

# Blue Care Network

[www.MiBCN.com](http://www.MiBCN.com)



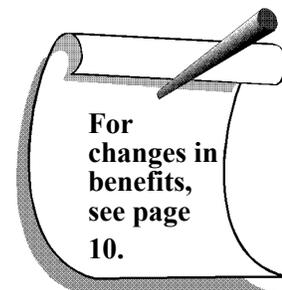
A nonprofit corporation and independent licensee  
of the Blue Cross and Blue Shield Association

## 2012

## A Health Maintenance Organization (High Option)

**Serving: East, Southeast and West Michigan**

**Enrollment in this plan is limited. You must live or work  
in our geographic service area to enroll.  
See Pages 8-9 for requirements.**



### Enrollment codes for this Plan:

#### East Region

K51 High Option Self Only  
K52 High Option Self and Family

#### Southeast Region

LX1 High Option Self Only  
LX2 High Option Self and Family

#### West Region

H61 High Option Self only with pilot program  
H62 High Option Self and Family with pilot program

J31 High Option Self only with pilot program

J32 High Option Self and Family with pilot program



Since 2000, Blue Care Network has received  
Excellent Accreditation for plan performance  
from the National Committee for Quality Assurance.



Authorized for distribution by the:



United States  
Office of Personnel Management

Healthcare and Insurance  
<http://www.opm.gov/insure>

RI 73-153

Important Notice from Blue Care Network about

Our Prescription Drug Coverage and Medicare

OPM has determined that Blue Care Network prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

*For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).*

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit [www.medicare.gov](http://www.medicare.gov) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048).

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## Introduction

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This brochure describes the benefits of Blue Care Network (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's administrative offices is:

Blue Care Network  
20500 Civic Center Drive  
Southfield, MI 48076

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, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 10. Rates are shown at the end of this brochure.

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## Plain Language

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All FEHB brochures are written in plain language to make them easy to understand. Here are some examples.

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's “Rate Us” feedback area at [www.opm.gov/insure](http://www.opm.gov/insure) or e-mail OPM at [fehbwebcomments@opm.gov](mailto:fehbwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel, Management Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 1900 E Street, NW, Washington, DC 20415-3650.

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## Stop Health Care Fraud!

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- Fraud increases the cost of health care for everyone and increases your Federal Employees 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 that you can do to prevent fraud:
- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits 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) statements that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.

- 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  
1-202-418-3300**

**OR WRITE TO  
United States Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street NW — Room 6400  
Washington, DC 20415-1100**

- 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)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26) prior to age 26
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not an eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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## Preventing Medical Mistakes

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An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That’s about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care and that of your family members. Take these simple steps:

### 1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

### 2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines such as vitamins and herbal supplements.

- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

### **3. Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

### **4. Talk to your doctor about which hospital is best for your health needs.**

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

### **5. Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

"Exactly what will you be doing?"

"About how long will it take?"

"What will happen after surgery?"

"How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia and any medications you are taking.

### **Patient Safety Links**

- [www.ahrq.gov/consumer](http://www.ahrq.gov/consumer). The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- [www.npsf.org](http://www.npsf.org). The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- [www.talkaboutrx.org/](http://www.talkaboutrx.org/). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.
- [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

**Never Events**

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Blue Care Network providers. This policy helps protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

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## Section 1. Facts about this HMO Plan

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This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals and other providers that contract with us. Our Plan providers coordinate your health care services, and we are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory by calling 1-800-662-6667 or by visiting our website [www.MiBCN.com/find](http://www.MiBCN.com/find).

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 pay only 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.**

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply may be directed to us at 1-800-662-6667. You can also read additional information from the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov).

### **General features of our High Option Benefit**

BCN offers a High Option Benefit that is described in Section 5. Make sure you review the coverage that is available.

Under the High Option Benefit, there is no calendar year deductible. High Option benefits are paid in full or in full after you pay a copayment amount when you receive a referral for nonpreventive services.

### **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 18,000 participating physicians (primary care physicians and specialists) provide health care services to BCN enrollees. These doctors are located in private offices and medical centers throughout the service area. We also contract with all acute care hospitals in Michigan.

### **Your rights**

OPM requires that all FEHB plans provide certain information to their FEHB members about us, our networks and our providers. OPM's FEHB Web site ([www.opm.gov/insure](http://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 nonemergency 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 nonemergency 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 is federally qualified and licensed. BCN is a nonprofit HMO and an affiliate of Blue Cross Blue Shield of Michigan. It was 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.

If you want more information about us, call 1-800-662-6667, write to Blue Care Network, P.O. Box 5043, Southfield, MI 48086-5043 or visit our Web site at [www.MiBCN.com](http://www.MiBCN.com).

**Your medical and claims records are confidential**

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

**Service Area**

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

**East Michigan — Code K5**

Serving Arenac, Bay, Genesee, Gratiot, Isabella, Lapeer, Midland, Saginaw, Shiawassee (excluding the towns of Perry, Shaftsbury and Morrice) and Tuscola counties.

**Southeast Michigan — Code LX**

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

**West Michigan-Grand Rapids — Code J3**

Serving Kent, Muskegon, Oceana, Ottawa and Newaygo counties.

**West Michigan-Traverse City— Code H6**

Serving Benzie, Grand Traverse, and Leelanau counties.

**Out-of-Area Care**

Blue Care Network is affiliated with BlueCard<sup>®</sup>, a national network of Blue Cross and Blue Shield plans. Members can obtain follow up and urgent care when traveling outside of Michigan by contacting BlueCard at 1-800-810-BLUE or [www.bcbs.com](http://www.bcbs.com). Members living away from home for part of the year — students at college, for instance — can also use BlueCard for routine care.

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.

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## Section 2. How we change for 2012

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Do not rely only on these change descriptions; this section 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**

- Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

### **Changes to this Plan**

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family (see page 75).

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## Section 3. How you get care

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<b>Identification cards</b>	<p>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 letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>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, P.O. Box 5043, Southfield, MI 48086-5043. You may also request replacement cards through our Web site at <a href="http://www.MiBCN.com">www.MiBCN.com</a>.</p>
<b>Where you get covered care</b>	<p>You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and/or coinsurance.</p>
<ul style="list-style-type: none"><li>• <b>Plan providers</b></li></ul>	<p>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.</p> <p>We list Plan providers in our provider directory, which we update periodically. You can also find Plan providers in your area on our Web site at <a href="http://www.MiBCN.com/find">www.MiBCN.com/find</a>.</p>
<ul style="list-style-type: none"><li>• <b>Plan facilities</b></li></ul>	<p>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 our provider directory, which we update periodically. You can also find Plan facilities in your area on our Web site at <a href="http://www.MiBCN.com/find">www.MiBCN.com/find</a>.</p>
<b>What you must do to get covered care</b>	<p>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.</p>
<ul style="list-style-type: none"><li>• <b>Primary care</b></li></ul>	<p>Your primary care physician can be a family or general practitioner, an 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.</p> <p>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 at <a href="http://www.MiBCN.com/find">www.MiBCN.com/find</a>.</p>
<ul style="list-style-type: none"><li>• <b>Specialty care</b></li></ul>	<p>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 authorizes 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.</p> <p>Here are some other things you should know about specialty care:</p> <ul style="list-style-type: none"><li>• If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.</li></ul>

Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician.

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 and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program 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 hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, 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 and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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 92<sup>nd</sup> day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

**You need prior Plan approval for certain services**

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

• **Inpatient hospital admission**

**Precertification** is the process by which — prior to your inpatient hospital admission — we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. Services that require prior authorization include, but are not limited to:

- Reconstructive surgery
- Transplants
- Certain infertility treatments
- Nursing home care
- Physical/occupational/speech therapy
- Cardiac/pulmonary rehabilitation
- Surgical treatment of morbid obesity
- Growth hormone therapy

**How to request precertification for an admission or get prior authorization for Other services**

First, your physician, your hospital, you, or your representative, must call us at 1-800-392-2512 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

Prior authorization is not required for maternity services.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

**What happens when you do not follow the precertification rules when using non-network facilities**

Your primary care physician provides your care or manages it through a referral process. Only your primary care physician can refer you to specialist care. If your primary care physician doesn't refer you, you are responsible for the charges.

**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.

**If you disagree with our pre-service claim decision**

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

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## Section 4. Your costs for covered services

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This is what you will pay out of pocket for covered care.

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

Example: In the High Option and Standard Plans, when you see your primary care physician you pay a copayment of \$15 per office visit and when you go to the hospital emergency room, you pay \$100 per visit for emergency care.

**Cost-sharing** Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance and copayments) for the covered care you receive.

**Coinsurance** Coinsurance is the percentage of our allowance that you must pay for your care.

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

**Your catastrophic protection out-of-pocket maximum** There is no out-of-pocket maximum for the High Option Benefit or for Healthy *Blue* Living Enhanced and Standard Benefits.

**Carryover** If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

**When government facilities bill us** Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

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## Section 5. High Option Table of Contents

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## Section 5. High Option Benefits Overview

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Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice or more information about benefits, call us at 1-800-662-6667 (TTY 1-800-257-9980) or visit our Web site at [www.MiBCN.com](http://www.MiBCN.com).

### High Option

- **No deductible**
- **Office visits**  
You pay \$15 for visits to your primary care physician.  
You pay \$25 for visits to a specialist.
- **Adult and child preventive care (physicals and screenings)**  
Covered in full.
- **Maternity care**  
You pay \$15 per visit for prenatal and postnatal care.
- **Prescription drugs**  
**Retail:** For a 30-day supply, you pay a \$5 copayment for Formulary Preferred (Tier 1) generic drugs and a \$50 copayment for Formulary Option (Tier 2) brand-name drugs. For an 84-90-day supply, you pay a \$10 copayment for Formulary Preferred (Tier 1) generic drugs and a \$100 copayment for Formulary Option (Tier 2) brand-name drugs. (Days 31-83 are not covered.)  
**Mail order:** For a 30-day supply, you pay a \$5 copayment for Formulary Preferred (Tier 1) generic drugs and a \$50 copayment for Formulary Option (Tier 2) brand-name drugs. For a 31-90-day supply, you pay a \$10 copayment for Formulary Preferred (Tier 1) generic drugs and a \$100 copayment for Formulary Option (Tier 2) brand-name drugs.
- **Chiropractic care**  
You pay \$25 per office visit. Requires plan notification and a referral from your primary care physician.

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

**Important things you should 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.

Benefit Description	You pay
<b>Diagnostic and treatment services</b>	<b>High Option</b>
Professional services of physicians (except preventive care) <ul style="list-style-type: none"> <li>• In physician's office</li> <li>• Office medical consultations</li> <li>• At home</li> </ul>	\$15 per primary care physician visit \$25 per specialist visit
Second surgical opinion <ul style="list-style-type: none"> <li>• During a hospital stay</li> <li>• In skilled nursing facility</li> </ul>	\$25 per office visit Nothing
<ul style="list-style-type: none"> <li>• In an urgent care center</li> </ul>	\$15 per visit or 50% of the approved amount, whichever is less
<b>Lab, X-ray and other diagnostic tests</b>	<b>High Option</b>
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Nonroutine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Nonroutine mammograms</li> <li>• Ultrasound</li> <li>• CAT Scans/MRI</li> <li>• Electrocardiogram and EEG</li> </ul>	Nothing if received during your office visit otherwise: \$15 per primary care physician visit \$25 per specialist visit
<b>Preventive care, adult</b>	<b>High Option</b>
Routine physical every year, which includes routine screenings, such as: <ul style="list-style-type: none"> <li>• Total blood cholesterol</li> <li>• Colorectal cancer screening, including <ul style="list-style-type: none"> <li>- Fecal occult blood test</li> <li>- Sigmoidoscopy, screening — every five years starting at age 50 with fecal occult blood test every 3 years</li> <li>- Colonoscopy screening — every 10 years starting at age 50</li> </ul> </li> </ul>	Nothing

*Preventive care, adult - continued on next page*

Benefit Description	You pay
<b>Preventive care, adult (cont.)</b>	<b>High Option</b>
<p>Note: Preventive services as defined by the Patient Protection and Affordable Care Act may be modified from time to time by the federal government. For a detailed list of preventive services, please visit <a href="http://www.MiBCN.com">www.MiBCN.com</a> or contact Customer Service at 1-800-662-6667.</p>	Nothing
<ul style="list-style-type: none"> <li>• Routine Prostate Specific Antigen (PSA) test</li> <li>• Routine Pap test</li> </ul>	Nothing
<p>Routine mammogram — covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five-year period</li> <li>• From age 40 through 64, one every calendar year</li> <li>• At age 65 and older, one every two consecutive calendar years</li> </ul>	Nothing
<p>Adult routine immunizations as recommended by the Advisory Committee on Immunization Practices</p>	Nothing
<p><i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance or for attending schools or camp</i></p>	<i>All charges</i>
<b>Preventive care, children</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	Nothing
<ul style="list-style-type: none"> <li>• Well-child care charges for routine examinations, immunizations and care</li> <li>• Examinations, such as: <ul style="list-style-type: none"> <li>- Vision screening to determine the need for vision exam</li> <li>- Hearing screening to determine the need for hearing exam</li> </ul> </li> </ul>	Nothing
<b>Maternity care</b>	<b>High Option</b>
<p>Complete maternity (obstetrical) prenatal and postnatal care</p>	\$15 per primary care physician or OB-GYN visit
<p>Delivery</p> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery.</li> <li>• 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.</li> <li>• 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 nonroutine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision.</li> <li>• We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.</li> </ul>	Nothing

Benefit Description	You pay
<b>Family planning</b>	<b>High Option</b>
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures Section 5b)</li> <li>• Surgically implanted contraceptives* (such as Mirena®)</li> <li>• Injectable contraceptive drugs* (such as Depo-Provera®)</li> <li>• Intrauterine devices (IUDs)</li> <li>• Diaphragms</li> </ul> <p>Note: Contraceptive devices, injectables and implants are provided in your physician's office. We cover contraceptive drugs under the pharmacy benefit.</p>	<p>\$15 per primary care physician visit</p> <p>\$25 per specialist visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary surgical sterilization</i></li> </ul>	<p><i>All charges</i></p>
<b>Infertility services</b>	<b>High Option</b>
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>- Intravaginal insemination (IVI)</li> <li>- Intracervical insemination (ICI)</li> <li>- Intrauterine insemination (IUI)</li> </ul> </li> <li>• Fertility drugs</li> </ul> <p>Note: We cover injectable and oral fertility drugs under the medical benefit.</p>	<p>50% coinsurance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>- <i>In vitro fertilization</i></li> <li>- <i>Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i></li> <li>- <i>Zygote transfer</i></li> </ul> </li> <li>• <i>Services and supplies related to ART procedures</i></li> <li>• <i>Cost of donor sperm</i></li> <li>• <i>Cost of donor egg</i></li> </ul>	<p><i>All charges</i></p>
<b>Allergy care</b>	<b>High Option</b>
<p>Allergy testing and treatment</p>	<p>\$15 per primary care physician visit</p> <p>\$25 per specialist visit</p>
<ul style="list-style-type: none"> <li>• Tests</li> <li>• Serum</li> <li>• Injections</li> </ul>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Provocative food testing</i></li> <li>• <i>Sublingual allergy desensitization</i></li> </ul>	<p><i>All charges</i></p>

Benefit Description	You pay
<b>Treatment therapies</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 30.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis — hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV) /Infusion Therapy — Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See <i>Other services</i> under <i>You need prior Plan approval for certain services</i> on page 13.</p>	<p>\$15 per primary care physician visit</p> <p>\$25 per specialist visit</p> <p>Nothing in outpatient facility setting</p>
<b>Physical and occupational therapies</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• 60 visits combined per year per medical condition for physical therapy, medical rehabilitation and occupational therapy</li> </ul> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 consecutive days. Phases three and four of cardiac rehab are not covered.</p>	<p>\$25 per visit or 50% of the approved amount, whichever is less</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Long-term rehabilitative therapy</i></li> <li>• <i>Exercise programs</i></li> </ul>	<p><i>All charges</i></p>
<b>Speech therapy</b>	<b>High Option</b>
<p>60 visits per medical diagnosis</p>	<p>\$25 per office visit</p>
<b>Hearing services (testing, treatment, and supplies)</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist</li> </ul> <p>Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) <i>Preventive care, children</i>.</p>	<p>\$15 per primary care physician visit</p> <p>\$25 per specialist visit</p>
<ul style="list-style-type: none"> <li>• External hearing aids <ul style="list-style-type: none"> <li>- Binaural hearing aid for children under age 19 every 36 months</li> <li>- One unilateral hearing aid every 36 months for adults age 19 and older</li> </ul> </li> <li>• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants</li> </ul>	<p>\$15 per primary care physician visit</p> <p>\$25 per specialist visit</p>

*Hearing services (testing, treatment, and supplies) - continued on next page*

Benefit Description	You pay
<b>Hearing services (testing, treatment, and supplies) (cont.)</b>	<b>High Option</b>
<p>Note: We cover standard (conventional) hearing aids only. The approved amount for a conventional aid may be applied toward the price of a nonconventional aid at the member's option. You are responsible for any costs over the approved amount. For implanted devices benefits, see Section 5(b) <i>Surgical and anesthesia services</i>.</p>	<p>\$15 per primary care physician visit \$25 per specialist visit</p>
<b>Vision services (testing, treatment, and supplies)</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Annual eye examination from Plan optometrists or ophthalmologists to determine the need for lenses to correct or improve eyesight. Note: Your vision benefits are administered by Blue Cross Blue Shield of Michigan. Please contact Blue Cross Blue Shield of Michigan concerning your vision benefits. <ul style="list-style-type: none"> <li>- If you live in southeastern, eastern or mid-Michigan, call 1-800-637-2227.</li> <li>- If you live in western Michigan, call 1-800-972-9797.</li> </ul> </li> </ul>	<p>\$5 per vision exam Non-Plan providers of vision services are paid at 75% of reasonable charges.</p>
<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> </ul>	<p>\$7.50 copay</p>
<p>One pair of frames every 24 months</p>	<p>All charges above \$42.50</p>
<p>We pay for nonmedically necessary but prescribed contact lenses. We do not pay for cosmetic contact lenses that do not improve vision. Contact lenses are considered necessary if:</p> <ul style="list-style-type: none"> <li>• They are the only way to correct vision to 20/70 in the better eye; or</li> <li>• They are the only effective treatment to correct keratoconus, irregular astigmatism or irregular corneal curvature.</li> </ul>	<p>All charges above \$42.50</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Eye exercises</i></li> <li>• <i>Photo-sensitive lenses</i></li> <li>• <i>Nonmedically necessary tinted lenses</i></li> <li>• <i>Safety glasses</i></li> <li>• <i>Repair or replacement of lost or broken lenses or frames</i></li> </ul>	<p><i>All charges</i></p>

Benefit Description	You pay
<b>Foot care</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>Foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</li> </ul> <p>See <i>Orthopedic and prosthetic devices</i> below for information on podiatric shoe inserts.</p>	<p>\$15 per primary care physician visit</p> <p>\$25 per specialist visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><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></li> <li><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></li> </ul>	<p><i>All charges</i></p>
<b>Orthopedic and prosthetic devices</b>	<b>High Option</b>
<p>Prosthetics and orthotics are covered for the basic item and any special features that are medically necessary and preauthorized by BCN.</p> <ul style="list-style-type: none"> <li>Artificial limbs and eyes</li> <li>Stump hose</li> <li>Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy</li> <li>Corrective orthopedic appliances for nondental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</li> <li>Cochlear implants</li> <li>Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants and surgically implanted breast implant following mastectomy</li> </ul> <p>Note: For information on the professional and facility charges for implanted devices, see Sections 5(b) and 5(c). The implanted device is part of the surgical benefit and not subject to additional cost sharing.</p>	<p>50% of charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups</i></li> <li><i>Lumbosacral supports</i></li> <li><i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> <li><i>Repair or replacement due to loss or damage</i></li> </ul>	<p><i>All charges</i></p>
<b>Durable medical equipment (DME)</b>	<b>High Option</b>
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> <li>Oxygen</li> <li>Dialysis equipment</li> <li>Hospital beds</li> <li>Wheelchairs</li> <li>Motorized wheelchairs if medical criteria are met</li> </ul>	<p>50% of charges</p>

*Durable medical equipment (DME) - continued on next page*

Benefit Description	You pay
<b>Durable medical equipment (DME) (cont.)</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Crutches</li> <li>• Walkers</li> <li>• Audible prescription reading devices</li> <li>• Speech generating devices</li> <li>• Blood glucose monitors and testing supplies</li> <li>• Insulin pumps</li> <li>• Oxygen therapy</li> <li>• Nebulizers and supplies</li> </ul> <p>Note: Call our DME provider, Northwood, at 1-800-667-8496 as soon as your Plan physician prescribes this equipment. Northwood specialists 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. Call J&amp;B Medical Supply Company at 1-888-896-6233 for diabetic materials, including insulin pumps, blood glucose meters, test strips and lancets.</p>	50% of charges
<i>Not covered: Deluxe equipment and items for comfort and convenience</i>	<i>All charges</i>
<b>Home health services</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• 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.</li> <li>• Services include oxygen therapy, intravenous therapy and medications.</li> </ul>	\$25 or 50% of the approved amount, whichever is less
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Nursing care requested by, or for the convenience of, the patient or the patient's family.</i></li> <li>• <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.</i></li> <li>• <i>Custodial care is not covered in settings such as your home, a nursing home, residential institution or any other setting that is not required to support medical and skilled nursing care.</i></li> </ul>	<i>All charges</i>
<b>Chiropractic</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Chiropractic manipulation of the spine</li> </ul>	\$25 per office visit
<ul style="list-style-type: none"> <li>• Chiropractic X-rays of the spine when taken by a chiropractor in the office</li> </ul>	Nothing
<i>Not covered: All other chiropractic services</i>	<i>All charges</i>

Benefit Description	You pay
<b>Alternative treatments</b>	<b>High Option</b>
No benefits	<i>All charges</i>
<b>Educational classes and programs</b>	<b>High Option</b>
<p>Tobacco cessation programs, including:</p> <ul style="list-style-type: none"> <li>• Individual/group counseling</li> <li>• 8 telephone counseling sessions with trained counselors</li> <li>• 2 quit attempts per year</li> <li>• Approved nicotine replacement medications and supplies (see <i>Prescription drug benefits</i>)</li> </ul> <p>Note: We encourage you to look at our BlueHealthConnection<sup>®</sup> suite of programs that offer integrated health information to help members stay healthy, get better or improve their quality of life while living with an illness. See Page 48, <i>Special Features</i>.</p>	Nothing

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

**Important things you should 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 the facility (i.e., hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAPPROVAL FOR SOME SURGICAL PROCEDURES.** Please refer to the information shown in Section 3 to be sure which services require preapproval and identify which surgeries require preapproval.

Benefit Description	You pay
<b>Surgical procedures</b>	<b>High Option</b>
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and postoperative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see <i>Reconstructive surgery</i>)</li> <li>• Voluntary sterilization (e.g., tubal ligation, vasectomy) [But not for reversal of voluntary sterilization]</li> <li>• Treatment of burns</li> <li>• Surgical treatment of morbid obesity (bariatric surgery). The criteria we consider are:               <ul style="list-style-type: none"> <li>- BMI</li> <li>- Age</li> <li>- Previous professional supervised weight loss programs</li> <li>- Patient's understanding of risks</li> <li>- Presurgical psychological evaluation</li> </ul> </li> </ul> <p>For more information, call 1-800-662-6667.</p> <ul style="list-style-type: none"> <li>• Insertion of internal prosthetic devices. See 5(a) — <i>Orthopedic and prosthetic devices</i> for device coverage information</li> </ul> <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. See <i>Hospital Benefits</i> (Section 5c) and <i>Surgery Benefits</i> (Section 5b).</p>	<p>Nothing</p>

Benefit Description	You pay
<p><b>Reconstructive surgery</b></p> <ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>- The condition produced a major effect on the member’s appearance and</li> <li>- The condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• 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.</li> <li>• Breast reconstructive surgery following a mastectomy for treatment of cancer, such as: <ul style="list-style-type: none"> <li>- Surgery to produce a symmetrical appearance of breasts;</li> <li>- Treatment of any physical complications, such as lymphedemas;</li> <li>- Breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>)</li> </ul> </li> </ul> <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. See <i>Hospital Benefits</i> (Section 5c) and <i>Surgery Benefits</i> (Section 5b).</p>	<p><b>High Option</b></p> <p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <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></li> <li>• <i>Transgender surgeries and related procedures</i></li> </ul>	<p><i>All charges</i></p>
<p><b>Oral and maxillofacial surgery</b></p> <p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> <li>• Treatment of temporomandibular joint (TMJ), including surgical and nonsurgical intervention, corrective orthopedic appliance and physical therapy.</li> </ul> <p>Note: If performed in a hospital setting, see <i>Hospital Benefits</i> (Section 5c) and <i>Surgery Benefits</i> (Section 5b).</p>	<p><b>High Option</b></p> <p>Nothing</p>

Benefit Description	You pay
<p><b>Organ/tissue transplants</b></p> <p>These solid organ transplants are covered. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Intestinal transplants <ul style="list-style-type: none"> <li>- Small intestine</li> <li>- Small intestine with the liver</li> <li>- Small intestine with multiple organs, such as the liver, stomach, and pancreas</li> </ul> </li> <li>• Kidney</li> <li>• Liver</li> <li>• Lung: single/bilateral</li> <li>• Pancreas</li> <li>• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis</li> </ul>	<p><b>High Option</b></p> <p>Nothing</p>
<p>These <b>tandem blood or marrow stem cell transplants for covered transplants</b> are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p> <ul style="list-style-type: none"> <li>• Autologous tandem transplants for <ul style="list-style-type: none"> <li>- Multiple myeloma (de novo and treated)</li> <li>- Recurrent germ cell tumors (including testicular cancer)</li> </ul> </li> </ul>	<p>Nothing</p>
<p><b>Blood or marrow stem cell transplants</b> limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none"> <li>• Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>• Advanced Hodgkin’s lymphoma with reoccurrence (relapsed)</li> <li>• Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed)</li> <li>• Acute myeloid leukemia</li> <li>• Advanced Myeloproliferative Disorders (MPDs)</li> <li>• Advanced neuroblastoma</li> <li>• Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>• Hemoglobinopathy</li> <li>• Infantile malignant osteopetrosis</li> <li>• Kostmann’s syndrome</li> <li>• Leukocyte adhesion deficiencies</li> <li>• Marrow failure and related disorders (i.e., Fanconi’s, PNH, Pure Red Cell Aplasia)</li> </ul>	<p>Nothing</p>

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay
<p><b>Organ/tissue transplants (cont.)</b></p> <ul style="list-style-type: none"> <li>• Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfillippo’s syndrome, Maroteaux-Lamy syndrome variants)</li> <li>• Myelodysplasia/Myelodysplastic syndromes</li> <li>• Paroxysmal Nocturnal Hemoglobinuria</li> <li>• Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)</li> <li>• Severe combined immunodeficiency</li> <li>• Severe or very severe aplastic anemia</li> <li>• Sickle cell anemia</li> <li>• X-linked lymphoproliferative syndrome</li> </ul> <p>Autologous transplants for</p> <ul style="list-style-type: none"> <li>• Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia</li> <li>• Advanced Hodgkin’s lymphoma with reoccurrence (relapsed)</li> <li>• Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed)</li> <li>• Amyloidosis</li> <li>• Breast Cancer</li> <li>• Ependyoblastoma</li> <li>• Epithelial ovarian cancer</li> <li>• Ewing’s sarcoma</li> <li>• Multiple myeloma</li> <li>• Medulloblastoma</li> <li>• Pineoblastoma</li> <li>• Neuroblastoma</li> <li>• Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors</li> </ul>	<p>Nothing</p>
<p><b>Mini-transplants performed in a clinical trial setting</b> (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures:</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none"> <li>• Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>• Advanced Hodgkin’s lymphoma with reoccurrence (relapsed)</li> <li>• Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed)</li> <li>• Acute myeloid leukemia</li> <li>• Advanced Myeloproliferative Disorders (MPDs)</li> <li>• Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>• Hemoglobinopathy</li> <li>• Marrow failure and related disorders (i.e., Fanconi’s, PNH, Pure Red Cell Aplasia)</li> </ul>	<p>Nothing</p>

Benefit Description	You pay
<p><b>Organ/tissue transplants (cont.)</b></p> <ul style="list-style-type: none"> <li>• Myelodysplasia/Myelodysplastic syndromes</li> <li>• Paroxysmal Nocturnal Hemoglobinuria</li> <li>• Severe combined immunodeficiency</li> <li>• Severe or very severe aplastic anemia</li> </ul> <p>Autologous transplants for</p> <ul style="list-style-type: none"> <li>• Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia</li> <li>• Advanced Hodgkin’s lymphoma with reoccurrence (relapsed)</li> <li>• Advanced non-Hodgkin’s lymphoma with reoccurrence (relapsed)</li> <li>• Amyloidosis</li> <li>• Neuroblastoma</li> </ul>	<p><b>High Option</b></p> <p>Nothing</p>
<p>Tandem transplants for covered transplants; Subject to medical necessity</p>	<p>Nothing</p>
<p>These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health <b>approved clinical trial</b> or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient’s condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for <ul style="list-style-type: none"> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Beta Thalassemia Major</li> <li>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>- Multiple myeloma</li> <li>- Multiple sclerosis</li> <li>- Sickle Cell anemia</li> </ul> </li> <li>• Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Chronic lymphocytic leukemia</li> <li>- Chronic myelogenous leukemia</li> <li>- Colon cancer</li> <li>- Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)</li> </ul> </li> </ul>	<p>Nothing</p>

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay
<p><b>Organ/tissue transplants (cont.)</b></p> <ul style="list-style-type: none"> <li>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>- Multiple myeloma</li> <li>- Multiple sclerosis</li> <li>- Myeloproliferative disorders (MSDs)</li> <li>- Non-small cell lung cancer</li> <li>- Ovarian cancer</li> <li>- Prostate cancer</li> <li>- Renal cell carcinoma</li> <li>- Sarcomas</li> <li>- Sickle cell anemia</li> <li>• Autologous Transplants for <ul style="list-style-type: none"> <li>- Advanced Childhood kidney cancers</li> <li>- Advanced Ewing sarcoma</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Childhood rhabdomyosarcoma</li> <li>- Chronic myelogenous leukemia</li> <li>- Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)</li> <li>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>- Mantle Cell (Non-Hodgkin lymphoma)</li> <li>- Multiple sclerosis</li> <li>- Small cell lung cancer</li> <li>- Systemic lupus erythematosus</li> <li>- Systemic sclerosis</li> </ul> </li> </ul>	<p>Nothing</p>
<p>National Transplant Program (NTP)</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those shown above</i></li> <li>• <i>Implants of artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> </ul>	<p><i>All charges</i></p>

Benefit Description	You pay
<b>Anesthesia</b>	<b>High Option</b>
Professional services provided in – <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Hospital outpatient department</li> <li>• Freestanding ambulatory surgical center</li> <li>• Skilled nursing facility</li> <li>• Office</li> </ul>	Nothing

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

**Important things you should 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 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 in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PLAN APPROVAL FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require plan approval.

Benefit Description	You pay
<b>Inpatient hospital</b>	<b>High Option</b>
<p>Room and board, such as</p> <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations</li> <li>• General nursing care</li> <li>• Meals and special diets</li> </ul> <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>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Dressings, splints, casts and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home</li> <li>• Administration of blood and blood products</li> <li>• Blood or blood plasma, if not donated or replaced</li> <li>• Dressings, splints, casts and sterile tray services</li> </ul> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a nondental physical impairment. We do not cover the dental procedures.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Custodial care</i></li> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i></li> </ul>	<i>All charges</i>

*Inpatient hospital - continued on next page*

<b>Benefit Description</b>	<b>You pay</b>
<b>Inpatient hospital (cont.)</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• <i>Private nursing care</i></li> </ul>	<i>All charges</i>
<b>Outpatient hospital or ambulatory surgical center</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Operating, recovery and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a nondental 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>
<b>Skilled nursing care facility benefits</b>	<b>High Option</b>
Skilled nursing facility (SNF): 730 days if the patient meets criteria	Nothing
<i>Not covered: Custodial care</i>	<i>All charges</i>
<b>Hospice care</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• In the home</li> <li>• In a skilled nursing facility</li> </ul>	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>
<b>Ambulance</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Nonemergency ground and air transport when preauthorized (See Section 5(d) for <i>Emergency services/accidents.</i>)</li> </ul>	Nothing

## Section 5(d). Emergency services/accidents

### Important things you should 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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

### What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that requires immediate medical or surgical care because you believe endangers your life or could result in serious injury or disability. Examples include heart attacks, strokes, poisoning, gunshot wounds, deep cuts and broken bones.

### What to do in case of emergency

You're always covered for emergency care — in Michigan, across the country and around the world. Call 911 or go to the nearest emergency room. Be sure to tell the emergency room personnel that you are a member of Blue Care Network so they can notify us. You or a family member should notify your primary care physician within 24 hours unless it is not medically reasonable to do so. It is your responsibility to ensure that this Plan has been notified in a timely manner.

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.

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

Services and treatment provided while you are considered to be admitted for an observation stay are subject to the emergency services copayment. If the emergency results in admission as an inpatient to a hospital, the emergency care copay is waived.

Benefit Description	You pay
<b>Emergency within and outside of our service area</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Emergency care at an urgent care center</li> </ul>	\$15 per visit
<ul style="list-style-type: none"> <li>• Emergency care in a hospital emergency room or as an outpatient at a hospital, including doctors' services</li> </ul> <p>Note: We waive the ER copay if you are admitted as an inpatient to the hospital.</p>	\$100 per visit
<i>Not covered: Elective care or nonemergency care</i>	<i>All charges</i>
<b>Ambulance</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Emergency ground and air transport when medically appropriate.</li> </ul> <p>Note: See 5(c) for nonemergency service.</p>	Nothing

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

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

**Important things you should 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.
- 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 FOR THESE SERVICES.** 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. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. Members must call **1-800-482-5982** to arrange behavioral health services. Also call this number for information about referral procedures, providers and inpatient and outpatient services.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- 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.

Benefit Description	You pay
<b>Professional Services</b>	<b>High Option</b>
<p>When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.</p> <p>Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:</p> <ul style="list-style-type: none"> <li>• Diagnostic evaluation</li> <li>• Crisis intervention and stabilization for acute episodes</li> <li>• Medication evaluation and management (pharmacotherapy)</li> <li>• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment</li> <li>• Treatment and counseling (including individual or group therapy visits)</li> <li>• Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling</li> <li>• Professional charges for intensive outpatient treatment in a provider’s office or other professional setting</li> <li>• Electroconvulsive therapy</li> </ul>	Nothing

Benefit Description	You pay
<b>Diagnostics</b> <ul style="list-style-type: none"> <li>• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner</li> <li>• Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility</li> <li>• Inpatient diagnostic tests provided and billed by a hospital or other covered facility</li> </ul>	<b>High Option</b>  Nothing
<b>Inpatient hospital or other covered facility</b> <ul style="list-style-type: none"> <li>Inpatient services provided and billed by a hospital or other covered facility</li> <li>• Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services</li> </ul>	<b>High Option</b>  Nothing
<b>Outpatient hospital or other covered facility</b> <ul style="list-style-type: none"> <li>Outpatient services provided and billed by a hospital or other covered facility</li> <li>• Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment</li> </ul>	<b>High Option</b>  Nothing
<b>Not covered</b> <ul style="list-style-type: none"> <li>Services that are not part of a preauthorized approved treatment plan</li> </ul>	<b>High Option</b>  <i>All charges</i>

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## Section 5(f). Prescription drug benefits

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### Important things you should keep in mind about these benefits:

- We cover prescribed generic and brand-name drugs (Tier 1 and Tier 2) that are listed in our Custom Formulary. Visit [MiBCN.com/pharmacy](http://MiBCN.com/pharmacy).
- 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.
- 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.

### 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 over 2,000 participating retail pharmacies in the state and 50,000 nationwide or through Medco Health, our mail order pharmacy.
- **We use a closed formulary.** BCN has a closed formulary that is maintained by the BCBSM/BCN Pharmacy and Therapeutics Committee. Generic substitution is mandatory where appropriate. Some drugs on the formulary are part of the BCN Quality Interchange Program and may require step therapy or prior authorization. Requests for *nonformulary drugs* will only be considered when the following criteria have been met:
  - The member has tried and failed to respond to an adequate trial of the available formulary agents from the same drug class, or the available formulary agents would pose unnecessary risk to the member.
  - The prescriber and BCN agree that it is medically necessary.
- **These are the dispensing limitations.** A 30-day supply is the limit for the first prescription of a brand-name drug dispensed for prescriptions filled at participating retail pharmacies. After the initial prescription has been dispensed, the pharmacy can dispense most drugs in 90-day supplies. Specialty drugs, prescription medications for complex and chronic conditions that require special handling, administration or monitoring are limited to a 30-day supply. Certain select specialty drugs are limited to a 15-day supply for the first prescription, reducing your copayment by half.
- BCN has also established quantity limits on certain medications based on clinical criteria and generally acceptable use.

Note: The Plan will approve a prescription for the same medication when it is filled no more than one week in advance of the next fill date. The pharmacy will charge you a separate copayment for each prescription when a vacation supply is requested. For example, if you request a two-month supply, you will be charged two copayments. Plan members called to active military duty or in time of national emergency who need to obtain prescribed medications should call our Customer Service department at 1-800-662-6667.

- **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, you have to pay the difference in cost between the name-brand drug and the generic in addition to your copayment for brand-name formulary drugs.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that contain the same active ingredients and must be equivalent in strength and dosage to the original 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.
- **When do you have to file a claim?** Prescriptions for covered medications filled at non-network pharmacies will be reimbursed based on our negotiated rate, less your copayment in urgent or emergency situations. Prescriptions filled at non-network pharmacies for nonemergency situations are not covered. You must submit proof of payment for prescription services to Customer Service. Visit [www.MiBCN.com/forms](http://www.MiBCN.com/forms) for the Medco Prescription Reimbursement Form.

Benefit Description	You pay
<p><b>Covered medications and supplies</b></p> <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"> <li>• 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></li> <li>• Insulin</li> <li>• Insulin syringes and needles (when dispensed with insulin)</li> <li>• Diaphragms</li> <li>• Injectable contraceptive drugs</li> <li>• Oral contraceptive drugs</li> </ul>	<p><b>High Option</b></p> <p><b>Retail and mail order (1-30-day supply)</b></p> <p>\$5 per prescription for Formulary Preferred (Tier 1) generic drugs  \$50 per prescription for Formulary Option (Tier 2) brand-name drugs</p> <p><b>Retail (84-90 day supply; days 31-83 are not covered)</b></p> <p>\$10 per prescription for Formulary Preferred (Tier 1) generic drugs  \$100 per prescription for Formulary Option (Tier 2) brand-name drugs</p> <p><b>Mail order (31-90 day supply)</b></p> <p>\$10 per prescription for Formulary Preferred (Tier 1) generic drugs  \$100 per prescription for Formulary Option (Tier 2) brand-name drugs</p> <p>Note: If there is no generic equivalent available and a brand-name drug is dispensed, you must pay the brand copayment.</p>
<p>Drugs to treat sexual dysfunction are limited. Contact us at 1-800-662-6667 for dose limits.</p>	<p>50% coinsurance up to the dose limit; all charges thereafter</p>
<p>Fertility drugs</p> <p>Note: These require preauthorization and are covered under this Plan's infertility benefit (see page 22).</p>	<p>50% coinsurance</p>
<p>Tobacco cessation drugs</p> <p>Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence require a written prescription by an approved provider.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Medical supplies such as dressings and antiseptics</i></li> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i></li> <li>• <i>Vitamins and nutritional substances that can be purchased without a prescription</i></li> <li>• <i>Nonprescription medicines</i></li> <li>• <i>Drugs acquired without cost to the providers or included in the cost of other services or supplies</i></li> <li>• <i>Replacement prescriptions resulting from loss, theft or mishandling</i></li> </ul>	<p><i>All charges</i></p>

## Section 5(g). Dental benefits

**Important things you should 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 condition 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.

Benefit Description	You Pay
<b>Accidental injury benefit</b>	<b>High Option</b>
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. To be payable, services have to be provided within 72 hours of the injury.	\$25 per specialist visit

**Dental benefits**

We have no other dental benefits.

## Section 5(h). High Option Healthy *Blue Living* Pilot Program

### About the Pilot Program

Blue Care Network is offering Healthy *Blue Living* to Federal employees in Grand Rapids (Kent, Muskegon, Oceana, Ottawa and Newaygo counties) and Traverse City (Benzie, Leelanau and Grand Traverse counties).

### General features of Healthy *Blue Living*<sup>SM</sup>

As a member of Healthy *Blue Living*, you're eligible for two benefit levels: enhanced and standard.

You automatically have enhanced benefits when you first enroll. Enhanced benefits offer significantly lower copayments when you visit your doctor and get other services. To continue at the enhanced benefit level, you and your covered spouse must complete these steps within the deadlines shown. If you don't, everyone on your contract will move to the standard benefit level 91 days after the start of your plan year. You will remain with standard benefits throughout the plan year.

- **Immediately:** Make an appointment with your BCN primary care physician for a physical exam.
- **Within 90 days of the start of your plan year:** Complete a *Qualification Form* with your physician and return it to BCN. Your doctor will assign a grade for each of six health measures: tobacco, weight, blood pressure, cholesterol, blood sugar and depression. In order to qualify for enhanced benefits, you and your eligible spouse must receive a grade of "A" or "B" for all measures. One or more grades of C will move you to the standard benefit level.
- **Within 90 days of the start of your plan year:** Complete a health assessment, which provides a picture of your health and health risks so you can take active steps toward your wellness goals. The health assessment is available online at [www.MiBCN.com](http://www.MiBCN.com) or by calling Customer Service at 1-800-662-6667.

You may also have these requirements:

- If you use tobacco, you must enroll in BCN's tobacco cessation program **within 120 days of the start of your plan year.**
- If you have a body mass index (BMI) of 30 or higher then you will need to actively participate in a BCN-sponsored weight management program **within 120 days of the start of your plan year.**
- If you have depression, high blood pressure, high cholesterol or high blood sugar, you must follow your doctor's treatment requirements.

Benefit description	You pay	
	Enhanced Benefit	Standard Benefit
<b>Diagnostic and treatment services</b>		
<ul style="list-style-type: none"> <li>• In primary care physician office</li> <li>• In specialist office</li> <li>• At home</li> </ul>	\$5 per visit	\$15 per visit \$25 per visit
<ul style="list-style-type: none"> <li>• During a hospital stay</li> </ul> <p>For details, see Section 5(a) <i>Medical services and supplies provided by physicians and other health care professionals.</i></p>	Nothing	Nothing
<b>Lab, X-ray and other diagnostic tests</b>		
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Nonroutine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Nonroutine mammograms</li> </ul>	Nothing	Nothing

*Lab, X-ray and other diagnostic tests - continued on next page*

Benefit description	You pay	
<b>Lab, X-ray and other diagnostic tests (cont.)</b>	<b>Enhanced Benefit</b>	<b>Standard Benefit</b>
<ul style="list-style-type: none"> <li>• Prenatal ultrasound</li> <li>• Other ultrasound</li> <li>• CAT Scans/MRI</li> <li>• Electrocardiogram and EEG</li> </ul>	Nothing	Nothing
<b>Preventive care, adult and child</b>	<b>Enhanced Benefit</b>	<b>Standard Benefit</b>
Note: For details, see Section 5(a) <i>Medical services and supplies provided by physicians and other health care professionals.</i>	Nothing	Nothing
<b>Maternity care</b>	<b>Enhanced Benefit</b>	<b>Standard Benefit</b>
Prenatal and postnatal care  Note: For details, see Section 5(a) <i>Medical services and supplies provided by physicians and other health care professionals.</i>	\$5 per primary care physician or OB-GYN visit	\$15 per primary care physician or OB-GYN visit
<b>Family planning</b>	<b>Enhanced Benefit</b>	<b>Standard Benefit</b>
Note: For details, see Section 5(a) <i>Medical services and supplies provided by physicians and other health care professionals.</i>	\$5 per visit	\$25 per visit
<b>Infertility services</b>	<b>Enhanced Benefit</b>	<b>Standard Benefit</b>
Note: For diagnosis and treatment details, see Section 5(a) <i>Medical services and supplies provided by physicians and other health care professionals.</i>	50% coinsurance	50% coinsurance
<b>Allergy care</b>	<b>Enhanced Benefit</b>	<b>Standard Benefit</b>
Testing and treatment	Nothing	Nothing
Office visit  Note: For details, see Section 5(a) <i>Medical services and supplies provided by physicians and other health care professionals.</i>	\$5 per visit	\$25 per visit
<b>Treatment therapies</b>	<b>Enhanced Benefit</b>	<b>Standard Benefit</b>
Chemotherapy and radiation  Note: For details, see Section 5(a) <i>Medical services and supplies provided by physicians and other health care professionals.</i>	\$5 per primary care physician visit	\$25 per specialist visit

Benefit description	You pay	
	Enhanced Benefit	Standard Benefit
<b>Physical, speech and occupational therapies</b>		
Note: For details on numbers of visits allowed, see Section 5(a) <i>Medical services and supplies provided by physicians and other health care professionals.</i>	\$5 per visit	\$25 per visit
<b>Hearing services</b>		
Testing treatment and supplies	\$5 per visit	\$25 per visit
Note: For hearing aid coverage, see Section 5 (a) <i>Medical services and supplies provided by physicians and other health care professionals.</i>		
<b>Vision care</b>		
Annual vision exam	\$5 per visit	\$5 per visit
Note: For details, see Section 5(a) <i>Medical services and supplies provided by physicians and other health care professionals.</i>		
<b>Foot care</b>		
When under active treatment for a metabolic or peripheral vascular disease, such as diabetes	\$5 per visit	\$15 per primary care physician visit \$25 per specialist visit
Note: For details, see Section 5(a) <i>Medical services and supplies provided by physicians and other health care professionals.</i>		
<b>Orthopedic and prosthetic devices</b>		
Basic items covered when medically necessary and preauthorized by BCN.	50% of charges	50% of charges
Note: For details, see Section 5(a) <i>Medical services and supplies provided by physicians and other health care professionals.</i>		
<b>Durable medical equipment (DME)</b>		
Rental or purchase when medically necessary and preauthorized	50% of charges	50% of charges
<b>Home health services</b>		
Note: For details, see Section 5(a) <i>Medical services and supplies provided by physicians and other health care professionals.</i>	\$5 per visit	\$25 per visit
<b>Chiropractic care</b>		
Office visit (when referred)	\$5 per visit	\$25 per visit

Benefit description	You pay	
	Enhanced Benefit	Standard Benefit
<b>Surgical procedures</b>		
Note: For details, see Section 5(b) <i>Surgical and anesthesia services provided by physicians and other health care professionals.</i>	Nothing	Nothing
<b>Reconstructive surgery</b>		
Note: For details, see Section 5(b) <i>Surgical and anesthesia services provided by physicians and other health care professionals.</i>	Nothing	Nothing
<b>Oral and maxillofacial surgery</b>		
Note: For details, see Section 5(b) <i>Surgical and anesthesia services provided by physicians and other health care professionals.</i>	Nothing	Nothing
<b>Organ and tissue transplants</b>		
Note: For details, see Section 5(b) <i>Surgical and anesthesia services provided by physicians and other health care professionals.</i>	Nothing	Nothing
<b>Anesthesia</b>		
Provided in an inpatient, outpatient, freestanding facility, skilled nursing facility or in the doctor's office	Nothing	Nothing
<b>Inpatient hospital services</b>		
Room and board, general nursing care, services and supplies  Note: For details, see Section 5(c) <i>Services provided by a hospital or other facility and ambulance services.</i>	Nothing	Nothing
<b>Outpatient hospital and ambulatory surgical center</b>		
Note: For details, see Section 5(c) <i>Services provided by a hospital or other facility and ambulance services.</i>	Nothing	Nothing
<b>Skilled nursing care facility benefits</b>		
Limited to 730 days.  Note: For details, see Section 5(c) <i>Services provided by a hospital or other facility and ambulance services.</i>	Nothing	Nothing
<b>Hospice care</b>		
Note: For details, see Section 5(c) <i>Services provided by a hospital or other facility and ambulance services.</i>	Nothing	Nothing

Benefit description	You pay	
<b>Ambulance</b>	<b>Enhanced Benefit</b>	<b>Standard Benefit</b>
Note: For details, see Section 5(c) <i>Services provided by a hospital or other facility and ambulance services.</i>	Nothing	Nothing
<b>Emergency services</b>	<b>Enhanced Benefit</b>	<b>Standard Benefit</b>
• In an urgent care center	\$10 per visit	\$15 per visit
In a hospital emergency room  Note: We waive the ER copay if you are admitted as an inpatient to the hospital.	\$25 per visit	\$100 per visit
<b>Mental health and substance abuse services</b>	<b>Enhanced Benefit</b>	<b>Standard Benefit</b>
Inpatient and outpatient services when authorized  Note: For details, see Section 5(e) <i>Mental health and substance abuse benefits.</i>	Nothing	Nothing
<b>Prescription drugs</b>	<b>Enhanced Benefit</b>	<b>Standard Benefit</b>
<b>Prescription Drugs — Retail</b> • 1-30-day supply • 84-90-day supply  Note: For details, see Section 5(f). <i>Prescription drug benefits.</i>	<ul style="list-style-type: none"> <li>• \$5 copayment for Formulary Preferred (Tier 1) generic drugs; \$10 copayment for Formulary Option (Tier 2) brand-name drugs</li> <li>• \$10 copayment for Formulary Preferred (Tier 1) generic drugs; \$20 copayment for Formulary Option (Tier 2) brand-name drugs</li> </ul>	<ul style="list-style-type: none"> <li>• \$5 copayment for Formulary Preferred (Tier 1) generic drugs; \$50 copayment for Formulary Option (Tier 2) brand-name drugs</li> <li>• \$10 copayment for Formulary Preferred (Tier 1) generic drugs; \$100 copayment for Formulary Option (Tier 2) brand-name drugs</li> </ul>
<b>Prescription Drugs — Mail Order</b> 90-day supply  Note: For details, see Section 5(f). <i>Prescription drug benefits.</i>	<ul style="list-style-type: none"> <li>• \$10 copayment for Formulary Preferred (Tier 1) generic drugs</li> <li>• \$20 copayment for Formulary Option (Tier 2) brand-name drugs</li> </ul>	<ul style="list-style-type: none"> <li>• \$10 copayment for Formulary Preferred (Tier 1) generic drugs</li> <li>• \$100 copayment for Formulary Option (Tier 2) brand-name drugs</li> </ul>

## Section 5(i). Special features

Feature	Description
<b>BCN's BlueHealthConnection</b>	<p>BCN's BlueHealthConnection is a suite of programs that provide integrated health information to help members stay healthy, get better or improve their quality of life while living with an illness. Under this umbrella of BCN care — comprising health education, disease management, case management — members receive the information, tools and assistance they need to make informed health care choices. To access these programs, call:</p> <p><b>BlueHealthConnection Health Education: 1-800-637-2972</b>            BCN reminds members through various media (<i>Good Health</i> magazine, sent twice a year; online health information; phone calls) to get important health screenings or services. The preventive recommendations include: screening tests for members with diabetes, breast cancer screenings, cervical cancer screenings, childhood and adolescent immunizations, flu vaccines and annual checkups.</p> <p>BCN members can order self-help guides about nutritious eating, exercise, depression, high blood pressure, stress management, losing weight, back pain, cholesterol or quitting smoking.</p> <p><b>BlueHealthConnection Disease Management: 1-800-392-4247</b>            BCN's disease management programs help members better understand and manage their condition to live healthier lives. They feature educational materials and self-management tools mailed to members at their homes. Our programs designed in partnership with primary care physicians help members and their families manage:</p> <ul style="list-style-type: none"> <li>• Asthma</li> <li>• Cardiovascular disease</li> <li>• Chronic kidney disease</li> <li>• Chronic obstructive pulmonary disease</li> <li>• Congestive heart failure</li> <li>• Depression</li> <li>• Diabetes</li> </ul> <p>We also offer disease management programs for rare, chronic and progressive diseases. For more information call Care Management at 1-800-392-2512 to speak with a case manager.</p>
<b>High-risk pregnancies</b>	<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>
<b>Money-saving extras</b>	<p>The Blues help you stay healthy and save money at the same time.</p> <ul style="list-style-type: none"> <li>• <b>Healthy Blue Xtras<sup>SM</sup></b> is a Blues program with special offers from companies across Michigan. Savings cover a variety of healthy goods and services from groceries and fitness gear to yoga and gym packages. Members can access Healthy Blue Xtras from the <a href="http://www.MiBCN.com">www.MiBCN.com</a> home page.</li> <li>• Members can stay healthy 365 days a year by using <b>Blue365<sup>®</sup></b>, a program sponsored by the Blue Cross and Blue Shield Association. Savings cover activities such as fitness, weight control, recreation and alternative medicine. Blue365 also provides helpful resources that allow you to make informed health care decisions. For more information, visit <a href="http://www.MiBCN.com/blue365">www.MiBCN.com/blue365</a>.</li> </ul>

Feature	Description
<b>Blue Distinction Centers®</b>	<p>We've identified hospitals and other facilities that have consistently demonstrated better outcomes and fewer complications in bariatric surgery, cardiac care, complex and rare cancers and transplants. These hospitals and facilities are called Blue Distinction Centers. Part of a national program developed with the Blue Cross and Blue Shield Association and other Blue plans across the country, the Blue Distinction designation helps members and physicians make informed decisions when selecting a quality facility for certain procedures. For a list of these centers, visit our Web site at <a href="http://www.MiBCN.com/coe">www.MiBCN.com/coe</a> or call Customer Service at 1-800-662-6667.</p>
<b>Travel benefits</b>	<p><b>Outside Michigan</b>  BCN members have access to medical care through BlueCard® when they travel in the United States but outside Michigan. BlueCard is a Blue Cross Blue Shield Association program that gives members access to physicians anywhere in the United States outside of Michigan where a Blue Plan is offered. BlueCard can be reached at 1-800-810-BLUE (2583).</p> <p><b>Within Michigan</b>  Members who live away from home but within the BCN service area simply select a primary care physician near their temporary residence. Family members can select primary care physicians from different regions.</p> <p><b>Out of the country</b>  Members are always covered for emergency care — in Michigan, across the country and around the world. Outside the United States, members may be required to pay for services and then seek reimbursement.</p>
<b>Online resources</b>	<p>Our website is a valuable resource for health information as well as for BCN services that can help you get the most from your coverage. Here's what you can do:</p> <ul style="list-style-type: none"> <li>• Complete a health assessment and develop a personal action plan with our online health coach.</li> <li>• Verify eligibility for everyone on your contract.</li> <li>• Order ID cards.</li> <li>• View and print claim summaries.</li> <li>• Change your primary care physician.</li> <li>• Use our Healthcare Advisor™ to research and compare doctors, investigate hospital quality and explore medical and drug treatments.</li> <li>• HBL members can monitor their requirements and check on their benefit levels.</li> </ul> <p>Federal employees can find information about their benefits at <a href="http://MIBCN.com/fehbp">MIBCN.com/fehbp</a>.</p>

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## Non-FEHB benefits available to Plan members

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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 catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow BCN guidelines. For additional information, call BCN's Customer Service department at 1-800-662-6667.

### **Medicare prepaid plan**

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 your FEHB enrollment and changing to a Medicare prepaid plan. Call us at 1-800-529-8360 for information on the Medicare prepaid Plan and the cost of that enrollment.

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## Section 6. General exclusions – things we don't cover

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The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services*.

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs or supplies you receive while you are not enrolled in this Plan.
- Services, drugs or supplies 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 (see specifics regarding transplants).
- 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 transgender procedures.
- 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.
- Costs related to conducting a clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

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## Section 7. Filing a claim for covered services

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This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. 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 a claim, here is the process:

### **Medical and hospital benefits**

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 1-800-662-6667.

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

- Covered member’s name, date of birth, address, phone number 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 payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Member Claims  
Blue Care Network of Michigan  
P.O. Box 68767  
Grand Rapids, MI 49516-8753

### **Prescription drugs**

For pharmacy claims, submit documentation with a completed Medco Drug Reimbursement Form that is available online at [www.MiBCN.com/forms](http://www.MiBCN.com/forms) or by calling Customer Service at 1-800-662-6667. Submit your claims to:

Medco Health Solutions, Inc.  
P.O. Box 14711  
Lexington, KY 40512

### **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.

**Post-service claims procedures**

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

**Authorized Representative**

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

## Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit [www.MiBCN.com/fehbp](http://www.MiBCN.com/fehbp).

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"> <li>a) Write to us within six months from the date of our decision; and</li> <li>b) Send your request to us at:   Appeals and Grievances — Mail Code C248  Blue Care Network  P.O. Box 284  Southfield, MI 48037-0284</li> <li>c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure.</li> <li>d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li> <li>e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.</li> </ul> <p>We will provide you, free of charge and in a timely manner, any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.</p>
<b>2</b>	<p>In the case of a post-service claim, we have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> <li>a) Pay the claim, or</li> <li>b) Write to you and maintain our denial, or</li> <li>c) Ask you or your provider for more information</li> </ul> <p>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.</p> <p>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.</p>

Step	Description
<p><b>3</b></p>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"> <li>• 90 days after the date of our letter upholding our initial decision; or</li> <li>• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or</li> <li>• 120 days after we asked for additional information.</li> </ul> <p>Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"> <li>• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;</li> <li>• Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;</li> <li>• Copies of all letters you sent to us about the claim;</li> <li>• Copies of all letters we sent to you about the claim; and</li> <li>• Your daytime phone number and the best time to call.</li> <li>• Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.</li> </ul> <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim appeals and the exchange of information by telephone, electronic mail, facsimile, or other methods.</p> <p>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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
<p><b>4</b></p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

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 you did not indicate that your claim was for urgent care, then call us at 1-800-662-6667. We will speed up our review (if we have not yet responded to your claim), or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern time.

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## Section 9. Coordinating benefits with other coverage

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### When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

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

When we are the secondary payor, 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.

Coordination of benefits information should be updated at least once a year or whenever your other health insurance information changes. You can update your information online at [www.MiBCN.com/cob](http://www.MiBCN.com/cob).

### What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with end stage renal disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four 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. (If you were a federal employee at any time both before and during January 1983, you will receive credit for your federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-800-486-2048) 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s low-income benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits three months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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.

**Claims process when you have the Original Medicare Plan** – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-662-6667 or visit our Web site at [www.MiBCN.com](http://www.MiBCN.com).

**We do not waive any costs if the Original Medicare Plan is your primary payor.**

You can find more information about how our plan coordinates benefits with Medicare at [www.MiBCN.com/cob](http://www.MiBCN.com/cob).

- **Tell us about your Medicare coverage**  
You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.
  
- **Medicare Advantage (Part C)**  
If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (633-4227), (TTY 1-800-486-2048) or at [www.medicare.gov](http://www.medicare.gov).  
  
If you enroll in a Medicare Advantage plan, the following options are available to you:  
  
**This Plan and another plan's Medicare Advantage plan:** You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments and coinsurance. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.  
  
**Suspended FEHB coverage to enroll in a Medicare Advantage plan:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.
  
- **Medicare prescription drug coverage (Part D)**  
When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

<b>Primary Payor Chart</b>		
<b>A. When you - or your covered spouse - are age 65 or over and have Medicare and you...</b>	<b>The primary payor for the individual with Medicare is...</b>	
	<b>Medicare</b>	<b>This Plan</b>
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) 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) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓ *	
<b>B. When you or a covered family member...</b>		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD <b>(30-month coordination period)</b>		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD <b>(for 30 month coordination period)</b>		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD <b>(for the 30 month coordination period)</b>		✓
• Medicare based on ESRD <b>(after the 30 month coordination period)</b>	✓	
<b>C. When either you or a covered family member are eligible for Medicare solely due to disability and you...</b>		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
<b>D. When you are covered under the FEHB Spouse Equity provision as a former spouse</b>		
	✓	

\*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

**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 TRICARE or CHAMPVA.

**Workers' Compensation**

We do not cover services that:

- You (or a covered family member) 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.

**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.

**When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage**

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

**Clinical Trials**

If you are a participant in a clinical trial, Blue Care Network will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by BCN.

- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care. BCN covers some of these costs, providing we determine the services are medically necessary. Please contact BCN to discuss specific services if you participate in a clinical trial.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials; BCN does not cover these costs.

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## Section 10. Definitions of terms we use in this brochure

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<b>BlueHealthConnection</b>	Blue Care Network offers an integrated health information approach to help members stay healthy, get better or improve their quality of life while living with an illness. Under the BlueHealthConnection umbrella of BCN care — comprising health education, disease management, case management — members receive the information, tools and assistance they need to make informed health care choices.
<b>Calendar year</b>	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.
<b>Clinical Trials Cost Categories</b>	<ul style="list-style-type: none"><li>• Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient’s condition, whether the patient is in a clinical trial or is receiving standard therapy</li><li>• Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care</li><li>• Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes</li></ul>
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. See page 16.
<b>Cost-sharing</b>	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance and copayments) for the covered care you receive.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 16.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Experimental or investigational services</b>	<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"><li>• It has final approval from the appropriate government regulatory bodies;</li><li>• The scientific evidence permits conclusions concerning the effect of the technology on health outcomes;</li><li>• The technology improves the net health outcome; and</li><li>• The technology is as beneficial as any established alternatives.</li></ul> <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>
<b>Health care professional</b>	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
<b>Plan allowance</b>	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways.
<b>Post-service claims</b>	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

**Pre-service claims** Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

**Urgent care claims** A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-662-6667. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

**Us/We** Us and We refer to Blue Care Network.

**You** You refers to the enrollee and each covered family member.

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## Section 11. FEHB Facts

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### Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition 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/health](http://www.opm.gov/insure/health) for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits* brochure 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
- What happens when your enrollment ends
- 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. For information on your premium deductions, you must also contact 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 dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 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 benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

**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.**

• **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

<b>Children</b>	<b>Coverage</b>
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26 <sup>th</sup> birthday.
Foster Children	Foster children are eligible for coverage until their 26 <sup>th</sup> birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but <b>NOT</b> their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at [www.opm.gov/insure](http://www.opm.gov/insure).

• **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 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 cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2012 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2011 benefits until the effective date of your coverage with your new plan. 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.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

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 provide health coverage for you. However, you may be eligible for your own FEHB coverage under either 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 Benefits 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](http://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 (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your federal job, if you are a covered dependent child and you turn 26, 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from [www.opm.gov/insure](http://www.opm.gov/insure). It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

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

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

The Health Insurance Portability 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 at [www.opm.gov/insure/health](http://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 information about federal and state agencies you can contact for more information.

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## Section 12. Other Federal Programs

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### Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pretax money from your salary to reimburse you for eligible dependent care/ or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out of pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long-term care costs, which are not covered under the FEHB Program.

### The Federal Flexible Spending Account Program – *FSAFEDS*

#### What is an FSA?

It is an account where you contribute money from your salary BEFORE taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** — Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26), which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** — Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26), which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible nonmedical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee, you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

#### Where can I get more information about FSAFEDS?

Visit [www.FSAFEDS.com](http://www.FSAFEDS.com) or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

## The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

### **Important Information**

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing limitations for enrollment.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pretax basis.

### **Dental Insurance**

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and X-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.

### **Vision Insurance**

All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

### **Additional Information**

You can find a comparison of the plans available and their premiums on the OPM website at [www.opm.gov/insure/vision](http://www.opm.gov/insure/vision) and [www.opm.gov/insure/dental](http://www.opm.gov/insure/dental). These sites also provide links to each plan's Web site, where you can view detailed information about benefits and preferred providers.

### **How do I enroll?**

You enroll on the Internet at **www.BENEFEDS.com**. For those without access to a computer, call 1-877-888-3337(TTY 1-877-889-5680).

## The Federal Long Term Care Insurance Program – *FLTCIP*

### **It's important protection**

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long-term care services that are not covered by FEHB plans. Long-term care is help you receive to perform activities of daily living — such as bathing or dressing yourself — or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY: 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

## Pre-existing Condition Insurance Program (PCIP)

**Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.**

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit [www.pcip.gov](http://www.pcip.gov) and/or [www.healthcare.gov](http://www.healthcare.gov) or call 1-866-717-5826 (TTY 1-866-561-1604).

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## Summary of benefits for Blue Care Network High Option — 2012

- **Do not rely on this chart alone.** On this page we summarize specific expenses we cover. All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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.

High Option Benefits	You pay	Page
<b>Medical services provided by physicians</b>		
<ul style="list-style-type: none"> <li>• Diagnostic and treatment services in your primary care physician's office</li> </ul>	\$15 copay per visit	20
<ul style="list-style-type: none"> <li>• Care in a specialist's office</li> </ul>	\$25 copay per visit	20
<b>Services provided by a hospital</b>		
<ul style="list-style-type: none"> <li>• Inpatient and outpatient</li> </ul>	Nothing	35-36
<b>Emergency benefits in- and out-of-service area</b>		
<ul style="list-style-type: none"> <li>• Copay waived if admitted to the hospital.</li> </ul>	\$100 copay	37
<b>Home health care service visits</b>	\$25 or 50% of approved amount, whichever is less	26
<b>Prescription drugs</b>		
<ul style="list-style-type: none"> <li>• Retail pharmacy</li> </ul>	\$5 Tier 1 for generic drugs and \$50 for Tier 2 brand-name drugs per prescription fill	41
<ul style="list-style-type: none"> <li>• Mail order and BCN 90-day retail program</li> </ul>	\$10 for Tier 1 generic drugs and \$100 for Tier 2 brand-name drugs per prescription fill	41
<b>Tobacco cessation drugs</b> (over-the-counter and prescription drugs approved by the FDA)	Nothing	41
<b>Dental care</b>		
<ul style="list-style-type: none"> <li>• Accidental injury</li> </ul>	The appropriate copayment may apply.	42
<b>Hearing services</b>		
<ul style="list-style-type: none"> <li>• Hearing exam</li> <li>• Binaural hearing aid for children under 19</li> <li>• Unilateral hearing aid for adults</li> </ul>	Office visit copay may apply.	23
<b>Vision care</b>		
<ul style="list-style-type: none"> <li>• Annual eye exams</li> </ul>	\$5 copay per eye exam	24
<ul style="list-style-type: none"> <li>• Lenses and contact lenses</li> </ul>	\$7.50	24
<ul style="list-style-type: none"> <li>• Frames</li> </ul>	All charges above \$42.50	24
<b>Special features</b> include BlueHealthConnection programs and coverage that travels with you.	Nothing	45-46

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## 2012 Rate Information

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For 2012 health premium information, please see <http://www.opm.gov/insure/health/tribes/rates/> or contact your tribe's Human Resources department.