CompcareBlue

www.compcare.uwz.com

(formerly known as Compcare Health Services) **2001**

A Health Maintenance Organization

Serving: Southeast, Northcentral and Northwestern Wisconsin

Enrollment in this Plan is limited; see page 7 for requirements.

Southeastern Wisconsin enrollment codes:

691 Self Only
692 Self and Family

Northcentral and Northwestern enrollment codes:

6X1 Self Only
6X2 Self and Family

Authorized for distribution by the:

OPM Logo

United States
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Table of Contents

Introduction

CompcareBlue
401 W. Michigan Street
Milwaukee, WI 53203

This brochure describes the benefits of CompcareBlue under our contract (CS1361) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means CompcareBlue.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Who provides my healthcare?

CompcareBlue is a mix of both medical groups and individual doctors. In Burlington, Janesville, Racine, Sheboygan, Waukesha, and West Bend, the Plan has medical groups. In Milwaukee and the Northcentral and Northwestern regions, the Plan has both medical groups and individual doctors. Each medical group consists of doctors from different specialties who practice in a common center or centers. The individual doctors are generally available to Plan members in groupings commonly known as Individual Practice Associations (IPAs), which consist of doctors of different specialties who practice in their own offices.

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. See "What you must do to get covered Specialty care" below for services that you can receive without a referral from your primary care doctor.

Please note:

- If you want to enroll in a certain medical group or IPA, you must reside within the area in which that group or IPA practices. For example, the Milwaukee area providers (IPA doctors and medical groups) are available only to people who live in the enrollment area for the Milwaukee region shown on page 7. The areas in which the various Plan providers practice and are available for selection are shown in detail in the Plan's provider directory.
- Members within the same family may choose physicians from different networks. For example, a member can belong to one medical group/IPA, a spouse can belong to a different medical group/IPA and a child can belong to yet another medical group/IPA.

Our provider directory lists primary care doctors (family practitioners, pediatricians and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Member Services Department at 1-800-492-4049 or 414-276-2273 in the Southeast region; by calling 1-800-258-5299 in the Northcentral region; or by calling 1-800-368-4453 in the Northwestern region; you can also find out if your doctor participates with our Plan by calling these numbers. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates in the Plan and is accepting new patients.

Important note: **When you enroll in our Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.**

If you enroll, you will be asked to let us know which primary care doctor(s) you've selected for you and each member of your family by sending a selection form to us. If you need help in choosing a doctor, call us. Members may change their doctor selection by notifying us 30 days in advance.

If you are receiving services from a doctor who leaves the Plan, we will pay for covered services until we can arrange with you for you to be seen by another participating doctor.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about your health plan, its networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Compliance with State licensing requirements
- Years in existence
- Profit status

If you want more information about us, call 1-800-492-4049 or 414-276-22273 in the Southeastern region; 1-800-258-5299 in the Northcentral region; or 1-800-368-4453 in the Northwestern region; or write to CompcareBlue 401 W. Michigan Street, Milwaukee, WI 53203. You may also contact us by fax at 414-226-2636 or visit our website at www.compcare.uwz.com.

Service Area

To enroll with us, you must live in our service area. This is where our providers practice. Our service area is:

Southeastern Region:

Milwaukee area: The counties of Milwaukee, Ozaukee, Racine, Washington, and Waukesha. Also portions of Dodge, Fond du Lac, Jefferson, Kenosha, Racine, Sheboygan, and Walworth counties denoted by the zip codes on page 7.

Waukesha area: The counties of Milwaukee and Waukesha. Also portions of Dodge, Jefferson, Ozaukee, Racine, Walworth and Washington counties denoted by the zip codes on page 7.

West Bend area: The counties of Ozaukee and Washington. Also portions of Dodge, Fond du Lac, Jefferson, Sheboygan, and Waukesha counties denoted by the zip codes on page 8.

Janesville area: Rock County. Also portions of Dane, Green, Jefferson, Racine, and Walworth counties denoted by the zip codes on page 8.

Racine area: Racine and Kenosha Counties, Milwaukee County south of the I-94 East/West Expressway. Also portions of Walworth and Waukesha counties denoted by the zip codes on page 8.

Burlington area: Portions of Kenosha, Milwaukee, Racine, Walworth, and Waukesha counties denoted by the zip codes on page 8.

Sheboygan area: Brown, Sheboygan and Manitowoc Counties. Also portions of Fond du Lac, Ozaukee, and Washington counties denoted by zip codes on page 8.

Northcentral Region:

The counties of Clark, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Shawano, Taylor, Vilas, Waupaca and Wood.

Northwestern Region:

The counties of Ashland, Bayfield, Burnett, Douglas, Iron, Pepin, Pierce, Polk, Price, Sawyer, St. Croix, and Washburn.

You may also enroll with us if you live or work in the following zip code locations:

Southeastern Region:

Milwaukee area:

53002-04	53027	53075	53105	53148-49	53176-77
53010	53036	53091	53118-20	53152	53182
53013	53040	53101	53138-39	53159	53403
53021	53066				

Waukesha area:

53003	53036-38	53092	53120-21	53150	53182
53012	53047	53094-95	53126	53156	53185
53017	53059-60	53103	53130	53157	53190
53022	53066	53105	53137	53176	53538
53027	53076-78	53108	53138-39	53178	53549
53033-34	53086	53118-19	53148-49		

West Bend area:

53001-07	53023	5303940	5305960	53077-79	53099
53009-11	53026-27	53043	553064-66	53085	53209
53013	53029	53046-48	53070	53087	53217-18
53016-17	5303l-32	53050-51	53072-73	53089-91	53219
53021	53034-36	53056-57	53075	53093-94	53223-25
					53935

Janesville area:

53114-15	53138	53180	53502	53538	53574-75
53120-21	53147-48	53184-85	53508	53549-50	53585
53125	53156-57	53190-91	53520-21	53566	53589
53128	53176	53195	53523	53570	
	53570				

Racine area:

53103	53120	53130	53148-50	53157	53176
53105	53128	53138			

Burlington area:

53101	53120-21	53138-39	53159	53176	53185
53104-05	53125-26	53147-50	53167-68	53179	53191-92
53108-09	53128	53152	53170	53181-82	53194
53115	53130	53157			

Sheboygan area:

53004	53021	53040	53057	53060-62	53079

Northcentral Region

54401	54439-43	54462-3	54484-5	54548	54566
54403	54445-49	54465-7	54487-90	54554	54568
54405-14	54451-52	54469-71	54531	54558	54746
54418-28	54454-57	54473-6	54539-41	54561-2	54776
54433-37	54460	54479-81			

Northwestern Region:

54514	54546-7	54814	54834-6	54859	54880
54517	54550	54816-7	54838-9	54861-2	54888
54525	54559	54820-1	54842-7	54864-5	54890-1
54527-8	54565	54827-8	54849-50	54867	54893
54534	54801	54832	54854-6	54870-6	54896
54536	54806				

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area we will pay only for emergency care. We will not pay for any other health care services, particularly those of specialists, unless they are obtained through your Primary Care Physician. Chiropractic services, oral surgery and mental health and substance abuse services are covered without a referral when performed by one of our Plan providers.

If you or a covered family member reside/live outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), they may be able to receive benefits under our Away From Home Care guest membership program. This program provides care for routine, follow-up urgent and emergency situations just as your home Plan does. Contact our Customer Services Department for information on how to access and use the Away From Home Care guest membership program. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling our Member Services Department at the phone numbers listed on page 5. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- **CODE 69**
  Your share of the non-Postal premium will increase by
  87.8% for Self Only or **65.0%** for Self and Family.

  CODE 6X
  Your share of the non-Postal premium will increase by
  44.7 % for Self Only or **21.7 %** for Self and Family.
- Brown County has been added to the Plan's service area.
- Compcare Health Services now utilizes the trade name CompcareBlue.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call the Member Services Department at 1-800-492-4049 or 414-276-2273 in the Southeast region; 1-800-258-5299 in the Northcentral region; or 1-800-368-453 in the Northwestern region.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments or coinsurance, and you will not have to file claims. When you receive emergency services you may have to submit claim forms (See "Emergency services/accidents").

• Plan providers

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

•Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care

•Primary care

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist (See "Who provides my health care?" for more details).

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

• Specialty care

Your primary care physician will refer you to a specialist for needed care. However, you may receive the following services from a Plan provider without a referral: chiropractic services, oral surgery, mental health, and substance abuse services. A woman may also select an obstetrician/gynecologist as her secondary primary care physician; this selection must be made from her primary care physician's medical group or IPA. A woman may see her Plan obstetrician/gynecologist for her annual routine examination without a referral.

When you receive a referral from your primary care physician, you return to the primary care physician after the consultation unless your physician authorizes additional visits. All follow-up care must be provided or authorized by the primary care physician. Do not go to the specialist for a second visit unless your primary care physician has arranged for, and we have issued an authorization for, the referral in advance.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  - terminate our contract with your specialist for other than cause; or

  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  - reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

• Hospital care

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 1-800-492-4049 or 414-276-2273 in the Southeast region; 1-800-258-5299 in the Northcentral region; or 1-800-368-453 in the Northwestern. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process pre-authorization. Your physician must obtain our approval before sending you to the hospital, referring you to a specialist, or recommending follow-up care.

We will ask you to submit information that establishes that the service is medically necessary. If you do not ask or we determine that the service is not medically necessary, we will not cover the service or related services and supplies.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

• **Copayments**	A copayment is a fixed amount of money you pay to the provider when you receive services. Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay $100 per admission.
•**Deductible**	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. We have no deductibles. NOTE: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan. And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to any deductible of your new plan.
•**Coinsurance**	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Example: In our Plan, you pay 50% of charges for fertility drugs after the $2,000 per member infertility treatment limit is reached.
Your out-of-pocket maximum for deductibles, coinsurance, and copayments	We have no out-of-pocket maximum.

Section 5. Benefits -- OVERVIEW

(See page 9 for how our benefits changed this year and page 56 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-492-4049 or 414-276-2273 in the Southeast region; by calling 1-800-258-5299 in the Northcentral region; or by calling 1-800-368-453 in the Northwestern region or at our website at www.compcare.uwz.com.

Section 5 (a) Medical services and supplies provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians or chiropractors · In physician's or chiropractor's office	$10 per office visit
Professional services of physicians · In an urgent care center · During a hospital stay · In a skilled nursing facility · Initial examination of a newborn child covered under a family enrollment · Office medical consultations · Second surgical opinion	$10 per office visit
Professional services of physicians · In an outpatient treatment facility	$25 per office visit
Professional services of physicians · At home	$10 per office visit

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: · Blood tests · Urinalysis · Non-routine pap tests · Pathology · X-rays · Non-routine Mammograms · CAT Scans/MRI · Ultrasound · Electrocardiogram and EEG	$10 per office visit
Preventive care, adult	**You pay**
Routine screenings, such as: · Blood lead level – One annually · Total Blood Cholesterol – once every three years, ages 19 through 64 · Colorectal Cancer Screening, including ·· Fecal occult blood test	$10 per office visit
·· Sigmoidoscopy, screening – every five years starting at age 50	$10 per office visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnostic and Treatment*, above.	$10 per office visit
Routine mammogram –covered for women age 35 and older, as follows: · From age 35 through 39, one during this five year period · From age 40 through 64, one every calendar year · At age 65 and older, one every two consecutive calendar years	$10 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
· Routine Immunizations	$10 per office visit
Preventive care, children	**You pay**
· Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit

Preventive care, children *(Continued)*	**You pay**
· Examinations, such as: ·· Eye exams through age 17 to determine the need for vision correction. ·· Ear exams through age 17 to determine the need for hearing correction ·· Examinations done on the day of immunizations (through age 22) · Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per office visit
Maternity care	**You pay**
Complete maternity (obstetrical) care, such as: · Prenatal care · Delivery · Postnatal care Note: Here are some things to keep in mind: · You do not need to precertify your normal delivery. · You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. · We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. · We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing.
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	**You pay**
· Voluntary sterilization · Surgically implanted contraceptives · Injectable contraceptive drugs · Intrauterine devices (IUDs) Note: We cover contraceptive drugs and devices under the prescription drug benefit.	$10 per office visit

Family planning *(Continued)*	You pay
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges.*
Infertility services	**You pay**
Diagnosis and treatment of infertility, such as: · Artificial insemination: ·· *intravaginal insemination (IVI)* ·· *intracervical insemination (ICI)* ·· *intrauterine insemination (IUI)* · Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	Nothing for first $2,000 in charges per member for the first treatment program.You pay 50% of charges after you pay the first $2,000 for all infertilty services you receive while covered by us.
Not covered: · *Assisted reproductive technology (ART) procedures, such as:* ·· *in vitro fertilization* ·· *embryo transfer and GIFT* · *Services and supplies related to excluded ART procedures* · *Cost of donor sperm*	*All charges.*
Allergy care	**You pay**
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*

Treatment therapies	You pay
· Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 27. · Respiratory and inhalation therapy · Dialysis – Hemodialysis and peritoneal dialysis · Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy · Growth hormone therapy (GHT)	$10 per office visit

Rehabilitative therapies	You pay
· Physical therapy, occupational therapy and speech therapy	$10 per office visit
· Cardiac rehabilitation Phase I and II following a heart transplant, bypass surgery or a myocardial infarction	Nothing
Not covered: · *long-term rehabilitative therapy* · *exercise programs*	*All charges.*

Hearing services (testing, treatment, and supplies)	You pay
· Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
Not covered: · *all other hearing testing* · *hearing aids, testing and examinations for them*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
Diagnosis and treatment of diseases of the eye; eye exams and refractions as medically necessary.	$10 per office visit
· Eye exam to determine the need for vision correction for children through age 17 (see preventive care)	$10 per office visit
Not covered: · *Corrective lenses or frames* · *Eyeglasses or contact lenses and, after age 17, examinations for them* · *External lenses following cataract removal* · *Eye exercises and orthoptics* · *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	**You pay**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: · *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* · *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*

Orthopedic and prosthetic devices	You pay
· Artificial limbs and eyes; stump hose · Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy · Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. · Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	$25 copay per person per calendar year (Combined with DME)
Not covered: · *orthopedic and corrective shoes* · *arch supports* · *foot orthotics* · *heel pads and heel cups* · *lumbosacral supports* · *corsets, trusses, elastic stockings, support hose, and other supportive devices* · *prosthetic replacements that are not medically necessary*	*All charges.*
Durable medical equipment (DME)	**You pay**
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: · hospital beds; · wheelchairs · crutches; · walkers; · blood glucose monitors; and · one insulin pump per calendar year for diabetes is covered under this benefit provided you use it successfully for 30 days prior to coverage.	$25 copay per person per calendar year (Combined with Prosthetics)
Not covered: · *Motorized wheel chairs*	*All charges.*

Home health services	You pay
· Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. · Services include oxygen therapy, intravenous therapy and medications.	$10 per office visit

Home health services *(Continued)*	You pay
Not covered: · *nursing care requested by, or for the convenience of, the patient or the patient's family;* · *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*
Educational classes and programs	**You pay**
Coverage is limited to: · Diabetes self-management	$10 per office visit

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5 (c) for charges associated with the facility (i.e. hospital, surgical center, etc.) are covered in Section 5 (c).
- YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
· Treatment of fractures, including casting · Normal pre- and post-operative care by the surgeon · Correction of amblyopia and strabismus · Endoscopy procedure · Biopsy procedure · Removal of tumors and cysts · Correction of congenital anomalies (see reconstructive surgery) · Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over · Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	$10 per visit

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
· Voluntary sterilization · Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). · Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per visit
Not covered: · *Reversal of voluntary sterilization* · *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*
Reconstructive surgery	**You pay**
· Surgery to correct a functional defect · Surgery to correct a condition caused by injury or illness if: ·· the condition produced a major effect on the member's appearance and ·· the condition can reasonably be expected to be corrected by such surgery · Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	$10 per visit
· All stages of breast reconstruction surgery following a mastectomy, such as: ·· surgery to produce a symmetrical appearance on the other breast; ·· treatment of any physical complications, such as lymphedemas; ·· breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure	$10 per visit
Not covered: · *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* · *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	**You pay**

Oral surgical procedures, limited to: · Reduction of fractures of the jaws or facial bones; · Surgical correction of cleft lip, cleft palate or severe functional malocclusion; · Removal of stones from salivary ducts; · Excision of leukoplakia or malignances; · Excision of cysts and incision of abscesses when done as independent procedures; and · Other surgical procedures that do not involve the teeth or their supporting structures	Nothing
Not covered: · *Oral implants and transplants* · *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone)* · *All other procedures involving the teeth or intra-oral areas surrounding the teeth not specifically mentioned above.*	*All charges.*

Organ/tissue transplants	You pay
Limited to: · Cornea · Heart · Heart/lung · Single lung · Double lung · Kidney · Liver · Pancreas · Allogeneic (donor) bone marrow transplants · Autologous bone marrow transplants with high doses chemotherapy (ABMT/HDC) are covered for breast cancer, multiple myeloma, epithelial ovarian cancer, testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. · Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) are covered for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma	Nothing
We cover related medical and hospital expenses of the donor when we cover the recipient	20% of charges.
Not covered: · *Donor screening tests and donor search expenses, except those performed for the actual donor* · *Implants of artificial organs* · *Transplants not listed as covered*	*All charges*

Anesthesia	You pay
Professional services provided in – · Hospital (inpatient) · Hospital outpatient department · Skilled nursing facility · Ambulatory surgical center · Office	$10 per visit

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as · ward, semiprivate, or intensive care accommodations; · general nursing care; and · meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$100 per admission, up to an annual maximum of $200 per member per year.

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay**
Other hospital services and supplies, such as: · Operating, recovery, maternity, and other treatment rooms · Prescribed drugs and medicines · Diagnostic laboratory tests and X-rays · Administration of blood and blood products · Blood or blood plasma, if not donated or replaced · Dressings, splints, casts, and sterile tray services · Medical supplies and equipment, including oxygen · Anesthetics, including nurse anesthetist services · Take-home items · Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: · *Custodial care, rest cures, domiciliary or convalescent care* · *Non-covered facilities, such as nursing homes, extended care facilities, schools* · *Personal comfort items, such as telephone, television, barber services, guest meals and beds* · *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	**You pay**
· Operating, recovery, and other treatment rooms · Prescribed drugs and medicines · Diagnostic laboratory tests, X-rays, and pathology services · Administration of blood, blood plasma, and other biologicals · Blood and blood plasma, if not donated or replaced · Pre-surgical testing · Dressings, casts, and sterile tray services · Medical supplies, including oxygen · Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$25 per visit
Not covered: blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/skilled nursing care facility benefits	**You pay**
Covered for up to 30 days per member per year when full time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by us. All necessary services are covered, including: · Bed, board and general nursing care · Biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor. Drugs are covered under the prescription drug benefit.	Nothing

Extended care benefits/skilled nursing care facility benefits *(Continued)*	**You pay**
Not covered: custodial care, rest cures, domiciliary or convalescent care	*All charges*
Hospice care	**You pay**
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness with a life expectancy of six months or less.	Nothing
Ambulance	**You pay**
· Local professional ambulance service when medically appropriate	$25 per occurrence

Section 5 (d). Emergency services/accidents

IMPORTANT		IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your primary care physician. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify us. You or a family member must notify your Plan primary care physician within 48 hours or on the first working day following your admission to arrange follow-up care, unless it is not reasonably possible to do so. It is your responsibility to ensure that your primary care physician has been timely notified.

If you need to be hospitalized, we must be notified within 48 hours or on the first working day following your admission, unless it is not reasonably possible to notify us within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

For services to be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by us or provided by Plan providers.

We pay reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay $25 per member per hospital emergency room visit or urgent care center visit for emergency services which are covered benefits of the Plan. Inpatient admissions are subject to the hospital copay of $100 per admission, up to an annual maximum of $200 per member per year. If you are admitted as an inpatient, the $25 copayment will be waived and the inpatient copayment will be apply. If you have met your annual maximum, the $25 copayment will apply.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, we must be notified within 48 hours or on the first working day following your admission, unless it is not reasonably possible to notify us within that time. If you are hospitalized

in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

For services to be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by us or provided by Plan providers.

We pay reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay $25 per member per hospital emergency room visit or urgent care center visit for emergency services which are covered benefits of the Plan. Inpatient admissions are subject to the hospital copay of $100 per admission, up to an annual maximum of $200 per member per year. If you are admitted as an inpatient, the $25 copayment will be waived and the inpatient copayment will be apply. If you have met your annual maximum, the $25 copayment will apply.

Filing claims for non-Plan providers: With your authorization, we will pay benefits directly to the providers of your emergency room care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to us along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reason for the denial. If you disagree with our decision, you may request reconsideration in accordance with the disputed claims procedure described on page 44.

Benefit Description	You pay
Emergency within our service area	
· Emergency care at a doctor's office	$10 per office visit
· Emergency care at an urgent care center or hospital emergency room Note: $25 copayment is waived if you are admitted as an inpatient. Inpatient admission will be subject to the $100 per admission copay. If the annual maximum is met, the $25 copayment will apply.	$25 per visit
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	**You pay**
· Emergency care at a doctor's office	$10 per office visit
· Emergency care at an urgent care center or hospital emergency room Note: $25 copayment is waived if you are admitted as an inpatient. Inpatient admission will be subject to the $100 inpatient copayment. If the annual copayment maximum is met, the $25 copayment will apply.	$25 per visit
Not covered: · *Elective care or non-emergency care* · *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* · *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges.*
Ambulance	**You pay**
Professional local ambulance service when medically appropriate. See 5(c) for non-emergency service.	$25 per occurrence

Section 5 (e). Mental health and substance abuse benefits

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible. For facility care, the inpatient admission copay applies to some benefits in this Section. We indicate where the inpatient admission copay applies.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
· Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers · Medication management	$10 per office visit

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
· Diagnostic tests	$10 per office visit
· Services provided by a hospital or other facility · Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$100 copay per inpatient admission, up to an annual maximum of $200 per member per year.
Not covered: Services we have not approved. **Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.**	*All charges.*

Preauthorization — We do not require preauthorization, but we strongly recommend that your provider seek preauthorization prior to rendering services

.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition:

· If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Limitation

We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed Plan physician or a referral physician must write the prescription .
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail if necessary. Call 1-800-522-3636 for more information regarding mail order pharmacy benefits.
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with our managed care formulary. We make the determination to include/exclude specific drugs on our formulary based on: medical policy on therapy protocols; and managed formulary decisions such as identical products or drugs considered less than effective. Should a physician ask for prior approval or a denied drug claim is appealed, our Pharmacy Services department will request patients' medical and pharmacy history and will request a physician consultant's opinion. A full medical review will be done if necessary.
- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral physician and obtained at a Plan pharmacy will be dispensed for up to a 34-day supply. You pay a $7 copay per prescription unit or refill for up to a 34-day supply or 100-unit supply, whichever is less; 240 milliliters of liquid (8 oz) ; 60 grams of ointment creams or topical preparation; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin) for generic drugs or $12 for name brand drugs when generic substitution is not permissible or available.
- **When you have to file a claim.** Plan pharmacies will file the claim directly with us.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: · Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase. · Insulin; with a copay charge per vial · Diabetic supplies including insulin syringes, needles, glucose test tablets and test tape. Benedicts solution or equivalent gluclose monitor supplies and acetone test tablets; one month supply of each item purchased at one time may be obtained for one copay. · Disposable needles and syringes needed to inject covered prescribed medication · Full range of FDA approved drugs, prescriptions and devices for birth control; injectable contraceptive drugs (subject to the office visit copay); Norplant is covered; you pay nothing for the implantation You must pay the cost of its removal if, for whatever reason, the Norplant is surgically removed before three years have elapsed from the date of its insertion. · Nitroglycerin, phenobarbital or Thyroid U.S.P. · Intravenous fluids and medication for home use · Drugs to treat sexual dysfunction are limited. Contact us for dose limits. You pay the applicable copayment up to the dosage limits and all charges thereafter. **Note:** The following drugs are only available through the designated Plan pharmacy: · Self-injectable medications (except for insulin, glucagon, epinephrine kits, and Imitrex) · Prescriptions which exceed $150 in cost · Growth hormones · Fertility drugs (you pay 50% of charges after the $2,000 per member infertility treatment limit is reached. See page 18) · A 90-day supply of maintenance drugs. You pay three copays.	$ 7 per prescription unit or refill for generic drugs $ 12 per prescription unit or refill for name brand drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copay.

Covered medications and supplies *(continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: · A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.	
Not covered: · *Drugs available without a prescription or for which there is a nonprescription equivalent available* · *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* · *Vitamins and nutritional substances that can be purchased without a prescription* · *Medical supplies such as dressings and antiseptics* · *Drugs and supplies for cosmetic purposes* · *Drugs to enhance athletic performance* · *Smoking cessation drugs and medications, including nicotine patches* · *Non precsription medicines*	*All Charges*

Section 5 (g). Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. · We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. · Alternative benefits are subject to our ongoing review. · By approving an alternative benefit, we cannot guarantee you will get it in the future. · The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. · Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization medically necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	**You pay**
We cover restorative services and supplies necessary to promptly repair (or initially replace) sound natural teeth are covered. The need for these services must result from an accidental injury.	20% of covered charges
Teeth extraction benefit	
We will cover the extraction of seven or more fully erupted natural teeth at one time.	20% of covered charges
We have no other dental benefits	

Section 5 (i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Expanded dental Benefits

Choose Dentacare 160 for quality, coverage, convenience and choice.

Valuable dental coverage

- No deductible before benefits begin
- No annual dollar maximum
- No claim forms
- No waiting periods
- No pre-existing condition limitations
- No pre-authorization requirements

Available at low monthly cost

- Only $13.64 for Self Only coverage
- Only $39.83 for Self and Family coverage
- Billed directly to you on a quarterly basis

100 percent coverage for preventive and diagnostic care

- 100% for regular exams
- 100% for regular cleanings
- 100% for x-rays

60 percent coverage for:

- Restorative Services
- Endonics
- Periodontics
- Prosthodontics
- Oral Surgery

Orthodontics covered up to 50% up to a lifetime maximum per person of $1,250 (for dependents only through age 19, or age 23 if 50% support and a full-time student).

Professional care at Convenient locations

- Over 70 professional dental centers
- Locations throughout Wisconsin
- Select the center most convenient for your family
- One center services you and all eligible family members
- Evening and Saturday hours at many centers
- Each family member chooses own dentist at selected center

For more information

Call our customer service department today at 414-226-6744 in Milwaukee or 1-800-242-7312 in Wisconsin

Section 6. General exclusions -- things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term;
- Services, drugs, or supplies related to sex transformations;
- Expenses you incurred while you were not enrolled in this Plan; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-492-4049 or 414-276-2273 in the Southeastern region; 1-800-258-5299 in the Northcentral region; or 1-800-368-4453 in the Northwestern region. .

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer --such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: The address on your ID card.

Prescription drugs

Submit your claims to: The address on your ID card.

Other supplies or services

Submit your claims to: The address on your ID card.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. Write to us at: 401 West Michigan Street, Milwaukee, Wisconsin 53203.You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: 401 West Michigan Street, Milwaukee, Wisconsin 53203; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: · 90 days after the date of our letter upholding our initial decision; or · 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or · 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436. Send OPM the following information: · A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; · Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; · Copies of all letters you sent to us about the claim; · Copies of all letters we sent to you about the claim; and · Your daytime phone number and the best time to call. Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs or supplies. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-492-4049 or 414-276-2273 in the Southeastern region; 1-800-258-5299 in the Northcentral region; or 1-800 368-4453 in the Northwestern region and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division III at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

•What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

• The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. For example, your care must continue to be authorized by your Plan PCP.

We will not waive any of our copayments, coinsurance, and deductibles.

(Primary payer chart begins on next page.)

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… …….		
a) The position is excluded from FEHB, or……	✓	
b) The position is not excluded from FEHB……		✓
Ask your employing office which of these applies to you.		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or ……	✓	
b) Are an active employee……		✓

Claims process -- You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at our Member Services Department phone numbers listed on page 5.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare+Choice service area.

- **Enrollment in Medicare Part B**

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care which is designed to assist in meeting the activities of daily living and which does not require the continuing attention of trained medical personnel. It includes services such as help in walking, getting in and out of bed, assistance in bathing, dressing, feeding and using the toilet.
Experimental or investigational services	Devices, drugs, biologic products, procedures, programs of diagnosis or treatment, and facilities for which there is a lack of scientific evidence permitting conclusions as to the effect of the health outcome; that the net health outcome is beneficial; that the beneficial outcome is better than that achieved under established alternatives; and that the effect is attainable under the usual conditions of medical practice.
Medical necessity	Means that the service or supply is: (a.)appropriate and consistent with the symptoms or diagnosis and treatment; (b) in accordance with standards of good medical practice; (c) not primarily for convenience; and(d) the most appropriate and least costly supply or level of service which can be safely provided.
Us/We	Us and we refer to CompcareBlue.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you *a Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

•When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

• Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, *the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices.

•TCC

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Get the RI 79-27, which describes TCC, and the RI 70-5, *the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure.

Converting to individual coverage

You may convert to an non-FEHB individual policy if:

·· Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;

·· You decided not to receive coverage under TCC or the spouse equity law; or

·· You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at the Member Services Department numbers listed on page 5 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Summary of benefits for CompcareBlue - 2001

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	**You Pay**	**Page**
Medical services provided by physicians: · Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	15
Services provided by a hospital: · Inpatient · Outpatient	Nothing after $100 copay per admission up to annual maximum of $200. Nothing	28 29
Emergency benefits: · In-area and Out-of area	$10 per visit to physician, $25 per visit to emergency room or urgent care center.	31
Mental health and substance abuse treatment	Regular cost sharing.	34
Prescription drugs	$7 generic drugs $12 name brand drugs	36
Dental Care (Accidental dental injury; Teeth extraction benefit)	20% of covered charges.	40
Vision Care	$10 per visit	21
Special features	Flexible benefits option	39

2001 Rate Information for
Compcare Health Services

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Southeastern Wisconsin							
Self Only	691	$86.59	$48.97	$187.61	$106.10	$102.22	$33.34
Self and Family	692	$195.82	$155.04	$424.28	$335.92	$231.17	$119.69
Northcentral/Northwest Wisconsin							
Self Only	6X1	$86.59	$42.07	$187.61	$91.15	$102.22	$26.44
Self and Family	6X2	$195.82	$125.90	$424.28	$272.78	$231.17	$90.55