

LOCAL ANNUITANT HEALTH PROGRAM

YOU ARE ONLY ELIGIBLE TO ENROLL
IN THIS PROGRAM IF
YOU RECEIVE MONTHLY ANNUITY PAYMENTS

OR

AT THE TIME A LUMP
SUM ANNUITY IS TAKEN.

ENROLLMENT IS COMPLETELY OPTIONAL.



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



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.

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* 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 Medicare Supplement (over age 65) and the LAHP Preferred Provider Plan (PPP) coverage is provided in the Certificate 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 WPS Health Insurance (WPS) 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 Medicare Supplement for individuals age 65 and over who are enrolled in Medicare, and the LAHP Preferred Provider Plan (PPP) for those under age 65. Both single and family coverages are available. Both policies are insured through WPS Health Insurance (WPS) 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 or domestic partner and dependents) who are receiving a monthly annuity from the Wisconsin Retirement System (WRS).
- Local government retirees (including their spouse, domestic partner and dependents) at the time a lump sum annuity is taken.
- The insured surviving spouse, domestic partner and eligible dependent children of a deceased local government retiree.
- The surviving spouse, domestic partner and eligible dependent children of a deceased active local government employee.

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

Eligible dependents are the spouse, domestic partner 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, a child of your insured domestic partner, 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.

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 or turns age 27.
2. The last day of the calendar year in which the child:
 - a. Reaches age 19.
 - b. Ceases to be dependent for support and maintenance.
 - c. 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.

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. If your domestic partnership terminates, your former domestic partner (and eligible children of a domestic partnership) can remain covered under your family plan until the end of the month in which your domestic partnership terminates. If you fail to provide timely notice of termination of the domestic partnership, you may be responsible for premiums paid in error which covered your ineligible former domestic partner and eligible children of a domestic partnership. After termination, your ex-domestic partner and ineligible children of the domestic partnership will then be offered continuation of coverage.

The LAHP Medicare Supplement 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 Medicare Supplement 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 Preferred Provider Plan (PPP) and also continue the Medicare insurance. The premium for the LAHP PPP will be reduced due to the Medicare coverage.

If coverage is in force when your monthly annuity ends, WPS 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 Medicare Supplement or page 24 for the LAHP PPP 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 Medicare Supplement) or page 24 (LAHP PPP).

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 (ETF) 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 ETF receives the application or your termination date, whichever is later. Please note that your application **must** be received by ETF 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 WPS'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 WPS approval, for up to 90 days from the date ETF 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 ETF approves your disability annuity. The effective date of coverage will be the first of the month following ETF approval of your disability annuity and WPS 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: Coverage will automatically be continued for the spouse, domestic partner and/or dependent(s) who are insured at the time of the annuitant's death. Coverage for a surviving spouse or domestic partner may be continued for life; children may continue coverage for as long as they meet the definition of dependent.

Uninsured Survivor: If the spouse, domestic partner 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, domestic partner 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 WPS will provide to subscribers. Both you and your spouse or domestic partner should read this section carefully.

You have the right to apply for continuation coverage if:

- You are the insured spouse or domestic partner 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 ETF of a divorce or a child's loss of dependent status under the program. It is then the responsibility of ETF 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 coverage. 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 or domestic partner move to a new address, please notify ETF 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 WPS within 31 days after termination of coverage. If you have questions regarding conversion, write or call WPS.

TERMINATION OF COVERAGE

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

LAHP Medicare Supplement subscribers who cancel coverage and return the insurance booklet to WPS 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 WPS 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 WPS claims decision. Most benefits and claims questions can be resolved informally. Therefore, we urge you to first contact the WPS Customer Service department by telephone or in writing.

The toll-free Customer Service telephone number is 1-800-634-6448. The Customer Service address is:

WPS Health Insurance
P.O. Box 8190
Madison, WI 53707-8190

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.

WPS will provide a prompt, complete, and unbiased review of your request and their claims decision. WPS 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 ETF'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 WPS's decision, you may be eligible to have your appeal reviewed by an Independent Review Organization (IRO). WPS's appeal decision letter will include a list of approved IRO's. To qualify for External Review, your claims must cost more than \$292.

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

Attn: IRO Coordinator
P.O. Box 7458
Madison, WI 53708

WPS must receive your request within 4 months of the date that they denied your appeal. When you send in the request you must tell WPS which IRO you choose for your review. Note that the decision of the IRO is binding.

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 or domestic partner 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 Medicare Supplement 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 WPS at the telephone number provided on the top of page 31 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, for example, those determined to be necessary and reasonable. The LAHP Medicare Supplement will pay on this same basis. If Medicare approves a charge and pays 80% of that amount, the LAHP Medicare Supplement Plan will pay the remaining 20%. If you continue to be billed for charges which Medicare determines are excessive, neither Medicare nor the LAHP Medicare Supplement 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 Medicare Supplement 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 Medicare Supplement must be enrolled in both Parts A and B of Medicare. However, you may also choose to apply for the LAHP PPP, which would not require enrollment in Medicare.
- 5. Q. I am enrolled in Medicare but my spouse or domestic partner is not yet eligible. Will both of us be eligible for coverage?**

A. Yes, but you will be enrolled in the LAHP Medicare Supplement and your spouse or domestic partner must enroll in the LAHP PPP. 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 or domestic partner 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, domestic partner or dependent who becomes eligible for Medicare Part B, and is 65 years old, the dependent/spouse or domestic partner may then enroll under the open enrollment provisions.

- 7. Q. If I enroll in the LAHP PPP, what will happen when I become 65?**
- A. Your coverage will be switched to the LAHP Medicare Supplement. 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 WPS 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 PPP.
- 8. Q. I am under age 65 but I am disabled and have Medicare coverage. Can I apply for the LAHP Medicare Supplement policy?**
- A. No. The LAHP Medicare Supplement is available only to persons age 65 or above. You must apply for the LAHP PPP and also continue the Medicare insurance. The premium for the LAHP PPP 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 WPS.
- 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 domestic partner 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 2 through 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, your spouse or domestic partner enroll in Medicare.
- 19. Q. Will my premium rate change as I grow older?**
- A. If you are over 65 and on the LAHP Medicare Supplement plan, yes. This plan's premium is structured similar to other commercially available supplements where your rate depends on the age band you fall into. Age bands are from 65-67, 68-69, 70-74, and 75+.
- If you are under 65 and on the PPP, rates are the same regardless of your age.
- 20. Q. When will the first premium be deducted from my annuity check?**
- A. The first premium deduction depends upon when your application and WPS approval, if required, are received and processed by ETF. In order to be taken from your annuity payment, a deduction must be processed by ETF by the 15th of the previous month. Your first deduction may be more than one premium because premiums are paid in advance.

**WPS Health Insurance (WPS)
Outline of Supplement to Medicare Insurance
LOCAL ANNUITANT HEALTH PROGRAM (LAHP)
Medicare Supplement Insurance**

This Wisconsin Insurance Commissioner has set standards for LAHP Medicare Supplement 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 WPS booklet's most important features. The booklet you receive from WPS 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 WPS, P.O. Box 8190, Madison, WI 53707-8190. 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 the LAHP Medicare Supplement to Medicare
neither WPS nor its agents are connected with Medicare.**

LAHP Medicare Supplement Outline of 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 \$1,100*	\$1,100*	Nothing
	61st to 90th day	All but \$275* a day	\$275* a day	Nothing
	91st to 150th day	All but \$550* a day	\$550* 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 \$155* a day	\$155* 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.	Nothing
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 2010 LAHP Medicare Supplement benefits are also adjusted annually to pay these deductibles.

LAHP Medicare Supplement 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 \$135* deductible	\$0	\$135*	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.	Charges that exceed Medicare eligible charges.
OUTPATIENT PRESCRIPTION DRUGS				
		\$0	\$0	All charges
BLOOD				
		80% of costs except non-replacement fees (blood deductible) for first 3 pints (after \$135* 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 \$135* deductible/ calendar year)	20% of allowable charges for immunosuppressive drugs for covered transplants	All charges not paid by Medicare or LAHP Medicare Supplement
PART B POLICY LIMITS PER CALENDAR YEAR			No limit	

* Federal Medicare deductibles are adjusted annually; figures shown here are for 2010. LAHP Medicare Supplement benefits are also adjusted annually to pay these deductibles.

GENERAL INFORMATION

This is only a general outline of the LAHP Medicare Supplement benefits, limitations and exclusions. This is not a contract of insurance. A more detailed description of LAHP Medicare Supplement coverage is provided in the LAHP Medicare Supplement 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 WPS 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 Medicare Supplement 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 Medicare Supplement 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.
- Blood not covered by Medicare
- Emergency care when covered by Medicare, whether in a participating or non-participating hospital

Skilled Nursing Care

LAHP Medicare Supplement 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 Medicare Supplement 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 WPS for more details.

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

Home Health Care

LAHP Medicare Supplement 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 WPS or more details.

Chiropractic Services

LAHP Medicare Supplement 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 Medicare Supplement 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.

Kidney Disease

LAHP Medicare Supplement 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 Medicare Supplement provides benefits up to a lifetime maximum of 175 days of confinement after Medicare pays the lifetime limit of 190 days.

Outpatient Services: LAHP Medicare Supplement provides benefits at 100%.

Transitional Care Services: LAHP Medicare Supplement provides benefits at 100%.

See the WPS LAHP Medicare Supplement booklet for further information.

A usual, customary, or reasonable charge, as used in this brochure, is an amount WPS determines to be reasonable. In determining what is a reasonable charge, WPS 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 Medicare Supplement 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 fractures 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 Medicare Supplement 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 Medicare Supplement 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 90 days following your effective date.

By our definition, a pre-existing condition is any illness or injury for which, within six months 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 Medicare Supplement:

- WPS 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.

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 Medicare Supplement, you **didn't** have coverage under:

- A WPS 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 WPS when you become insured.

LAHP Medicare Supplement booklet does NOT cover:

- Drugs and medicines you buy with or without a prescription including insulin and certain diabetic supplies
- Personal comfort items
- Routine exams and related tests unless covered by Medicare
- Orthopedic shoes or other supporting devices for the feet unless Medicare pays first.
- Subluxations of the feet, or routine foot care not covered by Medicare
- 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 PREFERRED PROVIDER PLAN (PPP) HIGHLIGHTS (For Persons Under Age 65)

GENERAL INFORMATION

This is only a general outline of the LAHP PPP benefits, limitations and exclusions. This is not a contract of insurance. A more detailed description of PPP coverage is provided in the Booklet of Insurance from WPS which will be issued to each subscriber who becomes insured under PPP. Coverage is subject to all terms and conditions of the WPS 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 PPP mean a charge that does not exceed the general level of charges and is reasonable, as determined by WPS, for such a service or item when provided in the same general area under similar or comparable circumstances. All other charges are incurred on the date the participant receives the service or item.

LAHP PPP 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 WPS, 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.

WPS does not interfere with the professional relationship a member (anyone covered under the policy) has with his or her physician or hospital. WPS is not responsible to a member for the acts of any health care provider or any services or facilities. WPS 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.

Annual Deductible Amount

The annual deductible amount is \$250 per participant, not to exceed \$750 per family. Charges for covered expenses for health care services directly provided to you must add up to the appropriate deductible amount before benefits are payable for other charges for covered expenses. You are responsible for paying the charges used to satisfy the appropriate deductible amount.

If all or any part of your annual deductible amount has been satisfied in the last three months of a calendar year, your annual deductible amount of the next calendar year will be reduced by an equal amount.

Coinsurance

1. Coinsurance for Health Care Services Directly Provided to a Participant by a Preferred Provider.

After the deductible amount stated above is satisfied, LAHP PPP will pay benefits at 80% of the charges for the covered expenses for health care services directly provided to a member by a preferred provider, unless specifically stated otherwise in the policy, up to the annual out-of-pocket limit stated below.

2. Coinsurance for Health Care Services Directly Provided to a Participant by a Health Care Provider Other Than a Preferred Provider.

After the deductible amount stated above is satisfied, LAHP PPP will pay benefits at 60% of the charges for the covered expenses for health care services directly provided to a member by a health care provider other than a preferred provider, unless specifically stated otherwise in the policy, up to the annual out-of-pocket limit stated below.

3. Coinsurance for Independent Radiologists, Pathologists, Laboratories and Anesthesiologists, Emergency Medical Care & Services in a Hospital Emergency Room.

After the deductible amount stated above is satisfied, LAHP PPP will pay benefits at 80% of the charges for health care services provided and billed by a radiologist, pathologist, laboratory, anesthesiologist, and emergency medical care & services in a hospital emergency room.

Annual Out-of-Pocket Limit

1. Annual Out-of-Pocket Limit for Health Care Services Directly Provided To You by a Preferred Provider.

The annual out-of-pocket limit for covered expenses for health care services directly provided to you by a health care provider other than a preferred provider is \$750 per member, not to exceed \$2,250 per family. This total is made up of the annual deductible amount and coinsurance amounts which you pay for covered expenses for health care services directly provided to you by a health care provider other than a preferred provider in one calendar year. Charges for covered expenses for health care services applied by WPS to satisfy the annual out-of-pocket limit stated in paragraph 2. will also be used to satisfy this annual out-of-pocket limit.

2. Annual Out-of-Pocket Limit for Health Care Services Directly Provided To You by a Health Care Provider Other Than a Preferred Provider.

The annual out-of-pocket limit for covered expenses for health care services directly provided to you by a health care provider other than a preferred provider is \$1,250 per member, not to exceed \$3,750 per family. This total is made up of the annual deductible amount and coinsurance amounts which you pay for covered expenses for health care services directly provided to you by a health care provider other than a preferred provider in one calendar year.

Charges for covered expenses for health care services applied by WPS to satisfy the annual out-of-pocket limit stated in paragraph 1. will also be used to satisfy this annual out-of-pocket limit.

The annual out-of-pocket limits stated in 1. and 2. do not include: (1) the coinsurance amounts for covered expenses for the treatment of alcoholism, drug abuse and nervous or mental disorders; and (2) any reductions in benefits otherwise payable for failure to comply with pre-admission and continued stay certification requirements.

No benefits are payable for charges used to satisfy the annual out-of-pocket limit, including your annual deductible and coinsurance amounts. You are responsible for paying the charges used to satisfy the appropriate deductible and coinsurance amounts.

After the applicable annual out-of-pocket limit is reached, LAHP PPP will pay benefits at 100% of the charges for covered expenses, unless specifically stated otherwise in the policy, incurred by you during the remainder of the calendar year, subject to the lifetime maximum benefit limit and all other limitations, terms, conditions and provisions of the policy.

Lifetime Maximum:

The lifetime maximum benefit limit is the total amount of benefits payable for all covered illnesses and injuries for each member and is \$1,000,000.

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 directly provided to you by a physician of your choice to treat your illness or injury. Such services also include services provided by a certified registered nurse anesthetist, registered or licensed practice nurse, laboratory/x-ray technician and physician assistant, provided such person is lawfully employed by the supervising physician or the facility where the service is provided and he/she provides an integral part of the supervising physician's professional services while the physician is present in the facility where the service is provided. With respect to such services provided by a registered or licensed practical nurse, laboratory/x-ray technician and physician assistant, such services must be billed by the supervising physician or the facility where the service is provided.

- Surgical services
- Maternity services
- Oral surgery services (limited to specific procedures)
- Treatment of temporomandibular disorders (TMJ) - Benefits for diagnostic procedures and 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
- Chiropractic services

Other Services and Supplies

- Professional licensed ambulance
- Drugs and medicines which by law require a written prescription for the treatment of an illness or injury
- Injectable and oral insulin

- Immunizations
- 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
- Medical supplies prescribed by a physician
- Rental of, or, at WPS's option, purchase of certain durable medical equipment
- Outpatient cardiac rehabilitation services for specified conditions in a facility approved by WPS, subject to contract limitations
- Mammography screening every year

Transplants

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

Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders

LAHP PPP 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 100% at in-network providers or 90% at out-of-network providers per participant per calendar year.

Outpatient Services: LAHP PPP will pay benefits at 100% at in-network providers or 90% at out-of-network providers per participant each calendar year.

Transitional Care Services: LAHP PPP will pay benefits at 100% at in-network providers or 90% at out-of-network providers per participant each calendar year.

See your WPS booklet for further information.

Equipment and Supplies for Treatment of Diabetes

LAHP PPP 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, 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, LAHP PPP 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. LAHP PPP 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;
- Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

Licensed Skilled Nursing Care

LAHP PPP 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. LAHP PPP 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

LAHP PPP 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. All of the specific covered services, limitations and exclusions are described in detail in the policy.

WAITING PERIODS FOR PRE-EXISTING CONDITIONS

WPS 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.
- WPS 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

This section describes the types of health care services that should be preauthorized. WPS does not pay benefits for health care services that are experimental, investigative or not medically necessary or excluded from coverage due to an exclusion, as determined by them.

The types of health care services that may fall in to this category , but not limited to these, are:

- Transplants and Implants of body organs;
- New medical or biomedical technology;
- Methods of treatment by diet or exercise;
- New surgical methods or techniques;
- Acupuncture or similar methods;
- Sleep studies; and
- Sclerotherapy.

WPS may determine that a procedure or service does not qualify for coverage. You should know this in advance. Therefore, WPS 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 WPS, no payment will be made by WPS 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 WPS when you become insured.

The LAHP PPP 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 6 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.
7. Professional services not provided by a physician or any of the health care providers listed in the description of Professional Services on page 22.
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, except as specified in the contract.
 14. Personal hygiene or convenience items. This includes:
 - Air conditioners;
 - Humidifiers; and
 - Physical fitness equipment.
 15. 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.
 16. Inpatient hospital admissions primarily for:
 - Physical therapy; or
 - X-ray or radiation therapy.
 17. Services, supplies, or equipment:
 - For custodial care;
 - For care in custodial institutions or residential treatment facilities;
 - For rest cures;
 - Associated with travel.
 18. 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, 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.

19. 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.

20. Weight loss programs, including any related hospital, professional, or diagnostic services, and prescription drugs; liquid diet supplements.

21. 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.

22. 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.

23. 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.

24. 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.

25. 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.

26. 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.

27. 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. For further detail, see the WPS booklet.

MISCELLANEOUS INFORMATION

If a member is confined in a hospital other than a preferred hospital as an inpatient due to a medical emergency, WPS reserves the right to coordinate his/her transfer to a preferred hospital once he/she is stable and can be safely moved to that preferred hospital.

2010 Premium Rates

Persons who have turned age 65 and are eligible for Medicare must elect the LAHP Medicare Supplement; persons under age 65 must choose the LAHP PPP. 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 WPS 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 WPS.

LAHP MEDICARE SUPPLEMENT (MS) COVERAGE			MONTHLY PREMIUM
Age 65 or Over: Subscribers Age Band	Single Medicare	Family Medicare	One MS + One PPP
65 to 67	\$142.60	\$282.60	\$1,081.40
68 to 69	\$158.60	\$314.40	\$1,097.30
70 to 74	\$195.30	\$388.00	\$1,134.10
75+	\$221.60	\$440.50	\$1,160.30

LAHP PPP		
Under Age 65:	-single	\$ 941.60
	-family	\$1,877.90
Under Age 65 with Medicare*	-single	\$ 659.70
	-family	\$ 1,317.00
Under Age 65 with one Medicare*, one not:	-family of 2	\$ 1,598.60
Under Age 65 with two Medicare*, third not	-family of 3 or more	\$ 1,885.00
*Disability Medicare		

OTHER

Single Medicare Supplement plus Single PPP - one age 65 or over and one age 65 is equal to your single Medicare Supplement rate added to the single PPP rate of \$941.60.

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 2010, the administrative fee is \$2.50 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 ETF 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 or specific claims you may contact:

WPS Health Insurance
P.O. Box 8190
Madison, WI 53707-8190
Telephone: (800) 634-6448
Web Site: www.wpsic.com/state

Contacting the Department of Employee Trust Funds (ETF)

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.*

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.

Call During Office Hours

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

Telephone: 1-877-533-5020 (toll free)
(608) 266-3285 (local Madison)

Wisconsin Relay Service (for hearing & speech impaired)
7-1-1
1-800-947-3529 (English)
1-800-833-7813 (Spanish)

Write Us

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

Visit Us

Appointments: 

Madison: **An appointment is recommended**
801 West Badger Road