

Blue Care Network

<http://www.MiBCN.com>



2006

A Health Maintenance Organization (High and Standard Option)

Serving: Most of Michigan

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

Enrollment codes for this Plan:

East Region

- K51 High Option Self Only
- K52 High Option Self and Family
- K54 Standard Option Self Only
- K55 Standard Option Self and Family

Mid Region

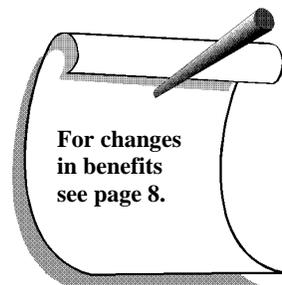
- LN1 High Option Self Only
- LN2 High Option Self and Family
- LN4 Standard Option Self Only
- LN5 Standard Option Self and Family

West Region

- KR1 High Option Self Only
- KR2 High Option Self and Family
- KR4 Standard Option Self Only
- KR5 Standard Option Self and Family

Southeast Region

- LX1 High Option Self Only
- LX2 High Option Self and Family
- LX4 Standard Option Self Only
- LX5 Standard Option Self and Family



This Plan has 2006 accreditation from the NCOA. See the 2006 Guide for more information on accreditation.

Special Notice: Effective Jan. 1, 2006, Blue Care Network will offer a new product called Standard Option.



Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI73-153

Notice of the United States Office of Personnel Management's Privacy Practices

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

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

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

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

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

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

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

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

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

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

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

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

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

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

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

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, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. 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 FEHBP coverage.

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

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

Please be advised

If you lose or drop your FEHBP coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug 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 most other people pay. You may also have to wait until the next open enrollment period 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, 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 coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

Notes

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Introduction

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 Dr.
Southfield, Michigan 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, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means Blue Care Network.
- 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 or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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:
- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 1-800-662-6667 and explain the situation.

If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

OR WRITE TO:

**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); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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.
- 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.

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 reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.htm. 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. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/consumer.jsp. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. We give you a choice of enrollment in a High Option or a Standard Option.

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, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

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

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

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

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

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

BCN members also have responsibilities as outlined in this brochure.

All members have the responsibility to:

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

- Protect their identification card against misuse and contact Customer Service immediately if a card is lost or stolen
- Report all other insurance programs that cover their health and their family's health

Blue Care Network is federally qualified and licensed. BCN is a nonprofit HMO and an affiliate of Blue Cross Blue Shield of Michigan. It formed in February 1998 when four affiliated Blue Care Network organizations (Blue Care Network of East Michigan, Blue Care Network-Great Lakes, Blue Care Network Mid-Michigan and Blue Care Network of Southeast Michigan) merged into a single, new company. Of these former separate entities, BCN of East Michigan is the oldest. It became federally licensed as an HMO in 1975. BCN Mid-Michigan was established in 1977. BCN of Southeast Michigan was licensed in 1981 and BCN-Great Lakes began operation in 1983. If you want more information about us, call 1-800-662-6667 or write to Blue Care Network, 20500 Civic Center Dr., Southfield, Michigan 48076 or visit our Web site at www.MiBCN.com.

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, Shaftsburg and Morrice) and Tuscola counties.

Mid-Michigan

Code LN – Serving Clinton, Eaton, Ingham, Jackson, Livingston and parts of Shiawassee (the towns of Perry, Shaftsburg and Morrice), parts of Ionia (the township of Danby and town of Portland) and Hillsdale (except for Somerset and Wright townships and Waldron Village) counties.

West Michigan

Code KR – Serving these counties: Allegan, Barry, Calhoun, Cass, Kalamazoo, Kent, Muskegon, Oceana, Ottawa, St. Joseph, Van Buren and parts of Berrien, Ionia, Mecosta, Montcalm and Newaygo.

Southeast Michigan

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

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. Blue Care Network is affiliated with BlueCard, 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. 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.

Section 2 How we change for 2006

Do not rely 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.

Changes to this Plan

- Your share of the non – Postal premium will increase by:
 - 18.7% for Self only or 46.0 % for Self and Family for East Michigan (code K5).
 - 27.0 % for Self only or 25.5% for Self and Family for Mid Michigan (code LN).
 - 22.2% for Self only or 18.0% for Self and Family for West Michigan (code KR).
 - 10.4% for Self only or 19.2% for Self and Family for Southeast Michigan (code LX).
- Blue Care Network is offering Standard Option as a new product in addition to High Option.

Changes to High Option only

- We decrease the copay for emergency care as an outpatient within its service area from \$75 per visit to \$50 per visit (waived if admitted)
- We increase the copay for a 90 day supply of mail order prescription drugs from \$5 / \$20 (Generic / Brand Name) to \$10 / \$40 (Generic / Brand Name)
- We change the copay for a 34 day supply of retail prescription drugs from “\$5 or 50% whichever is less for generic drugs / \$20 or 50% whichever is less for brand name drugs” to “\$5 generic / \$20 brand name”

Section 3 How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment or if you need replacement cards, call us at 1-800-662-6667 or write to us at Blue Care Network, 20500 Civic Center Dr., Southfield, MI 48076. You may also request replacement cards through our Web site at www.MiBCN.com

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance. If you use our point-of-service program, you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more.

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

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

- **Primary care**

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

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, female members may self refer to a gynecologist or obstetrician-gynecologist for their annual well-woman exams and routine services.

Here are some other things you should know about specialty care:

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

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB 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 in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-662-6667. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the 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 case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

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

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

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

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

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

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

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

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

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

Section 4 Your cost for covered services

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 services.

Example: When you see your primary care physician you pay a copayment of \$10 per office visit and when you go to the hospital, you pay \$50 per visit for emergency care.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- For High Option there is no deductible.
- For Standard Option, the calendar year deductible is \$500 per person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$1,000.
- The deductible does not apply to the following: periodic physical exams, eye exams, prenatal care, postnatal care, immunizations, allergy serum, prosthetic devices and durable medical equipment, prescription drugs, emergency care except at outpatient facility, outpatient mental health and substance abuse care.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

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

Your catastrophic protection out-of-pocket maximum

For High Option, there is no out-of-pocket maximum.

For Standard Option, after your total \$1,000 per person or \$2,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic out-of-pocket maximum, and you must continue to pay copayments for these services: infertility services, breast reconstructive surgery and treatment of TMJ.

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.

High and Standard Option Benefits

See page 8 for how our benefits changed this year. Page 62 and page 63 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5 High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read the 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 filling advice, or more information about High and Standard Option benefits, contact us at 1-800-662-6667 (1-800-257-9980, TTY) or at our Web site at www.MiBCN.com.

Each option offers unique features.

• **High Option**

- No deductible
- Office visits: You pay \$10 for office visits
- Adult routine physicals and screening: You pay \$10 for periodic routine physicals by your Primary Care provider.
- Maternity care: You pay \$10 for prenatal and postnatal care.
- Prescription drugs. Retail: You pay a \$5 copayment for generic drugs, a \$20 copayment for brand name drugs. Mail order: You pay a \$10 copayment for generic drugs, a \$40 copayment for brand-name drugs.
- Chiropractic care: You pay \$10 per office visit. A referral is required by your primary care physician

• **Standard Option**

- Deductible: \$500 per person / \$1000 per family
- Office visits: You pay \$20 for office visits
- Adult routine physicals and screening: You pay \$20 for periodic routine physicals by your Primary Care provider.
- Maternity care: You pay \$20 for prenatal and postnatal care.
- Prescription drugs. Retail: You pay a \$10 copayment for generic drugs, a \$40 co-payment for brand name drugs. Mail order: You pay a \$20 copayment for generic drugs, a \$80 copayment for brand name drugs.
- Chiropractic Care: Member pays 20% coinsurance after the deductible up to \$1000/\$2000 (self only/ self and family). Your primary care physician must provide a referral.

Note: The deductible does not apply to the following: periodic physical exams, eye exams, prenatal care, postnatal care, immunizations, allergy serum, prosthetic devices, durable medical equipment, prescription drugs, and emergency care except at outpatient facility, outpatient mental health and substance abuse care.

**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.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- For Standard Option, the calendar year deductible is: \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this Section. We added “No deductible” to show when the calendar year deductible does not apply. For High Option, there is no deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
	After the calendar year deductible under Standard Option is paid.	
Note: The calendar year deductible applies to almost all benefits under Standard Option in this Section. We say “(No deductible)” when it does not apply.		

Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$10 per office visit	\$20 per office visit (No deductible)
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion 	\$10 per office visit	\$20 per office visit (No deductible)
<ul style="list-style-type: none"> • At home 	\$10 per office visit	\$20 per office visit (No deductible)

Lab, X-ray and other diagnostic tests	You pay	
	High Option	Standard Option
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • Non-routine mammograms • Prenatal ultrasound 	Nothing; otherwise if you receive these services during your office visit, \$10 copay per office visit.	Nothing; otherwise if you receive these services during your office visit, \$20 copay per office visit. (No deductible)
<ul style="list-style-type: none"> • X-rays • CAT Scans/MRI • Ultrasound (except prenatal) • Electrocardiogram and EEG 	Nothing; otherwise if you receive these services during your office visit, \$10 copay per office visit.	Nothing; otherwise if you receive these services during your office visit, \$20 copay per office visit. (Deductible applies)
Preventive care, adult		
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 – Double contrast barium enema – every five years starting at age 50 – Colonoscopy screening – every ten years starting at age 50 	Nothing; otherwise if you receive these services during your office visit, \$10 copay per office visit..	Nothing; otherwise if you receive these services during your office visit, \$20 copay per office visit. (No deductible)
<ul style="list-style-type: none"> • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older 	Nothing; otherwise if you receive these services during your office visit, \$10 copay per office visit.	Nothing; if you receive these services during your office visit, \$20 copay per office visit. (No deductible)
<ul style="list-style-type: none"> • Routine Pap test <p>Note: The office visit is covered if Pap test is received on the same day; see <i>Diagnostic and treatment services</i>, above.</p>	Nothing; otherwise if you receive these services during your office visit, \$10 copay per office visit.	Nothing; otherwise if you receive these services during your office visit, \$20 copay per office visit. (No deductible)

Preventive care, adult continued on next page.

Preventive care, adult <i>(continued)</i>	You pay	
	High Option	Standard Option
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	Nothing; otherwise if you receive these services during your office visit, \$10 copay per office visit.	Nothing; otherwise if you receive these services during your office visit, \$20 copay per office visit. (No deductible)
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	Nothing; otherwise if you receive these services during your office visit, \$10 copay per office visit.	Nothing; otherwise if you receive these services during your office visit, \$20 copay per office visit. (No deductible)
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>	<i>All charges.</i>
Preventive care, children		
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing; otherwise if you receive these services during your office visit, \$10 copay per office visit.	Nothing; otherwise if you receive these services during your office visit, \$20 copay per office visit. (No deductible)
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> – Vision screening to determine the need for vision exam – Hearing screening to determine the need for hearing exam 	Nothing; otherwise if you receive these services during your office visit, \$10 copay per office visit.	Nothing; otherwise if you receive these services during your office visit, \$20 copay per office visit. (No deductible)

High and Standard Option

Maternity care	You pay	
	High Option	Standard Option
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> • Prenatal care • Postnatal care 	\$10 copay per office visit	\$20 copay per office visit (No deductible)
<ul style="list-style-type: none"> • Delivery 	Nothing (See inpatient hospitalization.)	20% coinsurance (Deductible applies)
Note: Here are some things to keep in mind: <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see this page for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 		
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges.</i>	<i>All charges.</i>
Family planning		
<ul style="list-style-type: none"> • A range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	Nothing; otherwise if you receive these services during your office visit, \$10 copay per office visit. Drugs are paid under the pharmacy benefit.	Nothing; otherwise if you receive these services during your office visit, \$20 copay per office visit. Drugs are paid under the pharmacy benefit. (Deductible applies)
<i>Not covered:</i> <ul style="list-style-type: none"> • Reversal of voluntary surgical sterilization • Genetic counseling 	<i>All charges.</i>	<i>All charges.</i>

High and Standard Option

Infertility services	You pay	
	High Option	Standard Option
<ul style="list-style-type: none"> • Diagnosis and treatment of infertility such as: • Artificial insemination: <ul style="list-style-type: none"> – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) • Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	50% coinsurance	50% coinsurance Out-of-pocket maximum does not apply. (Deductible applies)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>in vitro fertilization</i> – <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> – <i>zygote transfer</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<i>All charges.</i>	<i>All charges.</i>
Allergy care		
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	Nothing	\$20 per office visit (Deductible applies)
<ul style="list-style-type: none"> • Allergy serum 	Nothing	Nothing
<ul style="list-style-type: none"> • Allergy care office visit 	\$10 per office visit	\$20 per office visit (No deductible)
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<i>All charges.</i>	<i>All charges.</i>

High and Standard Option

Treatment therapies	You pay	
	High Option	Standard Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 29.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We only cover GHT when we preauthorize the treatment. Call 1-800-662-6667 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$10 per office visit</p> <p>Outpatient facility setting: no copayment</p>	<p>20% coinsurance (Deductible applies)</p>
Physical and occupational therapies		
<ul style="list-style-type: none"> • 60 visits per condition for the services of the following: <ul style="list-style-type: none"> – qualified physical therapists and – occupational therapists <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>\$10 per office visit</p> <p>\$10 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</p>	<p>\$20 per office visit</p> <p>\$20 per outpatient visit</p> <p>Inpatient: See Hospital Benefits, Section 5(c). (Deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

High and Standard Option

Speech therapy	You pay	
	High Option	Standard Option
60 visits per condition	\$10 per office visit	\$20 per office visit (Deductible applies)
Hearing services (testing, treatment, and supplies)		
Hearing screening performed at your primary care physician's office to determine the need for a hearing exam	\$10 per office visit	\$20 per office visit (Deductible applies)
<i>Not covered:</i> <i>All other hearing testing</i> <i>Hearing aids, testing and examinations for them</i>	<i>All charges.</i>	<i>All charges.</i>
Vision services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> • Annual eye examination from Plan optometrists or ophthalmologists to determine the need for lenses to correct or improve eyesight. • One pair of colorless plastic or glass lenses every 12 months when prescribed or dispensed by a physician or optician. The lenses may be single, bifocal, trifocal or lenticular. • Elective contacts may be chosen instead of spectacle lenses and a frame. There is no copay for elective contacts, but you are responsible for any charges in excess of our allowance. • We pay for one pair of medically necessary contact lenses every 12 months, in lieu of lenses and frames. The member is responsible for the applicable copayment. 	\$5 per eye exam \$7.50 copay	\$5 per eye exam (No deductible) \$7.50 copay (No deductible)
Note: Contact lenses are considered medically necessary if: <ul style="list-style-type: none"> • They are the only way to correct vision to 20/70 in the better eye; or • They are the only effective treatment to correct keratoconus, irregular astigmatism or irregular corneal curvature. We pay for non-medically necessary but prescribed contact lenses. The member is responsible for the difference between the Plan's payment (a maximum of \$35) and the provider's charge for the contact lenses. We do not pay for cosmetic contact lenses that do not improve vision.		
<ul style="list-style-type: none"> • One pair of frames every 24 months 	All charges above \$42.50	All charges above \$42.50 (No deductible)

Vision services continued on next page.

Vision Services (continued)	You pay	
	High Option	Standard Option
<ul style="list-style-type: none"> • Non-Plan providers of vision services are paid at 75 percent of reasonable charges. 	\$5 plus all charges above Plan allowance	\$20 plus all charges above Plan allowance (No deductible)
Note: See <i>Preventive care, children</i> for eye exams for children.		
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. If you live in southeastern Michigan, call 1-800-637-2227; if you live in eastern or mid-Michigan, call 1-800-637-2227; if you live in western Michigan, call 1-800-972-9797 and if you live in the Upper Peninsula, call 1-800-562-7884.		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eye exercises</i> • <i>Photo-sensitive lenses</i> • <i>Non-medically necessary tinted lenses</i> • <i>Safety glasses</i> • <i>Repair or replacement of lost or broken lenses or frames</i> 	<i>All charges.</i>	<i>All charges.</i>
Foot care	High Option	Standard Option
<ul style="list-style-type: none"> • Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. <p>See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$10 per office visit	\$20 per office visit (Deductible applies)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All charges.</i>	<i>All charges.</i>

High and Standard Option

Orthopedic and prosthetic devices	You pay	
	High Option	Standard Option
<ul style="list-style-type: none"> • Prosthetics and orthotics are covered for the basic item and any special features that are medically necessary and preauthorized by BCN. • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of Temporomandibular Joint (TMJ) pain dysfunction syndrome. 	50% of charges	50% of all charges (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Repair or replacement due to loss or damage</i> 	<i>All charges.</i>	<i>All charges.</i>
Durable medical equipment (DME)		
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. This equipment must be obtained from an approved provider. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs; • Motorized wheelchairs if medical criteria are met; • Crutches; 	50% of all charges	50% of all charges (No deductible)

Durable medical equipment continued on next page.

Durable medical equipment (DME) (continued)	You pay	
	High Option	Standard Option
<ul style="list-style-type: none"> • Walkers; • Blood glucose monitors; • Insulin pumps; and • Oxygen therapy <p>Note: Call our DME provider, Northwood, at 1-800-667-8496 as soon as your Plan physician prescribes this equipment. It will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	50% of all charges	50% of all charges (No deductible)
<i>Not covered: Deluxe equipment and items for comfort and convenience</i>	<i>All charges.</i>	<i>All charges.</i>
Home health services		
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	\$10 per visit	\$20 per visit (Deductible applies)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> • <i>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> 	<i>All charges.</i>	<i>All charges.</i>
Chiropractic		
<p>Chiropractic visits require a primary care physician referral.</p> <ul style="list-style-type: none"> • Manipulation of the spine 	\$10 per office visit	\$20 per office visit (Deductible applies)
<ul style="list-style-type: none"> • Chiropractic X-rays of the spine when taken by a chiropractor in the office, limited to \$1,000 per member, \$2,000 per family 	Nothing	20% coinsurance (Deductible applies)
<i>Not covered: All other chiropractic services</i>	<i>All charges.</i>	<i>All charges.</i>

Alternative treatments	You pay	
	High Option	Standard Option
No benefits.	<i>All charges.</i>	<i>All charges.</i>
Educational classes and programs		
<p>Blue Care Network’s Health Education department provides a number of special events each year. Although topics change from time to time, recent examples include programs on general health, healthy cooking, men’s health, women’s health and menopause. BCN sends members a catalog of classes and invitations to special events.</p> <p>The Disease Management Department provides comprehensive programs designed in partnership with primary care physicians to help members and their families manage:</p> <ul style="list-style-type: none"> ● Asthma ● Cardiovascular disease ● Congestive heart failure ● Depression ● Diabetes ● Low back pain ● Migraine 	No charge	No charge
<p>Call to enroll in one of our programs, request self-care materials or our disease-specific newsletters.</p> <p>In addition to these more common ailments, we also offer disease management programs for 14 rare, chronic and progressive diseases. BCN works with Accordant Health Services, Inc. to care for eligible members as identified by BCN or primary care physicians. For more information call Customer Service at 1-800-662-6667.</p> <p>Blue Care Network offers the following programs for all members:</p> <ul style="list-style-type: none"> ● Quit the Nic smoking cessation program - Nicotine replacement therapy prescriptions are a covered benefit for members. Quit the Nic is a voluntary program for members and involves eight telephone counseling sessions with trained counselors during the first 90 days following members’ established smoking quit date. Group counseling sessions are encouraged and are a covered benefit for members. Blue Care Network has developed smoking cessation clinical practice guidelines that are distributed to all physicians. ● Diabetes self-management 		

**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.
- For the Standard Option, the calendar year deductible is: \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. For High Option, there is no deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAPPROVAL OF 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
	After the calendar year deductible under Standard Option is paid.
Note: The calendar year deductible applies to almost all benefits under Standard Option in this Section. We say "(No deductible)" when it does not apply.	

Surgical procedures	High Option	Standard Option
A comprehensive range of services, such as: <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery). The criteria we consider are: <ul style="list-style-type: none"> – BMI – Age – Previous professionally supervised weight loss programs – Patient’s understanding of risks – Presurgical psychological evaluation For more information, call 1-800-662-6667.	\$10 per office visit Outpatient and inpatient – no charge	\$20 per office visit Outpatient and inpatient – 20% coinsurance (Deductible applies)

*Surgical procedures - continued on next page.
High and Standard Option Section 5(b)*

Surgical procedures <i>(continued)</i>	You pay	
	High Option	Standard Option
<ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	\$10 per office visit Outpatient and inpatient – no charge	\$20 per office visit Outpatient and inpatient – 20% coinsurance (Deductible applies)
<ul style="list-style-type: none"> • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns 	\$10 per office visit Outpatient and inpatient – no charge	\$20 per office visit Outpatient and inpatient – 20% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Reconstructive surgery		
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – the condition produced a major effect on the member’s appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance of breasts; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	\$10 per office visit	20% coinsurance (No deductible)

Reconstructive surgery – continued on next page.

Reconstructive surgery (continued)	You pay	
	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All charges.</i>	<i>All charges.</i>
Oral and maxillofacial surgery		
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Treatment of temporomandibular joint (TMJ), including surgical and nonsurgical intervention, corrective orthopedic appliance and physical therapy. 	<p>\$10 per office visit</p> <p>Note: If performed in a hospital setting, see Hospital Benefits (Section 5c) and Surgery Benefits (Section 5b).</p>	<p>\$20 per office visit</p> <p>Note: If performed in a hospital setting, see Hospital Benefits (Section 5c) and Surgery Benefits (Section 5b). (Deductible applies)</p>
Organ/tissue transplants		
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung • Pancreas • Allogeneic (donor) bone marrow transplants 	<p>Nothing. See Hospital Benefits (Section 5c) and Surgery Benefits (Section 5b).</p>	<p>Nothing. See Hospital Benefits (Section 5c) and Surgery Benefits (Section 5b)</p>

Organ/tissue transplants – continued on next page.

Organ/tissue transplants <i>(continued)</i>	You pay	
	High Option	Standard Option
<ul style="list-style-type: none"> Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas National Transplant Program (NTP) Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols. <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing. See Hospital Benefits (Section 5c) and Surgery Benefits (Section 5b).	Nothing. See Hospital Benefits (Section 5c) and Surgery Benefits (Section 5b)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Donor screening tests and donor search expenses, except those performed for the actual donor Implants of artificial organs Transplants not listed as covered 	<i>All charges.</i>	<i>All charges.</i>
Anesthesia		
Professional services provided in – <ul style="list-style-type: none"> Hospital (inpatient) Hospital outpatient department Freestanding ambulatory surgical center Skilled nursing facility 	Nothing	20% coinsurance (Deductible applies)
<ul style="list-style-type: none"> Office 	\$10 per office visit	\$20 per office visit

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.
- For Standard Option in this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. In that case, we added “ deductible applies.” The calendar year deductible is: \$500 per person (\$1,000 per family). High Option has no deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require plan approval.

Benefit Description	You pay	
Note: The calendar year deductible applies only when we say below: “(calendar year deductible applies)”.		
Inpatient hospital	High Option	Standard Option
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen 	Nothing	\$100 copay per day up to three days per admission (Deductible applies)

Inpatient hospital - continued on next page.

Inpatient hospital (continued)	You pay	
	High Option	Standard Option
<ul style="list-style-type: none"> • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts and sterile tray services 	Nothing	\$100 copay per day up to three days per admission (Deductible applies)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	<i>All charges.</i>	<i>All charges.</i>
Outpatient hospital or ambulatory surgical center		
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	Nothing	20% coinsurance (Deductible applies)
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges.</i>	<i>All charges.</i>

Skilled nursing care facility benefits	You pay	
	High Option	Standard Option
<ul style="list-style-type: none"> • Skilled nursing facility (SNF): 730 days if the patient meets criteria 	Nothing	\$100 copay per day up to three days per admission (Deductible applies)
<i>Not covered: Custodial care</i>	<i>All charges.</i>	<i>All charges.</i>
Hospice care		
<ul style="list-style-type: none"> • If hospice care is provided in the home, the home health care benefit applies. 	\$10 per visit	\$20 per visit (Deductible applies)
<ul style="list-style-type: none"> • If hospice care is provided in a skilled nursing facility, the skilled nursing facility benefit applies. 	Nothing	\$100 copay per day up to three days per admission (Deductible applies)
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges.</i>	<i>All charges.</i>
Ambulance		
<ul style="list-style-type: none"> • Non-emergency and emergency ground professional ambulance service when medically appropriate • Air ambulance service when medically appropriate 	Nothing	20% coinsurance (Deductible applies)

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.
- For Standard Option, the deductible does not apply to emergency services except at an outpatient 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.

What is a medical emergency?

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

What to do in case of emergency:

If you have an immediate and unforeseen emergency and taking time to call your primary care physician may mean permanent damage to your health, please call 911 or go to the nearest emergency room. Be sure to tell the emergency room personnel that you are a member of this Plan so they can notify this Plan. You or a family member should notify this Plan and 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.

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

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

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

For High Option, you pay \$50 per visit in a hospital emergency room, \$35 per visit in an urgent care facility and \$10 per visit in a physician's office for emergency care services that are covered benefits of this Plan. For Standard Option, you pay \$75 per visit in a hospital emergency room, \$50 per visit in an urgent care facility and \$20 per visit in a physician's office for emergency care services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

High and Standard Option

Benefit Description	You pay	
Emergency services within and outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$10 per visit	\$20 per visit (No deductible)
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$35 per visit	\$50 per visit (No deductible)
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital, including doctors' services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	\$50 per visit	\$75 per visit (Deductible applies)
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>	<i>All charges.</i>
Ambulance		
<ul style="list-style-type: none"> Non-emergency and emergency professional ambulance service when medically appropriate Air ambulance when medically appropriate Note: See 5(c) for non-emergency service 	Nothing	20% coinsurance (Deductible applies)

Section 5(e) Mental health and substance abuse benefits

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

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.
- For Standard Option, the calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible under Standard Option is paid.
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Note: The calendar year deductible applies to almost all benefits under Standard Option in this Section. We say “(No deductible)” when it does not apply.

Mental health and substance abuse benefits	High Option	Standard Option
<ul style="list-style-type: none"> • All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	\$10 per visit	\$20 per visit (Deductible applies)
<ul style="list-style-type: none"> • Diagnostic tests 	Nothing if you receive these services during your office visit; otherwise \$10 copay applies.	Nothing if you receive these services during your office visit; otherwise \$20 copay applies.

Mental health and substance abuse benefits – continued on next page.

Mental health and substance abuse benefits <i>(continued)</i>	You pay	
	High Option	Standard Option
<ul style="list-style-type: none"> Services provided by a hospital or other facility Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	If performed in an inpatient hospital, please refer to Section 5 (c).	If performed in an inpatient hospital, please refer to Section 5 (c).
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges.</i>	<i>All charges.</i>

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

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

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

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs, brand-name and generic that are listed in the Clinical Formulary, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For Standard Option, the deductible does not apply to prescription drugs.
- 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: 2,200 participating retail pharmacies in the state; 60,000 MedCare pharmacies out-of-state or through Medco Health, our mail order pharmacy. You can order up to a 90-day supply of a mail order prescription for these copayments: High Option — \$10 for generic drugs or \$40 for brand-name drugs, Standard Option — \$20 for generic drugs or \$80 for brand-name drugs.
- **We use a modified, open formulary.** BCN has a modified, open formulary that is maintained by the BCN Pharmacy and Therapeutics Committee. Generic substitution is mandatory where appropriate. Generic substitution is not mandatory for critical drugs. Critical drugs are products where clinical judgment recommends using the brand-name drug because the generic drug cannot be safely substituted. These drugs are Lanoxin, Dilantin, Coumadin, Premarin, Theodur, Slophyllin and Tegretol. A few select drugs on the formulary are part of the BCN Quality Interchange Program and may require prior authorization. Coverage is provided for a nonformulary drug when the Plan and doctor agree that it's medically necessary.
- **These are the dispensing limitations.** A 34-day supply is the limit for most prescription drugs filled at a participating retail pharmacy. The pharmacy may dispense up to a 100-day supply for certain maintenance drugs. Copies of the maintenance drug list can be requested from Customer Service.

Note: The Plan will approve a prescription for the same medication when it is filled at least one week in advance of the next fill date. The pharmacy will charge you a separate copay for each prescription when a vacation supply is requested, e.g., if you request a two-month supply, you will be charged two copays, \$10 for generic drugs or \$40 for brand-name drugs. You may be required to pay the difference in costs between a brand-name drug and the price of its generic equivalent if a dispense-as-written (DAW) prescription is not preauthorized by the Plan. 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 and your physician has not specified Dispense as Written for the name-brand drug, you have to pay the difference in cost between the name-brand drug and the generic.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. You can save money by using generic drugs. However, you and your physician have the option to request a name brand if a generic option is available. Using the most cost-effective medication saves money.
- **When you do have to file a claim?** Prescriptions filled at non-network pharmacies will be reimbursed in full, less your \$5/\$20 copayment for High Option and \$10/\$40 copayment for Standard Option, in urgent or emergency situations. Non-emergency prescriptions will be reimbursed at the Plan's cost, less the \$5/\$20 copayment for High Option and \$10/\$40 copayment for Standard Option. You must submit proof of payment for prescription services to Customer Service.

Prescription drug benefits begin on the next page.

Prescription drugs (continued)		
Benefit Description	You pay	
Covered medications and supplies	High Option	Standard Option
<p>We cover the following medications and supplies when prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as Not covered • Insulin; • Insulin syringes and needles; • Disposable needles and syringes for the administration of covered medications; • Intravenous fluids and medications for home use; • Contraceptive devices, including diaphragms, IUDs and implants; • Injectable contraceptive drugs; • Fertility drugs are covered under this Plan’s infertility benefit with 50 percent coinsurance (see page 20); • Oral contraceptive drugs – up to a 34-day supply; mail order up to a 90-day supply • Smoking cessation drugs and medications or gum • Growth hormone • Appetite suppressants are covered when preauthorized 	<p>Retail (34 day supply)</p> <p>\$5 per prescription for generic drugs</p> <p>\$20 per prescription for brand-name drugs</p> <p>Includes contraceptives.</p> <p>Mail Order (90 day supply)</p> <p>\$10 per prescription for generic drugs</p> <p>\$40 per prescription for brand-name drugs</p> <p>Includes contraceptives.</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>Retail (34 day supply)</p> <p>\$10 per prescription for generic drugs</p> <p>\$40 per prescription for brand-name drugs</p> <p>Includes contraceptives.</p> <p>Mail Order (90 day supply)</p> <p>\$20 per prescription for generic drugs</p> <p>\$80 per prescription for brand-name drugs</p> <p>Includes contraceptives.</p> <p>Note: If there is no generic equivalent available and a brand-name drug is dispensed, you must pay the brand copayment.</p>
<ul style="list-style-type: none"> • Drugs to treat sexual dysfunction are limited. Contact this Plan for dose limits. 	50 percent coinsurance up to the dose limit, all charges thereafter	50 percent coinsurance up to the dose limit, all charges thereafter
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins and nutritional substances that can be purchased without a prescription</i> • <i>Nonprescription medicines</i> 	<i>All charges.</i>	<i>All charges.</i>

Section 5(g) Special features

Feature	Description
<p>Flexible benefits option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> ● We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. ● Alternative benefits are subject to our ongoing review. ● By approving an alternative benefit, we cannot guarantee you will get it in the future. ● The decision to offer an alternative benefit is solely ours and we may withdraw it at any time and resume regular contract benefits. ● Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
<p>BCN's BlueHealthConnection</p>	<p>The BCN BlueHealthConnection health care management model is an array of Blue Care Network programs to help members stay healthy, get better or improve the quality of life while living with an illness. BlueHealthConnection provides members with the information, tools and assistance to make the most informed health care choices. We offer:</p> <p>Blue Care Network's BlueHealthConnection Health Education line: 1-800-637-2972 Members can call for information on health topics, request self-help guides, order a health program catalog or find out about our next health fair.</p> <p>BlueHealthConnection Disease Management line: 1-800-392-4247 We offer comprehensive programs designed in partnership with primary care physicians to help members and their families manage:</p> <ul style="list-style-type: none"> ● Asthma ● Cardiovascular disease ● Congestive heart failure ● Depression ● Diabetes ● Low back pain ● Migraine <p>Call to enroll in one of our programs, request self-care materials or our disease-specific newsletters.</p> <p>In addition to these more common ailments, we also offer disease management programs for 14 rare, chronic and progressive diseases. BCN works with Accordant Health Services, Inc. to care for eligible members as identified by BCN or primary care physicians. For more information call Customer Service at 1-800-662-6667.</p>

<p>Travel benefits</p>	<p>Outside Michigan</p> <p>BCN members can use BlueCard for all their medical care when they travel or live in the U.S. but outside Michigan.</p> <p>BlueCard is a Blue Cross Blue Shield Association program. It 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.</p> <p>Within Michigan</p> <p>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 now select primary care physicians from different regions.</p>
<p>High-risk pregnancies</p>	<p>Our pregnancy program identifies high-risk pregnancies and refers expectant mothers to our case management program for personalized intervention and follow-up. Studies have proven that early intervention in high-risk pregnancies significantly increases positive outcomes.</p> <p>The same program provides education and support to not only pregnant women but to those who are thinking of becoming pregnant.</p> <p>Though our health education program, we encourage expectant parents to attend prenatal education classes offered by BCN network hospitals.</p>
<p>Travel benefit/services overseas</p>	<p>Immunizations to meet foreign travel requirements are a covered benefit. Emergency treatment is also covered. Members must submit bills and documentation.</p>
<p>Educational classes and programs</p>	<p>Blue Care Network’s Health Education Department provides a number of special events each year. Although topics change from time to time, recent examples include programs on general health, healthy cooking, men’s health, women’s health and menopause. BCN sends members a catalog of classes and invitations to special events.</p>

Section 5(h) 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
- Under Standard Option, the calendar year deductible is: \$500 per person (\$1,000 per family). The calendar year deductible applies to all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. 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.

Accidental injury benefit	You pay	
	High Option	Standard Option
<ul style="list-style-type: none"> • 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. 	The appropriate copayment may apply.	The appropriate copayment may apply.

Dental benefits

We have no other dental benefits.

Non-FEHB benefits available to Plan members

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

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

Section 6 General exclusions – things we don't cover

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

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency 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;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7 Filing a claim for covered services

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

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

Medical, hospital benefits and drug benefits

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

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

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

Submit your claims to:

Member Claims
Blue Care Network of Michigan
P.O. Box 68767

Grand Rapids, MI 49516-8767

Deadline for filing your claim

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

When we need more information

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

Section 8 The disputed claims process

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">(a) Write to us within 6 months from the date of our decision; and(b) Send your request to us at: Appeals and Grievances — mail code B845 Blue Care Network 20500 Civic Center Dr. Southfield, MI 48076 <p>And</p> <ul style="list-style-type: none">(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">(a) Pay the claim (or arrange for the health care provider to give you the care); or(b) Write to you and maintain our denial — go to step 4; or(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request — go to step 3.
3	<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.</p> <p>We will write to you with our decision.</p>
4	<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">• 90 days after the date of our letter upholding our initial decision; or• 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or• 120 days after we asked for additional information. <p>Write to OPM at: Office of Personnel Management, Insurance Services Programs, Health Insurance Group III, 1900 E Street, NW, Washington, D.C. 20415-3600.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;• Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records and explanation of benefits (EOB) forms;• Copies of all letters you sent to us about the claim;• Copies of all letters we sent to you about the claim; and• Your daytime phone number and the best time to call. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

The disputed claims process *(continued)*

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

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

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

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

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-662-6667 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

What is Medicare?

Medicare is 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- 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, 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 FEHBP 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 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 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 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.

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

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

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-800-662-6667 or see our Web site at www.MiBCN.com.

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

- **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 (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan:

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, coinsurance, or deductibles. 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 payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHBP plan.

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

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) 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 #1 above	✓	
4) 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	✓	
5) 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 #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
B. When you or a covered family member...		
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 (30-month coordination period)		✓
• 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 payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
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	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

*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 the program.

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 12.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Covered services	Care we provide benefits for, as described in this brochure.
Deductible	The amount that you must pay for covered services under your health plan before benefits are payable.
Experimental or investigational services	<p>A product or procedure is considered not experimental or investigational if it meets all of the following conditions:</p> <ul style="list-style-type: none">• It has final approval from the appropriate government regulatory bodies;• The scientific evidence permits conclusions concerning the effect of the technology on health outcomes;• The technology improves the net health outcome; and• The technology is as beneficial as any established alternatives. <p>The investigational setting may be eliminated if the research and experimental stage of development is completed and the improvement in net health outcome is attainable outside the investigational settings.</p> <p>Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you would be able to accept treatment or procedures that may be recommended by this Plan's providers.</p>
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:
Us/We	Us and We refer to
You	You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

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 for enrollment 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 Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

- **Types of coverage available for you and your family**

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

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

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

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

- **Children’s Equity Act**

OPM has implemented the Federal Employees Health Benefits Children’s Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the 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 2006 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 2005 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.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage** If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse’s enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse’s employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM’s Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)** If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (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 22 or marry, etc.

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

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

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

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

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

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

- **Getting a Certificate of Group Health Plan Coverage** The Health Insurance Portability 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; 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.

Section 12 Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – *FSAFEDS*

• What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$5,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled for 2005, you must make a new election to continue participating in 2006. Enrollment is easy!

- Online: visit www.fsafeds.com and click on Enroll.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for the enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in an FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

• How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2 ½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15 of the following year. For example if you enrolled in FSAFEDS for the 2005 Plan Year, you will have from January 1, 2005 until March 15, 2006 to incur eligible expenses and, you may submit claims for those expenses through May 31, 2006.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

• What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 12 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the High Option of this plan, typical out-of-pocket expenses include:

- \$10 per office visit for diagnostic and treatment services provided in the office
- \$50 per emergency visit (waived if admitted)
- \$5/\$20 (Generic/Brand Name) per prescription filled

The following services are not covered:

- Assisted reproductive technology (ART) procedures
- Provocative food testing and sublingual allergy desensitization
- Hearing aids, testing and examinations for them

Under the Standard Option of this plan, typical out-of-pocket expenses include:

- 20 per office visit for diagnostic and treatment services provided in the office
- \$75 per emergency visit (waived if admitted)
- \$10/\$40 (Generic/Brand Name) per prescription filled

The following services are not covered:

- Assisted reproductive technology (ART) procedures
- Provocative food testing and sublingual allergy desensitization
- Hearing aids, testing and examinations for them

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

• **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

• **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

Health care expenses

The HCFSA is Federal Income tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal

Income Tax return. In addition, money set aside through an HCFSAs is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

Paperless Reimbursement – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSAs, you will have the opportunity to enroll for paperless reimbursement. You must re-enroll every Open Season to remain in the paperless reimbursement program. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

Dependent care expenses

The DCFSAs generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSAs up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.FSAFEDS.com and download the **Dependent Care Tax Credit Worksheet** from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

• Does it cost me anything to participate in FSAFEDS?

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year plus 2 ½ month grace period, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

• Contact us

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

• It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," 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. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care

Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.

- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

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Summary of benefits for Blue Care Network High Option - 2006

Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$10 copay per office visit	16
Services provided by a hospital:		
Inpatient	Nothing	31
Outpatient	Nothing	32
Emergency benefits:		
In and out of service area	\$50 per visit; waived if admitted	35
Mental health and substance abuse treatment:	Regular cost sharing	36
Prescription drugs:		38
Retail	\$5/\$20 per prescription filled	39
Mail Order	\$10/40 per prescription filled	39
Dental care:		42
Accidental injury	The appropriate copayment may apply.	42
Vision care:		22
Annual eye exams	\$5 copay per eye exam	22
Lenses and contact lenses	\$7.50	22
Frames	All charges above \$42.50	22
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. If you live in southeastern Michigan, call 1-800-637-2227; if you live in eastern or mid Michigan, call 1-800-637-2227; if you live in western Michigan, call 1-800-972-9797 and if you live in the Upper Peninsula, call 1-800-562-7884.		
Special features:		40
<ul style="list-style-type: none"> ● Flexible benefits option ● High-risk pregnancies ● Travel benefit/services overseas ● Educational classes and programs 		

Summary of benefits for Blue Care Network Standard Option - 2006

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the \$500 per person, \$1,000 per family calendar year deductible.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office*	\$20 per office visit	16
Services provided by a hospital:		
Inpatient	\$100 copay per day up to three days per admission	31
Outpatient	20% coinsurance	32
Emergency benefits:		
In and out of service area	\$75 per visit, waived if admitted	35
Mental health and substance abuse treatment:		
	Regular cost sharing	36
Prescription drugs:		
		38
Retail pharmacy	\$10/40 per prescription filled	39
Mail order	\$20/80 per prescription filled	39
Dental care:		
		42
Accidental injury	The appropriate copayment may apply.	42
Vision care:		
		22
Annual eye exams	\$5 copay per eye exam	22
Lenses and contact lenses	\$7.50	22
Frames	All charges above \$42.50	22
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. If you live in southeastern Michigan, call 1-800-637-2227; if you live in eastern or mid Michigan, call 1-800-637-2227; if you live in western Michigan, call 1-800-972-9797 and if you live in the Upper Peninsula, call 1-800-562-7884.		
Special features:		
<ul style="list-style-type: none"> • Flexible benefits option • High-risk pregnancies • Travel benefit/services overseas • Educational classes and programs 		40
Protection against catastrophic costs (out-of-pocket maximum):		
Nothing after \$1,000 (self) and \$2,000 (self and family) Some costs do not count toward this protection.		12

Notes

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2006 Rate Information for Blue Care Network

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

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

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

East Region							
<i>Serving these counties:</i> Serving Arenac, Bay, Genesee, Gratiot, Isabella, Lapeer, Midland, Saginaw, Shiawassee (excluding the towns of Perry, Shaftsbury and Morrice) and Tuscola.							
Type of Enrollment	Enrollment Code	<i>Non-Postal Premium</i> <u>Biweekly</u> Government Share	<i>Non-Postal Premium</i> <u>Biweekly</u> Your Share	<i>Non-Postal Premium</i> <u>Monthly</u> Government Share	<i>Non-Postal Premium</i> <u>Monthly</u> Your Share	<i>Postal Premium</i> <u>Biweekly</u> USPS Share	<i>Postal Premium</i> <u>Biweekly</u> Your Share
High Option Self Only	K51	\$138.45	\$46.15	\$299.98	\$99.99	\$163.83	\$20.77
High Option Self and Family	K52	\$316.08	\$200.23	\$684.84	\$433.83	\$373.15	\$143.16
Standard Option Self Only	K54	\$105.13	\$35.04	\$227.78	\$75.92	\$124.40	\$15.77
Standard Option Self and Family	K55	\$293.93	\$97.97	\$636.84	\$212.28	\$347.81	\$44.09

(Continued on the next page.)

Mid-Michigan Region

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

Type of Enrollment	Enrollment Code	<i>Non-Postal Premium Biweekly Government Share</i>	<i>Non-Postal Premium Biweekly Your Share</i>	<i>Non-Postal Premium Monthly Government Share</i>	<i>Non-Postal Premium Monthly Your Share</i>	<i>Postal Premium Biweekly USPS Share</i>	<i>Postal Premium Biweekly Your Share</i>
High Option Self Only	LN1	\$139.18	\$103.33	\$301.56	\$223.88	\$164.31	\$78.20
High Option Self and Family	LN2	\$316.08	\$267.91	\$684.84	\$580.47	\$373.15	\$210.84
Standard Option Self Only	LN4	\$124.61	\$41.53	\$269.98	\$89.99	\$147.45	\$18.69
Standard Option Self and Family	LN5	\$300.08	\$100.02	\$650.16	\$216.72	\$355.09	\$45.01

West Region

Serving these counties: Allegan, Barry, Calhoun, Cass, Kalamazoo, Kent, Muskegon, Oceana, Ottawa, St. Joseph, Van Buren and parts of Berrien, Ionia, Mecosta, Montcalm and Newaygo.

Type of Enrollment	Enrollment Code	<i>Non-Postal Premium Biweekly Government Share</i>	<i>Non-Postal Premium Biweekly Your Share</i>	<i>Non-Postal Premium Monthly Government Share</i>	<i>Non-Postal Premium Monthly Your Share</i>	<i>Postal Premium Biweekly USPS Share</i>	<i>Postal Premium Biweekly Your Share</i>
High Option Self Only	KR1	\$139.18	\$95.04	\$301.56	\$205.92	\$164.31	\$69.91
High Option Self and Family	KR2	\$316.08	\$361.01	\$684.84	\$782.19	\$373.15	\$303.94
Standard Option Self Only	KR4	\$100.67	\$33.55	\$218.11	\$72.70	\$119.12	\$15.10
Standard Option Self and Family	KR5	\$291.24	\$97.08	\$631.02	\$210.34	\$344.63	\$43.69

(Continued on next page.)

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

Type of Enrollment	Enrollment Code	<i>Non-Postal Premium Biweekly Government Share</i>	<i>Non-Postal Premium Biweekly Your Share</i>	<i>Non-Postal Premium Monthly Government Share</i>	<i>Non-Postal Premium Monthly Your Share</i>	<i>Postal Premium Biweekly USPS Share</i>	<i>Postal Premium Biweekly Your Share</i>
High Option Self Only	LX1	\$108.43	\$36.14	\$234.93	\$78.31	\$128.31	\$16.26
High Option Self and Family	LX2	\$316.08	\$116.76	\$684.84	\$252.98	\$373.15	\$59.69
Standard Option Self Only	LX4	\$81.71	\$27.24	\$177.05	\$59.01	\$96.69	\$12.26
<i>Standard Option Self and Family</i>	<i>LX5</i>	<i>\$244.48</i>	<i>\$81.49</i>	<i>\$529.70</i>	<i>\$176.57</i>	<i>\$289.30</i>	<i>\$36.67</i>