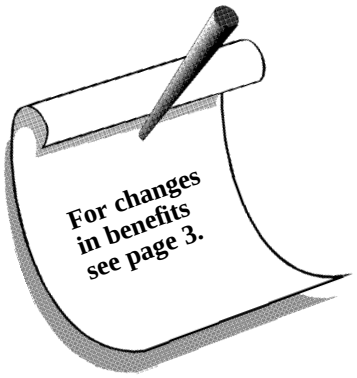
Compcare Health Services 2000

A Health Maintenance Organization



Serving: Southeast, Northcentral and Northwestern Wisconsin

Enrollment in this Plan is limited: see page 4 for requirements.

Southeast Wisconsin enrollment codes:
691 Self Only
692 Self and Family

Northcentral and Northwestern Wisconsin enrollment codes:
6X1 Self Only
6X2 Self and Family

Visit the OPM Website at http://www.opm.gov/insure
and
our website at http://www.compcare.uwz.com

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Federal Employees Health Benefits Program

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Table of Contents

Introduction

Compcare Health Services Insurance Corporation
401 W. Michigan Street, Milwaukee, Wisconsin 53203

This brochure describes the benefits you can receive from Compcare under its contract (CS1361) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 3. Premiums are listed 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. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Compcare Health Services Insurance Corporation as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How To Use This Brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Health Maintenance Organizations (HMO). This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.
2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.
3. How to get benefits. Make sure you read this section; it tells you how to get services and how we operate.
4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.
7. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.
8. FEHB facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1 — Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2 — How We Change For 2000

Program-wide changes

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. (See Section 3, How to get benefits, for more information.)

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

- Enrollment Code **69**: Your share of the non-postal premium will increase by 9.1% for Self Only or 8% for Self and Family.
- Enrollment Code **6X**: Your share of the non-postal premium will increase by 23.3% for Self Only or 23.3% for Self and Family.
- The Plan has expanded its service area by covering all of Manitowoc County and adding Waupaca and Price counties. Previously, the Plan only covered a portion of Manitowoc County.
- Mental Conditions/Substance Abuse Benefits have been clarified to show how you can access these providers directly without a referral from your primary care doctor.

Section 3 — How To Get Benefits

What is this Plan's 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 5.

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 5.

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 5.

Janesville area: Rock County. Also **portions** of Dane, Green, Jefferson, Racine, and Walworth counties denoted by the zip codes on page 5.

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 5.

Burlington area: Portions of Kenosha, Milwaukee, Racine, Walworth, and Waukesha counties denoted by the zip codes on page 5.

Sheboygan area: Sheboygan and Manitowoc Counties. Also **portions** of Fond du Lac, Ozaukee, and Washington counties denoted by zip codes on page 5.

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.

Section 3 — How To Get Benefits *(continued)*

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	53039-40	53059-60	53077-79	53099
53009-11	53026-27	53043	553064-66	53085	53209
53013	53029	53046-48	53070	53087	53217-18
53016-17	3031-32	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	

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				

Section 3 — How To Get Benefits *(continued)*

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 move 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. 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.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services, except for pre-natal office visits and all necessary medical and surgical care in a hospital or extended care facility from Plan providers

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

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care?

Compcare Health Services 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 "How do I get 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 4. 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;

Section 3 — How To Get Benefits *(continued)*

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.

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or authorized specialist will make the necessary hospital arrangements and supervise your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department 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. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist.

Except in a medical emergency, or in case of the exceptions mentioned on page 6, 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. 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. A woman 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.

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 we have issued an authorization for, the referral in advance.

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, and will require our approval before beginning the treatment.

Section 3 — How To Get Benefits *(continued)*

What do I do if I am seeing a specialist when I enroll?

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. Generally we will not pay for you to see a specialist who does not participate with our Plan.

What do I do if my 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.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary to prevent, diagnose or treat your illness or condition, and if it follows generally accepted medical practice.

How do you decide if a service is experimental or investigational?

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.

Section 4 — What To Do If We Deny Your Claim Or Request For Service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

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.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division IV at (202) 606-0737 between 8 a.m and 5 p.m. Serious or life-threatening conditions are ones that cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We did not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we do not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;
2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
3. Copies of all letters you sent us about the claim;
4. Copies of all letters we sent you about the claim; and
5. Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Section 4 — What To Do If We Deny Your Claim Or Request For Service *(continued)*

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim to OPM?

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

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5 — Benefits

Medical and Surgical Benefits:

All care must be received from or arranged by Plan doctors.

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

Section 5 — Benefits *(continued)*

- 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 20. 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. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

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, breast prosthesis and surgical bras, 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.

Section 5 — Benefits *(continued)*

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

Section 5 — Benefits *(continued)*

Hospital/Extended Care Benefits:

What is covered:

Hospital care: We provide 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: We provide 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 us. 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

Section 5 — Benefits *(continued)*

Emergency Benefits:

What is a medical emergency?

A medical 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 we may determine are medical emergencies — what they all have in common is the need for quick action.

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

We pay: 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.

Section 5 — Benefits *(continued)*

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 us

What is 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

Filing claims for non-Plan providers:

With your authorization, we 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 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 reasons for the denial and the provisions of the contract on which denial was based. If you disagree with our decision, you may request reconsideration in accordance with the disputed claims procedure described on page 10.

Section 5 — Benefits *(continued)*

Mental Conditions/Substance Abuse Benefits

Important Note: A primary care doctor referral is not required for members to access mental conditions/substance abuse providers. To find out who your provider is: call our Customer Service Department (at the phone numbers listed on page 7) or your medical group's patient coordinator, or you may refer to our medical group listing in the Plan's Provider Directory.

Mental Conditions

What is covered: To the extent shown below, we provide 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: We provide 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 us; you pay nothing.

What is not covered:

- Treatment that is not authorized by a Plan doctor

Transitional care:

What is covered: In addition to our inpatient and outpatient care for the treatment of both mental conditions and substance abuse, we 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

Section 5 — Benefits *(continued)*

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 our managed drug formulary.

We make 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, 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.

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law
- Full range of FDA-approved drugs, prescriptions, and devices for birth control; 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.
- 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
- 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 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 18.)
- A 90-day supply of maintenance drugs. You pay three copays.

Mail order pharmacy benefit
Mail orders will be filled when necessary. Call 1-800-522-3636 for information.

Section 5 — Benefits *(continued)*

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
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs and medication, including nicotine patches

Section 5 — Benefits *(continued)*

Other Benefits

Dental care

What is covered: We 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 12.

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 $12.18 for Self Only coverage
- Only $35.56 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-rayst

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

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 or condition.

We do not cover the following:

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

Section 7 — Limitations – Rules That Affect Your Benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800-638-6833.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

TRICARE

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

Section 7 — Limitations – Rules That Affect Your Benefits *(continued)*

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 determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

Section 8 — FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (**www.opm.gov**) lists the specific types of information that we must make available to you.

If you want specific information about us, call 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, or write to Compcare Health Services Insurance Corporation, 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.**

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Season for enrollment.

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.

When are my benefits and premiums effective?

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 January 1.

What happens when I 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, which is described later in this section.

What types of coverage are available for my family and me?

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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

Are my medical and claims records 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 payment 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse 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 more information about your coverage choices.

What is TCC?

Temporary Continuation of Coverage (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 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.

Section 8. FEHB FACTS *(continued)*

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

How can I get 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. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

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

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 1-800-544-3873 and explain the situation.

• If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE

202/418-3300
U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

• Try to obtain services for a person who is not an eligible family member; or

• Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Compcare Health Services Insurance Corporation — 2000

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	14
	Extended Care	All necessary services for up to 30 days per member per year. **You pay** nothing	14
	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	11
	Home Health Care	All necessary visits by nurses and health aides. **You pay** a $10 copay per visit	12
	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
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	20
Vision care		One refraction annually, **you pay** a $10 copay per visit	20
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.	

2000 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. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Services Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				**Postal Premium A**		**Postal Premium B**	
		Biweekly		**Monthly**		**Biweekly**		**Biweekly**	
Type of Enrollment	**Code**	**Gov't Share**	**Your Share**	**Gov't Share**	**Your Share**	**USPS Share**	**Your Share**	**USPS Share**	**Your Share**
Southeastern Wisconsin									
Self Only	691	$ 78.22	$ 26.07	$169.47	$ 56.49	$ 92.56	$11.73	$ 92.56	$11.73
Self and Family	692	$175.97	$ 93.97	$381.27	$203.60	$207.74	$62.20	$201.02	$68.92
Northcentral/Northwest Wisconsin									
Self Only	6X1	$ 78.83	$ 29.08	$170.80	$ 63.01	$ 93.06	$14.85	$ 93.26	$14.65
Self and Family	6X2	$175.97	$103.42	$381.27	$224.08	$207.74	$71.65	$201.02	$78.37