Blue Care Network

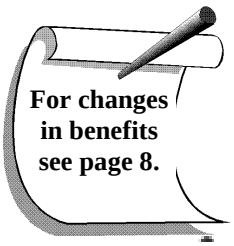
http://www.bcbsm.com/bcn/

Blue Care Network

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

2001

A Health Maintenance Organization



Serving: Most of Michigan

Enrollment in this Plan is limited; see page 6 for requirements.

Enrollment codes for this Plan:

East Region
- KN1 Self Only
- KN2 Self and Family
- K51 Self Only
- K52 Self and Family

Southeast Region
- LX1 Self Only
- LX2 Self and Family

Mid Region
- LN1 Self Only
- LN2 Self and Family

West Region
- KR1 Self Only
- KR2 Self and Family
- KF1 Self Only
- KF2 Self and Family
- G71 Self Only
- G72 Self and Family

Authorized for distribution by the:

OPM

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
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FEHB
Federal Employees
Health Benefits Program

RI 73-153

Table of Contents

Introduction

Blue Care Network of Michigan
25925 Telegraph
Southfield, Michigan 48086-5043

This brochure describes the benefits of Blue Care Network of Michigan (BCN) under our contract (CS 2011) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 8. Rates are shown on the back cover of this brochure.

Plain Language

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

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

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

Section 1. Facts about this HMO plan

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

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

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

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

How we pay providers

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

More than 11,000 participating physicians provide health care services to enrollees in this Plan. These doctors are located in private offices and medical centers throughout the service area.

Patients' Bill of Rights

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

Member Rights
Blue Care Network believes that members are an essential part of the health care team and have responsibility for their own health.

All members have the right to:
- Receive information about their health care in a manner that is understandable to them
- Receive medically necessary care as outlined in this brochure
- Receive considerate and courteous care with respect for privacy and human dignity
- Candidly discuss appropriate medically necessary treatment options for their conditions, regardless of cost of benefit coverage
- Participate with practitioners in decision making regarding their health care
- Expect confidentiality regarding their care
- Refuse treatment to the extent permitted by law and be informed of the consequences of those actions
- Voice concerns about their health care by submitting a formal written complaint or grievance through the BCN Member Grievance program
- Receive written information about BCN, its services, practitioners and providers, and member rights and responsibilities in a clear and understandable manner
- Know BCN's financial relationships with its health care facilities or primary care physician groups

Member Responsibilities
BCN members also have responsibilities as outlined in this brochure.

All members have the responsibility to:

- Read this brochure and all other materials for members, and call Customer Service with any questions
- Coordinate all non-emergency care through their primary care physician
- Use the BCN provider network unless otherwise approved by BCN and the primary care physician
- Comply with the treatment plans and instructions for care as prescribed by their practitioners. Members, who choose not to comply, must advise their physician
- Provide, to the extent possible, information that BCN and its physicians and providers need in order to provide care
- Make and keep appointments for non-emergency medical care, calling the doctor's office to promptly cancel appointments when necessary
- Participate in medical decisions about their health
- Be considerate and courteous to providers, their staff and other patients
- Notify BCN of address changes and additions or deletions of dependents covered by their contract
- Protect their identification card against misuse and contact Customer Service immediately if a card is lost or stolen
- Report all other insurance programs that cover their health and their family's health

Blue Care Network of Michigan is federally qualified and licensed. BCN is a nonprofit HMO and an affiliate of Blue Cross Blue Shield of Michigan. It formed in February 1998 when four affiliated Blue Care Network organizations (Blue Care Network of East Michigan, Blue Care Network-Great Lakes, Blue Care Network Mid Michigan and Blue Care Network of Southeast Michigan) merged into a single, new company. Of these former separate entities, BCN of East Michigan is the oldest. It became federally licensed as an HMO in 1975. BCN Mid Michigan was established in 1977. BCN of Southeast Michigan was licensed in 1981 and BCN-Great Lakes began operation in 1983.

If you want more information about us, call 1-800-662-6667, or write to Blue Care Network of Michigan, 25925 Telegraph, Southfield, MI 48086-5043. Our website is www.bcbsm.com/bcn/

Service Area

To enroll in this Plan, you must live, or work, in our Service Area. This is where our providers practice. Our Service Area is:

East Michigan
Code K5 – serving Arenac, Bay, Gratiot, Isabella, Midland, Saginaw and Tuscola counties
Code KN – serving Genesee, Lapeer and Shiawassee (excluding the towns of Perry, Shaftsburg and Morice) counties.

Mid-Michigan
Code LN – serving Clinton, Eaton, Ingham, Jackson, Livingston and parts of Shiawassee (the towns of Perry, Shaftsburg and Morice), Ionia (the towns of Danby and Portland) and Hillsdale (except for Somerset and Wright townships and Waldron Village) counties.

Southeast Michigan
Code LX – serving Macomb, Monroe, Oakland, St. Clair, Washtenaw and Wayne counties.

West Michigan
Code G7 – serving Alcona, Alpena, Antrium, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Mackinac, Manistee (portions of), Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle and Roscommon counties.
Code KF – serving Berrien, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren and the portions of Allegan, Barry and Eaton (those areas served by postal zip codes 49010, 49020, 49046, 49060, 49073, 49078 and 49080) counties.
Code KR – serving Kent, Muskegon Oceana, Ottawa and portions of Ionia, Mecosta, Montcalm, Newaygo and Wexford counties. And the portion of Allegan County served by postal zip codes 49070, 49311, 49314, 49323, 49328, 49335, 49344, 49348, 49406, 49408, 49416, 49419, 49423, 49447, 49450 and 49543.

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.

If you or a covered family member move outside 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), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. Almost anywhere within the state of Michgan, urgent care and in some cases, routine services, can be arranged. Blue Care Network is also a part of a national network of Blue Cross and Blue Shield HMOs, BluesConnect®. Members can obtain urgent care in areas served by other Blue Cross and Blue Shield HMOs affiliated with BluesConnect. If you would like more information about receiving care away from home, please contact Customer Service. If you or a family member move, you do not have to wait until open enrollment season to change plans. Contact your employment or retirement office.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many health care organizations have turned their attention this past year to improving health care quality and patient safety. OPM asked all FEHB plans to join it in this effort. You can find specific information on our patient safety activities by calling Customer Service at 1-800-662-6667. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your health care, take these five steps.
  - •• Speak up if you have questions or concerns.
  - •• Keep a list of all the medicines you take.
  - •• Make sure you get the results of any test or procedure.
  - •• Talk with your doctor and health care team about your options if you need hospital care.
  - •• Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-postal premium will increase by:
  - 37.2% for Self Only or 31% for Self and Family for West Michigan (code G7)
  - 14% for Self Only or 20% for Self and Family for East Michigan (code K5)
  - 44.5% for Self Only or 120.5% for Self and Family for West Michigan (code KF)
  - 17.6% for Self Only or 29.8% for Self and Family for East Michigan (code KN)
  - 52.5% for Self Only or 87.1 for Self and Family for West Michigan (code KR)
  - 88.7% for Self Only or 75.4% for Self and Family for Mid-Michigan (code LN)
  - 19.7% for Self Only or 20% for Self and Family for Southeast Michigan (code LX)

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-662-6667.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, and you will not have to file claims.

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You can select any primary care physician who is accepting new patients from our provider directory for your region.

- **Primary care**

Your primary care physician can be a family practitioner, internist or, for your children, a pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, female members may self refer to a gynecologist or obstetrician -gynecologist for their annual well-woman exams and routine services.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will manage your care, referring you to a specialist when it is medically appropriate. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

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

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

- If you have a chronic or disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service department immediately at 1-800-662-6667. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the hospital benefit of the hospitalized person; we cover your other non-hospital care.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process plan approval. Your physician must obtain plan approval for services such as, but not limited to:

- Inpatient hospitalization
- Reconstructive surgery
- Transplants
- Certain infertility treatments
- Home Health Care
- Nursing Home Care
- Physical/Occupational/Speech Therapy
- Cardiac/Pulmonary Rehabilitation

Your primary care physician has been advised of the procedures that require plan approval. The PCP must send a copy of the referral, along with the appropriate medical records to BCN so that BCN can review the request for medical appropriateness. If the proper procedure is not followed and BCN does not assign an authorization for the procedure in question, the procedure will not be covered and you may be financially liable for all costs. Your PCP must issue the referral and initiate this process. If your PCP will not initiate the referral for you, you should contact Customer Services at 1-800-662-6667 to determine how to proceed. BCN will make every effort to ensure that appropriate care is provided for you and your family in a timely fashion.

The contracted obstetrician-gynecologist practitioner must still obtain prior authorization from the PCP for hospital admissions and outpatient surgeries for eligible conditions.

To ensure continuity of care, the member's PCP coordinates direct access to specialty care. When indicated, authorization is given for an adequate number of direct access visits under an approved treatment plan.

The role of the specialist physician in part is to accept referrals of members from PCP's and except in emergencies, provide only those services that were authorized by the member's PCP. The specialist physician should consult with and seek further authorization from the member's PCP if additional treatment or tests are needed.

In instances where the member has a complex or serious medical condition such as AIDS, end stage renal disease, or advanced cancer a case manager can work with a PCP to eliminate barriers caused by the referral process. For example, a case manager will coordinate the member's care between the PCP and specialty care physician(s) by facilitating close communication among them via telephone and written progress reports.

The PCP is fully apprised of the specialist's treatment plan, thereby decreasing the frequency of member visits to the PCP.

Section 4. Your costs for covered services

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

• **Copayments**	A copayment is a fixed amount of money you pay to the provider when you receive services. Example: When you see your primary care physician you pay a copayment of $10 per office visit.
• **Coinsurance**	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Example: In our Plan, you pay 50 percent of our allowance for infertility services and durable medical equipment.

Your out-of-pocket maximum for copayments and coinsurance	We do not have an out-of-pocket maximum.

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and page 50 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also, read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-662-6667 (1-800-257-9980, TTY for the hearing impaired) or at our website at www.bcbsm.com/bcn/.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	**You pay**
Professional services of physicians • In physician's office	$10 per office visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion	$10 per office visit
At home	Nothing
Lab, X-ray and other diagnostic tests	**You pay**
Tests such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $10 per office visit

Preventive care, adult	You pay
Routine screenings, such as: • Blood lead level – one annually • Total blood cholesterol – once every three years, ages 19 through 64 • Colorectal cancer screening, including •• Fecal occult blood test •• Sigmoidoscopy, screening – every five years starting at age 50 • Travel immunizations	$10 per office visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnostic and Treatment Services*, above.	$10 per office visit
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five-year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive years	$10 per office visit
Not covered: physical exams required for obtaining or continuing employment or insurance, attending schools or camp	*All charges*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under childhood immunizations) • Influenza/pneumococcal vaccines, annually, age 65 and over	$10 per office visit
Preventive care, children	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit
• Examinations, such as: •• Eye exams through age 17 to determine the need for vision correction. •• Ear exams through age 17 to determine the need for hearing correction •• Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per office visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 16 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay, we will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 per office visit
Not covered: routine sonograms to determine fetal age, size or sex	*All charges*

Family planning	You pay
• Voluntary sterilization	$10 per office visit
• Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$5 copayment (paid under the pharmacy benefit) and $10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling	*All charges*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: •• intravaginal insemination (IVI) •• intracervical insemination (ICI) •• intrauterine insemination (IUI) • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	50 percent of charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *in vitro fertilization* •• *embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm*	*All charges*

Allergy care	You pay
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 23. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: We will only cover GHT when we preauthorize the treatment. Call 1-800-662-6667 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$10 per office visit

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy -- • 60 visits per condition for the services of each of the following: •• qualified physical therapists; •• speech therapists; and •• occupational therapists Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, limited to 60 consecutive days. Phases three and four of cardiac rehab are not covered.	$10 per office visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges*

Hearing services (testing, treatment and supplies)	You pay
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment and supplies)	**You pay**
• Annual eye refraction from Plan optometrists to provide a written lens prescription for eyeglasses	$5 per office visit
• One pair every 12 months of: colorless glass lenses, medically necessary tinted #1 and #2 lenses, bifocal and trifocal lenses, or contact lenses when provided by an optician or physician.	$7.50
• One pair of frames	All charges above $42.50
• Non-Plan providers of vision services are paid at 75% of reasonable charges less the $5 copay.	$5 plus all charges above Plan allowance
Not covered: • *Eye exercises* • *Photo-sensitive lenses* • *Non-medically necessary tinted lenses* • *Safety glasses* • *Repair or replacement of lost or broken lenses or frames*	*All charges*
Foot care	**You pay**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device.	50 percent of charges
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than three years after the last one we covered* • *bite splints*	*All charges*
Durable medical equipment (DME)	**You pay**
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • wheelchairs; • motorized wheelchairs, if medical criteria are met; • crutches; • walkers; • blood glucose monitors; • insulin pumps; and • oxygen therapy. Note: Call our DME provider, Northwood, at 1-800-677-8496 as soon as your Plan physician prescribes this equipment. It will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	50 percent of charges
Not included: deluxe equipment and convenience items	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	$10 per visit

Home health services (continued)	
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges*
Educational classes and programs	**You pay**
Blue Care Network's Health Education department provides a number of special events each year. Although topics change from time to time, recent examples include programs on general health, healthy cooking, men's health, women's heath and menopause. BCN sends members a catalog of classes and invitations to special events. The Disease Management Department provides support and educational opportunities for members with asthma, diabetes and congestive heart failure and for expectant mothers.	No charge

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with facility (i.e. hospital, surgical center, etc.)
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	**You pay**
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity — a condition in which an individual weighs 100 pounds or 100 percent over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). • Treatment of burns • Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for a pacemaker and surgery benefits for insertion of the pacemaker.	$10 per office visit
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges*

Reconstructive surgery	You pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	Nothing
• All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	**You pay**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Bite splints*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/pancreas • Liver • Lung: single – double • Pancreas • Allogenic (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; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • National Transplant Program (NTP) • Limited benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**You pay**
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Nothing
• Office	$10 per office visit

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. *Other hospital services and supplies, such as:* • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing

Inpatient hospital (continued)	
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	**You pay**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/skilled nursing care facility benefits	**You pay**
Extended care	Nothing
Skilled nursing facility (SNF): 730 days if the patient meets criteria.	Nothing
Not covered: custodial care	*All charges*
Hospice care	**You pay**
If hospice care is provided in the home, the home health care benefit applies. If hospice care is provided in a skilled nursing facility, the skilled nursing facility benefit applies.	Nothing
Not covered: independent nursing, homemaker services	*All charges*
Ambulance	**You pay**
• Local professional ambulance service when medically appropriate • Air ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT		IMPORTANT
	• Here are some important things to keep in mind about these benefits: • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure. • Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your primary care 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 member of this Plan so they can notify this Plan. You or a family member should notify this Plan within 24 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that this Plan has been notified in a timely manner.

If you need to be hospitalized, this Plan should be notified within 24 hours unless it was not reasonably possible to do so. If you are hospitalized in a non-Plan facility and a Plan physician believes 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.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by this 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 visit in a hospital emergency room, or $10 per visit in an urgent care facility, and $10 per visit in a physician's office for emergency care services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

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

If you need to be hospitalized, this Plan must be notified within 24 hours unless it was not reasonably possible to do so. If a Plan physician believes care can be better provided in a Plan hospital, you would be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by this 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 visit in a hospital emergency room, or $10 per visit in an urgent care facility, and $10 per visit in a physician's office for emergency care services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

Benefit Description	You pay
Emergency within our service area	**You pay**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per office visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per visit (waived if admitted)
Not covered: elective care or non-emergency care	*All charges*
Emergency outside our service area	**You pay**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per visit (waived if admitted)
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges.*
Ambulance	**You pay**
Professional ambulance service when medically appropriate. Air ambulance when medically appropriate. See 5(c) for non-emergency service.	Nothing

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

IMPORTANT

Parity

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

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per office visit
• Diagnostic tests	$10 per office visit
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: services we have not approvd.. Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.	*All charges.*

Preauthorization	To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes: Members call ValueOptions at 1-800-482-5982 to arrange behavioral health services. Call this number for information on referral procedures, providers and inpatient and outpatient services.
Special transitionalbenefit	*If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition:* • If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause. *If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.*
Limitation	*We may limit your benefits if you do not follow your treatment plan.*

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescription drugs, brand name and generic, which are listed in the Clinical Formulary, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when your doctor and health plan feel they are medically necessary.
- A single copayment of $5 will be applied to each prescription.
- Be sure to read Section 4 , Y*our costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A Plan physician or referral physician must write the prescription. Coverage is also provided for any prescription(s) prescribed by a licensed dentist or podiatrist.
- **Where you can obtain them.** You may have your prescription filled at:
  - 2,200 participating retail pharmacies in the state,
  - 60,000 MedCare pharmacies out-of-state,
  - Merck-Medco Managed Care, LLC , our mail order pharmacy

  Your doctor can order up to a 90-day supply of a mail order prescription for a $5 copayment.
- **We use a modified, open formulary.** Blue Care Network has a modified, open formulary that is maintained by the BCN Pharmacy and Therapeutics Committee. Generic substitution is mandatory where appropriate. Generic substitution is not mandatory for critical drugs. Critical drugs are products where clinical judgment recommends using the brand-name drug because the generic drug cannot be safely substituted. These drugs are Lanoxin, Dilantin, Coumadin, Premarin, Theodur, Slophyllin, and Tegretol. A few select drugs on the formulary are part of the BCN Quality Interchange Program and may require prior authorization. Coverage is provided for a nonformulary drug when the Plan and doctor agree that it's medically necessary.
- **These are the dispensing limitations.** A 34-day supply is the limit for most prescription drugs filled at a participating retail pharmacy. The pharmacy may dispense up to a 100-day supply for certain maintenance drugs. Copies of the maintenance drug list can be requested from Customer Service.

  Note: The Plan will approve a prescription for the same medication when it is filled at least one week in advance of the next fill date. The pharmacy will charge you a separate copay for each prescription when a vacation supply is requested, e.g., if you request a two-month supply, you will be charged two copays or $10. You may be required to pay the difference in costs between a brand name drug and the price of its generic equivalent if a dispense-as-written (DAW) prescription is not preauthorized by the Plan.
- **When you have to file a claim.** Prescriptions filled at non-network pharmacies will be reimbursed in full, less your $5 copayment, in urgent or emergency situations. Non-emergency prescriptions will be reimbursed at the Plan's cost, less the $5 copayment. You must submit proof of payment for prescription services to Customer Services.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies when prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Generic and brand-name formulary drugs for which a prescription is required by law; • Insulin; • Insulin syringes and needles; • Disposable needles and syringes for the administration of covered medications; • Intravenous fluids and medications for home use; • Contraceptive devices, including diaphragms, IUDs, and implants; • Injectable contraceptive drugs; • Fertility drugs are covered under this Plan's infertility benefit with 50 percent coinsurance (see page 16); • Smoking cessation drugs and medications or gum; • Drugs to treat sexual dysfunction are limited. Contact this Plan for dose limits. • Oral contraceptive drugs – up to a three-cycle supply	$5 per prescription Note: If there is no generic equivalent available, you will still have to pay the brand name copay. $5 up to the dose limits — all charges thereafter
• Appetite suppressants are covered when preauthorized	$5 up to dose limits
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally approved generic drug is available, and your physician has not specified Dispense as Written (DAW) for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. • We have an open formulary. If your physician believes a name brand product is medically necessary or there is no generic available, your physician may prescribe a name brand drug from the formulary list. The formulary is a preferred list of brand name and generic drugs covered by the Plan. To request a copy of the formulary call Customer Service at 1-800-662-6667.	
Not covered: • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *Vitamins and nutritional substances that can be purchased without a prescription* • *Nonprescription medicines* • *Drugs to enhance athletic performance*	*All charges*

Section 5 (g). Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24-hour nurse line	For any of your health concerns, 24 hours a day, seven days a week, you may call 1-800-622-6252 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Reciprocity benefit	Blue Care Network works with Blue plans across the United States to provide care for members who are travelling or who are temporarily living away from home. Away from Home Care: Urgent care is available throughout Michigan. Contact the Away from Home Care coordinator at 1-877-465-5122 during regular business hours. The coordinator will direct you to the most convenient BCN locations. Blues*Connect*: BCN participates in a nationwide network of Blue Cross and Blue Shield Association HMOs to provide urgent care for members travelling outside Michigan. Contact BluesConnect at 1-800-446-6872 to make arrangements for care. The coordinator is available 24-hours a day, seven days a week. Guest membership program: You can prearrange for routine care for members who are seasonal residents or for families living apart, such as for covered dependents attending college or a family member living in a different BCN service region. Guest memberships are only available when a member is going to be out of the service region for more than 90 consecutive days. Guest memberships are limited to a six-month maximum for subscribers. Guest memberships must be renewed annually. Contact the Away from Home coordinator at 1-877-465-5122 to arrange guest membership.
High-risk pregnancies	Our pregnancy program identifies high-risk pregnancies and refers expectant mothers to our case management program for personalized intervention and follow-up. Studies have proven that early intervention in high-risk pregnancies significantly increases positive outcomes. The same program provides education and support to not only pregnant women but to those who are thinking of becoming pregnant. Though our health education program, we encourage expectant parents to attend prenatal education classes offered by BCN network hospitals.

Centers of excellence for transplants	Blue Care Network uses the Blue Cross Blue Shield of Michigan Centers of Excellence for Transplants.
Travel benefit/ services overseas	Immunizations to meet foreign travel requirements are a covered benefit. Emergency treatment is also covered. Members must submit bills and documentation.
Educational classes and programs	Blue Care Network's Health Education Department provides a number of special events each year. Although topics change from time to time, recent examples include programs on general health, healthy cooking, men's health, women's health and menopause. BCN sends members a catalog of classes and invitations to special events. The Disease Management Department provides support and educational opportunities for members with asthma diabetes and congestive heart failure and for expectant mothers.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing

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

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

BlueSafe[sm]	BlueSafe offers discounts on safety equipment such as child car seats, bicycle helmets, smoke and carbon monoxide detectors, baby gates, fire escape ladders, home medical equipment and athletic gear. Call toll free 1-877-BLUESAFE for discount coupons and more information on participating retailers.
Disease management	Members with asthma, congestive heart failure and diabetes are supported through BCN's Disease Management program. Participants receive educational materials through the mail and are invited to special programs that help them learn more about their conditions and how to maximize their health.
Publications	Each household receives Good Health twice a year, a newsletter from BCN that includes health information, notices of coming events and updates on benefits. Blue Cross Blue Shield of Michigan sends members a magazine twice a year. Living Healthy is a lively publication that features wellness articles, features about Blue members and other timely information.
Medicare prepaid plan enrollment	BCN offers Medicare recipients the opportunity to enroll in this Plan through Medicare. Annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join the Medicare prepaid Plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join this Plan, ask whether this Plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping you FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-529-8360 for information on the Medicare prepaid Plan and the cost of that enrollment. If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800-529-8360 for information on the benefits available under the Medicare HMO.
Community education programs	The Health Education Department arranges discounts for community and hospital-based educational programs and fitness activities. It sends members a catalog of classes and programs annually.

Dental benefits from Dental Care Network

Dental Care Network, an affiliate of Blue Cross Blue Shield of Michigan, provides a complete package of individual dental benefits. Your dental care is provided, arranged and coordinated by a qualified participating dentist who practices from his or her own private office. All DCN participating dentists are licensed and carefully chosen by DCN's credentialling staff. Each dentist is reviewed periodically to ensure compliance with DCN's quality assurance guidelines, and they must also uphold DCN's managed care standards.

Enrollment is offered twice a year. The first enrollment period is May 1 to 31 for a July 1 effective date. The second enrollment period is Nov. 1 to Dec. 15 for a Jan. 1 effective date.

To receive an enrollment package with rates, benefit description., provider directory and application, call a DCN Customer Service representative at 1-800-321-8077. Be sure to identify yourself as a Federal employee when calling during the November-December open season.

These dental benefits are not a part of the FEHB contract.

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical, hospital and prescription drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-662-6667.

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

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

Submit your claims to:

Member Claims
Blue Care Network of Michigan
P.O. Box 68767
Grand Rapids, MI 49516-8767

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Appeals and Grievances — mail code B845 Blue Care Network P.O. Box 284 25925 Telegraph Road Southfield, MI 48037-0284 and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial — go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request — go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436.

Disputed Claims Process (continued)

Send OPM the following information:

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

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

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

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-662-6667 and we will expedite our review; or

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

(c) •• If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or

•• You can call OPM's Health Benefits Contracts Division III at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

• What is Medicare?

Medicare is the Health Insurance Program for:

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

Medicare has two parts:

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

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

• The Original Medicare Plan

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

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

(Primary payer chart begins on next page.)

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

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800-662-6667.

When Medicare is the primary payer, we do not waive any out-of-pocket costs.

- **Medicare managed care plan**

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

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

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

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

- **Enrollment in Medicare Part B**

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

TRICARE

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Covered services

Care we provide benefits for, as described in this brochure.

Experimental or investigational services

A product or procedure is considered not experimental or investigational if it meets all of the following conditions:

- It has final approval from the appropriate government regulatory bodies;
- The scientific evidence permits conclusions concerning the effect of the technology on health outcomes;
- The technology improves the net health outcome; and
- The technology is as beneficial as any established alternatives.

The investigational setting may be eliminated if the research and experimental stage of development is completed, and the improvement in net health outcome is attainable outside the investigational settings.

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 would be able to accept treatment or procedures that may be recommended by this Plan's providers.

Us/We

Us and we refer to Blue Care Network of Michigan

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

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

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

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

- **TCC**

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

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

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

- **Converting to individual coverage**

You may convert to an individual policy if:

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

- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Inspector General advisory

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800-662-6667 and explain the situation.

If we do not resolve the issue, call THE HEALTH CARE FRAUD HOTLINE — 202/418-3300 or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for fraud

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

Index

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

Summary of benefits for Blue Care Network of Michigan — 2001

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

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$10 per office visit	14
Services provided by a hospital:		24
• Inpatient	Nothing	
• Outpatient	Nothing	25
Emergency benefits:		
• In-area	$25 per visit, waived if admitted	27
• Out-of-area	$25 per visit, waived if admitted	27
Mental health and substance abuse treatment	Regular cost sharing.	28
Prescription drugs	$5 per prescription filled	30
Dental Care		
Accidental injury benefit	Nothing	34
Vision Care:		
• Annual eye exams.,	$5 copayment per office visit	18
• Lenses and contact lenses	$7.50	18
• Frames	All charges above $42.50	18
Special features:		
• Flexible benefits option		32
• 24-hour nurse line		32
• Reciprocity benefit		32
• High-risk pregnancies		32
• Centers of excellence for transplants		33
• Travel benefit/services overseas		33
• Educational classes and programs		33

2001 Rate Information for Blue Care Network of Michigan

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

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

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

Type of **Enrollment**	Code	**Non-Postal Premium**				**Postal Premium**	
		Biweekly		**Monthly**		**Biweekly**	
		Govt share	Your share	Govt share	Your share	USPS share	Your share
East Michigan Region							
Self Only	K51	$82.17	$27.39	$178.04	$59.34	$97.23	$12.33
Self and Family	K52	$195.82	$110.14	$424.28	$238.63	$231.17	$74.79

Serving these counties: Arenac, Bay, Gratiot, Isabella, Midland, Saginaw and Tuscola

East Michigan Region							
Self Only	KN1	$86.09	$28.69	$186.52	$62.17	$101.87	$12.91
Self and Family	KN2	$195.82	$124.75	$424.28	$270.29	$231.17	$89.40

Serving these counties: Genessee, Lapeer and Shiawassee (excluding the towns of Perry, Shaftsburg and Morice)

Mid Michigan Region							
Self Only	LN1	$86.59	$49.15	$187.61	$106.49	$102.22	$33.52
Self and Family	LN2	$195.82	$130.90	$424.28	$283.61	$231.17	$95.55

Serving these counties: Clinton, Eaton, Ingham, Jackson, Livingston and parts of Shiawassee (the towns of Perry, Shaftsburg and Morice), Ionia (the towns of Danby and Portland) and Hillsdale (except for Somerset and Wright townships and Waldron Village)

Southeast Michigan Region							
Self Only	LX1	$59.10	$19.70	$128.05	$42.68	$69.94	$8.86
Self and Family	LX2	$194.26	$64.75	$420.89	$140.30	$229.87	$29.14

Serving these counties: Macomb, Monroe, Oakland, St. Clair, Washtenaw and Wayne counties.

Type of **Enrollment**	Code	**Non-Postal Premium**				**Postal Premium**	
		Biweekly		**Monthly**		**Biweekly**	
		Govt share	Your share	Govt share	Your share	USPS share	Your share
West Michigan Region							
Self Only	G71	$86.59	$61.92	$187.61	$134.16	$102.22	$46.29
Self and Family	G72	$195.82	$179.52	$424.28	$388.96	$231.17	$144.17

Serving these counties: Alcona, Alpena, Antrium, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Mackinac, Manistee (portions of), Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle and Roscommon

West Michigan Region							
Self Only	KF1	$86.59	$29.47	$187.61	$63.85	$102.22	$13.84
Self and Family	KF2	$195.82	$123.38	$424.28	$267.32	$231.17	$88.03

Serving these counties: Berrien, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren and the portions of Allegan, Barry and Eaton (those areas served by postal zip codes 49010, 49020, 49046, 49060, 49073, 49078 and 49080)

West Michigan Region							
Self Only	KR1	$86.59	$34.14	$187.61	$73.97	$102.22	$18.51
Self and Family	KR2	$195.82	$152.47	$424.28	$330.35	$231.17	$117.12

Serving these counties: Kent, Muskegon Oceana, Ottawa and portions of Ionia, Mecosta, Montcalm, Newaygo and Wexford. And the portion of Allegan served by postal zip codes 49070, 49311, 49314, 49323, 49328, 49335, 49344, 49348, 49406, 49408, 49416, 49419, 49423, 49447, 49450 and 49543