rejected or, if accepted, coverage may be subject to certain waiting periods for pre-existing conditions, depending upon the plan selected. For further information on waiting periods, see page 18 (LAHP Classic Blue) or page 23 (LAHP Copay).

Note: Retirees who elect a lump sum annuity may only enroll at the time the lump sum payment is taken.

COVERAGE EFFECTIVE DATE

During an open enrollment period: Coverage will be effective on the first of the month following either receipt of the health application by the Department of Employee Trust Funds (DETF) or the effective date of your annuity, whichever is later. At your request, the effective date can be delayed for up to 90 days from the date DETF receives the application or your termination date, whichever is later. Please note that your application **must** be received by DETF within 60 days after your retirement, even if you are requesting a deferred effective date.

Outside of an open enrollment period: Coverage will be effective on the first of the month following BCBSUW's approval of the application. Therefore, the effective date of coverage depends upon how long it takes to process your application. The effective date can be delayed, with BCBSUW approval, for up to 90 days from the date DETF receives the application.

As a disability annuitant: If you apply later than 60 days after you cease to be an active employee participating in the Wisconsin Retirement System, you must furnish evidence of insurability by completing the health questionnaire section of the LAHP application. Coverage cannot be effective until DETF approves your disability annuity. The effective date of coverage will be the first of the month following DETF approval of your disability annuity and BCBSUW approval of your application.

IMPORTANT: Do not cancel any other health insurance policy until receiving written notice of acceptance into the Local Annuitant Health Program.

HOW TO APPLY

Complete the Local Annuitant Health Program application form (ET-2330) and submit it to the Department of Employee Trust Funds. The address is shown on the application.

SURVIVOR BENEFITS

Insured Survivor: If the spouse and/or dependent(s) were insured at the time of the annuitant's death, coverage may be continued by filing an application with the Department of Employee Trust Funds within 90 days of the date of death. Coverage for a surviving spouse may be continued for life; children may continue coverage for as long as they meet the definition of dependent.

Uninsured Survivor: If the spouse and/or dependent(s) were not insured at the time of the death, but are receiving a continuation of the deceased employee's monthly annuity, he/she may apply for coverage at any time through evidence of insurability. Note that eligibility to apply for coverage ends when the annuity ends.

Survivor of Deceased Active Employee: Surviving spouse and dependents of a deceased active employee who take the WRS death benefit as a monthly annuity may enroll without furnishing evidence of insurability by filing an application with this Department within 60 days of the employee's date of death. Enrollment at a later time requires furnishing evidence of insurability.

CONTINUATION

In addition to the survivor benefits described above, you are eligible under state and federal law to continue your group coverage temporarily, at group rates, in certain situations where your coverage under the plan would otherwise end. That temporary extension of coverage is called "continuation coverage." This section summarizes your rights and obligations under the continuation coverage provisions of the federal law. State mandates are described in the booklet which BCBSUW will provide to subscribers. Both you and your spouse should read this section carefully.

You have the right to apply for continuation coverage if:

- You are the insured spouse of an annuitant covered by this program and you lose group health coverage because of divorce from your spouse.
- You are the dependent child of an annuitant covered by this program and coverage is lost for either of the following reasons:
    1. The death of a parent, or
    2. You lose dependent status under the program.

You or a family member have the responsibility to inform DETF of a divorce or a child's loss of dependent status under the program. It is then the responsibility of DETF to notify you of your right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage due to one of the events described above to apply for continuation cover-

age. If you do not apply for continuation coverage, your group health insurance coverage will end as of the date eligibility ended.

Continuation coverage is identical to the old coverage. You do not have to provide evidence of insurability to obtain continuation coverage. You can maintain continuation coverage for thirty-six months; however, your continuation coverage may be terminated for any of the following three reasons:

1. The premium for your continuation coverage is not paid, or
2. You become an employee covered under another group health plan that does not have a pre-existing condition clause that applies to you or your covered dependents, or
3. You were divorced from a covered annuitant and subsequently remarry and are covered through your new spouse by a group health plan offering similar benefits.

If your marital status changes, or you or your spouse move to a new address, please notify DETF of the change immediately.

The failure to continue coverage under the provisions outlined above is deemed to be voluntary cancellation of coverage.

CONVERSION

At the end of the 36-month continuation coverage period, you will be allowed to convert your coverage to an individual (non-group) health plan. Individual conversion coverage is available with no medical examination required, provided the group coverage has been in effect for at least three months prior to termination of coverage. The coverage offered will be the individual conversion contract (not the group plan) available at the time, subject to the rates and regulations then in effect.

The conversion privilege is also available to insured dependents when they cease to be eligible under the subscriber's contract. A request for conversion must be received by BCBSUW within 31 days after termination of coverage. If you have questions regarding conversion, write or call BCBSUW.

TERMINATION OF COVERAGE

If you wish to cancel your coverage you must notify the Department of Employee Trust Funds in writing.

LAHP Classic Blue subscribers who cancel coverage and return the insurance booklet to BCBSUW within 30 days of first receiving it will have all premiums refunded.

If you fail to pay the required premiums, your coverage will cease at the end of the period for which premiums were paid. Unless you voluntarily cancel your coverage or discontinue paying the premium while eligible, benefits will continue when confined in a general hospital or a specialty hospital until discharge or until the maximum contract benefit has been provided, whichever occurs first.

CLAIMS

Because there are time limits for submitting claims, it is to your advantage to file claims promptly. Claims must be received by BCBSUW within one year of the date incurred except in circumstances beyond your control, and in any case no later than two years after the occurrence.

CLAIMS REVIEW AND APPEAL PROCEDURES

Situations might arise when you have a question about your benefits or a BCBSUW claims decision. Most benefits and claims questions can be resolved informally. Therefore, we urge you to first contact the BCBSUW Service department by telephone or in writing.

The toll-free Customer Service telephone number is 1-800-755-6400. The local Customer Service telephone number is (920) 923-7575. The Customer Service address is:

Blue Cross & Blue Shield United of Wisconsin
P.O. Box 110
Fond du Lac, WI 54936-0110

If your benefits or claims questions can't be resolved by the Customer Service department, you can appeal the claims decision as follows:

- Prepare a written appeal request detailing the reasons you disagree with the claims decision.
- Mail your written appeal request, along with copies of any related material (such as letters or other supporting documents) to the above address.

You can designate a representative to act for you by completing and sending a signed letter of authorization along with your written appeal request.

BCBSUW will provide a prompt, complete, and unbiased review of your request and their claims decision. BCBSUW will send you the results of the review within 30 days after the receipt of your written appeal request. These results will include the claims decision, the reason for the decision, and identify the policy provisions on which the decision was based.

If you do not agree with the decision you can appeal it to the State of Wisconsin Department of Employee Trust Funds. If you do not agree with DETF's decision, you have the right to appeal that decision to the State of Wisconsin Group Insurance Board for its consideration and final decision in accordance with the administrative review procedures applicable to matters brought before the Board for consideration, and subsequent appeal, if any, to the courts.

In addition, if you disagree with the outcome of BCBSUW's decision, you may be eligible to have your appeal reviewed by an Independent Review Organization (IRO). BCBSUW's appeal

decision letter will include a list of approved IRO's. To qualify for External Review, your claims must involve one of the following:

1. An Adverse Determination involving medical necessity; or
2. A determination that a treatment is Experimental/Investigational.

In either case, the treatment must cost more than $250 to qualify.

If you wish to pursue External Review with the IRO, you must notify BCBSUW at:

Attn: Appeal Department
401 West Michigan Street, C-10
Milwaukee, WI 53203

BCBSUW must receive your request within 4 months of the date that they denied your appeal. When you send in the request you must tell BCBSUW which IRO you choose for your review, and include a check for $25 made payable to that IRO.

Note that the decision of the IRO is binding. If the IRO overturns BCBSUW's denial, BCBSUW will refund your $25. For further information, please see your benefit booklet.

COORDINATION OF BENEFITS

If you are covered under two or more group health insurance policies at the same time, and each contains a coordination of benefit provision, insurance regulations require that the primary carrier be determined by an established sequence. This means that the primary carrier will pay its full benefits first, then the secondary carrier will determine its payment for the remaining expenses.

Generally, the primary carrier is the plan identified first in the following sequence:

1. Your own plan (e.g., the plan covering you as a subscriber or policyholder).
2. The plan covering you as a dependent.
3. For a dependent child covered by both parents' plans, the plan of the parent whose birthday occurs earliest in the year. (For example, if the mother's birthday is in January and the father's is in September, the mother's policy would be primary.)
4. The plan covering you as a laid-off or retired person or as a continuant (COBRA).
5. If none of the above rules apply, then the plan which has been covering you the longest pays first.

However, for dependent children when parents are divorced or separated, the sequence of plans covering the child is:

1. The plan subscribed to by the parent who, by court decree, is responsible for insurance coverage.
2. The plan subscribed to by the parent who has custody.
3. The plan of the spouse of the custodial parent.
4. The non-custodial parent's plan.

COMMON QUESTIONS AND ANSWERS

1. Q. How do the benefits for this program compare with other plans?

A. The benefits are comparable with those currently available in the individual insurance market. The LAHP Classic Blue conforms to the Wisconsin Insurance Commissioner's requirements for Medicare Supplement insurance. If you have any questions concerning how the benefits are provided under this program, contact BCBSUW at the telephone number provided on page 29 of this brochure.

2. Q. If I am enrolled under Medicare, will this plan pay for that part of my doctor's charges which are not paid by Medicare?

A. In some cases, no. Medicare usually approves only a portion of the charges, e.g., those determined to be necessary and reasonable. The LAHP Classic Blue Plan will pay on this same basis. If Medicare approves a charge and pays 80% of that amount, the LAHP Classic Blue Plan will pay the remaining 20%. If you continue to be billed for charges which Medicare determines are excessive, neither Medicare nor the LAHP Classic Blue will pay and you will be responsible for that difference.

3. Q. How do I determine if my doctor will charge more than Medicare thinks is reasonable?

A. Ask your doctor if he or she accepts Medicare assignment. If so, you will not be charged more than the Medicare-approved charge for the services received, and you can then be assured that either Medicare or the LAHP Classic Blue will cover the full charges for approved services.

4. Q. I happen to be an annuitant who was never covered by Social Security. Am I still required to enroll in Medicare, even though I will have to pay the Part A premium?

A. All applicants for the LAHP Classic Blue must be enrolled in both Parts A and B of Medicare. However, you may also choose to apply for the LAHP Copay Plan, which would not require enrollment in Medicare.

5. Q. I am enrolled in Medicare but my spouse is not yet eligible. Will both of us be eligible for coverage?

A. Yes, but you will be enrolled in the LAHP Classic Blue and your spouse must enroll in the LAHP Copay Plan. However, you are not required to fill out separate applications; one application will be sufficient.

6. Q. I am just becoming eligible for Medicare Part B and want to enroll under the open enrollment provision afforded at that time. Will my spouse and dependent(s) be allowed in under the open enrollment at that time?

A. No. Only the annuitant who is becoming Medicare eligible is offered an open enrollment period. However, if an insured annuitant has an LAHP eligible spouse or dependent who becomes eligible for Medicare Part B, and is 65 years old, the dependent/spouse may then enroll under the open enrollment provisions.

7. Q. If I enroll in the LAHP Copay Plan, what will happen when I become 65?

A. Your coverage will be switched to the LAHP Classic Blue. You should apply for Medicare Parts A and B through your Social Security office several months before you turn 65. You must submit copies of your Medicare identification cards. We will then arrange with BCBSUW to issue you a new booklet and ID card and we will change your annuity deduction to the new premium rate. However, if you are not eligible for Medicare, you may remain covered under the LAHP Copay Plan.

8. Q. I am under age 65 but I am disabled and have Medicare coverage. Can I apply for the LAHP Classic Blue policy?

A. No. The LAHP Classic Blue is available only to persons age 65 or above. You must apply for the LAHP Copay Plan and also continue the Medicare insurance. The premium for the LAHP Copay Plan will be reduced due to the Medicare coverage. Evidence of insurability is required if you do not apply within 60 days of your retirement.

9. Q. How will I be billed for premiums under this program?

A. As long as you are receiving a monthly annuity which is large enough to cover the cost of the health insurance premiums, your premiums will be deducted from your annuity. If your annuity is too small to cover the cost of the insurance premiums, you will be billed directly by BCBSUW.

10. Q. Are there any waiting periods for pre-existing conditions?

A. Depending upon when you apply for coverage, you may be subject to waiting periods for pre-existing conditions. If your application is received within 60 days after you terminate WRS employment and your annuity is in effect, there will be no waiting periods for pre-existing conditions. However, if you apply after the 60-day open enrollment period, there may be a waiting period. See the plan summaries for specific information.

11. Q. If I am applying for health insurance and evidence of insurability is required, is there any way I can expedite the processing of my application?

A. Yes. The processing of your application can take anywhere from 4 to 8 weeks. The reason for the variation is the time that it takes your doctor to respond to requests for the necessary medical information. Therefore, your application can be processed more quickly if you ask your doctor to fill out the requested forms as soon as possible.

12. Q. If I am already retired and my spouse is unable to provide satisfactory evidence of insurability, am I eligible for the program anyway?

A. Yes. As the annuitant, if you can provide satisfactory evidence of insurability, you are eligible even though other family members may not be eligible.

13. Q. If I am already retired and cannot provide satisfactory evidence of insurability, are my dependents eligible for this program?

A. No. However upon your death, an uninsured survivor who becomes eligible for an annuity may apply for the program by providing satisfactory evidence of insurability.

14. Q. I am a beneficiary (an insured survivor) who has remarried. Are my new spouse and stepchildren eligible for this program?

A. No. Eligibility is limited to the retired employee and his/her spouse or surviving spouse and their dependent children.

15. Q. How can I change my coverage to add or subtract family members?

A. Fill out a new application form (ET-2330), supplying change information and other data as appropriate, and submit the form to the Department of Employee Trust Funds. Evidence of insurability is required for any dependent you add more than 30 days after that person first became your dependent (60 days for a newborn or adopted child). For more information on enrollment periods, turn to pages 3 and 4.

16. Q. If I have other insurance in force, when should I cancel it?

A. Do NOT cancel any other insurance policy until you are informed in writing that your coverage has been approved and when it will become effective.

17. Q. How long will current premium rates remain in force?

A. Premium rates are established each October for the following calendar year. Once established, those rates will not change until the following January 1, unless required by law.

18. Q. Will my premium rate vary depending upon where I live?

A. No, the rate will be the same regardless of where you live. The rate will change only if you change from single to family coverage (or vice versa), or you or your spouse enroll in Medicare.

19. Q. When will the first premium be deducted from my annuity check?

A. The first premium deduction depends upon when your application and BCBSUW approval, if required, are received and processed by DETF. In order to be taken from your annuity payment, a deduction must be processed by DETF by the 15th of the previous month. Your first deduction may be more than one premium because premiums are paid in advance.

Blue Cross & Blue Shield United of Wisconsin (BCBSUW)
Outline of Supplement to Medicare Insurance
LOCAL ANNUITANT HEALTH PROGRAM (LAHP)
Classic Blue Supplement to Medicare Insurance

This Wisconsin Insurance Commissioner has set standards for LAHP Classic Blue Supplement to Medicare insurance. The booklet meets these standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all booklet limitations. For an explanation of these standards and other important information, see *"Health Insurance Advice for Senior Citizens,"* given to you when you applied for this booklet. Do not buy this booklet if you did not get this guide.

PREMIUM INFORMATION

We can only raise your premium if we raise the premium for all booklets like yours in this state.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ BOOKLET VERY CAREFULLY

This is only an outline describing the BCBSUW booklet's most important features. The booklet you receive from BCBSUW is your insurance contract. You must read that booklet itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN THE POLICY

If you find that you are not satisfied with the coverage described in your booklet, you may return it to BCBSUW, P.O. Box 2909, Milwaukee, WI 53201-2909. If you send the booklet back to us within 30 days after you receive it, we will treat the booklet as if it had never been issued and return all of your premium payments directly to you.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new booklet and are sure you want to keep it.

NOTICE

This supplement may not fully cover all of your medical costs.

In offering LAHP Classic Blue Supplement to Medicare neither BCBSUW nor its agents are connected with Medicare.

LAHP Classic Blue Outline of Supplement to Medicare Insurance

PART A

Medicare Part A Benefits	Per Benefit Period	Medicare Pays	This Plan Pays	You Pay
HOSPITALIZATION				
Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services.	First 60 days	All but $876	$876	Nothing
	61st to 90th day	All but $219 a day	$219 a day	Nothing
	91st to 150th day	All but $438 a day	$438 a day	Nothing
	Beyond 150 days	Nothing	All Medicare eligible charges	Charges that exceed Medicare eligible charges
SKILLED NURSING CARE				
Skilled nursing care in a facility approved by Medicare. Confinement must meet Medicare standards. You must have been in a hospital for at least three days and enter the facility within 30 days after the discharge.	First 20 days	100% of costs	$0	Nothing
	Additional 80 days	All but $109.50 a day	$109.50 a day	Beyond 100 days per benefit period
INPATIENT PSYCHIATRIC CARE				
Inpatient psychiatric care in a participating psychiatric hospital.		190 days per lifetime	175 additional days per lifetime. After these lifetime days are utilized, we will pay the lesser of 30 days or $7,000 minus a 10% copayment per calendar year. (These 30 days include any days paid in a calendar year as part of the 175 days.) With exception of the 365 day lifetime benefit, all psychiatric and substance abuse services are subject to a combined Inpatient, Transitional and Outpatient maximum of $7,000 per calendar year.	After 365 days per lifetime, you pay beyond the lesser of 30 inpatient days or $7,000 minus a 10% copayment per calendar year amount. (These 30 days include any days paid in a calendar year as part of the 175 days.) **or** Beyond the combined Inpatient, Transitional, and Outpatient maximum of $7,000 per calendar year.
BLOOD		All but first 3 pints	First 3 pints	Nothing
HOME HEALTH CARE		100% of charges for visits considered necessary by Medicare	365 visits per year	Charges beyond 365 visits per year

* *Federal Medicare deductibles are adjusted annually; figures shown here are for 2004. LAHP Classic Blue benefits are also adjusted annually to pay these deductibles.*

LAHP Classic Blue Outline of Supplement to Medicare Insurance

PART B

Medicare Part B Benefits	Per Calendar Year	Medicare Pays	This Plan Pays	You Pay
MEDICAL EXPENSES				
Eligible expenses for physicians' services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy, ambulance, and outpatient psychiatric care.	Initial $100 deductible	$0	$100	Nothing
	After initial deductible	80% of Medicare eligible charges	Generally, 20% of Medicare eligible charges or in case of hospital outpatient department services under a prospective payment system, applicable copayments. NOTE: For outpatient psychiatric and substance abuse care, we will pay a maximum of $2,000 minus a 10% copayment per calendar year. For Transitional services, we will pay a maximum of $3,000 minus a 10% copayment per calendar year. These services are subject to a combined Inpatient, Transitional and Outpatient maximum of $7,000 per calendar year.	Charges that exceed Medicare eligible charges; charges beyond the $2,000 minus a 10% copayment per calendar year; charges beyond the $3,000 minus a 10% copayment per calendar year; and charges beyond the Inpatient, Transitional and Outpatient combined maximum of $7,000 per calendar year.
OUTPATIENT PRESCRIPTION DRUGS		$0	$0	All charges
BLOOD		80% of costs except non-replacement fees (blood deductible) for first 3 pints (after $100 deductible/ calendar year)	20% of all costs and the first 3 pints in each calendar year.	Nothing
IMMUNOSUPPRESSIVE DRUGS		80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant after $100 deductible/ calendar year)	20% of allowable charges for immunosuppressive drugs for covered transplants	All charges not paid by Medicare or LAHP Classic Blue
PART B POLICY LIMITS PER CALENDAR YEAR			No limit	

* *Federal Medicare deductibles are adjusted annually; figures shown here are for 2004. LAHP Classic Blue benefits are also adjusted annually to pay these deductibles.*

GENERAL INFORMATION

This is only a general outline of the LAHP Classic Blue benefits, limitations and exclusions. This is not a contract of insurance. A more detailed description of LAHP Classic Blue coverage is provided in the LAHP Classic Blue Booklet of Insurance (booklet) which will be issued to each person who becomes insured under this plan. Coverage is subject to all terms and conditions of the BCBSUW Group Master Policy and all of its riders and endorsements issued to the Group Insurance Board.

We've added the subject headings in this brochure for easier reading and quick reference. These headings aren't part of the description of coverage, and aren't to be used in determining applicable limitations and exclusions.

This outline of coverage doesn't give all the details of Medicare coverage. Contact your local Social Security Office, or consult *"The Medicare Handbook"* for more details.

Hospital Benefits

LAHP Classic Blue pays benefits for the following inpatient services:

- The Medicare Part A hospital deductible
- Your Medicare coinsurance from the 61st to the 90th day of a hospital confinement. LAHP Classic Blue also pays your coinsurance for the 60 Medicare lifetime reserve days
- Room and board, up to the semi-private room rate, and miscellaneous hospital expenses for each day that you're confined after your Medicare benefits are exhausted
- Inpatient psychiatric care up to a lifetime maximum of 175 days of confinement after Medicare pays the lifetime limit of 190 days. The 175 day lifetime maximum benefit limit will be reduced by any benefits payable under the Treatment of Alcoholism, Drug Abuse or Nervous or Mental Disorders Section
- Blood not covered by Medicare
- Emergency care when covered by Medicare, whether in a participating or non-participating hospital

Skilled Nursing Care

LAHP Classic Blue provides benefits for certain skilled nursing care in a facility that participates in Medicare. It does not cover custodial care.

After Medicare pays benefits for the first 20 days of skilled nursing care, we'll pay your Medicare Part A daily coinsurance for the 21st through the 100th day of confinement, provided the charges are covered by Medicare.

LAHP Classic Blue also provides benefits for certain skilled nursing care in a facility that doesn't participate in Medicare, and for certain services that don't qualify for Medicare benefits. We'll pay benefits at the maximum daily rate established for the State of Wisconsin Medical Assistance program, up to 30 days for each confinement.

You may request a booklet from BCBSUW for more details.

LAHP Classic Blue pays benefits up to the usual, customary, and reasonable charge for the following medically necessary treatments, services, and supplies.

Home Health Care

LAHP Classic Blue provides benefits for certain home health care beyond what's covered by Medicare. Home health care must be medically necessary for your treatment and provided or coordinated by a home health agency licensed by the state or certified by Medicare, or by a certified rehabilitation agency. We'll pay benefits for up to 365 home health care visits each calendar year.

You may request a booklet from BCBSUW for more details.

Chiropractic Services

LAHP Classic Blue provides benefits for medically necessary services by a licensed chiropractor acting within the scope of his or her license even when the services are not covered by Medicare.

Equipment and Supplies for the Treatment of Diabetes

LAHP Classic Blue provides benefits for diabetic self-management education programs and the following to treat diabetes:

- The installation and use of an insulin infusion pump, and purchase of a pump after 30 days of use, limited to one pump per calendar year.
- Other equipment and supplies, including insulin, to treat diabetes.

Kidney Disease

LAHP Classic Blue provides benefits for inpatient, outpatient, and home treatment of kidney disease, dialysis, and kidney transplant expenses for both the recipient and donor. Treatment of kidney disease has a maximum benefit of $30,000 per year.

Women's Health Notice

Under the Women's Health and Cancer Act of 1998, coverage following a mastectomy includes:

- Reconstruction of the breast on which a mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Treatment of Alcoholism, Drug Abuse or Nervous or Mental Disorders

Inpatient Services: LAHP Classic Blue provides benefits up to a lifetime maximum of 175 days of confinement after Medicare pays the lifetime limit of 190 days. Benefits will be paid at 90% of the first $7,000 of charges incurred for inpatient services to $6,300 per participant per calendar year.

Outpatient Services: LAHP Classic Blue provides benefits at 90% for the first $2,000 in charges incurred by you in a calendar year for outpatient treatment of alcoholism, drug abuse, or nervous or mental disorders.

Transitional Care Services: LAHP Classic Blue provides benefits for 90% of the first $3,000 in charges incurred by you in a calendar year for transitional care services.

Total benefits payable under inpatient, outpatient, and transitional care services shall not exceed $7,000 per participant per calendar year. See the BCBSUW Classic Blue booklet for further information.

A usual, customary, or reasonable charge, as used in this brochure, is an amount BCBSUW determines to be reasonable. In determining what is a reasonable charge, BCBSUW considers such factors as the amount providers charge for similar treatments, services, and supplies provided in the same general area under similar circumstances.

Professional and Other Services

LAHP Classic Blue pays your Medicare deductible and Medicare Part B coinsurance (20%) for the following services:

- Medical services provided by a physician, as well as services by certain other medical care providers when required by law
- Surgical services, including pre- and post-operative care and services of surgical assistants
- X-rays and laboratory tests
- Anesthesia when connected with a covered surgery
- Consultation services, when ordered by your attending physician
- Outpatient services in a hospital emergency room or outpatient clinic
- Radiation therapy services, including materials and services of a technician
- Drugs and injections you can't administer for yourself
- Medical supplies, like surgical dressings, splints, and casts
- Rental and purchase of durable medical equipment, like hospital beds, wheelchairs and walkers
- Prosthetic devices (artificial legs, arms, etc.). Doesn't include dental prostheses
- Licensed ambulance service from an organization also receiving Medicare payments
- Dental care for surgery to the jaw or related facial structures; setting of factures of the jaw or facial bones
- Treatment of temporomandibular disorders (TMJ) - Benefits for diagnostic procedures and prior authorized non-surgical treatment up to $1,250 per contract year
- Blood transfusions
- Physical and speech therapy given by a physician or registered therapist
- Outpatient psychiatric care
- The first three pints of blood per year
- Immunosuppressive drugs during the first year following a covered transplant
- One mammogram every two years, with the limitation that 23 months have elapsed since the last screening. Covered annually after age 49.
- Home Health Care up to 365 visits per year, less what Medicare pays

A charge, as used in this brochure, means the reasonable charge for an item or service established by Medicare. Neither Medicare nor your LAHP Classic Blue Booklet will pay for charges Medicare determines are "unreasonable or unnecessary."

WAITING PERIODS FOR PRE-EXISTING CONDITIONS

While any new illness or injury that appears after your effective date of coverage under LAHP Classic Blue is covered immediately, you may have a waiting period for pre-existing conditions. If so, this policy won't provide benefits for pre-existing conditions for six consecutive months following your effective date.

By our definition, a pre-existing condition is any illness or injury for which, within 90 days before your effective date of coverage:

- You received medical advice from a physician
- A physician recommended or provided treatment

You don't have a waiting period for pre-existing conditions as long as you enroll during the 60-day open enrollment period at the time you retire or if, immediately prior to your effective date of coverage under LAHP Classic Blue, you had continuous coverage under:

- A BCBSUW health insurance policy
- Another Medicare Supplement policy
- Any employer's group health insurance policy, or self-insured group benefit plan, provided the employer isn't terminating the entire group policy
- An individual health policy which provides comprehensive benefits

You do have a waiting period for pre-existing conditions if you enroll at any other time other than the 60-day open enrollment period at the time you retired or if, prior to your effective date of coverage under LAHP Classic Blue, you **didn't** have coverage under:

- A BCBSUW health insurance policy
- Another Medicare Supplement policy
- Any employer's group health insurance policy or self-insured group benefit plan
- An individual health policy which provides comprehensive benefits

LIMITATIONS AND EXCLUSIONS

The following is a summary of limitations and exclusions. A complete description is included in the booklet which you will receive from BCBSUW when you become insured.

LAHP Classic Blue booklet does NOT cover:

- Drugs and medicines you buy with or without a prescription
- Personal comfort items
- Routine exams and related tests
- Orthopedic shoes or other supporting devices for the feet unless Medicare pays first.
- Subluxations of the feet, or routine foot care not covered by Medicine
- Custodial care
- Private duty nursing
- Cosmetic surgery, except as stated in the booklet
- Professional services not provided by a physician
- Charges that exceed Medicare eligible expenses, for treatment, services or supplies

- Routine immunizations, unless covered by Medicare
- Preparation, fitting, or purchase of eyeglasses, or hearing aids, unless covered by Medicare
- Care, treatment, filling, removal, or replacement of teeth; dental x-rays, root canals, surgery for impacted teeth, or other surgical procedures to the teeth or supporting structures
- Home health care beyond 365 visits per calendar year
- Any treatments, services, or supplies:
    - Not covered by Medicare, unless specifically stated in the booklet
    - For which you, or anyone on your behalf, aren't legally obligated to pay
    - To the extent paid for by Medicare or another government entity or program
    - For any injury, occurring on or after your effective date, caused by an act of war
    - Provided by immediate family members or by anyone else who lives with you
    - To the extent covered by Workers' Compensation or other foreign nation, U.S. or State plan
    - Provided before the effective date of coverage or after coverage ends
    - For any pre-existing condition provided during the applicable waiting period
    - Determined by Medicare to be unreasonable or unnecessary
    - Provided if you're not age 65 or older, or are not covered by Medicare Parts A and B
    - Received outside the United States
    - For a military service-related condition treated at any military or veterans hospital, or at any hospital by the government or any national agency

RENEWAL TERMS AND PREMIUM RATES

As long as you are enrolled for the Local Annuitant Health Program and your premiums are paid on time, coverage under the policy cannot be canceled or non-renewed because you have submitted claims.

If you wish to cancel coverage you must notify the Department of Employee Trust Funds in writing. Refunds may be made for premiums paid in advance if we receive your written request before the first day of the month for which you request the refund. The policy may change from year to year in response to changes in the federal Medicare program. The premium rates change effective January 1 of each year.

LAHP COPAY PLAN HIGHLIGHTS
(For Persons Under Age 65)

GENERAL INFORMATION

This is only a general outline of the LAHP Copay Plan (LCP) benefits, limitations and exclusions. This is not a contract of insurance. A more detailed description of LCP coverage is provided in the Booklet of Insurance from BCBSUW which will be issued to each subscriber who becomes insured under LCP. Coverage is subject to all terms and conditions of the BCBSUW group master policy and all of its riders and endorsements (the policy) issued to the Group Insurance Board.

The words "charge" and "charges" used in the LAHP Copay Plan mean a charge that does not exceed the general level of charges and is reasonable, as determined by BCBSUW, for such a service or item when provided in the same general area under similar or comparable circumstances. Charges for hospital or other institutional confinements are incurred on the date of admission. The benefit levels in force on the hospital admission date apply to the charges for the entire confinement regardless of changes in benefit levels during the confinement. All other charges are incurred on the date the participant receives the service or item.

LCP will pay benefits for covered charges for the services and supplies described on the following pages if such services and supplies are for the treatment of a covered illness or injury and are medically necessary as determined by BCBSUW, and are not excluded by the policy. Covered services must be ordered by a physician, or other licensed provider, and be within the scope of the provider's license.

BCBSUW does not interfere with the professional relationship a member (anyone covered under the policy) has with his or her physician or hospital. BCBSUW is not responsible to a member for the acts of any health care provider or any services or facilities. BCBSUW is obligated only to provide the benefits as stated in the policy.

The subject headings in this brochure are inserted for the convenience of the reader only. They are not to be considered in interpreting this brochure or the detailed provisions of the policy.

Deductibles/Coinsurance/Out-of-Pocket Limits

Benefit payments are subject to a $250 deductible applied to each member each calendar year. After the deductible amount is satisfied, benefits will be paid at 80% for covered expenses up to the annual out-of-pocket limit of $800 per individual covered and $2,400 for each family covered. After the out-of-pocket limit is reached, benefits will be paid at 100% for covered expenses for the remainder of the calendar year, subject to each member's lifetime maximum benefit of $1,000,000. All benefit payments are subject to exclusions, limitations, and all other terms and conditions of the policy. Coverage for inpatient, outpatient and transitional treatment for nervous or mental disorders, alcoholism and drug abuse is limited.

Hospital Services

INPATIENT HOSPITAL SERVICES

- Room and board charges up to the semiprivate room rate
- Miscellaneous hospital expenses
- Intensive care unit room, board and miscellaneous hospital expenses

OUTPATIENT HOSPITAL SERVICES

- Accidental injury care
- Emergency medical services
- Diagnostic x-ray and laboratory services
- Radiation therapy services
- Miscellaneous hospital outpatient services for a physical illness or injury

Professional Services

Professional services are services for a physical illness or injury provided by a physician or surgeon. They may also be performed by a chiropractor provided they are within the scope of the chiropractor's license. Professional services performed by a chiropodist, podiatrist, dentist or other medical care provider required by law are also included, as long as they are within the scope of their licenses and are the same as services covered if performed by a physician or surgeon.

- Surgical services
- Maternity services
- Oral surgery services (limited to specific procedures)
- Treatment of temporomandibular disorders (TMJ) - Benefits for diagnostic procedures and prior authorized non-surgical treatment up to $1,250 per contract year
- Diagnostic x-ray and laboratory services
- Medical or consultation services
- Anesthesia services
- Radiation therapy services for benign or malignant conditions
- Childhood immunizations from birth to age 6.

Other Services and Supplies

- Professional licensed ambulance
- Drugs and medicines which by law require a written prescription
- Injectable and oral insulin
- Appropriate and necessary immunizations from birth to age 6.
- Dental repair due to an accident
- Physical, speech, occupational and respiratory therapy
- Casts, splints, strapping, orthopedic braces and crutches, blood and blood plasma
- Oxygen and respiratory therapy equipment, subject to BCBSUW approval
- Medical supplies prescribed by a physician, subject to BCBSUW approval

- Rental of, or, at our option, purchase of certain medical equipment
- Outpatient cardiac rehabilitation services for specified conditions in a facility approved by BCBSUW, subject to contract limitations
- Mammography screening every two years, with the limitation that 23 months have elapsed since the last screening. Covered annually after age 49.

Transplants

- Kidney transplants to the extent specifically covered under the policy
- Cornea transplants

Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders

LCP will pay benefits for covered charges incurred in a calendar year for services for alcohol, drug abuse and nervous or mental disorders for a member (anyone covered under the policy) subject to the following limitations:

Inpatient Services: Benefits will be paid at the lesser of 30 days or 90% of the first $7,000 of charges incurred for inpatient services to $6,300 per participant per calendar year. Thereafter one additional day of care for the treatment of nervous and mental conditions is available per participant per year.

Outpatient Services: LCP will pay benefits at 90% for the first $2,000 of charges incurred for outpatient services up to $1,800 per participant each calendar year. Thereafter one additional visit for nervous and mental conditions is available per participant per year.

Transitional Care Services: LCP will pay benefits at 90% for the first $3,000 of charges incurred for transitional care services up to $2,700 per participant each calendar year. Thereafter one additional visit for nervous and mental conditions is available per participant per year.

See your BCBSUW booklet ET-2134 for further information.

Equipment and Supplies for Treatment of Diabetes

LCP will pay benefits for covered charges incurred for diabetic self-management education programs and for the installation and use of an insulin infusion pump or other equipment or supplies, including insulin, in the treatment of diabetes. This benefit is limited to the purchase of one pump per calendar year. A member must use the pump for 30 days before purchase.

Kidney Disease Care

If medically necessary, LCP will pay benefits for covered charges for kidney dialysis treatment and kidney transplant expenses of both recipient and donor up to a maximum of $30,000 per year. This benefit only applies if charges are not covered elsewhere in the policy. LCP will not pay any benefits for charges paid for or covered by Medicare.

Women's Health Notice

Under the Women's Health and Cancer Act of 1998, coverage following a mastectomy includes:

- Reconstruction of the breast on which a mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Licensed Skilled Nursing Care

LCP will pay benefits for covered charges for skilled nursing care in a licensed skilled nursing home if you (or anyone covered under the policy) are admitted to the nursing home within 24 hours of discharge from a general hospital, and if your admission to the nursing home is for the same condition treated in the hospital. LCP will pay benefits for up to 30 days per nursing home confinement up to a maximum of 100 days per calendar year. To be eligible for benefits beyond the first 30 days per admission, the prior hospitalization must have been at least 5 days. The attending physician must certify every seven days that the care is medically necessary and is not domiciliary or custodial.

Home Care Services

LCP will pay benefits for covered charges for certain skilled home care services provided under an approved home care plan for 40 visits per calendar year. An additional 40 home hospice visits will be paid, if applicable. All of the specific covered services, limitations and exclusions are described in detail in the policy.

WAITING PERIODS FOR PRE-EXISTING CONDITIONS

BCBSUW considers a pre-existing condition to exist if within the six (6) months before the member's effective date you:

- Had an illness or injury diagnosed;
- Received medical care or treatment for an illness or injury;
- Had symptoms of an illness which would have caused an ordinarily prudent person to seek medical care or treatment.

Benefits are available for the pre-existing condition after the earlier of:

- The end of 90 days in a row after the effective date during which the member received no medical or dental care or treatment for the pre-existing condition; or
- The end of six months in a row during which the member was insured under this contract.
- BCBSUW will shorten the waiting period by the number of days a member was continuously insured under the policyholder's prior group health insurance policy and there was no lapse in coverage.

If a dependent child is born or adopted while family coverage is in force, the dependent child does not have a waiting period for coverage.

PRE-AUTHORIZATION OF EXPERIMENTAL OR INVESTIGATIVE PROCEDURES

LCP does not pay for procedures or services that are experimental, investigative, or of questionable medical value, as determined by BCBSUW. The types of procedures or services that may fall into this category include, but are not limited to:

- New medical or biomedical technology:
- Methods of treatment by diet or exercise;
- New surgical methods or techniques;
- Acupuncture or similar methods; and
- Transplant or implant of body organs, unless specifically covered.

BCBSUW may determine that a procedure or service does not qualify for coverage. You should know this in advance. Therefore, BCBSUW encourages you to seek pre-authorization before the procedure or service is performed to ask whether or not a service will be covered and how such will be paid. Even if a service is pre-authorized by BCBSUW, no payment will be made by BCBSUW unless coverage is in force at the time the service is performed.

LIMITATIONS AND EXCLUSIONS

The following is a summary of limitations and exclusions. A complete description is included in the booklet which you will receive from BCBSUW when you become insured.

The LAHP Copay Plan does NOT cover:

1. Services, supplies, or equipment which:
   - Are not specifically described as covered services; or
   - Are furnished in connection with or as a result of a non-covered service, even though the services, supplies, or equipment would otherwise be covered services.
2. Services, supplies, or equipment furnished:
   - Before the member's effective date;
   - During a confinement that began before the member's effective date; or
   - After the date the member's coverage ends.
3. Any portion of charge which is more than the usual, customary, and reasonable charge.
4. Services, supplies, or equipment that are not medically necessary.
5. Services, supplies, or equipment that are experimental/investigational.
6. Services, supplies, or equipment for a pre-existing condition which manifests itself in the 12 months before the member's effective date. Benefits are available for the pre-existing condition after the earlier of:
   - The end of 90 days in a row after the effective date during which the member received no medical or dental care or treatment for the pre-existing condition; or
   - The end of six consecutive months during which the member was insured under this contract.

   This exclusion does not apply to dependent children members who are adopted by or placed for adoption with a subscriber after the subscriber's effective date. If the exclusion does not apply to any other class of members, this is shown in the Schedule of Benefits.
7. Services, supplies, or equipment prescribed by or performed by a/an:
   - Masseur or masseuse (massage therapist);
   - Midwife;
   - Physical therapist technician;
   - Hearing aid dealer or fitter;
   - Social worker;
   - Audiologist;
   - Registered nurse;
   - Provider who is a member of the member's immediate family. Immediate family means the subscriber's or member's spouse, children, parents, grandparents, brothers and sisters and their spouses;

- Private duty nurse (his or her board is also not a covered service) or
- Any licensed or unlicensed professional or institutional health care provider other than a physician or hospital;

unless the contract specifically includes that provider as a covered service. Then, benefits are available only to the extent of, and subject to any limitations set forth in, the contract.

8. Services, supplies, or equipment:
   - For organ transplants other than:
     —Kidney
     —Cornea
   - Required in connection with or as a result of non-covered organ transplants.
   - Hematopoietic stem cell support.
9. Services, supplies, or equipment for:
   - In-vitro fertilization, artificial insemination, and all other insemination and/or fertilization services intended to induce ovulation and/or to promote spermatogenesis and/or to achieve conception;
   - Transsexual surgery or any treatment leading to or connected with transsexual surgery;
   - Treatment of sexual dysfunction which is not related to organic disease;
   - Reversals of sterilizations.
10. Alcoholism, drug addiction, or mental illness except as specified in the contract.
11. Dentistry or dental or oral surgery processes except as specified in the contract. This also excludes:
    - Orthognathic surgery or osteotomies.
12. The following items:
    - Prescription drugs, appliances, or prosthetic devices, except as specified in the contract;
    - Prescription drugs, or a deductible applied to prescription drugs, if benefits are provided to the member under one of our group prescription drug policies.
13. External or internal mechanical hearing aids, whether removable or surgically implanted, or examinations for the prescription or fitting of hearing aids.
14. Eyeglasses or contact lenses, or examinations for the prescription or fitting of eyeglasses or hearing aids. Benefits are available for the first pair of eyeglasses or contact lenses:
    - For aphakia;
    - For keratoconus;
    - Following cataract surgery.
15. Personal hygiene or convenience items. This includes:
    - Air conditioners;
    - Humidifiers; and
    - Physical fitness equipment.

16. Surgeries or procedures and their related hospital and professional services intended primarily to improve appearance, but not intended to restore normal bodily function or to correct deformity resulting from disease, trauma, or a previous therapeutic process that is a covered service. This exclusion does not apply to contralateral breast reconstruction following mastectomy for cancer.
17. Inpatient hospital admissions primarily for:
    - Physical therapy; or
    - X-ray or radiation therapy.
18. Services, supplies, or equipment:
    - For custodial care;
    - For care in custodial institutions or residential treatment facilities;
    - For rest cures;
    - Associated with travel.
19. Routine or administrative examinations and their related services. This includes services:
    - To screen for specific disease(s) when there is no evidence of the disease(s); or
    - For primary or secondary preventive (routine) care, including immunizations, well-baby care, monitoring, and education (except for mammograms and childhood immunizations); or
    - For administrative purposes, including those performed for occupation or employment, sports, purchase of insurance, and admission to school.

    This exclusion does not apply to mammograms.
20. Non-medical diagnostic evaluations, therapies and treatment of learning disabilities or developmental delays in dependent children members who have reached age 3 or older. This includes tests required in connection with those evaluations.
21. Weight loss programs, including any related hospital, professional, or diagnostic services, and prescription drugs; liquid diet supplements.
22. Speech therapy for psychosocial speech delay, behavior problems (including impulsivity syndrome), attention disorders, and conceptual handicaps.
23. Any illness or Injury:
    - Which occurs in the course of employment; and
    - For which the member is eligible for compensation, in whole or in part, under any Worker's Compensation Act or Employer Liability Law.

    This exclusion applies whether or not the member:
    - Claims the benefit or compensation; or
    - Recovers losses from a third party.
24. Charges resulting from an illness contracted or injury sustained as a result of:
    - War, whether declared or undeclared; or
    - Service in the Armed Forces of any country or state.
25. Services, supplies or equipment to the extent benefits are provided by any governmental unit. This exclusion does not apply to covered services provided to a member by a hospital operated by:

- The United States Veteran's Administration, when the covered services are for non-service related disability; or
- The Armed Forces of the United States, when the member is either retired from, or a dependent of a person on, active duty with the Armed Forces.

26. Services, supplies or equipment to the extent Medicare is the member's primary payor, which it is, except where Medicare is secondary by law. Where Medicare is primary payor, no benefits are available for services, supplies, or equipment:
    - For which the member would have been entitled to Medicare benefits had he or she enrolled in Medicare or complied with Medicare requirements.
    - Which Medicare considers not reasonable or not medically necessary.
27. Free care, or care for which a member would have no legal obligation to pay if he or she did not have this or any similar coverage.
28. Services, supplies or equipment received from a dental or medical department maintained by or on behalf of a/an:
    - Employer;
    - Mutual benefit association;
    - Labor union;
    - Trust;
    - Academic institution; or
    - Similar person or group.
29. The following charges:
    - Telephone consultation charges;
    - Charges for failure to keep a scheduled visit;
    - Charges for completion of a claim form or return to school/work form;
    - Charges which are not documented in provider records; or
    - State tax on goods or services.

TERMINATION OF COVERAGE

If you wish to cancel your coverage, you must notify the Department of Employee Trust Funds in writing. Refunds may be made for premiums paid in advance if we receive your written request before the first day of the month for which you request the refund.

If you fail to pay the required premiums, your coverage will cease at the end of the period for which premiums were paid. Unless you voluntarily cancel your coverage or discontinue paying the premium while eligible, benefits will continue when confined in a general hospital or a speciality hospital until discharge or until the maximum contract benefit has been provided, whichever occurs first.

2004 Premium Rates

Persons who have turned age 65 and are eligible for Medicare must elect the LAHP Classic Blue; persons under age 65 must choose the LAHP Copay Plan. If the annuitant does not enroll, his/her dependents are not eligible (surviving dependents who are receiving an annuity are eligible.) Some dependents may not be approved by BCBSUW even though the annuitant is approved. Therefore, the premium schedule below is for your information. Final determination of your premium will depend on which family members are approved by BCBSUW.

	MONTHLY PREMIUM
LAHP Classic Blue Medicare Supplement Coverage	
Age 65 or Over:	
● Single Coverage	$ 141.80
● Family Coverage	$ 281.70
LAHP Copay Plan	
Under Age 65:	
● Single Coverage	$ 721.50
● Family Coverage - LAHP Copay Plan For families in which all insured persons are under age 65.	$1,441.10
● Enrolled in Medicare under age 65, disabled Single	$ 502.80
Husband and Wife	$1,003.70
● Single Non-Medicare plus Single Medicare under age 65	$1,222.40
OTHER	
● Single Classic Blue plus Single Copay Plan - one age 65 or over and one under age 65	$ 861.40

A monthly administrative fee is added to the premium by the Department of Employee Trust Funds and is included in the premium shown above. In 2004, the administrative fee is $1.90 per contract.

If you are retired and have life insurance coverage through the Wisconsin Public Employers' Group Life Insurance Program, you may be eligible to convert the present value of your life insurance to pay health insurance premiums. You must be at least 67, or age 66 if your employer provides post-retirement life insurance coverage at the 50% level. If you make this election, your life insurance coverage will cease and you will receive credits in a conversion account equal to the present value of your life insurance. The present value ranges from about 44% to 80% of the amount, depending on your age. The life insurance company, Minnesota Life, will pay health insurance premiums on your behalf from your conversion account until the account is exhausted. If you would like more information from DETF regarding this program, please request the brochure, *Converting Your Group Life Insurance to Pay Health Insurance Premiums,* form ET-2325.

For Additional Information

If you have questions concerning benefit levels, the status of submitted claims, or you have claims to submit, you may contact:

Blue Cross & Blue Shield United of Wisconsin
P.O. Box 110
Fond du Lac, WI 54936-0110
Telephone: (414) 923-4141
(800) 755-6400

Contacting the Department of Employee Trust Funds

Self-Service Toll-Free Telephone Services

Available 24 hours a day, seven days a week. You must have a touch-tone telephone to use these systems.

SELF-SERVICE LINE: Call 1-877-383-1888 or (608) 266-2323 (local Madison) to request forms and brochures. Wisconsin Retirement System annuitants may also change their home mailing address or tax withholding election through this self-service line.

TELEPHONE MESSAGE CENTER: Call 1-800-991-5540 or (608) 264-6633 (local Madison) to hear detailed recorded messages covering a variety of Wisconsin Retirement System topics.

Note: *You will not be able to talk to a "live" person using these systems. To speak to a benefits specialist, call the telephone numbers listed below.*

To Visit our Internet Site

Access the Internet site at etf.wi.gov. A tremendous amount of information is on-line regarding the Wisconsin Retirement System and other benefit programs. You may e-mail the Department through this site.

To Call During Office Hours

Office Hours: 7:45 am to 4:30 pm, Monday through Friday (except holidays)

Toll Free: 1-877-533-5020

Madison: (608) 266-3285
To make an appointment: (608) 266-5717
TTY (Teletypewriter for hearing & speech impaired): (608) 267-0676

Milwaukee: To make an appointment: (414) 227-4294

To Write Us

Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

To Visit Us
(An appointment is recommended)

Madison: 801 West Badger Road
Milwaukee: 819 North Sixth Street, Room 550

The Department of Employee Trust Funds does not discriminate on the basis of disability in the provision of programs, services or employment. If you are speech, hearing or visually impaired and need assistance, call toll free 1-877-533-5020, (608) 266-3285 (local Madison) or TTY (608) 267-0676. We will try to find another way to get the information to you in a usable form.

ALWAYS INCLUDE YOUR NAME, SOCIAL SECURITY NUMBER, AND DATE OF BIRTH ON ALL CORRESPONDENCE TO THIS DEPARTMENT.