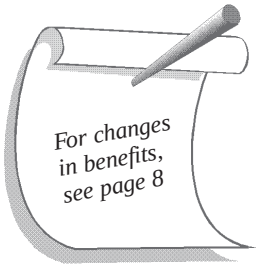
M-CARE 2002

www.mcare.org

A Health Maintenance Organization

Serving: *Mid and Southeastern Michigan*

Enrollment in this Plan is limited. You must live in our Geographic service area to enroll. See page 7 for requirements.



M-CARE HMO Health Plan

This Plan has an Excellent accreditation from the NCQA. See the 2002 Guide for more information on NCQA.

Enrollment code:

EG1 Self Only
EG2 Self and Family

Special notice: If you are enrolled in M-CARE and live in Calhoun or Hillsdale County, you should choose another health plan during the Federal Employees Health Benefits Program Open Season. We have eliminated these counties from our 2002 service area and you will no longer have access to Plan providers.

Authorized for distribution by the:

United States
Office of Personnel Management

Retirement and Insurance Service
http://www.opm.gov/insure

Federal Employees Health Benefits Program

RI 73-445

Table of Contents

Introduction

M-CARE
2301 Commonwealth Boulevard
Ann Arbor, MI 48105

This brochure describes the benefits of M-CARE under our contract CS 2341 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; "we" means M-CARE.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of 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.

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 (800) 658-8878 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
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.

Section 1. Facts about this HMO plan

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

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

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

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

How we pay providers

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

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. 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.

- M-CARE is licensed by the State of Michigan to operate as an HMO and has been in existence since 1986.
- M-CARE is a non-profit organization.
- M-CARE has an *Excellent* accreditation from the NCQA.

If you want more information about us, call (800) 658-8878, TDD (800) 649-3777, or write to M-CARE, Customer Service, 2301 Commonwealth Boulevard, Ann Arbor MI 48105. You may also contact us by fax at (734) 332-2027 or visit our website at www.mcare.org.

Service Area

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

The entire Michigan counties of:

- **Clinton, Eaton, Genesee, Ingham, Livingston, Macomb, Oakland, Shiawassee, Washtenaw, and Wayne**.

And portions of the following counties:

- **Jackson**:
  Jackson City, Parma Village, Blackman, Columbia, Grass Lake, Henrietta, Leoni, Liberty, Napoleon, Norvell, Parma, Rivers, Sandstone, Spring Arbor, Springport, Summit, Tompkins, and Waterloo Townships.

- **Lapeer**:
  Almont, Arcadia, Attica, Deerfield, Dryden, Elba, Hadley, Imlay, Lapeer, Marathon, Mayfield, Metamora, Oregon, Rich Townships, Lapeer City, and Imlay Village.

- **Monroe**:
  Ash, Berlin, Frenchtown, London, and Milan Townships.

- **St. Clair**:
  Berlin and Ira Townships.

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 benefits. We will not pay for any other health care services out of our Service Area unless the services have prior plan approval.

If you or a covered family member move outside of our Service Area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- There are no program-wide changes for 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 6.4% for Self Only or 6.4% for Self and Family.
- We cover up to 20 visits of medically necessary speech therapy per calendar year. We now cover habilitative as well as rehabilitative speech therapy. (Section 5 (a))
- We no longer cover hearing aids. (Section 5(a))
- We no longer serve Calhoun and Hillsdale counties.
- We now cover certain intestinal transplants. (Section 5(b))
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now offer a complimentary alternative medicine discount program. (Section 5 (j))

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 (800) 658-8878.

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. Our M-CARE provider network recruitment process is a very selective process. Our physician screening and credentialing is rigorous and comprehensive. For credentialing, we verify state licensure, hospital privileges, board certification, and whether there is adequate malpractice coverage.

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

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You must choose a primary care physician from the primary care physicians listed in the M-CARE Provider Directory. You can select a primary care physician from M-CARE's Provider Directory or by calling us at (800) 658-8878 for help with choosing or changing your primary care physician.

- **Primary care**

Your primary care physician can be a family practitioner, internist, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist. If you have not chosen a M-CARE pediatrician to be your child's PCP and want to take your child to a M-CARE pediatrician for routine services, you can without a referral. M-CARE may assign that pediatrician to be your child's PCP.

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, a female member may see her M-CARE OB/GYN for routine gynecological services, without referral.

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 work with us and plan specialists to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

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

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

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

  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (800) 658-8878. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process pre-authorization. Your physician must obtain pre-authorization for the following services:

- All non-emergency inpatient hospitalization
- Outpatient/ambulatory surgery
- Skilled nursing facility admissions
- Home health care services
- Hospice
- Durable medical equipment
- Orthopedic and prosthetic devices

Our pre-authorization process is as follows:

- Your primary care physician determines a need for an elective admission or other medically necessary service that requires pre-authorization.
- Your primary care physician contacts M-CARE's Authorization Department.
- Your primary care physician, or specialist with the primary care physician's approval, notifies a participating hospital or facility of the need for this procedure.
- If there are any questions related to admission, care setting, benefit, coverage, or medical necessity, M-CARE's Utilization Management Department will contact your primary care physician or treating physician directly.

You are responsible for obtaining authorization for mental health and substance abuse services from the Central Diagnostic and Referral (CDR) unit assigned to you before seeking treatment. Your CDR authorizes and coordinates all of your mental health and substance abuse care. Simply call the CDR phone number that is listed on the front of your M-CARE identification card. You do not need a referral from your primary care physician. M-CARE will not cover unauthorized care. If you need additional information or the phone number of your CDR, please call M-CARE Customer Service.

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, facility, pharmacy, etc., when you receive services.

  Example: When you see your primary care physician you pay a copayment of $10 per office visit.

- **Deductible** — We do not have a deductible.

- **Coinsurance** — We do not have coinsurance.

Your out-of-pocket maximum for deductibles, coinsurance, and copayments

After your copayments total $4,000 per person or $8,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for prescription drugs do not count toward your out-of-pocket maximum, and you must continue to pay copayments for them.

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and page 56 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at (800) 658-8878 or at our website at www.mcare.org.

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	$10 per office visit.
Professional services of physicians • During a hospital stay • In an urgent care center • In a skilled nursing facility	Nothing.
• At home Note: We cover house calls within the service area if your doctor determines that such care is necessary and appropriate.	$10 per house call.

Diagnostic and treatment services -- continued on next page

Diagnostic and treatment services *(continued)*	**You pay**
Lab, X-ray and other diagnostic tests	
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	
Routine screenings, such as: • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 – 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 *Diagnosis and Treatment*, above.	$10 per office visit.

Preventive Care - Adult -- continued on next page

Preventive care, adult *(continued)*	**You pay**
Routine mammogram – covered as follows: • From age 35 through 39, one during this five-year period • From age 40-64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$10 per office visit.
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, travel, or to obtain a marriage license.	*All charges.*
Routine immunizations such as: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza vaccine- annually, age 50 and over • Pneumococcal vaccines- annually, age 65 and over	$10 per office visit.
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit.
• Well-child care charges for routine examinations, immunizations and care • 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	Nothing for well-child care visits through age 6. $10 per office visit after age 6.

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 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). • We cover one routine ultrasound per low-risk pregnancy.	Nothing.
Not covered: Multiple sonograms to determine fetal age, size or sex.	*All charges.*
Family planning	
A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Genetic counseling • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$10 per office visit.
Not covered: reversal of voluntary surgical sterilization.	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)*	$10 per office visit.
• Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	50% copay per prescription unit or refill for fertility drugs to induce ovulation.
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* – *in vitro fertilization* – *embryo transfer, gamete GIFT and zygote ZIFT* – *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Services related to surrogate parenthood* • *Cost of donor sperm* • *Cost of donor egg*	*All charges.*
Allergy care	
• Testing and treatment • Allergy injection	$10 per office visit.
Allergy serum	Nothing.
Not covered: provocative food testing and sublingual allergy desensitization.	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 27. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: – We will only cover GHT when we pre-authorize the treatment and it is documented that the member has a growth hormone deficiency. Call (800) 658-8878 for prior authorization. We cover GHT under the plan's prescription drug benefit. See *Services requiring our prior approval* in Section 3.	Nothing if you receive these treatments during your visit; otherwise, $10 copay per office visit.
Physical and occupational therapies	
• 60 visits per condition per calendar year for the services of each of the following: – qualified physical therapists, and – occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to six consecutive weeks.	Nothing.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges.*

Speech therapy	You pay
• 20 visits per condition per calendar year for medically necessary speech therapy services with qualified speech pathologists.	Nothing.
Not covered: • Evaluations and treatments covered in a school program or public agency. • Foreign accent reduction or English as a second language spoken at home. • Maintenance therapy, i.e., treatment that does not require the use of a qualified speech therapist to perform. • Treatment for disorders that are self-correcting as determined by the member's PCP/specialist and speech therapist.	*All charges.*
Hearing services (testing, treatment, and supplies)	
• Hearing testing	$10 per office visit.
Not covered: • *All other hearing testing* • *Hearing aids and hearing aid evaluations*	*All charges.*
Vision services (testing, treatment, and supplies)	
In addition to the medical and surgical benefits provided for the diagnosis and treatment of diseases of the eye, we cover an annual refraction (to provide a written lens prescription) by a plan provider.	Nothing.
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*

Foot care	You pay
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open-cutting surgery).*	*All charges.*
Orthopedic and prosthetic devices	
• 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. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. Limited to one per member per lifetime. Note: Your plan physician must write the prescription and we must authorize the equipment. We base our decision on medical necessity. You must obtain authorized equipment from a plan contracted provider. We reserve the right to require use of the least costly medically-effective device.	Nothing.

Orthopedic and prosthetic devices - Continued on next page

Orthopedic and prosthetic devices *(continued)*	**You pay**
Not covered: • *Orthopedic and corrective shoes,* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Wigs, prosthetic hair, or hair transplants* • *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*	*All charges.*
Durable medical equipment (DME)	
We cover 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; *{the type depends on your illness);* • Crutches; • Walkers; • Blood glucose monitors; • Insulin pumps; and • Diabetic supplies including glucose test tablets and test tape, Benedict's solution or equivalent, and acetone test tablets Note: Your plan physician must write the prescription and we must authorize the equipment. We base our decision on medical necessity. You must obtain authorized equipment from a plan contracted DME provider. We reserve the right to require use of the least costly medically-effective device.	Nothing.
Not covered: • *Over-the-counter medical supplies such as gauze, bandages, tape, and dressings* • *Over-the-counter or custom-fitted braces*	*All charges.*

Home health services	You pay
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	$5 per home health visit.
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges.*
Chiropractic	
No benefit. *See Non-FEHB benefits section for Complimentary Alternative Medicine discount program.*	*All charges.*

Alternative treatments	You pay
We do not cover alternative treatments such as: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* *See Non-FEHB benefits section for Complimentary Alternative Medicine discount program.*	*All charges.*
Educational classes and programs	
Coverage is limited to: • Health education classes including childbirth preparation, breastfeeding nutrition, CPR, first aid, and smoking cessation classes are limited to one per category per calendar year. Classes must be provided at a plan provider. • Free access to the University of Michigan Health System's Health Education Resource Center to borrow a variety of health-related videos, audiotapes, and books. • Asthma, heart failure, and diabetes management programs. • A limited number of visits for nutritional counseling provided by a registered dietician are covered when ordered by the member's PCP for the following medical diagnoses: – Hyperlipidemia, Hypertension, Heart Failure, and Previously diagnosed diabetes (four visits per year); – Newly diagnosed diabetes (six visits the first year following diagnosis); – Gestational diabetes (four visits per pregnancy).	Nothing.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR 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	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information	Nothing if your doctor performs the procedure in the hospital outpatient department; otherwise, $10 per office visit.

Surgical procedures continued on next page.

Surgical procedures *(continued)*	**You pay**
• Voluntary sterilization • 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.	Nothing if your doctor performs the procedure in the hospital outpatient department; otherwise, $10 per office visit.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges.*
Reconstructive surgery	
• 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 if your doctor performs the procedure in the hospital outpatient department; otherwise, $10 per office visit.
• All stages of breast reconstruction surgery following a mastectomy, such as: – Surgery to produce a symmetrical appearance on the other breast; – Treatment of any physical complications, such as lymphedemas; – Breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing if your doctor performs the procedure in the hospital outpatient department; otherwise, $10 per office visit.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges.*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or 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 if your doctor performs the procedure in the hospital outpatient department; otherwise, $10 per office visit.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone)*	*All charges.*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas Note: The Plan's providers participate with the United Network Organ Sharing (UNOS) and the National Marrow Donor Program. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing.

Organ/tissue transplants (*continued*)	**You pay**
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* • *Travel and lodging expenses*	*All charges.*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Physician's office	Nothing.

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR 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 • Semi-private, 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 semi-private room rate.	Nothing.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing.
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, 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	
We cover up to 100 days of skilled nursing facility care per calendar year when full-time skilled nursing care is medically necessary and arranged and authorized by M-CARE. All necessary services are covered, including: • Bed, board, and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor	Nothing.
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Personal comfort items, such as telephone and television*	*All charges.*
Hospice care	
We cover supportive and palliative care for a terminally ill member in the home or a hospice facility. Services include inpatient and outpatient care, and family counseling. All services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. Hospice services must be arranged and authorized by M-CARE.	Nothing.
Not covered: Independent nursing, homemaker services	*All charges.*
Ambulance	
• Local professional ambulance service when medically appropriate. Non-emergent ambulance service must be pre-authorized by M-CARE	Nothing.

Section 5 (d). Emergency services/accidents

IMPORTANT

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

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

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within or outside of our service area:

If you consider your condition to be so serious or life-threatening that delay might cause death, severe injury, or serious impairment, you should call 911 or seek help from the nearest medical facility as soon as possible.

If possible, we also recommend that you attempt to contact your PCP for medical advice. If you are unable to reach your PCP, you may contact the M-CARE After Hours Line for assistance at (800) 658-8878, extension 6. We strongly recommend that you contact your PCP within 48 hours after seeking emergency services (or as soon as possible if circumstances make 48 hours impossible) to arrange for follow-up medical care. Your PCP must arrange all of your follow-up care after an emergency in order for us to cover it.

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

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

IMPORTANT

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- 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 PRE-AUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

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

Mental health and substance abuse benefits -- continued on next page

Mental health and substance abuse benefits *(continued)*	**You pay**
• Diagnostic tests	Nothing if you receive these services during your office visit; otherwise, $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 approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Pre-authorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

Before seeking treatment, you must call the phone number of the Central Diagnostic and Referral (CDR) unit listed on the front of your M-CARE identification card. Your CDR authorizes and coordinates all of your mental health and substance abuse care. You do not need a referral from your PCP. **M-CARE will not cover unauthorized care.** You may also call M-CARE Customer Service for information and the phone number of your CDR.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

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

IMPORTANT

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

- **Who can write your prescription.** A plan contracted physician must write the prescription.
- **Where you can obtain them.** M-CARE contracts with a network of pharmacies that includes most large chains and independent pharmacies operating nationwide. If you need help in locating a contracted pharmacy, please call M-CARE Customer Service at (800) 658-8878.
- **We use a formulary.** We have a preferred list of cost-effective drugs. We encourage Plan physicians to prescribe medications listed in the therapeutic selection guide but we do not require it. We have an "open" or "voluntary" prescription drug formulary because we cover non-formulary drugs when your doctor prescribes them.
- Our doctors prescribe from that list as appropriate for your condition. When your doctor prescribes a drug that is not on the preferred list, your pharmacist may contact your doctor to check whether a preferred drug is right for you. To view M-CARE's list of preferred drugs, visit www.mcare.org, or call M-CARE Customer Service at (800) 658-8878 for more information.
- **These are the dispensing limitations.** Plan pharmacies dispense prescription drugs for up to a 34-day supply or one commercially prepared unit such as one inhaler, one vial ophthalmic medication or one vial of insulin. Generally, the Plan pharmacy will dispense a generic drug that meets the equivalency standards of the Food and Drug Administration. If you request a name brand drug when a generic drug is available, you must pay the price difference between the name brand and generic drug, unless your doctor writes "Dispense as Written" on the prescription. Additionally, M-CARE retains the right to place prior authorization requirements or a maximum supply limit on certain prescriptions.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. To maximize your prescription drug benefit and avoid paying any cost difference, ask your prescribing physician to help you decide whether a generic alternative is available and appropriate for you.
- **When you have to file a claim.** If you are a new member of M-CARE and have not yet received your M-CARE identification card, you may be asked to pay for your prescriptions until you get your card. You can request can request a prescription drug claim form by calling M-CARE Customer Service at (800) 658-8878. Customer Service will then send you the appropriate claim form and provide instructions on submitting the form and receipt for reimbursement.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Disposable needles and syringes for the administration of covered medications other than insulin • Contraceptive drugs and devices • Smoking cessation drugs and medications, including nicotine patches	$5 per generic prescription unit or refill. $10 per brand-name prescription unit or refill. Note: If there is no generic equivalent available, you will still have to pay the brand-name copay.
• Drugs for sexual dysfunction have dispensing limitations (contact M-CARE for details), and require prior authorization for males under the age of 35.	50% copay per prescription unit (six pills per month) or refill for generic or brand-name drugs.
• Insulin and disposable needles and syringes used for its injection.	Nothing.
• Fertility drugs to induce ovulation	50% copay per prescription unit or refill.
• Maintenance drugs Note: You may receive up to a 90-day or 100 unit supply (whichever is greater) of M-CARE approved maintenance drugs. Please contact us if you would like a copy of M-CARE's maintenance drug list.	$5 for generic maintenance drugs. $10 for brand-name maintenance drugs.

Covered medications and supplies -- continued on next page

Covered medications and supplies *(continued)*	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs used for the purpose of weight loss* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients, food and liquid supplements, and infant formula even if a physician prescribes or administers them* • *Nonprescription medicines* • *Medical supplies such as dressing and antiseptics*	*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.
Services for deaf and hearing impaired	Hearing impaired members may contact M-CARE at (800) 649-3777 TDD.
Health management program	M-CARE's Lifelong Health Management Program includes the following programs for you at no charge: member newsletter, health survey, health management programs, and personal health risk assessments. You may call (888) 448-3865 or email lifelong@mcare.med.umich.edu. for more information.

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 providers must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental 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. We do not cover injuries to the teeth caused by chewing.	Nothing.

Dental benefits

We have no other dental benefits.

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

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

Lifelong Health Management Program

As part of M-CARE's Lifelong Health Management Program, M-CARE offers health education classes to all of its members. M-CARE pays 100% of the fee for approved classes in the following categories: Childbirth preparation, CPR, first aid, and smoking cessation. Classes are limited to one per category per year. If you would like more information on these classes, or would like a class listing, please contact M-CARE's Lifelong Health Management Program at (888) 448-3865 or via email at lifelong@mcare.med.umich.edu.

Alternative Medicine Discount Program

As part of M-CARE's alternative medicine discount program, M-CARE offers discounts to all of its members for the benefits listed below. These benefits must be received at M-CARE participating providers which are listed on our website at www.mcare.org. If you would like more information on these benefits, please contact M-CARE at (800) 658-8878. A 20% discount is offered for an unlimited number of visits for the following:

- Acupuncture
- Chiropractic
- Massage therapy
- Nutritional counseling

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.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at (800) 658-8878.

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: M-CARE Customer Service Department, 2301 Commonwealth Boulevard, Ann Arbor, MI 48105-2945.

Prescription drugs

If you are a new member of M-CARE and have not yet received your M-CARE identification card, you may be asked to pay for your prescriptions until you get your card. You can request a prescription drug claim form by calling M-CARE Customer Service at (800) 658-8878. Customer Service will then send you the appropriate claim form and provide instructions on submitting the form and receipt for reimbursement.

Submit your claims to: M-CARE Customer Service Department, 2301 Commonwealth Boulevard, Ann Arbor, MI 48105-2945.

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 pre-authorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within six months from the date of our decision; and (b) Send your request to us at: M-CARE Member Appeals Coordinator, 2301 Commonwealth Boulevard, Ann Arbor, MI 48105-2945; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial — go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request— go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.

The 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 include 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, or from the year in which you were denied precertification or prior approval. 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 pre-authorization/prior approval, then call us at (800) 658-8878 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment, too, or
- You can call OPM's Health Benefits Contracts Division 3 at (202) 606-0755 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 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. We will apply any copayments or limitations on your M-CARE coverage. We must receive the primary carrier's Explanation of Payment with the claim so that we can determine your M-CARE benefits.

When an M-CARE member receives treatment for injuries during a motor vehicle accident, we need a statement that tells us the type of medical coverage that the injured member carries on the automobile insurance. This statement will help us determine coverage.

• What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

- **The Original Medicare Plan (Part A or Part B)**

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

When you are enrolled in Original Medicare along with this Plan, 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 primary care physician. We do not waive your M-CARE copays.

(Primary payer chart begins on next page.)

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

Primary Payer Chart		
A. When either you -- or your covered spouse – are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a re-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, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

If your doctor does not participate with Medicare, you will have to file a claim with Medicare.

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

- 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 (800) 658-8878 or visit our website at www.mcare.org.

We do not waive any costs when you have the Original Medicare Plan.

● Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan -- 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 provide all the benefits that Original Medicare covers. 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 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. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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's service area.

● If you do not enroll in Medicare Part A or Part B

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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 illness 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 care. 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.

Coinsurance

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

Copayment

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

Covered services

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

Custodial care

Care is considered custodial whether it is provided in a hospital, skilled nursing facility, or your home through a home care agency when it is primarily for the purpose of meeting your personal needs and can be provided by persons without professional skills or training. Such care would include, but is not limited to, help in walking, bathing, taking medication, as well as getting in and out of bed.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.

Experimental or investigational services

A drug, device, treatment or procedure meeting one or more of the following criteria:

- It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use or;
- It is the subject of a current investigational new drug or new device application on file with the FDA; or
- It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental research arm of a Phase III clinical trial;
- It is being provided pursuant to a written protocol which describes among its objectives the determination of safety, efficacy, or efficiency in comparison to conventional alternatives; or
- It is described as experimental, investigational or research by informed consent or patient information documents; or
- It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services or successor agencies, or of a human subjects (or comparable) committee; or
- The predominant opinion among experts as expressed in the published authoritative medical or scientific literature is that usage should be substantially confined to experimental, investigational, or research settings; or
- The predominant opinion among experts as expressed in the published authoritative medical or scientific literature is that further experiment, investigation, or research is necessary in order to define safety, toxicity, effectiveness, or efficiency compared with conventional alternatives. Antineoplastic drug therapy shall be provided in accordance with Michigan law.

Group health coverage

An employer group is the employer with which M-CARE has contracted to provide services to eligible employees who choose M-CARE for themselves and their eligible dependents.

Medical necessity

A service or supply is considered to be medically necessary to the extent that M-CARE's Medical Director determines they satisfy all of the following criteria:

- They are medically appropriate for the diagnosis and treatment of your illness or injury,
- They are consistent with professionally recognized standards of health care,
- They do not involve costs that are excessive in comparison with alternative services that would be effective for the diagnosis and treatment of your illness and injury,
- Please note, the fact that a physician may have prescribed, ordered, recommended, or approved the provision of certain services to you does not necessarily mean that such services satisfy the above criteria.

Us/We

Us and we refer to M-CARE.

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 joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. 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. It explains what you have to do to enroll.

• Converting to individual coverage

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

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

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

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

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability Group Health Plan Coverage and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group 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.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It is insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. It can supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club! Seventy-six percent of Americans believe they will never need long term care, but the facts are that about half them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planning.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care, a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older, or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of benefits for M-CARE for 2002

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

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist.	14
Services provided by a hospital:		
• Inpatient	Nothing.	14
• Outpatient	Nothing.	25
Emergency benefits:		
• Hospital emergency room	$25 per hospital emergency room visit.	32
• Urgent care center	$10 per urgent care center visit.	32
Mental health and substance abuse treatment	Regular cost sharing.	33
Prescription drugs	$5 generic/$10 brand-name copay per prescription unit or refill. 50% copay per prescription unit or refill for fertility drugs for induction of ovulation and sexual dysfunction drugs.	36
Dental Care	No benefit.	38
Vision Care	Nothing. Limited to one annual eye refraction.	20
Special features: Health Management Program, services for the deaf and hearing impaired.		37
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $4,000 Self Only or $8,000/Family enrollment per year. Some costs do not count toward this protection.	12

2002 Rate Information for
M-CARE

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, 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 who are not career postal employees. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	EG1	$ 76.11	$ 25.37	$164.90	$ 54.97	$ 90.06	$ 11.42
Self and Family	EG2	$201.68	$ 67.23	$436.98	$145.66	$238.66	$ 30.25