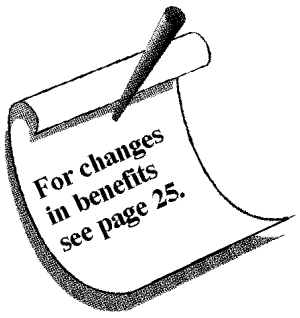
Compcare Health Services 1999

A HEALTH MAINTENANCE ORGANIZATION



SERVING**: Southeast, Northcentral and Northwestern Wisconsin**

SOUTHEAST WISCONSIN ENROLLMENT CODES:

691 Self Only
692 Self and Family

NORTHCENTRAL AND NORTHWESTERN WISCONSIN ENROLLMENT CODES:

6X1 Self Only
6X2 Self and Family

ENROLLMENT AREA**:** Enrollment in this plan is limited; see page 9 for requirements.

Visit the OPM Website at **http://www.opm.gov/insure**

and

this Plan's website at **http://www.compcare.uwz.com**

Authorized for distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 73-022

Compcare Health Services

Compcare Health Services Insurance Corporation, 401 W. Michigan Street, Milwaukee, Wisconsin 53203, has entered into a contract (CS 1361) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Compcare Health Services, Compcare, or the Plan.

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on page 25 of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 1-800-544-3873 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELPnumber to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. **As a member of this Plan, once your enrollment is effective, you will be covered only for services provided orarranged by a Plan doctor except in the case of emergency as described on page 15.** If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See "If you are hospitalized" on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

General Information *continued*

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800-638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

NOTIFICATION AND ELECTION REQUIREMENTS:

Separating employees — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36 month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. Afamily member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Certificate of Creditable Coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Facts about this plan

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll in an HMO, you are joining an organized system of health care that arranges in advance with specific doctors, hospitals and other providers to give care to members and pays them directly for their services. Benefits are available **only** from Plan providers except during a medical emergency. **Members are required to select a personal doctor from among participating Plan primary care doctors.** Services of a specialty care doctor can only be received by referral from the selected primary care doctor. There are no claim forms when Plan doctors are used.

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not because a particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Information you have a right to know

All carriers in the FEHBP Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the Carrier at 1-800-242-7312 or (414) 226-6744 in the Southeastern region, 1-800-242-7312 in the Northcentral region, or 1-800-368-4453 in the Northwestern region or you may write the Carrier at 1515 N. RiverCenter Drive, Milwaukee, WI 53212. You may also contact the Carrier by fax at (414) 226-2636, or at its website at http://www.compcare.uwz.com.

Information that must be made available to you includes:

- Plan had a disenrollment rate of 6.1 percent at end of 1997.
- Plan has been compliant with State of Wisconsin licensing since its inception in 1971. Plan has been federally qualified since 1984.
- Accreditations by recognized accrediting agencies and the dates received.
- Plan is incorporated under Wisconsin Statute 611 and has been in existence since 1971.
- Plan meets State and Federal requirements for fiscal solvency, confidentiality and transfer of medical records.

Who provides care to Plan members?

This Plan 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.

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 (IPAdoctors and medical groups) are available only to people who live in the enrollment area for the Milwaukee region shown on page one. 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/IPAand a child can belong to yet another medical group/IPA.

Role of your doctor

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. Services of other providers are covered only when you have been referred by your primary care doctor, with the following exceptions: Chiropractic services, oral surgery, and mental health and substance abuse services are covered without a referral when performed by a Plan provider. Awoman may also select an obstetrician/gynecologist as a secondary primary care doctor; this selection must be made from her primary care doctor's medical group or IPA. A woman may see her plan obstetrician/gynecologist for her annual routine examination without a referral. Certified nurse practitioners are covered when under the supervision of a Plan medical doctor.

Facts about this plan *continued*

Choosing your doctor

The Plan's 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 1-800-242-7312 or 414-226-6744 in the Southeast region; by calling 1-800-242-7312 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 this 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 with the Plan and is accepting new patients. Important note: **When you enroll in this 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 otherprovider, cannot be guaranteed.**

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

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

Referrals for specialty care

Except in a medical emergency, or in case of the exceptions mentioned on page 7, or when a primary care doctor has designated another doctor to see his or her patients, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will arrange appropriate referrals.

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

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist. The treatment plan will permit you to visit your specialist without the need to obtain further referral.

Authorizations

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Your Plan doctor must obtain the Plan's determination of medical necessity before you may be hospitalized, referred for specialty care or obtain follow-up care from a specialist.

For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan. If the doctor who originally referred you to this specialist is now your Plan primary care doctor, you need only call to explain that you are now a Plan member and ask that you be referred for your next appointment.

If you are selecting a new primary care doctor and want to continue with this specialist, you must schedule an appointment so that the primary care doctor can decide whether to treat the condition directly or refer you back to the specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket maximum

Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments which are required for a few benefits.

Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these

covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Experimental/ investigational determinations

Determinations are made by the Plan Medical Director. Various sources are used to assist the Medical Director in the decision-making process. These sources include peer-reviewed medical literature, Medicare Policy established by the Medicare Part B Carrier Advisory Committee, technology evaluations or clinical guidelines published by nationally recognized professional or government organizations and consultation with independent, board certified medical specialists.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

The Plan's Service Areas

The service area for this Plan, where Plan providers are located, is described below. You must live in the service area to enroll in this Plan.

Benefits for care outside the service area are limited to emergency services, as described on page 15.

If you or a covered family member move outside the service area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

Services from Plan providers are available only in the following areas:

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 10.

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 10.

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 10.

Janesville area: Rock County. Also portions of Dane, Green, Jefferson, Racine, and Walworth counties denoted by the zip codes on page 10.

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 10.

Burlington area: Portions of Kenosha, Milwaukee, Racine, Walworth, and Waukesha counties denoted by the zip codes on page 10.

Sheboygan area: Sheboygan County. Also portions of Fond du Lac, Manitowoc, Ozaukee, and Washington counties denoted by zip codes on page 10.

Northcentral Region:

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

Northwestern Region:

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

Facts about this plan *continued*

You may enroll in this plan if you live in one of the counties shown on page 9 of this brochure or in one of the zip code locations shown below.

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	53039-40	53059-60	53077-79	53099
53009-11	53026-27	53043	53064-66	53085	53209
53013	53029	53046-48	53070	53087	53217-18
53016-17	53031-32	53050-51	53072-73	53089-91	53223-25
53219	53034-36	53056-57	53075	53093-94	53935
53021					

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	

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	53042	53057	53060-63	53079
53015	53040				

Northcentral Region:

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

Northwestern Region:

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

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan orbe used in the prosecution or defense of a claim under this Plan.** This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Arbitration of claims

Any claim for damages for personal injury, mental disturbance or wrongful death arising out of the rendition of or failure to render services under this contract must be submitted to binding arbitration.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Medicare Part Aand/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies, unless you use Plan providers. You must tell your Plan that you or your family member is eligible for Medicare. Generally, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary care provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

General Limitations *continued*

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP(or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless yourPlan doctor determines it is medically necessary to prevent, diagnose or treat yourillness or condition as discussed underAuthorizations on page 8.** The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see *Emergency Benefits*) or eligible self-referred services.
- Expenses incurred while not covered by this Plan
- Services furnished or billed by a provider or facility barred from the FEHB Program
- Services not required according to accepted standards of medical, dental, or psychiatric practice
- Procedures, treatments, drugs or devices that are experimental or investigational
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and supplies relating to abortions, except when the life of the mother would be endangered if the fetus were carried to term.

Procedures, treatments, drugs and devices are considered experimental/investigational if there is a lack of scientific evidence permitting conclusions: as to the effect on health outcome; that the net health outcome is beneficial; that the beneficial outcome is better than established alternatives; and that the effect is attainable under the usual conditions of a medical practice. The Plan medical director determines whether a treatment, service, or supply is investigational after receiving input from a variety of sources. Individual consideration will be given. The decision as to the appropriateness of the investigational method of treatment for that particular case will first be considered by the Plan medical director in consultation with the group medical director and consultants. When necessary it will be brought before the Appeals Committee for final review.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** $10 per office visit; $25 per visit to an outpatient facility. Within your Service Area, house calls will be provided if in the judgement of the Plan doctor such care is necessary and appropriate; **you pay** a $10 copay for a doctor's house call or for home visits by nurses and health aides. **You pay** a $25 copay for services rendered in an outpatient treatment facility.

The following services are included and are subject to office visit copays unless stated otherwise:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and x-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. The copay is waived for all prenatal office visits. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization; family planning services
- Diagnosis and treatment of diseases of the eye; eye exams and refractions as necessary
- Allergy testing and treatment, including test and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Kidney, cornea, heart, heart/lung, liver, single lung, double lung and pancreas transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer, multiple myeloma, epithelial ovarian cancer, testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors. Donor costs are covered when the recipient is covered by the Plan, **you pay** 20% of charges.
- Physical and occupational therapy; speech therapy for impairments of organic origin
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Chiropractic services from a participating chiropractor (a referral from your primary care doctor is not necessary)
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you.

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts, and surgical treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. The extraction of seven or more fully erupted teeth is covered under Dental care, page 19. The following oral surgery procedures are also covered when performed by a Plan provider:

- Surgical removal of impacted teeth
- Apicoectomy, alveolectomy, frenectomy, vestibuloplasty
- Residual root removal; root amputation
- Periodontal surgery
- Excision of exostoses of the jaws and hard palate
- External incision and drainage of cellulitis
- Incision of accessory sinuses, salivary glands or ducts

All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

Diagnosis and treatment of infertility, including **artificial insemination,** is covered. **You pay** nothing for the first $2,000 of infertility testing and treatment per member per lifetime and 50% of charges thereafter. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI). Cost of donor sperm is not covered. Fertility drugs are covered under the Prescription Drug Benefit. **Other assisted reproductive technology (ART) procedures,** such as in-vitro fertilization and embryo transfer are not covered.

Cardiac rehabilitation Phase I and II following a heart transplant, bypass surgery or a myocardial infarction, is provided in full. **You pay** nothing.

Orthopedic devices, such as braces, **prosthetic devices,** such as artificial limbs, ostomy supplies, and lenses implanted following cataract surgery, and **durable medical equipment,** such as wheelchairs, glucose monitors and hospital beds, are covered. **You pay** a $25 deductible per member per year, nothing thereafter. One insulin infusion pump per calendar year for diabetes is covered under this benefit provided you use it successfully for 30 days prior to coverage.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Homemaker services; custodial care
- Hearing aids
- Transplants not listed as covered
- Orthopedic shoes, except for reverse and straight last shoes, shoes attached to a brace, and Thomas heels.
- Vision supplies, including eyeglasses or contact lenses, and their fitting, except when lenses are implanted during cataract surgery, external lenses following cataract surgery are not covered.
- Foot orthotics

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** a $100 copay per admission, subject to an annual maximum of $200 per member per year. **All necessary services are covered,** including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

Extended care

The Plan provides a comprehensive range of benefits 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 the Plan. **You pay** nothing. **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. See page 18.

Hospice care

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.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. **You pay** $25 per incident.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 17 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care

CARE MUSTBE RECEIVED FROM OR ARRANGED BYPLAN DOCTORS

Emergency Benefits

What is a medical emergency?

Amedical emergency is the sudden and unexpected onset of a condition or an injury that a prudent layperson would 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 the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

Emergency Benefits *continued*

Emergencies within the Service Area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. 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 for any necessary follow-up care. It is your responsibility to ensure that your primary care physician has been timely notified.

If you need to be hospitalized, the Plan **must** be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan 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 the Plan or provided by Plan providers.

Plan pays…

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 this Plan. Inpatient admissions are subject to the hospital deductible of $100 per admission, subject 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 deductible will apply. If you have met your annual maximum, the $25 copay will apply.

Emergencies outside the 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, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes 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 the Plan or provided by Plan providers.

Plan pays…

Reasonable charges for emergency care 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 this Plan. Inpatient admissions are subject to the hospital deductible of $100 per admission, subject 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 deductible will apply. If you have met your annual maximum, the $25 copay will apply.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan

What is not covered

- Elective care or nonemergency 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

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency 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 the Plan 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 reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 23.

Mental Conditions/Substance Abuse Benefits

Mental Conditions

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

All necessary outpatient visits to Plan doctors, consultants, or other psychiatric personnel each calendar year; **you pay** nothing for first 20 visits (or up to $1,800 in visit charges, whichever is greater); 20% of charges thereafter.

Inpatient care

Up to 120 days of hospitalization (including related doctors' charges) each calendar year; **you pay** nothing for first 30 days; 20% of charges for days 31-120; all charges after 120 days.

What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance Abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and, to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care

All necessary outpatient visits to Plan provider for treatment; **you pay** nothing for first 35 covered visits (or up to $1,800 in visit charges, whichever is greater); 20% of charges thereafter.

Inpatient care

All necessary substance abuse rehabilitation (intermediate care) in an alcohol detoxification or rehabilitation center approved by the Plan; **you pay** nothing.

What is not covered

- Treatment that is not authorized by a Plan doctor

Transitional care

What is covered

In addition to the Plan's inpatient and outpatient care for the treatment of both mental conditions and substance abuse, the Plan will provide transitional care up to the greater of 10 days of treatment or charges of $2,700 per person per year. This care consists of community-based residential care for persons who have been treated in institutions for either mental conditions or substance abuse. **You pay** nothing for the first 10 days of treatment or the first $2,700 of charges, whichever is greater; all charges thereafter.

What is not covered

- Treatment that is not authorized by a Plan doctor

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor 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 generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, **you pay** the price difference between the generic and name brand drug as well as the $7 copay per prescription unit or refill.

Drugs are prescribed by plan doctors and dispensed in accordance with the Plan's managed drug formulary.

The Plan makes the determination to include/exclude specific drugs on its formulary based on: the benefit design of coverage; 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, the Plan's Pharmacy Services department will request patients' medical and pharmacy history and will request a physician consultant's opinion. Afull medical review will be done if necessary.

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law
- Oral contraceptive drugs
- Insulin; with a copay charge applied to each vial
- Diabetic supplies including insulin syringes, needles, glucose test tablets and test tape, Benedicts solution or equivalent, glucose monitor supplies and acetone test tablets; one month's supply of each item purchased at one time may be obtained for one copay
- Nitroglycerin, phenobarbital or Thyroid U.S.P.
- Disposable needles and syringes needed to inject covered prescribed medication
- Intravenous fluids and medication for home use
- Injectable contraceptive drugs (subject to the office visit co-pay)
- 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.
- Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits. **You pay** the applicable copayment up to the dosage limits and all charges above that.

Limited benefits

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 14.)
- A90-day supply of maintenance drugs. **You pay** three copays.
- Mail orders will be filled when necessary. Call 1-800-522-3636 for information.

What is 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
- Contraceptive devices, except for IUDs (covered on page 13) and Norplant
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs and medication, including nicotine patches

Other Benefits

Dental care

What is covered	The Plan will cover the extraction of seven (7) or more fully erupted natural teeth at one time. **You pay** 20% of charges. For other covered oral surgery, see page 14.
Accidental injury benefit	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 occurring while the member is covered under the FEHB Program; **you pay** 20% of charges.
What is not covered	• Other dental services not shown as covered

Vision care

What is covered	In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (to provide a written lens prescription for eyeglasses) may be obtained from Plan providers. **You pay** a $10 copay per visit.
What is not covered	• Corrective lenses or frames
	• Eye exercises
	• External lenses following cataract removal

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum copay charges, etc. These benefits are not subject to the FEHB disputed claims procedure.

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 $11.02 for Self Only coverage
- Only $32.18 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

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

Professional, quality 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
- **(414) 226-6744 in Milwaukee area**
- **1-800-242-7312 toll-free in Wisconsin**

Benefits on this page are not part of the FEHB contract

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Customer Service Department at 1-800-242-7312 or (414) 226-6744 in the Southeastern region, 1-800-242-7312 in the Northcentral region, or 1-800-368-4453 in the Northwestern region, or you may write to the Plan at 1515 N. RiverCenter Drive, Milwaukee, WI 53212. You may also contact the Plan by fax at (414) 226-2636, or at its website at http://www.compcare.uwz.com.

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division IV, P.O. Box 436, Washington, DC 20044.

OPM review *cont'd*

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement — If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How Compcare Health Services Changes January 1999

Do not rely on this page; it is not an official statement of benefits.

Program-wide Changes

The following change has been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights.

- If you have a chronic, complex, or serious medical condition that causes you to frequently see a Plan specialist, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist without the need to obtain further referrals. (See page 8 for details.)
- Amedical emergency is defined as the sudden and unexpected onset of a condition or an injury that a prudent layperson would believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. (See page 15.)

The medical management of mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Examples include attention deficit disorder and Gilles de la Tourette's syndrome. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits.

Summary of Benefits for Compcare Health Services — 1999

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

Benefits		Plan Pays / Provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** $100 per admission up to an annual maximum of $200 per member per year	15
	Extended Care	All necessary services for up to 30 days per member per year. **You pay** nothing	15
	Mental Conditions	Up to 120 days of inpatient care per year for diagnosis and treatment of acute psychiatric conditions. **You pay** nothing for first 30 days, 20% of charges for days 31-120; transitional care following discharge is available, as described under Substance Abuse	17
	Substance Abuse	All necessary substance abuse treatment, including up to the greater of 10 days of treatment or $2,700 in charges per member per year for care in a transitional facility following discharge, in combination with Mental Conditions benefit. **You pay** nothing	17
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and x-rays; complete maternity care. **You pay** a $10 copay for office visits or house calls by a doctor (copays waived for prenatal visits); $25 per member per visit in an outpatient treatment facility	13
	Home Health Care	All necessary visits by nurses and health aides. **You pay** a $10 copay per visit	13
	Mental Conditions	All necessary outpatient visits. **You pay** nothing for first 20 visits per year, 20% of charges thereafter	17
	Substance Abuse	All necessary outpatient visits. **You pay** nothing for first 35 visits per year, 20% of charges thereafter	17
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** $25 per member per visit and charges for services that are not covered benefits of this Plan	15-16
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $7 copay per generic prescription, $12 for name brand prescription unit or refill	18
Dental care		Accidental injury benefit; **you pay** 20% of charges	19
Vision care		One refraction annually, **you pay** a $10 copay per visit	19
Out-of-pocket limit		Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments that are required for a few benefits.	

1999 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 most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		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**
Self Only	691	$71.69	$23.90	$155.33	$51.78	$84.84	$10.75
Self and Family	692	$160.39	$87.01	$347.51	$188.52	$183.29	$64.11
Self Only	6X1	$70.76	$23.58	$153.30	$51.10	$83.73	$10.61
Self and Family	6X2	$160.39	$83.86	$347.51	$181.70	$183.29	$60.96