



Blue Care Network

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

Blue Care Network

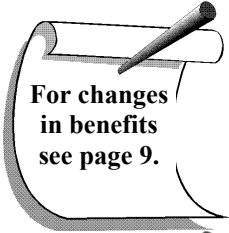
Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

2003

A Health Maintenance Organization

Serving: Most of Michigan

Enrollment in this Plan is limited; see page 7 for requirements.



**For changes
in benefits
see page 9.**

Enrollment codes for this Plan:

East Region

KN1 Self Only
KN2 Self and Family
K51 Self Only
K52 Self and Family

Southeast Region

LX1 Self Only
LX2 Self and Family

Mid Region

LN1 Self Only
LN2 Self and Family

West Region

KR1 Self Only
KR2 Self and Family
KF1 Self Only
KF2 Self and Family
G71 Self Only
G72 Self and Family



This Plan has 2003 accreditation from the NCQA. See the 2003 Guide for more information on accreditation.

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 73-153



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay Coles James".

Kay Coles James
Director



Notice of the Office of Personnel Management's Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO
THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

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Introduction

This brochure describes the benefits of Blue Care Network of Michigan (BCN) under our contract (CS 2011) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for Blue Care Network of Michigan's administrative offices is:

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

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in 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, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003 and changes are summarized on page 9. Rates are shown on the back cover of this brochure.

Plain Language

All FEHB brochures are written in plain language 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 Blue Care Network of Michigan.
- 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 this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW, Washington, D.C. 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself from Fraud – Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification number over the telephone or to people you do not know, except to your doctor, other provider or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review Explanations of Benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-800-662-6667 and explain the situation.
 - If we do not resolve the issue:

CALL --THE HEALTH CARE FRAUD HOTLINE

(202) 418-3300

OR WRITE TO:

The United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street, NW, Room 6400

Washington, DC 20415.

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 unless he or she is disabled and incapable of self-support.
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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

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

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

How we pay providers

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

More than 10,000 participating physicians provide health care services to enrollees in this Plan. These doctors are located in private offices and medical centers throughout the service area.

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 Web site (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.

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

All members have the right to:

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

BCN members also have responsibilities as outlined in this brochure.

All members have the responsibility to:

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

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

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

Service Area

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

East Michigan

Code K5 – serving Arenac, Bay, Gratiot, Isabella, Midland, Saginaw and Tuscola counties

Code KN – serving Genesee, Lapeer and Shiawassee (excluding the towns of Perry, Shaftsbury and Morice) counties.

Mid-Michigan

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

Southeast Michigan

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

West Michigan

Code G7 – serving Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Mackinac, Manistee (portions of), Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle and Roscommon counties.

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

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

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care 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 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. Blue Care Network is also a part of a national network of Blue Cross and Blue Shield HMOs. Members can obtain urgent care when travelling outside of Michigan by contacting BCBS at 1-800-810-BLUE or www.bcbs.com. The coordinator is available 24 hours a day, seven days a week. If you or a family member move, you do not have to wait until open enrollment season to change plans. Contact your employer or retirement office.

Section 2. How we change for 2003

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

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised
- By law, the DoD/FEHB Demonstration project ends on Dec. 31, 2002

Changes to this Plan

Your share of the non-Postal premium will increase by:

- 14.8 percent for Self Only or 14.5 percent for Self and Family for West Michigan (code G7).
- 9.6 percent for Self Only or 5.4 percent for Self and Family for East Michigan (code K5).
- 20.9 percent for Self Only or 18.6 percent for Self and Family for West Michigan (code KF).
- 9.3 percent for Self Only or 5.4 percent for Self and Family for East Michigan (code KN).
- 11.9 percent for Self Only or 11.8 percent for Self and Family for West Michigan (code KR).
- 10.8 percent for Self Only or 10.8 percent for Self and Family for Mid-Michigan (code LN).
- 15.3 percent for Self Only or 15.2 percent for Self and Family for Southeast Michigan (code LX).

Benefit changes:

- The office visit copayment increases from \$10 to \$15 per office visit.
- The emergency room copayment increases from \$50 to \$75 per visit.
- We added an inpatient hospital copayment of \$250 per admission.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment or if you need replacement cards, call us at 1-800-662-6667 or write to us at Blue Care Network of Michigan, 25925 Telegraph, Southfield, Michigan 48086-5043. You may also request replacement cards through our Web site at www.bcbsm.com/bcn.

Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do 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 can select any primary care physician who is accepting new patients from our provider directory for your region.

- **Primary care**

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

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

- **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, female members may self refer to a gynecologist or obstetrician -gynecologist for their annual well-woman exams and routine services.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex or serious medical condition, your primary care physician will manage your care, referring you to a specialist when it is medically appropriate. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause; or
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - reduce our service area and you enroll in another FEHB Plan,

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

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

• **Hospital care**

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

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

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

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

These provisions apply only to the hospital benefit of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In

that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

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

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

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

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

The contracted obstetrician-gynecologist practitioner must still obtain prior authorization from the PCP for hospital admissions and outpatient surgeries for eligible conditions, with the exception of routine deliveries.

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

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

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

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

Section 4. Your costs for covered services

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

- **Copayments**

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care physician you pay a copayment of \$15 per office visit.

- **Deductible**

We do not have a deductible.

- **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care.

Example: In our Plan, you pay 50 percent of our allowance for infertility services and durable medical equipment.

**Your catastrophic protection
out-of-pocket maximum
for copayments and coinsurance**

We do not have an out-of-pocket maximum.

Section 5. Benefits -- OVERVIEW

(See page 9 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 1-800-662-6667 (1-800-257-9980 for the hearing impaired) or at our Web site at www.bcbsm.com/bcn/.

(a) Medical services and supplies provided by physicians and other health care professionals	15 to 23
• Diagnostic and treatment services	• Speech therapy
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• Family planning	• Durable medical equipment (DME)
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Section 5 (a) Medical services and supplies provided by physicians and other health care professionals

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

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

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Benefit Description	You pay
Diagnostic and treatment services	You pay
Professional services of physicians <ul style="list-style-type: none"> • In physician's office 	\$15 per office visit
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion 	\$15 per office visit
At home	\$15 per visit
Lab, X-ray and other diagnostic tests	You pay
Tests such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	No copayment. Note: If services are provided in conjunction with an office visit, then the \$15 office visit copayment will apply.

Preventive care, adult	You pay
Routine screenings, such as: <ul style="list-style-type: none"> • Total blood cholesterol – once every three years • Colorectal cancer screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 	\$15 per office visit
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$15 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see <i>Diagnostic and Treatment Services</i> , above.	\$15 per office visit
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five-year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	\$15 per office visit
<i>Not covered: physical exams required for obtaining or continuing employment or insurance, attending schools or camp</i>	<i>All charges</i>
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, annually, age 65 and over 	\$15 per office visit
Preventive care, children	You pay
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	\$15 per office visit
<ul style="list-style-type: none"> • Well-child charges for routine examinations, immunizations and care (up to age 22) • Screenings, such as: <ul style="list-style-type: none"> – Vision screening to determine the need for vision exam. – Hearing screening to determine the need for hearing exam. 	\$15 per office visit

Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see this page for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay, we will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	<p>\$15 per office visit</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges</i></p>
Family planning	You pay
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>NOTE: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$15 per office visit (drugs paid under the pharmacy benefit)</p>
<p><i>Not covered: reversal of voluntary surgical sterilization, genetic counseling</i></p>	<p><i>All charges</i></p>
Infertility services	You pay
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) • Fertility drugs 	<p>50 percent of charges</p>

<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>in vitro fertilization</i> – <i>embryo transfer, gamete GIFT and zygote ZIFT</i> – <i>Zygote transfer</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<p><i>All charges</i></p>
<p>Allergy care</p>	<p>You pay</p>
<p>Testing and treatment</p> <p>Allergy injection</p> <p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered: provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges</i></p>
<p>Treatment therapies</p>	<p>You pay</p>
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 26.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We will only cover GHT when we preauthorize the treatment. Call 1-800-662-6667 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$15 per office visit</p>

Physical and occupational therapies	You pay
<p>Short-term outpatient physical and occupational therapy are covered when medically necessary for a condition that can be expected to improve significantly within 60 consecutive days.</p> <p>Note: Outpatient therapy provides a treatment for recovery from surgery, disease or injury. This also includes cardiac and pulmonary rehabilitation.</p> <p>Limitation: One period of treatment for any combination of physical therapy, occupational therapy and speech therapy within 60 consecutive days is covered per medical episode.</p> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Cognitive retraining • Vocational rehabilitation • Therapy to maintain current functional level and prevent further deterioration • Treatment during school vacations for children who would otherwise be eligible to receive therapy through the school or a public agency 	<p>\$15 per office visit</p> <p>\$15 per outpatient visit</p>
Speech therapy	You pay
<p>Short-term speech therapy is covered when medically necessary for a condition that can be expected to improve significantly within 60 consecutive days.</p> <p>Note: Outpatient therapy provides a treatment for recovery from surgery, disease or injury. This also includes cardiac and pulmonary rehabilitation.</p> <p>Limitation: One period of treatment for any combination of physical therapy, occupational therapy and speech therapy within 60 consecutive days is covered per medical episode.</p> <p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • <i>Cognitive retraining</i> • <i>Therapy to maintain current functional level and prevent further deterioration</i> • <i>Treatment during school vacations for children who would otherwise be eligible to receive therapy through the school or a public agency</i> • <i>Chronic conditions or congenital speech abnormalities</i> • <i>Learning disabilities</i> • <i>Deviant swallow or tongue thrust</i> • <i>Mild and moderate developmental speech or language disorders</i> • <i>Vocal cord abuse resulting from lifestyle activities</i> 	<p>\$15 per office visit</p>
Hearing services (testing, treatment and supplies)	You pay
<ul style="list-style-type: none"> • Hearing screening performed at your Primary Care Physician's office to determine the need for a hearing exam 	<p>\$15 per office visit</p>

<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • all other hearing testing • hearing aids, testing and examinations for them 	<p><i>All charges</i></p>
<p>Vision services (testing, treatment and supplies)</p>	<p>You pay</p>
<ul style="list-style-type: none"> • Annual eye examination from Plan optometrists or ophthalmologists to determine the need for lenses to correct or improve eyesight. 	<p>\$5 per office visit</p>
<ul style="list-style-type: none"> • One pair of colorless, plastic or glass lenses every 12 months when prescribed or dispensed by a physician or optician. The lenses may be single, bifocal, trifocal or lenticular. • Elective contacts may be chosen instead of spectacle lenses and a frame. There is no copay for elective contacts but you are responsible for any charges in excess of our allowance. • We pay for one pair of medically necessary contact lenses every 12 months, in lieu of lenses and frames. The member is responsible for the applicable copayment. <p>Contact lenses are considered medically necessary if:</p> <ul style="list-style-type: none"> - They are the only way to correct vision to 20/70 in the better eye; or - They are the only effective treatment to correct keratoconus, irregular astigmatism or irregular corneal curvature. <p>We pay for non-medically necessary but prescribed contact lenses. The member is responsible for the difference between the Plan's payment (a maximum of \$35) and the provider's charge for the contact lenses. We do not pay for cosmetic contact lenses that do not improve vision.</p>	<ul style="list-style-type: none"> • \$7.50 copay
<ul style="list-style-type: none"> • One pair of frames 	<p>All charges above \$42.50</p>
<ul style="list-style-type: none"> • Non-Plan providers of vision services are paid at 75 percent of reasonable charges less the \$5 copay. 	<p>\$5 plus all charges above Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Eye exercises • Photo-sensitive lenses • Non-medically necessary tinted lenses • Safety glasses • Repair or replacement of lost or broken lenses or frames 	<p><i>All charges</i></p>
<p>Foot care</p>	<p>You pay</p>
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$15 per office visit</p>

<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>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)</i> 	<p><i>All charges</i></p>
<p>Orthopedic and prosthetic devices</p>	<p>You pay</p>
<ul style="list-style-type: none"> • Prosthetics and orthotics are covered for the basic item and any special features that are medically necessary and preauthorized by BCN. • 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. 	<p>50 percent of charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>orthopedic and corrective shoes</i> • <i>arch supports</i> • <i>foot orthotics</i> • <i>heel pads and heel cups</i> • <i>lumbosacral supports</i> • <i>corsets, trusses, elastic stockings, support hoses and other supportive devices</i> • <i>repair of replacement due to loss or damage</i> 	<p><i>All charges</i></p>

Durable medical equipment (DME)	You pay
<p>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. The equipment must be obtained from an approved provider. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • hospital beds; • wheelchairs; • motorized wheelchairs, if medical criteria are met; • crutches; • walkers; • blood glucose monitors; • insulin pumps; and • oxygen therapy. <p>Note: Call our DME provider, Northwood, at 1-800-667-8496 as soon as your Plan physician prescribes this equipment. It will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	50 percent of charges
<i>Not covered: deluxe equipment and items for comfort and convenience</i>	<i>All charges</i>
Home health services	
<ul style="list-style-type: none"> • 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. 	\$15 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.</i> 	<i>All charges</i>
Chiropractic	You pay
<p>Chiropractic visits require a Primary Care Physician referral.</p> <ul style="list-style-type: none"> • Manipulation of the spine 	\$15 per office visit
<ul style="list-style-type: none"> • Chiropractic X-rays of the spine when taken by a chiropractor in his office. 	Nothing
<p><i>Not covered:</i></p> <p><i>All other chiropractic services</i></p>	<i>All charges</i>

Alternative treatments	You Pay
No benefits	All charges
Educational classes and programs	You pay
<p>Blue Care Network’s Health Education department provides a number of special events each year. Although topics change from time to time, recent examples include programs on general health, healthy cooking, men’s health, women’s health and menopause. BCN sends members a catalog of classes and invitations to special events.</p> <p>The Disease Management Department provides support and educational opportunities for members with asthma, diabetes and congestive heart failure and for expectant mothers.</p> <p>Blue Care Network offers the following programs for all members:</p> <ul style="list-style-type: none"> • Smoking Cessation - Nicotine replacement therapy prescriptions are a covered benefit for members. The smoking cessation program is a voluntary program for members and involves eight telephone counseling sessions with trained counselors during the first 90 days following members’ established smoking quit date. Group counseling sessions are encouraged and are a covered benefit for members. Blue Care Network has developed smoking cessation clinical practice guidelines that were distributed to all physicians. • Diabetes self-management 	No charge

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

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

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

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Benefit Description	You pay
Surgical procedures	You pay
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • 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 • Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g. Tubal ligation, Vasectomy) • Treatment of burns <p>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.</p>	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> 	<i>All charges</i>

Reconstructive surgery	You pay
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – 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. 	\$15 per office visit
<ul style="list-style-type: none"> • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – 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) <p>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.</p>	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Surgeries related to sex transformation</i> 	<i>All charges</i>
Oral and maxillofacial surgery	You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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. • Treatment of temporomandibular joint (TMJ), including surgical and non-surgical intervention, corrective orthopedic appliance and physical therapy. 	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)</i> • <i>Bite splints</i> 	<i>All charges</i>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/pancreas • Liver • Lung: single – double • Pancreas • Allogenic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas. • National Transplant Program (NTP) <p>Limited benefits – Treatment for breast cancer, multiple myeloma and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient</p>	<p>\$15 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<p><i>All charges</i></p>
Anesthesia	You pay
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	<p>Nothing</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Ambulatory surgical center • Office 	<p>\$15 per office visit</p>
<ul style="list-style-type: none"> • Skilled nursing facility 	<p>Nothing</p>

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

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Here are some important things to remember about these benefits:

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

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Benefit Description	You pay
Inpatient hospital	
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> <p><i>Other hospital services and supplies, such as:</i></p> <ul style="list-style-type: none"> • 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 	<p>\$250 per admission up to \$750 per individual or \$1000 per contract during a calendar year.</p>

Inpatient hospital (continued)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes and schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	You pay
<ul style="list-style-type: none"> • 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 <p>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.</p>	Nothing
<i>Not covered: blood and blood derivatives not replaced by the member</i>	<i>All charges</i>
Skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF): 730 days if the patient meets criteria.	Nothing
<i>Not covered: custodial care</i>	<i>All charges</i>
Hospice care	You pay
If hospice care is provided in the home, the home health care benefit applies.	\$15 per visit
If hospice care is provided in a skilled nursing facility, the skilled nursing facility benefit applies.	Nothing
<i>Not covered: independent nursing, homemaker services</i>	<i>All charges</i>
Ambulance	You pay
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate • Air ambulance service when medically appropriate 	Nothing

Section 5 (d). Emergency services/accidents

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

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

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What is a medical emergency?

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

What to do in case of emergency:

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

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

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

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

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

You pay: \$75 per visit in a hospital emergency room or \$10 per visit in an urgent care facility and \$15 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 but you are still subject to the inpatient hospital copayment.

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

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

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

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

You pay: \$75 per visit in a hospital emergency room or \$10 per visit in an urgent care facility and \$15 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 but you are still subject to the inpatient hospital copayment.

Benefit Description	You pay
Emergency within our service area	You pay
<ul style="list-style-type: none"> • Emergency care at a doctor's office 	\$15 per visit
<ul style="list-style-type: none"> • Emergency care at an urgent care center 	\$10 per visit
<ul style="list-style-type: none"> • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$75 per visit (waived if admitted)
<i>Not covered: elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	You pay
<ul style="list-style-type: none"> • Emergency care at a doctor's office 	\$15 per visit
<ul style="list-style-type: none"> • Emergency care at an urgent care center 	\$10 per visit
<ul style="list-style-type: none"> • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$75 per visit (waived if admitted)
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges.</i>
Ambulance	You pay
Professional ambulance service when medically appropriate. Air ambulance when medically appropriate. See 5(c) for non-emergency service.	Nothing

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

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

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

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

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Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits	
<p>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.</p> <p>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.</p>	<p>Your cost sharing responsibilities are no greater than for other illness or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists or clinical social workers • Medication management 	<p>\$15 per office visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>Nothing if you receive these services during your office visit. Otherwise, \$15 per office visit copay.</p>
<ul style="list-style-type: none"> • 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 	<p>If performed in an inpatient hospital, please refer to Section 5(c)</p>
<p><i>Not covered: services we have not approved..</i></p> <p><i>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.</i></p>	<p><i>All charges.</i></p>

Preauthorization

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

Members call ValueOptions at 1-800-482-5982 to arrange behavioral health services. Call this number for information on referral procedures, providers and inpatient and outpatient services.

Limitation

We may limit your benefits if you do not obtain a treatment plan

Section 5 (f). Prescription drug benefits

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

- We cover prescription drugs, brand-name and generic, which are listed in the Clinical Formulary, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when your doctor and health plan feel they are medically necessary.
- A single copayment of \$10 for generic drugs or \$20 for brand-name drugs will be applied to each prescription.
- 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.

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

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

You can order up to a 90-day supply of a mail order prescription for a copayment of \$10 for generic drugs or \$20 for brand-name drugs.
- **We use a modified, open formulary.** Blue Care Network has a modified, open formulary that is maintained by the BCN Pharmacy and Therapeutics Committee. Generic substitution is mandatory where appropriate. Generic substitution is not mandatory for critical drugs. Critical drugs are products where clinical judgment recommends using the brand-name drug because the generic drug cannot be safely substituted. These drugs are Lanoxin, Dilantin, Coumadin, Premarin, Theodur, Slophyllin and Tegretol. A few select drugs on the formulary are part of the BCN Quality Interchange Program and may require prior authorization. Coverage is provided for a nonformulary drug when the Plan and doctor agree that it's medically necessary.
- **These are the dispensing limitations.** A 34-day supply is the limit for most prescription drugs filled at a participating retail pharmacy. The pharmacy may dispense up to a 100-day supply for certain maintenance drugs. Copies of the maintenance drug list can be requested from Customer Service.

Note: The Plan will approve a prescription for the same medication when it is filled at least one week in advance of the next fill date. The pharmacy will charge you a separate copay for each prescription when a vacation supply is requested, e.g., if you request a two-month supply, you will be charged two copays, \$20 for generic drugs or \$40 for brand-name drugs. You may be required to pay the difference in costs between a brand-name drug and the price of its generic equivalent if a dispense-as-written (DAW) prescription is not preauthorized by the Plan.

- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name-brand drug when a Federally-approved generic drug is available and your physician has not specified Dispense as Written for the name-brand drug, you have to pay the difference in cost between the name-brand drug and the generic.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must 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.

You can save money by using generic drugs. However, you and your physician have the option to request a name brand if a generic option is available. Using the most cost-effective medication saves money.

- **When you have to file a claim.** Prescriptions filled at non-network pharmacies will be reimbursed in full, less your \$10/\$20 copayment, in urgent or emergency situations. Non-emergency prescriptions will be reimbursed at the Plan's cost, less the \$10/\$20 copayment. You must submit proof of payment for prescription services to Customer Services.

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies when prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not Covered</i>. • Insulin; • Insulin syringes and needles; • Disposable needles and syringes for the administration of covered medications; • Intravenous fluids and medications for home use; • Contraceptive devices, including diaphragms, IUDs and implants; • Injectable contraceptive drugs; • Fertility drugs are covered under this Plan’s infertility benefit with 50 percent coinsurance (see page 17); • Oral contraceptive drugs – up to a three-cycle supply; • Smoking cessation drugs and medications or gum • Growth hormone • Appetite suppressants are covered when preauthorized 	<p>\$10 or 50 percent (whichever is less) per prescription for generic drugs</p> <p>\$20 or 50 percent (whichever is less) per prescription for brand-name drugs</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand-name copay.</p>
<ul style="list-style-type: none"> • Drugs to treat sexual dysfunction are limited. Contact this Plan for dose limits. 	<p>\$10 up to dose limits, all charges thereafter</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins and nutritional substances that can be purchased without a prescription</i> • <i>Nonprescription medicines</i> 	<p><i>All charges</i></p>

Section 5 (g). Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24-hour nurse line	<p>For any of your health concerns, 24 hours a day, seven days a week, you may call 1-800-622-6252 and talk with a registered nurse who will discuss treatment options and answer your health questions.</p>
Reciprocity benefit	<p>Blue Care Network works with Blue plans across the United States to provide care for members who are travelling or who are temporarily living away from home.</p> <p>Away from Home Care: Urgent care is available throughout Michigan. Contact the Away from Home Care coordinator at 1-877-465-5122 during regular business hours. The coordinator will direct you to a participating provider in an area where BCN offers coverage.</p> <p>BCN participates in a nationwide network of Blue Cross and Blue Shield HMOs to provide urgent care for members travelling outside Michigan. Contact BCBS at 1-800-810-BLUE to make arrangements for care. The coordinator is available 24-hours a day, seven days a week.</p> <p>Guest membership program: You can prearrange for routine care for members who are seasonal residents or for families living apart, such as for covered dependents attending college or a family member living in a different BCN service region. Guest memberships are only available when a member is going to be out of the service region for more than 90 consecutive days. Guest memberships are limited to a six-month maximum for subscribers. Guest memberships must be renewed annually. Contact the Away from Home coordinator at 1-877-465-5122 to arrange guest membership.</p>
High-risk pregnancies	<p>Our pregnancy program identifies high-risk pregnancies and refers expectant mothers to our case management program for personalized intervention and follow-up. Studies have proven that early intervention in high-risk pregnancies significantly increases positive outcomes.</p> <p>The same program provides education and support to not only pregnant women but to those who are thinking of becoming pregnant.</p> <p>Though our health education program, we encourage expectant parents to attend prenatal education classes offered by BCN network hospitals.</p>

Section 5 (g). Special features

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

Section 5 (h). Dental benefits

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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.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. 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.

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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. All services must be provided within 72 hours.	The appropriate copayment may apply

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.

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

Non-FEHB benefits available to Plan members (continued)

Dental benefits from Dental Care Network	<p>Effective Dec. 31, 2002 Dental Care Network, an affiliate of Blue Cross Blue Shield of Michigan has made the difficult decision to withdraw from the dental HMO business. As a result, we are no longer able to offer DCN dental coverage.</p> <p>Blue Care of Michigan, Inc. is working with the State of Michigan to develop a new dental program for individuals. However, such a product requires State of Michigan approval and would not be in place before January 1, 2003.</p>
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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.
- Services, drugs or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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

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

Medical, hospital and Drug benefits

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

When you must file a claim -- such as for services you receive outside of the Plan's service area -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to:

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

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
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| 1 | Ask us in writing to reconsider our initial decision. You must: <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Appeals and Grievances — mail code B845
Blue Care Network
P.O. Box 284
25925 Telegraph Road
Southfield, MI 48037-0284 andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records and explanation of benefits (EOB) forms. |
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| 2 | We have 30 days from the date we receive your request to: <ol style="list-style-type: none">Pay the claim (or arrange for the health care provider to give you the care); orWrite to you and maintain our denial — go to step 4; orAsk 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. |
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| 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. |
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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.

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| 4 | If you do not agree with our decision, you may ask OPM to review it. |
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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, D.C. 20415-3630.

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 more than one claim, 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.

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 preauthorization/prior approval, then call us at 1-800-662-6667 and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/prior approval, then:
 - 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 may call OPM's Health Benefits Contracts Division 3 at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

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

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

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

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

What is Medicare?

Medicare is the Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. 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 managed care plan is the term used to describe the various health plan choices available to Medicare beneficiaries. The information on the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

- **The Original Medicare Plan (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 Plan PCP or precertified as required.

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 1-800-662-6667.

We do not waive any costs when you have Medicare.

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

- **Medicare managed care plan** If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists or hospitals that are part of the plan. Medicare managed care plans 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 our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments or coinsurance for your FEHB coverage.

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

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums). 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 under the program.

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.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB 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 under the State program.

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 13.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Covered services	Care we provide benefits for, as described in this brochure.
Experimental or investigational services	<p>A product or procedure is considered not experimental or investigational if it meets all of the following conditions:</p> <ul style="list-style-type: none">• 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. <p>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.</p> <p>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.</p>
Us/We	Us and we refer to Blue Care Network of Michigan
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

- 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.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your

children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option,
- If you have a Self-Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact your employing office for further information.

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 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.

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. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). 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. You can also download the guide from OPM's Web site www.opm.gov/insure.

- **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 Temporary Continuation of Coverage. 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 an individual policy if:

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

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

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

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability 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 Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But...

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or Web site listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337)** (TDD for the hearing impaired: **1-800-843-3557**) or visiting www.ltcfeds.com to get more information and to request an application.

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

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Summary of benefits for Blue Care Network of Michigan — 2003

- **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.....	\$15 per office visit	15
Services provided by a hospital:		
• Inpatient.....	\$250 per admission	27
• Outpatient.....	Nothing	28
Emergency benefits:		
• In-area	\$75 per visit, waived if admitted	29
• Out-of-area	\$75 per visit, waived if admitted	29
Mental health and substance abuse treatment	Regular cost sharing.	31
Prescription drugs	\$10/\$20 per prescription filled	33
Dental Care		
Accidental injury benefit	Nothing	38
Vision Care:		
• Annual eye exams.....	\$5 copayment per office visit	20
• Lenses and contact lenses.....	\$7.50	20
• Frames	All charges above \$42.50	20
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2003 Rate Information for Blue Care Network of Michigan

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

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

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Govt share	Your share	Govt Share	Your share	USPS share	Your Share

East Michigan Region

Self Only	K51	\$99.23	\$33.08	\$215.00	\$71.67	\$117.43	\$14.88
Self and Family	K52	\$249.62	\$120.21	\$540.84	\$260.46	\$294.70	\$75.13

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

East Michigan Region

Self Only	KN1	\$106.12	\$35.37	\$229.92	\$76.64	\$125.57	\$15.92
Self and Family	KN2	\$249.62	\$145.85	\$540.84	\$316.01	\$294.70	\$100.77

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

Mid Michigan Region

Self Only	LN1	\$109.30	\$68.39	\$236.82	\$148.18	\$129.03	\$48.66
Self and Family	LN2	\$249.62	\$178.24	\$540.84	\$386.19	\$294.70	\$133.16

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

Southeast Michigan Region

Self Only	LX1	\$77.01	\$25.67	\$166.85	\$55.62	\$91.13	\$11.55
Self and Family	LX2	\$230.30	\$76.76	\$498.98	\$166.32	\$272.52	\$34.54

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Govt share	Your share	Govt share	Your share	USPS share	Your Share

West Michigan Region

Self Only	G71	\$109.30	\$132.78	\$236.82	\$287.69	\$129.03	\$113.05
Self and Family	G72	\$249.62	\$362.52	\$540.84	\$785.46	\$294.70	\$317.44

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	\$109.30	\$65.05	\$236.82	\$140.94	\$129.03	\$45.32
Self and Family	KF2	\$249.62	\$230.39	\$540.84	\$499.18	\$294.70	\$185.31

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

West Michigan Region

Self Only	KR1	\$109.30	\$36.71	\$236.82	\$79.54	\$129.03	\$16.98
Self and Family	KR2	\$249.62	\$172.10	\$540.84	\$372.89	\$294.70	\$127.02

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