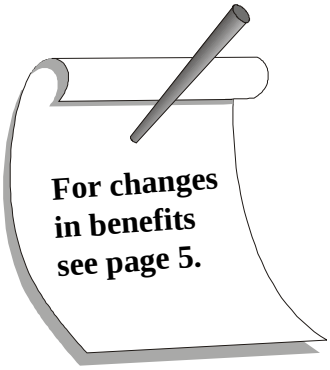
Blue Care Network

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

Blue Care Network of Michigan

2000

A Health Maintenance Organization



Serving: Most of Michigan
Enrollment in this Plan is limited; see page (5) for requirements.

Enrollment codes:

East Region:
KN1 Self Only
KN2 Self and Family
K51 Self Only
K52 Self and Family
Southeast Region
LX1 Self Only
LX2 Self and Family
Mid-Michigan Region:
LN1 Self Only
LN2 Self and Family
West Region:
KR1 Self Only
KR2 Self and Family
KF1 Self Only
KF2 Self and Family
G71 Self Only
G72 Self and Family

This Plan has full accreditation from the NCQA. See the *2000 Guide* for information on NCQA.

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's website at http://www.bcbsm.com

Authorized for distribution by the:

United States Office of Personnel Management

FEHB
Federal Employees Health Benefits Program

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Introduction

Blue Care Network of Michigan
25925 Telegraph Road
P.O. Box 5043
Southfield, Michigan 48086-5043

This brochure describes the benefits you can receive from Blue Care Network of Michigan under its contract (CS2011) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits.

OPM negotiates benefits and premiums with each Plan annually. Benefit changes are effective January 1, 2000 and are shown on page *4*. Premiums are listed at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Blue Care Network of Michigan as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

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

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

How to Use This Brochure

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

1. **Health Maintenance Organizations (HMO).** This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

2. **How We Change for 2000.** If you are a current member and want to see how we have changed, read this section.

3. **How to Get Benefits.** Make sure you read this section; it tells you how to get services and how we operate.

4. **What to Do If We Deny Your Claim or Request for Service.** This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. **Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. **General Exclusions – Things We Don't Cover.** Look here to see benefits that we will not provide.

7. **Limitations – Rules That Affect Your Benefits.** This section describes limits that can affect your benefits.

8. **FEHB Facts.** Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

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

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services you may have to submit claim forms.

You should join an HMO because you prefer this Plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves this Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How We Change for 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.

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

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

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

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

Changes to this Plan

Your share of the non-postal standard option premium will increase as follows:

by 20.1 % for Self Only or 16.2% for Self and Family for East Michigan (code KN)

by 9.7% for Self Only or 55.6% for Self and Family for East Michigan (code K5)

by 13.7% for Self Only or 23.6% for Self and Family for Mid-Michigan (code LN)

by 6.9% for Self Only or 5.9% for Self and Family for Southeast Michigan (code LX)

by 9.5% for Self Only or 8.6% for Self and Family for West Michigan (code G7)

by 14.1% for Self Only or 22.2 % for Self and Family for West Michigan (code KR)

Your share of the non-postal standard option premium will increase by 2.0% for Self Only or decrease by 6.9% for Self and Family for West Michigan (code KF)

Covered infertility services require a 50% copayment

One refractive vision examination, pair of lenses, frames or contact lenses every 12 months

Section 3. How to Get Benefits

What is this Plan's Service Area?

To enroll with us, you must live, or work, in our Service Area. This is where our providers practice. Our Service Area is:
SOUTHEAST MICHIGAN REGION *Code LX*- *Serving these counties:* Macomb, Monroe, Oakland, St. Clair, Washtenaw and Wayne.

EAST MICHIGAN REGION *Code K5*- *Serving these counties:* Arenac, Bay, Gratiot, Isabella, Midland, Saginaw and Tuscola ***Code KN*-** Serving these counties: Genesee, Lapeer and Shiawassee

MID-MICHIGAN REGION *Code LN*- *Serving these counties:* Clinton, Eaton, Hillsdale, Ingham, Jackson, Livingston, and parts of Shiawassee (the towns of Perry, Shaftsburg, and Morrice), Ionia (the towns of Danby and Portland) and Hillsdale (except for Somerset and Wright Townships, and Waldron Village).

WEST MICHIGAN REGION *Code G7*- *Serving these counties:* Alcona, Alpena, Antrim, Benzie, Charlevoix, , Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Mackinac, Manistee (portions of), Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle and Roscommon. ***Code KF*-** *Serving these counties:* Berrien, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren, and the portions of Allegan, Barry and Eaton counties served by the following postal zip codes: 49010, 49020, 49046, 49060, 49073, 49078, 49080. ***Code KR*-** *Serving these counties:* Ionia (portions of), Kent, Mecosta (portions of), Montcalm (portions of), Muskegon, Newaygo (portions of), Oceana, Ottawa, Wexford (portions of), and Allegan county served by the following postal zip codes:49070, 49311, 49314, 49323, 49328, 49335, 49344, 49348, 49406, 49408, 49416, 49419, 49423, 49447, 49450 and 49543.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our Service Area, we will pay only for emergency care. We will not pay for any other health care services.

If you or a covered family member move outside 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. Almost anywhere within the state of Michigan, urgent care and, in some cases, routine services, can be arranged through any one of the other Blue Care Network HMOs. Blue Care Network is also part of a national network of Blue Cross and Blue Shield HMOs, HMO-USA. Through HMO-USA, urgent care can be obtained in areas served by other Blue Cross and Blue Shield HMOs affiliated with HMO-USA. If you would like more information about receiving care away from home, please call the Customer Services Department in your area. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services.

Do I have to submit claims?

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

Who provides my health care?

Over 11,000 participating physicians currently provide health care services to enrollees in this Plan. These doctors are located in private offices and medical centers throughout the Service Area.

Section 3. How to Get Benefits *(continued)*

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

Call the Customer Service Department at (800) 662-6667. We will help you select a new primary care physician.

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

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

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

First, call our Customer Service Department at (800) 662-6667. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching to this Plan, your former plan will pay for the hospital stay until:

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

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

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

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

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

Your primary care physician will decide what treatment you need. If they decide 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 this Plan.

What do I do if my specialist leaves this Plan?

Call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

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

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

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

How do you authorize medical services?

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

Section 3. How to Get Benefits *(continued)*

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

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

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

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

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

Section 4. What to Do If We Deny Your Claim or Request for Service

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

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

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

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

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

When may I ask OPM to review a denial?

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

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

Call our Customer Service Department at (800) 662-6667 and we will expedite our review.

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

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

Are there other time limits?

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

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

Section 4. What to Do If We Deny Your Claim or Request for Service *(continued)*

What do I send to OPM?

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

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

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

Who can make the request?

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

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

Where can I send my disputed claim to OPM?

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

What if OPM upholds this Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to initiate a lawsuit.

If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies.

What laws apply if I file a lawsuit?

Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

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

Your records and the Privacy Act

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

Section 5. Benefits

MEDICAL AND SURGICAL BENEFITS

What is covered

Plan doctors and other Plan providers provide a comprehensive range of preventive, diagnostic and treatment services. This includes all necessary office visits; **you pay a $10 office visit copay**, but no additional copay for laboratory tests and X-rays. Within the Service Area, house calls will be provided if, in the judgment of this Plan's doctor, such care is necessary and appropriate. **You pay a $10 copay for home visits** by nurses and health aides.

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

- Preventive care, including well-baby care and periodic check-ups;
- Mammograms are covered as follows: women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor;
- Routine immunizations and boosters;
- Consultations by specialists;
- Diagnostic procedures, such as laboratory tests and X-rays;
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a Caesarian delivery. Inpatient stays will be extended if medically necessary. If enrollment in this Plan is terminated during pregnancy, benefits will not be provided after coverage under this Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of the infant requiring definitive treatment will be covered only if the infant is covered under a Self and Family enrollment;
- The following gynecological services are covered without a referral when the member has selected an internist as a primary care doctor and an OB/GYN as her second primary care physician: Obstetrical procedures including associated diagnostic lab and radiology services; maternity ultrasounds; breast physical exams; mammograms; gynecological exams, with related lab work such as Pap smears and non-surgical treatment of gynecological disorders such as cystitis during pregnancy; hospital admissions for delivery and infertility studies;
- Voluntary sterilization and family planning services, including Norplant;
- Diagnosis and treatment of diseases of the eye;
- Allergy testing and treatment, including testing and treatment materials;
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints;

Section 5. Benefits *(continued)*

MEDICAL AND SURGICAL BENEFITS

What is covered
(continued)

- Cornea, heart, kidney, liver, single lung, double lung, heart/lung, and kidney/pancreas transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retro-peritoneal and ovarian germ cell tumors. Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be subject to participation in non-randomized clinical trials, based on recommendations by the National Cancer Institute, and require the prior approval of this Plan's Medical Director. Related medical and hospital expenses of the donor are covered;

- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure;

- Dialysis;

- Chemotherapy, radiation therapy, and inhalation therapy;

- Surgical treatment of morbid obesity;

- Home health services of nurses, health aides, physical, occupational and speech therapists when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need. Medical supplies such as dressings and antiseptics are provided in conjunction with home health care services;

- All necessary medical or surgical care in a hospital or extended care facility from Plan physicians and other Plan providers, at no additional cost to you.

Limited Benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. Medical services and treatment (but not dental and orthodontic services, treatment or appliances) for temporomandibular joint syndrome (TMJ) and orthognathic surgery are both covered. **You pay 50% of charges**. All other procedures involving the teeth and intra-oral areas surrounding the teeth are not covered.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce asymmetrical appearance.

Short-term rehabilitative therapy (physical, cardiac, speech and occupational) is provided on an inpatient or outpatient basis for up to 60 days per condition per year if significant improvement can be expected within 60 days. **You pay** a $10 copay per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Cardiac rehabilitation is limited to Phase I programs for inpatients and Phase II outpatient programs following a heart transplant, myocardial infarction or bypass surgery; Phase III and IV programs are not covered.

Section 5. Benefits *(continued)*

MEDICAL AND SURGICAL BENEFITS

Limited Benefits
(continued)

Prosthetics, such as artificial limbs and external lenses following cataract removal, breast prostheses, surgical bras and replacements, **orthopedic devices,** such as braces, and **durable medical equipment,** such as wheelchairs and hospital beds are available when obtained from a Plan vendor. Diabetic equipment such as glucose test tablets and test tape, Benedict's solution or equivalent and acetone test tablets are provided under this benefit. **You pay 50% of charges.**

Vision and hearing examinations are limited to members up to age 17 (seventeen).

Diagnosis and treatment of infertility is covered. **You pay 50% of charges**. The following types of artificial insemination are covered: intravaginal insemination (IVI), intracervical insemination (ICI), and intrauterine insemination (IUI). **You pay 50% of charges**. Fertility drugs are covered. **You pay 50% of charges**.

Cost of donor sperm is **not covered.**

Other **assisted reproductive technology (ART) procedures** such as in vitro fertilization and embryo transfer are **not covered.**

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel;
- Reversal of voluntary, surgically-induced sterility;
- Surgery primarily for cosmetic purposes;
- Transplants not listed as covered;
- Foot orthotics;
- Hearing aids;
- Chiropractic services;
- Homemaker services;
- Long-term rehabilitative therapy

Section 5. Benefits *(continued)*

HOSPITAL/EXTENDED CARE BENEFITS

What is covered

Hospital care

This Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan physician. **You pay nothing. All necessary services are covered**, including:

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

Extended care

This Plan provides a comprehensive range of benefits for up to 730 days per confinement when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by this Plan. **You pay nothing. 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 physician.

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan physician.

Limited benefits

Inpatient dental procedures

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

Acute inpatient detoxification

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

What is not covered

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

Section 5. Benefits *(continued)*

EMERGENCY BENEFITS

What is a medical emergency?

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

Emergencies within the Service Area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a member of this Plan so they can notify this Plan. You or a family member should notify this Plan within 24 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that this Plan has been notified in a timely manner.

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

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

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by this Plan or provided by Plan providers.

Plan pays...

Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay...

$25 per visit in a hospital emergency room, or $10 per visit in an urgent care facility, and $10 per visit in a physician's office for emergency care services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

Benefits outside the Service Area

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

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

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by this Plan or provided by Plan providers.

Plan pays...

Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay...

$25 per visit in a hospital emergency room, or $10 per visit in an urgent care facility, and $10 per visit in a physician's office for emergency care services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

What is covered

- Emergency care at a physician's office or an urgent care center;
- Emergency care as an outpatient or inpatient at a hospital, including physicians' service;
- Ambulance service if approved by this Plan.

Section 5. Benefits *(continued)*

EMERGENCY BENEFITS *(continued)*

What is not covered

- Elective care, or non-emergency care;
- Emergency care provided outside the Service Area if the need for care could have been foreseen before departing the Service Area;
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the Service Area.

Filing claims for non-Plan providers

With your authorization, this Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to this Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with this Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 10.

Section 5. Benefits *(continued)*

MENTAL CONDITIONS / SUBSTANCE ABUSE BENEFITS

Mental Conditions

What is covered

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

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

Initial assessments and referrals must be arranged (by either the member or their primary care physician) by calling their Regional Plan Mental Health and Substance Abuse Case Management Department at:

West Michigan Region	(800) 733-1525
East Michigan Region	(800) 280-8708
Southeast Michigan Region	(800) 482-5982
Mid-Michigan Region	(800) 823-6369

Outpatient care

Up to 20 outpatient visits to Plan physicians, consultants, or other psychiatric personnel each calendar year; **you pay nothing for each covered visit** - all charges thereafter.

Inpatient care

Up to 45 days of hospitalization each calendar year; **you pay nothing for the first 45 days** - all charges thereafter.

What is not covered

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

Substance Abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and, to the extent shown below, the services necessary for diagnosis and treatment. Initial assessments and referrals must be arranged (by either the member or their primary care physician) by calling their Regional Plan Mental Health and Substance Abuse Case Management Department at:

West Michigan Region	(800) 733-1525
East Michigan Region	(800) 280-8708
Southeast Michigan Region	(800) 482-5982
Mid-Michigan Region	(800) 823-6369

Outpatient care

Up to 20 outpatient visits to Plan providers each calendar year; **you pay nothing for each covered visit** – all charges thereafter.

Inpatient care

The substance abuse benefit may be combined with the outpatient benefit shown above, provided such treatment is necessary and is approved by this Plan, to permit an additional 20 outpatient visits per calendar year with the applicable substance abuse conditions benefits copayments.

One substance abuse rehabilitation (intermediate care) program per 12-month period in an alcohol detoxification or rehabilitation center approved by this Plan; **you pay nothing during the benefit period** – all charges thereafter.

What is not covered

- Treatment that is not authorized by a Plan physician or the Mental Health and Substance Abuse Case Management Department.

Section 5. Benefits *(continued)*

PRESCRIPTION DRUG BENEFITS

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 34-day supply. **You pay a $5 copay** per prescription unit or refill for generic drugs or for name brand drugs when generic substitution is not permissible. When generic substitution is permissible (i.e., a generic drug is available and the prescribing physician does not require the use of a name brand drug), but you request the name brand drug, **you pay** the price difference between the generic and name brand drug as well as the $5 copay per prescription unit or refill. Emergency prescription drugs filled outside of this Plan's Service Area are reimbursed at 100% of cost, minus the $5 copay.

Blue Care Network currently has an open voluntary formulary that is maintained by the BCN Pharmacy and Therapeutics Committee. Generic substitution is mandatory where appropriate. Generic substitution is not mandatory for critical drugs. Critical drugs are products where clinical judgement recommends using the brand-name drug because the generic drug cannot be safely substituted. These drugs are Lanoxin, Dilantin, Coumadin, Premarin, Theodur, Slophyllin, Tegretol, and Synthroid. A few select drugs on the formulary are part of the BCN Quality Interchange Program and may require prior authorization.

Maintenance drugs may be obtained through this Plan's mail order drug program. Certain maintenance drugs may be obtained for up to a 90-day supply at the $5 copay. Call our Customer Services Department at (800) 662-6667.

Covered medications and accessories include:

- Formulary drugs for which a prescription is required by law;
- Contraceptive devices, including diaphragms and IUDs;
- Oral contraceptive drugs – up to a three-cycle supply may be obtained for a single copay;
- Injectable contraceptive drugs;
- Smoking cessation drugs and medication;
- Disposable needles and syringes needed to inject covered prescribed medications;
- Intravenous fluids and medications for home use;
- Insulin with a copay charge applied to each vial;
- Diabetic supplies including insulin syringes and needles;
- Fertility drugs are covered under this Plan's infertility benefit with 50% coinsurance (see page 13).

Limited Benefits

- Drugs to treat sexual dysfunction are limited. Contact this Plan for dose limits. **You pay $5 copayment** up to the dosage limits — all charges thereafter.

Section 5. Benefits *(continued)*

PRESCRIPTION DRUG BENEFITS

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance

Section 5. Benefits *(continued)*

OTHER BENEFITS

Dental Care

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound, natural teeth are covered. The need for these services must result from an accidental injury, not biting or chewing. **You pay nothing.**

What is not covered

- Other dental services not shown as covered.

Vision Care

In addition to medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refraction (to provide a written lens prescription for eyeglasses) may be obtained from Plan optometrists. **You pay a $5 copay** per visit and charges above this Plan's allowance for lenses and frames. Non-participating vision care professionals are paid at 75% of the reasonable charge for testing, less the $5 copay. For lenses and frames, this Plan pays a predetermined level. **You pay** non-participating professional all charges for lenses, frames and contact lenses.

What is covered

The following are also available from Plan providers when prescribed or dispensed by a physician or optician:

- One pair every 12 months of: colorless glass lenses, medically necessary tinted #1 and #2 lenses, bifocal and trifocal lenses, or contact lenses with a $7.50 copayment;
- $42.50 toward the cost of one pair of frames.

What is not covered

- Eye exercises;
- Photo-sensitive lenses;
- Non-medically necessary tinted lenses;
- Safety glasses;
- Repair or replacement of lost or broken lenses or frames.

Section 5. Benefits *(continued)*

NON-FEHB BENEFITS AVAILABLE TO THIS PLAN'S MEMBERS

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

Medicare prepaid plan enrollment

This Plan offers Medicare recipients the opportunity to enroll in this Plan through Medicare. As indicated on page 22, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those **without** Medicare Part A may join this Medicare prepaid Plan but will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join this Plan, ask whether this Plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at (888) 333-3129 for information on this Medicare prepaid Plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, please call (888) 333-3129 for information on the benefits available under the Medicare HMO.

Health Promotion and Education Programs

We offer you a host of wellness programs geared toward preventing illness and successfully dealing with certain chronic diseases. Some of these programs include:

- An asthma management program that's been proven to reduce hospitalizations and visits to the emergency room;
- A diabetes management program that teaches you, family members, or caregivers how to control diabetes through basic, self-monitoring procedures;
- A smoking cessation program offering effective tools and tips to help you quit smoking;
- A program that addresses congestive heart failure. You'll work closely with your primary care physician, using self-monitoring techniques and lifestyle adjustments to keep this condition under control.

For more information on Health Promotion and Education Programs in your area, call our Customer Service Department at (800) 662-6667.

Dental Care Network Personal Program

Dental Care Network (DCN) is an affiliate of Blue Cross Blue Shield of Michigan. DCN is one of the most complete packages of individual dental benefits available to Michigan residents. Under DCN your dental care is provided, arranged, and coordinated by a qualified participating dentist who practices from his, or her, own private office. All DCN participating dentists are licensed and carefully chosen by DCN's credentialing staff. Each dentist is reviewed periodically to ensure compliance with DCN's quality assurance guidelines and they also must uphold DCN's managed care standards. Enrollment in the DCN Personal Program is offered twice a year. The first enrollment period begins May 1 and runs through May 31 for a July 1 effective date. The second enrollment period begins November 1 and runs through December 15 for a January 1 effective date. To receive an enrollment package with rates, benefit description, provider directory and an application, please call a DCN Customer Service Representative at (800) 321-8077. Be sure to identify yourself as a Federal employee when calling during the November – December open season.

Benefits on this page are not part of the FEHB contract

Section 6. General Exclusions - Things We Don't Cover

What is not covered

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

We do not cover the following:

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

Section 7. Limitations - Rules that Affect Your Benefits

Medicare

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

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

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season.

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

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

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at (800) 638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 23.

Other group insurance coverage

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

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

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

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

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. We will cover the cost of treatment that exceeds the amount you received in the settlement. If you do not seek damages, you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

TRICARE

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

Section 7. Limitations - Rules that Affect Your Benefits *(continued)*

Workers' compensation

We do not cover services that:

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

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

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

Other Government Agencies

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

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Section 8. FEHB Facts

You have a right to information about your HMO.

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

If you want specific information about us, call (800) 662-6667, or write to Blue Care Network, MC B825, Attn: Customer Service Department, 25925 Telegraph Road, P.O. Box 5043, Southfield, Michigan 48086-5043. You may also contact us by fax at (248) 799-6969, or visit our web site at www.bcbsm.com.

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

Your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans and other materials you need to make an informed decision about:

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

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

When are my benefits and premiums effective?

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

What happens when I retire?

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

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

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

If you have a Self-Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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

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

Section 8. FEHB Facts *(continued)*

Are my medical and claims records confidential?

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

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

Information for New Members

Identification cards

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

What if I paid a deductible under my old plan?

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

Pre-existing conditions

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

When You Lose Benefits

What happens if my enrollment in this Plan ends?

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

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

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

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get more information about your coverage choices.

Section 8. FEHB Facts *(continued)*

What is TCC?

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

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

Key points about TCC:

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

How do I enroll in TCC?

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

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

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

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

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

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

Section 8. FEHB Facts *(continued)*

How can I convert to individual coverage?

You may convert to an individual policy if:

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

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

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

How can I get a Certificate of Group Health Plan Coverage?

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

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

Inspector General Advisory: Stop Health Care Fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at (800) 662-6667 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
(202) 418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in this Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Blue Care Network of Michigan - 2000

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

	Benefits	Plan pays/provides	Page
Inpatient Care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital physician care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care.	14
	Extended Care	All necessary services, for up to 730 days per confinement. **You pay nothing.**	14
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 45 days of inpatient care per year. **You pay nothing.**	17
	Substance Abuse	One substance abuse rehabilitation program per 12-month period. **You pay nothing.**	17
Outpatient Care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay a $10 copay per office visit.**	11
	Home Health Care	All necessary visits by nurses and health aides. **You pay a $10 copay per visit.**	12
	Mental Conditions	Up to 20 outpatient visits per year. **You pay nothing.**	17
	Substance Abuse	Up to 20 outpatient visits per year. **You pay nothing.**	17
Emergency Care		Reasonable charges for services and supplies required because of a medical emergency. **You pay a $25 copay to the hospital, a $10 copay to an urgent care center and a $10 copay in a physician's office for each emergency room visit and any charges for services that are not covered by this Plan.**	15
Prescription Drugs		Drugs prescribed by a Plan physician and obtained at a Plan pharmacy. **You pay a $5 copay per prescription unit or refill.**	18
Dental Care		Accidental injury benefit. **You pay nothing.**	20
Vision Care		Annual Eye Exam, Lenses, Frames and Contact Lenses.	20
Out-of-Pocket Limit		Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments that are required for a few benefits.	

2000 Rate Information for
Blue Care Network of Michigan

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

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

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

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
East Michigan Region									
Self Only	K51	$72.06	$24.02	$156.13	$52.04	$85.27	$10.81	$85.27	$10.81
Self and Family	K52	$175.97	$91.82	$381.27	$198.94	$207.74	$60.05	$201.02	$66.77

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

East Michigan Region									
Self Only	KN1	$73.20	$24.40	$158.60	$52.87	$86.62	$10.98	$86.62	$10.98
Self and Family	KN2	$175.97	$96.10	$381.27	$208.22	$207.74	$64.33	$201.02	$71.05

Serving these counties: Genesee, Lapeer and Shiawassee

Mid Michigan Region									
Self Only	LN1	$78.15	$26.05	$169.33	$56.44	$92.48	$11.72	$92.48	$11.72
Self and Family	LN2	$175.97	$74.61	$381.27	$161.65	$207.74	$42.84	$201.02	$49.56

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

Southeast Michigan Region									
Self Only	LX1	$49.40	$16.46	$107.03	$35.67	$58.45	$7.41	$58.45	$7.41
Self and Family	LX2	$161.86	$53.95	$350.69	$116.90	$191.53	$24.28	$191.53	$24.28

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

West Michigan Region

Self Only	G71	$78.83	$45.14	$170.80	$97.80	$93.06	$30.91	$93.26	$30.71
Self and Family	G72	$175.97	$137.05	$381.27	$296.94	$207.74	$105.28	$201.02	$112.00

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

West Michigan Region

Self Only	KF1	$61.16	$20.39	$132.52	$44.17	$72.38	$9.17	$72.38	$9.17
Self and Family	KF2	$167.84	$55.95	$363.66	$121.22	$198.61	$25.18	$198.61	$25.18

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

West Michigan Region

Self Only	KR1	$67.13	$22.38	$145.46	$48.48	$79.44	$10.07	$79.44	$10.07
Self and Family	KR2	$175.97	$81.50	$381.27	$176.58	$207.74	$49.73	$201.02	$56.45

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