Blue Care Network of Michigan

www.bcbsm.com

Customer service 800-662-6667

2026

A Health Maintenance Organization (High Option)

IMPORTANT
- Rates: Back Cover
- Changes for 2026: Page 15
- Summary of Benefits: Page 79

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See our FEHB Facts, page 7 for details. This plan is accredited. See Section 1, page 12.

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See Page 13 for requirements.

Postal Employees and Annuitants are no longer eligible for this plan. (unless currently under Temporary Continuation of Coverage)

Enrollment codes for this Plan:

Southeast Region
LX1 High Option Self Only
LX3 High Option Self Plus One
LX2 High Option Self and Family

Note: Plan Code K5 and its service area was terminated as of December 31, 2025

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-153

Important Notice from Blue Care Network of Michigan about
Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) 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 800-772-1213, (TTY: 800-325-0778).

Additional Premium for Medicare's High Income Members Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

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

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of Blue Care Network of Michigan (BCN) under contract (CS 2011) between Blue Care Network of Michigan and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law.

Customer service may be reached at 800-662-6667 or through our website: www.bcbsm.com. If you are deaf, hearing impaired or speech impaired, you can contact our Customer Service at 800-662-6667, TTY 711. If you need ASL providers see our website at www.bcbsm.com. The address for Blue Care Network of Michigan's administrative office is:

Blue Care Network Michigan

411 E. Jefferson Ave.

Detroit, MI 48226

This brochure is the official statement of benefits. No verbal 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 Plus One or 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, 2026, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2026, and changes are summarized in Section 2. Rates are shown at the end of this brochure.

Plain Language

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

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

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

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

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.

- 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 800-662-6667 and explain the situation.
  - If we do not resolve the issue:

CALL
THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go to

www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW — Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26)

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a family member, 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 (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not an eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, sex (pregnancy, or genetic information). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex (pregnancy, or genetic information).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

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

- Bring the actual medications or give your doctor and pharmacist a list of all the medications and dosages that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- 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 medication 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 medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understanding both the generic and brand names for all of your medication(s) is important. This helps ensure you do not receive double dosing from taking both a generic and a brand of the same medication. It also helps you avoid taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia and any medications you are taking.

Patient Safety Links

For more information on patient safety, please visit

- www.jointcommission.org/speakup.aspx. The Joint Commission’s Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspxThe Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/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 healthcare providers and improve the quality of care you receive.
- https://psnet.ahrq.gov/issue/national-patient-safety-foundation. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- 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 healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

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

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

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.

- **Minimum essential coverage (MEC)**

  Coverage under this Plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that 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, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee, and one or more eligible family members. Family members include your spouse and your children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or 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 Plus One or 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 Plus One or 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or 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 in Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- 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 Plus One or Self and Family, as appropriate, 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 a Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. 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 processed according to the 2026 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. **However**, if your prior plan left the FEHB Program at the end of 2025, you are covered under that plan's 2025 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC).

- **Upon divorce**

If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You **must** contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, 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 or Tribal job, or if you are a covered child and you turn 26.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

Converting to individual coverage

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-662-6667 or visit our website at **www.bcbsm.com.**

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Blue Care Network of Michigan holds the following accreditations: National Commitee for Quality Assurance (NCQA). To learn more about this plan's accreditation (s), please visit the following websites: www.ncqa.org. We require you to see specific physicians, hospitals and other providers that contract with us. Our Plan providers coordinate your health care services, and we are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory by calling 800-662-6667 or by visiting our website www.bcbsm.com/find-a-doctor.

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 coinsurance and copayments as applicable and 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.

General features of our High Option

Under the High Option, there is no calendar year deductible. Your required cost-share for most benefits are copayments; however, a few do require coinsurance. The plan also has an out-of-pocket maximum of $6,350 Self, $12,700 for Self Plus One and $12,700 Self and Family. Medical and prescription copayments and coinsurance count toward this annual out-of-pocket maximum.

Preventive care services are covered with no cost-sharing and are not subject to copayments when received from a network provider.

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 cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

More than 20,000 participating physicians (primary care providers and specialists) provide health care services to Blue Care Network of Michigan enrollees. These doctors are located in private offices and medical centers throughout the service area. We also contract with all acute care hospitals in Michigan.

Your rights and responsibilities
OPM requires that all FEHB plans provide certain information to their FEHB members about us, our networks and our providers. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

Blue Care Network of Michigan 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 Blue Care Network of Michigan Member Grievance program
- Receive written information about Blue Care Network of Michigan, its services, practitioners and providers and member rights and responsibilities in a clear and understandable manner
- Know Blue Care Network of Michigan's financial relationships with its health care facilities or primary care provider groups

Blue Care Network of Michigan members also have responsibilities as outlined in this brochure. All members have the responsibility to:

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

Blue Care Network of Michigan is a nonprofit HMO, an affiliate of Blue Cross Blue Shield of Michigan and an independent licensee of the Blue Cross and Blue Shield Association. It was formed in February 1998 when four affiliated Blue Care Network of Michigan organizations (Blue Care Network of East Michigan, Blue Care Network-Great Lakes, Blue Care Network Mid-Michigan and Blue Care Network of Southeast Michigan) merged into a single, new company.

If you want more information about us, call 800-662-6667, write to Blue Care Network of Michigan, 26255 American Dr., Southfield, MI 48034, Mail Code A02A or visit our website at www.bcbsm.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.bcbsm.com to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

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

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

Southeast Michigan — Code LX
Serving Lenawee, Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw and Wayne counties.

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

Out-of-Area Care

Members can obtain follow up and urgent care when traveling outside of Michigan, but still in the U.S. when you use a Blue Plan provider.

For more information, call 1-800-810-BLUE (2583). Members living away from home for part of the year — students at college, for instance — can also use a Blue Plan provider outside Michigan (but still in the U.S.) for routine care. Call your primary care provider before travel to arrange for coordinated care and required authorizations.

Section 2. Changes for 2026 for Blue Care Network of Michigan

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

- **Premium Rates –** Your share of the premium rate will increase for Self Only or increase for Self and Family. (See Rate Information, page 83.)

High Option

Benefit changes

- **Treatment of Gender Dysphoria –** Exclude coverage for surgical treatment for the purposes of gender transition for all individuals. (Please see page 63). If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. (See page 17).
- **Hormone Therapy –** Exclude coverage for hormone therapy (masculinization/feminization) for the purpose of gender transition for all individuals. (Please see page 63). If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. (See page 17).
- **Primary Care Physician Visit –** Increase the copay to $25 per primary care provider visit. (See page 27).
- **Specialist Visit** – Increase the member copay to $50 per specialist visit. (See page 27).
- **Urgent Care (Diagnostic and Treatment Services/Emergency Services/Accidents) –** Increase the copay for Urgent Care to $50 per visit or 50% of the approved amount, whichever is less. (See pages 28 and 51).
- **Advanced Diagnostic Imaging –** Increase the copay to $100 (see page 29) for the following services:
  - Magnetic Resonance Imaging (MRI)
  - Magnetic Resonance Angiography (MRA)
  - Computerized Axial Tomography (CAT)
  - Positron Emission Tomography (PET)
- **Physical, Occupational and Speech Therapies –** Increase the copays for Physical, Occupational and Speech therapy to $50 per visit. (See page 36).
- **Inpatient Hospital –** Add a co-pay for inpatient hospital of $100 per day up to $500 per admission. (See page 49).
- **Outpatient Surgery –** Add a $200 copay for the following services when performed in an outpatient facility setting. Authorization is required. (See page 50).
  - Surgical procedures
  - Reconstructive surgery
  - Oral and maxillofacial surgery
  - Organ/tissue transplant
- **Procurement of Sperm and Egg –** Add coverage for the procurement of sperm and egg. The copay will be $200. Authorization is required. (See page 35).
- **Ambulance (Emergency Services) –** Add a $100 copay for ambulance transport services. Authorization is required. (See page 27).

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 800-662-6667 or write to us at Blue Care Network of Michigan, 26255 American Dr., Southfield, MI 48034, Mail Code A02A. You may also request replacement cards through our website at www.bcbsm.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 but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care provider or by another participating provider in the network.

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

Plan providers

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list Plan providers in our provider directory, which we update periodically. You can also find Plan providers in your area on our website at www.bcbsm.com/find-a-doctor.

Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, pregnancy or genetic information.

This plan provides Care Coordinators for complex conditions and can be reached at 800-662-6667 for assistance.

- **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 our provider directory, which we update periodically. You can also find Plan facilities in your area on our website at www.bcbsm.com/find-care.

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 provider. This decision is important since your primary care provider provides or arranges for most of your health care.

- **Primary care**

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

If you want to change primary care provider or if your primary care provider leaves the Plan, call us. We will help you select a new one. You may also change primary care providers through our website at www.bcbsm.com/find-care.

- **Specialty care**

Your primary care provider will refer you to a specialist for needed care. When you receive a referral from your primary care provider, you must return to the primary care provider after the consultation, unless your primary care provider authorizes a certain number of visits without additional referrals. The primary care provider must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care provider gives you a referral.

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 provider will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

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

If they decide to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, 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.
- You may continue seeing your specialist for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you lose access to your specialist because:
  - we terminate our contract with your specialist for other than cause;
  - we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - we reduce our service area and you enroll in another FEHB plan;

Contact us at 800-662-6667 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.

> Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

Sex-Trait Modification: If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care. Our exception process is as follows: The exception process will be applied on a case-by-case basis. In order to apply for an exception to the exclusion of sex-trait medical interventions/transgender services call our customer service office at 1-800-662-6667. You will also find more information on our member website atbcbsm.com/fep/bcn. If you disagree with this information, please contact our customer service at 1-800-662-6667 to speak to a representative.

Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.

- **Hospital care**

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

If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Service department immediately at 800-662-6667. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

- you are discharged, not merely moved to an alternative care center;
- 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 cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

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

Your primary care doctor must get prior approval from Blue Care Network of Michigan for certain services. Failure to do so may result in no coverage of services.

- **Inpatient hospital admission**

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

- **Other services**

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

- Reconstructive surgery
- Transplants
- Certain infertility treatments
- Nursing home care
- Physical/occupational/speech therapy
- Cardiac/pulmonary rehabilitation
- Surgical treatment of morbid obesity
- Growth hormone therapy
- Genetic testing and treatment
- Inpatient admissions
- Diagnosis, evaluation and treatment for autism spectrum disorders
- Chiropractic care
- Dental services

- Durable medical equipment
- Orthotics and prosthetics
- Orthognathic surgery
- Pain management
- High tech radiology procedures
- TMJ treatment
- Nonemergency ambulance

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

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

Next, provide the following information:

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

Non-urgent care claims

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

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

Urgent care claims

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-662-6667. You may also call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-662-6667. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

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

- **Emergency inpatient admission**

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

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

If your treatment needs to be extended

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

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

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

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 800-662-6667.

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

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

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

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

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

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

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

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your Costs for Covered Services

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

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: In the High Option Plan, when you see your primary care provider you pay a copayment of $25 per office visit and when you go to the hospital emergency room you pay $100 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. This Plan does not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 50% of our allowance for durable medical equipment and prosthetics and orthotics.
Differences between our Plan allowance and the bill	You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.
Your catastrophic protection out-of-pocket maximum	After your (deductible, copayments and coinsurance) reaches the out-of-pocket maximum you do not have to pay any more for covered services, with the exception of certain cost sharing for the services below which do not count toward your catastrophic protection out-of-pocket maximum. • Dental discount benefits • Eyeglasses or contact lenses • Premiums paid • Balance bills charged • Health Care Services not covered by Blue Care Network of Michigan. This includes services that exceed benefit limits such as day and limit visits • Expenses from utilizing out-of-network providers Your out-of-pocket maximum for services rendered during the 2026 calendar year is: Self Only: $6,350 in network Self Plus One: $6,350 per person Self and Family: $12,700 Your out-of-pocket maximum may differ if you changed plans at Open Season. The maximum annual limitation on cost sharing listed under Self Only of $6,350 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.

Example Scenario: Your plan has a $6,350 Self Only maximum out-of-pocket limit and a $12,700 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $6,350 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $12,700, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $6,350 for the calendar year before their qualified medical expenses will begin to be covered in full.

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 prior 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 prior 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 prior 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 prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When government facilities bill us

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

Important Notice About Surprise Billing - Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

In addition, your health plan adopts and complies with the surprise billing laws of Michigan and NSA.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.bcbsm.com/important-information/federal-no-surprises-act or contact the health plan at 800-662-6667.

The Federal Flexible Spending Account Program – *FSAFEDS*

- **Healthcare FSA (HCFSA)** – Reimburses an FSA participant for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, over-the-counter drugs and medications, vision and dental expenses, and much more) for their tax dependents, and their adult children (through the end of the calendar year in which they turn 26).
- **FSAFEDS** offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. High Option Table of Contents

See Page 15 for how our benefits changed this year. See Page 79 for a benefit summary.

Section 5. High Option Benefits Overview

Section 5 for the High Option Benefit is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice or more information about benefits, call us at 800-662-6667 (TTY: 711) or visit our website at www.bcbsm.com.

High Option

- **No deductible**
- **Out-of-pocket maximum**
  There is an out-of-pocket maximum of $6,350 for Self Only, $12,700 for Self Plus One or $12,700 per Self and Family. Medical and prescription copayments and coinsurance count toward this annual out-of-pocket maximum.
- **Coinsurance**
  50% of the BCN approved amount for durable medical equipment; prosthetics/orthotics; infertility; orthognathic surgery; reduction mammoplasty and male mastectomy
- **Office visits**
  You pay $25 for visits to your primary care provider
  You pay $50 for visits to a specialist
- **Adult and child preventive care (physicals and screenings)**
  Covered in full
- **Maternity care**
  Covered in full
- **Emergency care**
  $100 copayment
- **Ambulance**
  $100 for each transport. Authorization required.
- **Prescription drugs**
  • **30-day retail and mail order:** $10 for Tier 1 (mostly generic drugs); $30 for Tier 2 (preferred brand-name drugs); $60 for Tier 3 (nonpreferred brand-name drugs).
  • **90-day retail and mail order:** $20 for Tier 1 drugs; $60 for Tier 2 drugs; $120 for Tier 3 drugs. Specialty drugs are limited to a 30-day supply.
  • **30-day retail and mail order specialty drugs:** 20% coinsurance up to a maximum of $100 for Tier 4 specialty preferred; 20% coinsurance up to a maximum of $200 for Tier 5 specialty nonpreferred. Certain select specialty drugs are limited to a 15-day supply for the first prescription, reducing your copayment by half.

  Note: If you get a brand-name drug when a generic equivalent is on the BCN Custom Drug List, you have to pay the difference in cost between the brand-name drug and the generic in addition to your copayment for the Tier 2 or Tier 4 drug — unless your provider receives prior approval to designate the brand-name drug.
- **Hearing services**
  BCN will cover, in full, up to two hearing aids in the TruHearing formulary every 36 months regardless of age. Members may choose any hearing aid available through the TruHearing formulary at no out-of-pocket cost. The copays will be $25 primary care/$50 per specialist.
- **Chiropractic care**
  You pay $50 per office visit. Requires plan approval and a referral from your primary care provider.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- There is an out-of-pocket maximum of $6,350 Self/$12,700 Self and Family. Medical and prescription copayments and coinsurance count toward this annual out-of-pocket maximum.
- 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.
- This Plan does not have a 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 coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians (except preventive care): • In a primary care provider (PCP) office	$25 per visit
• In a specialist office	$50 per visit
• Office medical consultations	$25 per primary care provider visit $50 per specialist visit
• In a skilled nursing facility	$25 per primary care provider visit $50 per specialist visit
• Initial examination of a newborn child	$25 per primary care provider visit $50 per specialist visit
• At home	$25 per primary care provider visit $50 per specialist visit
• Second surgical opinion	$50 per visit
• In an urgent care center	$50 per visit or 50% of the approved amount, whichever is less
• During a hospital stay	Nothing
• Online care	Nothing
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*

Benefit Description	You pay
Telehealth services	**High Option**
Telemedicine services	$25 per primary care provider visit $50 per specialist visit
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Nonroutine pap test • Pathology • X-ray • Nonroutine mammogram • Ultrasound • Electrocardiogram and EEG	• Nothing if received during your office visit; otherwise the following office visits may apply: $25 per primary care provider visit $50 per specialist visit
High technology imaging when performed in an outpatient facility setting (excluding emergency services and observation), free standing imaging center or in an office: Magnetic Resonance Imaging (MRI) Magnetic Resonance Angiolgraphy (MRA) Computerized Axial Tomography (CAT) Positron Emission Tomography (PET)	$100 per day per provider for any combination of outpatient high technology imaging services
Preventive care, adult	**High Option**
Routine physical every year. The following preventive services are covered at the time interval recommended at each of the links below. • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	Nothing
Routine mammogram	Nothing
Adult immunizations as endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/imz-schedules/index.html	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy – nutritional counseling 6 per calendar year; intensive behavioral counseling up to 26 per calendar year with BMI of 30 or higher. • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Nutritional, obesity, and weight counseling are covered services through the medical plan. These visits offer physician guidance to patients seeking to reach and maintain a healthy weight. Additionally, Blue Care Network also works with Teladoc Health to offer Teladoc Health Condition Management Solutions, a suite of solutions that offer an opportunity for people to prevent or manage their diabetes, hypertension and to achieve a healthy weight as well as addressing other associated conditions. This suite includes a diabetes management solution, diabetes prevention solution, hypertension management solution and a weight management solution. All four solutions provide members with connected technology and coaching by experts to help them understand how managing their conditions can have a positive effect on their overall health: • Diabetes Management: Data-driven digital health program that removes hurdles to proper diabetes management, including disease education and access to a Glucometer and free testing supplies. • Diabetes Prevention: Digital diabetes prevention program that helps people achieve health goals through sustainable lifestyle changes to reduce the risk of developing Type 2 diabetes. • Hypertension Management: Helps members develop healthy habits and control their blood pressure to better manage and improve their heart health with the cellular-connected blood pressure monitor. • Weight Management: Digital weight management prevention program that helps people achieve their health goals through sustainable lifestyle changes.	In-network: Nothing Out-of-network: All charges

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
Blue Care Network offers an online health assessment that helps you get a picture of your current health and your health risks. Weight is one of 11 modifiable areas addressed in the health assessment. If the assessment indicates weight should change, members receive tips for lowering their weight and may be invited to enroll in Digital Health Assistant tools including Lose Weight, Eat Better and Enjoy Exercise. Online tools for weight management include the Lose Weight Digital Health Assistant program. Members may also access healthy recipes, calorie trackers, diet trackers, online articles, news, tools, and other nutrition related content through their member account at bcbsm.com. In addition, Blue365®, our national savings program sponsored by the Blue Cross and Blue Shield Association, offers members big savings and discounts on weight management programs, gym memberships, family care and healthy travel getaways with many well-known companies. Blue Care Network members are encouraged to participate in these lifestyle management solutions to accompany drug treatment of obesity. Note: When anti-obesity medication is prescribed. See section 5(f). Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b).	In-network: Nothing Out-of-network: All charges
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Medications for travel or work-related exposure.*	*All charges*
Preventive care, children	**High Option**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows:	In network: Nothing Out of network: All Charges

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High Option**
• Intensive nutrition and behavioral weight-loss counseling therapy – nutritional counseling 6 per calendar year; intensive behavioral counseling up to 26 per calendar year with BMI of 30 or higher. • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Nutritional, obesity, and weight counseling are covered services through the medical plan. These visits offer physician guidance to patients seeking to reach and maintain a healthy weight. Additionally, Blue Care Network also works with Teladoc Health to offer Teladoc Health Condition Management Solutions, a suite of solutions that offer an opportunity for people to prevent or manage their diabetes, hypertension and to achieve a healthy weight as well as addressing other associated conditions. This suite includes a diabetes management solution, diabetes prevention solution, hypertension management solution and a weight management solution. All four solutions provide members with connected technology and coaching by experts to help them understand how managing their conditions can have a positive effect on their overall health: • Diabetes Management: Data-driven digital health program that removes hurdles to proper diabetes management, including disease education and access to a Glucometer and free testing supplies. • Diabetes Prevention: Digital diabetes prevention program that helps people achieve health goals through sustainable lifestyle changes to reduce the risk of developing Type 2 diabetes. • Hypertension Management: Helps members develop healthy habits and control their blood pressure to better manage and improve their heart health with the cellular-connected blood pressure monitor. • Weight Management: Digital weight management prevention program that helps people achieve their health goals through sustainable lifestyle changes. Blue Care Network offers an online health assessment that helps you get a picture of your current health and your health risks. Weight is one of 11 modifiable areas addressed in the health assessment. If the assessment indicates weight should change, members receive tips for lowering their weight and may be invited to enroll in Digital Health Assistant tools including Lose Weight, Eat Better and Enjoy Exercise. Online tools for weight management include the Lose Weight Digital Health Assistant program. Members may also access healthy recipes, calorie trackers, diet trackers, online articles, news, tools, and other nutrition related content through their member account at bcbsm.com. In addition, Blue365®, our national savings program sponsored by the Blue Cross and Blue Shield Association, offers members big savings and discounts on weight management programs, gym memberships, family care and healthy travel getaways with many well-known companies. Blue Care Network members are encouraged to participate in these lifestyle management solutions to accompany drug treatment of obesity. Note: When anti-obesity medication is prescribed. See section 5(f).	In network: Nothing Out of network: All Charges

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High Option**
Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b).	In network: Nothing Out of network: All Charges
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care and Postpartum care • Screening for gestational diabetes • Delivery • Screening and counseling for prenatal and postpartum depression • Breastfeeding and lactation support, supplies and counseling for each birth 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. Blue Cross Coordinated Care targets high-risk maternity members, and nurse care managers will support members with more complex comorbid situations. The nurse care managers will work with members to create care plans with goals aligning with best-practice interventions to help members reach desired outcomes. In addition, nurse care managers will refer members to high-performing providers and condition-specific programs based on the members' available benefits. It's free and completely confidential. A nurse care manager will contact you if you're eligible for the program. Or call Customer Service at 800-662-6667 for more information. Our Maternity program covers 12 months (pregnancy + 3 months postpartum) digital care and benefit navigation program supporting expecting mothers and fathers during pregnancy and for three months postpartum with a dedicated Care Advocate and clinical virtual support. The program includes support for prenatal, postnatal, NICU, high-risk pregnancy, and loss. Members also have access to Blue Cross Well-Being digital tools related to pregnancy through their member account at bcbsm.com. Notes: You do not need to precertify your vaginal delivery; see Section 3 for other circumstances, such as extended stays for you or your baby. • As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. • You may remain in the hospital up to 48 hours after a vaginal 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 We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	Nothing for routine prenatal and routine postpartum care visits Office visit cost sharing applies to non-routine prenatal and non-routine postpartum visits

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
• Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	Nothing for routine prenatal and routine postpartum care visits Office visit cost sharing applies to non-routine prenatal and non-routine postpartum visits
Family planning	**High Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories in the HRSA supported guidelines. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage in Section 5(f). Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. • For contraceptive exception requests, fill out the form at the following link: https://www.bcbsm.com/individuals/help/pharmacy/cover-prescription-drug-contraceptive/coverage-request-form/. For a 24-hour turnaround time, do NOT check "This is a standard request." If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov.	Nothing
Voluntary male sterilization	$25 per primary care provider visit $50 per specialist visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*

Benefit Description	You pay
Infertility Services	**High Option**
BCN's medical criteria require that the enrollee meet its definition of infertility. BCN defines infertility as the result of a disease (an interruption, cessation, or disorder of body functions, systems, or organs) involving the reproductive system, which prevents conception. The American Society for Reproductive Medicine defines infertility as a failure to achieve pregnancy after 12 months or more of unprotected intercourse or egg-sperm contact for individuals under age 35 and 6 months for individuals aged 35 and older or due to an impairment of an individual's capacity to reproduce either as an individual or with a partner due to medical history and diagnostic testing. Please refer to Section 10 for Definitions of Terms. Diagnosis, counseling, and treatment of infertility including oral and injectable drugs are covered for infertile members when preauthorized based on BCN's medical criteria. Treatment services include: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Assisted reproductive technology (ART) services, include, but not limited to the following procedures: - In-vitro fertilization (IVF) - Gamete intrafallopian transfer (GIFT) - Transuterine fallopian transfer (TUFT) - Natural oocyte retrieval with intravaginal fertilization (NORIF) - Pronuclear state tubal transfer (PROST) - Tubal embryo transfer (TET) - Zygote intrafallopian transfer (ZIFT) - Cryopreservation of sperm and mature oocytes; and cryopreservation storage for up to two years - Embryo and blastocyst transfer - Procedures associated with intracytoplasmic sperm injection (ICSI) for male infertility • Fertility drugs (See Section 5f) Note 1: We cover Injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. Note 2: Preservation of fertility for Members diagnosed with cancer and other diagnosis is a covered benefit. Preservation of fertility may be considered if treatment will affect the Member's fertility. Note 3: Sperm and egg bank is a covered benefit.	50% coinsurance
Fertility preservation for iatrogenic infertility: • Procurement of sperm or egg including medical, surgical, and pharmacy claims associated with retrieval	$200 Authorization required

Infertility Services - continued on next page

Benefit Description	You pay
Infertility Services (cont.)	**High Option**
Not covered: *Exclusions include, but are not limited to:* • *All services related to gestational surrogacy for non-members* • *Third party reproductive services (e.g., donor eggs, sperm or embryos, traditional or gestational surrogacy)* • *Assisted reproductive technology for fertile individuals* • *Experimental treatment* • *Reversal of prior sterilization*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections	$25 per primary care provider visit $50 per specialist visit
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on Page 44. • Respiratory and inhalation therapy • Cardiac rehabilitation following a qualifying event/condition is provided for up to 60 consecutive days • Dialysis - hemodialysis and peritoneal dialysis • Intravenous (IV) /infusion therapy - home IV and antibiotic therapy • Applied Behavior Analysis (ABA) - coverage for these services to members of any age if they are medically necessary Note: For applied behavior analysis, limitations and exclusions apply. Please contact BCN for additional information. • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit and subject to the prescription copayment. We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services* under *You need prior Plan approval for certain services* on Page 19.	$25 per primary care provider visit $50 per specialist visit Nothing in outpatient facility setting

Benefit Description	You pay
Physical and occupational therapies	**High Option**
• 60 visits combined per medical diagnosis for physical therapy, medical rehabilitation and occupational therapy Note: We only cover therapy when a physician: - orders the care - identifies the specific professional skills the patient requires and the medical necessity for skilled services; and - indicates the length of time the services are needed.	$50 per visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Phases three and four of cardiac rehab*	*All charges*
Speech therapy	**High Option**
60 visits per medical diagnosis	$50 per office visit
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	$25 per primary care provider visit $50 per specialist visit
• External hearing aids - Up to two hearing aids in the TruHearing formulary will be covered in full every 36 months regardless of age. Members may choose any hearing aid available through the TruHearing formulary at no out-of-pocket cost. - Inclusions with hearing aid purchase: • Risk-free 60-day trial period • Full 3-year manufacturer warranty (manufacturer and provider fees apply) • 1 year of follow-up visits • 80 free batteries per non-rechargeable hearing aid Note: TruHearing is the delegated provider network for your hearing benefits. Members must schedule appointments through TruHearing at 1-833-414-6908 and see a TruHearing provider to use this benefit. • Implanted hearing-related devices, such as bone anchored hearing aids and cochlear implants For implanted devices benefits, see Section 5(b) *Surgical and anesthesia services.*	$25 per primary care provider visit $50 per specialist visit

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	**High Option**
• Annual eye examination from Plan optometrists or ophthalmologists to determine the need for lenses to correct or improve eyesight. Note: Your vision benefits are administered by Vision Service Plan. Please contact Vision Service Plan at 800-877-7195 with questions about your vision benefits.	$5 per vision exam Non-Plan providers of vision services are paid at 75% of reasonable charges
• 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.	$7.50 copay
One pair of frames every 24 months	All charges above $150.00
We pay for nonmedically necessary but prescribed contact lenses. We do not pay for cosmetic contact lenses that do not improve vision. Contact lenses are considered necessary if: • 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.	All charges above $150.00
Not covered: • *Eye exercises* • *Photo-sensitive lenses* • *Nonmedically necessary tinted lenses* • *Safety glasses* • *Repair or replacement of lost or broken lenses or frames*	*All charges*
Foot care	**High Option**
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$25 per primary care provider visit $50 per specialist visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (except for surgical treatment)*	*All charges*

Benefit Description	You pay
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective orthopedic appliances for nondental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. Note: We cover basic items. Prior authorization is necessary for items with special features. See *Section 3. You need plan approval for certain services.*	50% of the approved amount
• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants and surgically implanted breast implant following mastectomy Note: For information on the professional and facility charges for implanted devices, see Sections 5(b) and 5(c). The implanted device is part of the surgical benefit and not subject to additional cost sharing. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	Nothing
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Repair or replacement due to loss or damage*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of prescribed durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Motorized wheelchairs if medical criteria are met • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors and testing supplies • Insulin pumps • Oxygen therapy • Nebulizers and supplies	50% of the approved amount

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
Note: Call our DME provider, Northwood, at 800-667-8496 as soon as your Plan physician prescribes this equipment. Northwood specialists will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates. Contact Northwood for diabetic materials, including insulin pumps, blood glucose meters, test strips and lancets.	50% of the approved amount
Breast pump (electric nonhospital), one every 24 months	Nothing
Not covered: Deluxe equipment and items for comfort and convenience	*All charges*
Home health services	**High Option**
• Home healthcare 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.	$50 per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.* • *Custodial care 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.*	*All charges*
End of life care	**High Option**
No benefits	All charges
Chiropractic	**High Option**
• Chiropractic manipulation of the spine will be limited to 30 visits. See *Section 3. You need plan approval for certain services.*	$50 per office visit
• Chiropractic X-rays of the spine when taken by a chiropractor in the office See *Section 3. You need plan approval for certain services.*	Nothing
Not covered: All other chiropractic services	*All charges*
Alternative treatments	**High Option**
No benefits	*All charges*
Educational classes and programs	**High Option**
• Tobacco cessation programs, including: - Individual/group counseling - 8 phone counseling sessions with trained counselors - 2 quit attempts per year - Approved nicotine replacement medications and supplies (see Preventive medications, Page 58). Note: We encourage you to look at our Blue Cross Health suite of programs comprising health education, chronic condition and case management services that help you stay healthy, get better or improve your quality of life while living with an illness.	Nothing

Benefit Description	You pay
Medical Foods	**High Option**
The following are covered services when coverage criteria in Our Benefit, Referral and Practice Policy is met. Must receive prior approval. Supplemental feedings administered ***via tube*:** This type of nutrition therapy is also known as **enteral feeding**. Formulas intended for this type of feeding as well as supplies, equipment, and accessories needed to administer this type of nutrition therapy, are covered. Supplemental feedings administered ***via an IV***: This type of nutrition therapy is also known as **parenteral nutrition**. Nutrients, supplies, and equipment needed to administer this type of nutrition are covered. **Oral medical formula:** Metabolic formula for consumption by mouth for individuals of any age is considered covered when all of the following are met: • The individual has a diagnosis of an inborn error of metabolism (IEM)* that requires oral medical formula; OR The individual has an inherited condition that is proven to be treated by oral medical formula; AND, • The oral medical formula is labeled and used for nutritional management of an inborn error of metabolism that interferes with the metabolism of specific nutrients (eg, Phenylketonuria, Homocystinuria, Maple Syrup Urine Disease, etc.); AND, • The oral medical formula nutrition is ordered by a clinical or medical biochemical geneticist or by other qualified medical professionals in consultation with a clinical or medical biochemical geneticist *Covered:* *Special food products and formulas that are part of a diet prescribed by a doctor for the treatment of phenylketonuria (PKU) or other inborn errors of metabolism. You can get most formulas used in the treatment of PKU or other inborn errors of metabolism from a drugstore.*	Nothing
Not covered: • *Formula for any condition other than an inborn error of metabolism (eg, diabetes, hypercholesterolemia, etc.)* • *Formula not specifically used for the nutrition of an individual with an inborn error of metabolism* • *Medical food product that is not formula (eg, food modified to be low in protein [meat or cheese substitutes, pasta, etc.])* • *Nutrition by tube feeding (refer to the Enteral Nutrition policy for guidelines)*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- There is an out-of-pocket maximum of $6,350 Self/$12,700 Self and Family. Medical and prescription copayments and coinsurance count toward this annual out-of-pocket maximum.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e., hospital, surgical center, etc.).
- YOUR PHYSICIAN MUST GET PREAPPROVAL FOR SOME SURGICAL PROCEDURES. Please refer to the information shown in Section 3 to be sure which services require preapproval and identify which surgeries require preapproval.
- This Plan does not have a deductible.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Routine pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of severe obesity (bariatric surgery) The criteria we consider are: - BMI - Age - Previous professional supervised weight loss programs - Patient's understanding of risks - Presurgical psychological evaluation • Insertion of internal prosthetic devices. See Section 5(a) *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns Note: For female surgical family planning procedures see Section 5(a), *Family Planning*. Note: For male surgical family planning procedures see Section 5(a), *Family Planning*. For more information, call 800-662-6667.	$200 copay for outpatient surgical procedures when performed in an outpatient facility setting. Authorization required.

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for a pacemaker and surgery benefits for insertion of the pacemaker. See *Hospital Benefits* (Section 5c) and *Surgery Benefits* (Section 5b).	$200 copay for outpatient surgical procedures when performed in an outpatient facility setting. Authorization required.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot (see Section 5(a) Foot care)*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities, cleft lip, cleft palate, birth marks, webbed fingers and webbed toes. • Breast reconstructive surgery following a mastectomy for treatment of cancer, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see Section 5 (a) Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. See Hospital Benefits (Section 5c) and Surgery Benefits (Section 5b).	$25 per primary care provider visit $50 per specialist visit $200 copay for outpatient surgical procedures when performed in an outpatient facility setting. Authorization required.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury (See Section 5(d) Accidental injury)* • *Surgery for Sex-Trait Modification to treat gender dysphoria* *If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care. Our exception process is as follows: The exception process will be applied on a case-by-case basis. In order to apply for an exception to the exclusion of sex-trait medical interventions/transgender services call our customer service office at 1-800-662-6667. You will also find more information on our member website at bcbsm.com/fep/bcn. If you disagree with this information, please contact our customer service at 1-800-662-6667 to speak to a representative.* *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*

Benefit Description	You pay
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Treatment of temporomandibular joint (TMJ). Note: If performed in a hospital setting, see *Hospital Benefits* (Section 5c) and *Surgery Benefits* (Section 5b).	$200 copay for outpatient surgical procedures when performed in an outpatient facility setting. Authorization required.
Organ/tissue transplants	**High Option**
These **solid organ and tissue transplants** are covered, limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Kidney-pancreas	$200 copay for outpatient surgical procedures when performed in an outpatient facility setting. Authorization required.
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing
Blood or marrow stem cell transplants Blue Care Network of Michigan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic stem cell transplant - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/myelodysplastic syndromes - Paroxysmal nocturnal hemoglobinuria - Phagocytic/hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Hematopoietic stem cell transplant - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced myeloproliferative disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, pure red cell aplasia) - Myelodysplasia/myelodysplastic syndromes - Paroxysmal nocturnal hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing
Tandem transplants for covered transplants; subject to medical necessity	Nothing
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition), if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta thalassemia major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or nonadvanced) small cell lymphocytic lymphoma - Multiple myeloma	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Multiple sclerosis - Sickle cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MSDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or nonadvanced) small cell lymphocytic lymphoma - Mantle Cell (Non-Hodgkin's lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	Nothing
National Transplant Program (NTP)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Freestanding ambulatory surgical center • Skilled nursing facility • Office	Nothing

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- There is an out-of-pocket maximum of $6,350 Self/$12,700 Self and Family. Medical and prescription copayments and coinsurance count toward this annual out-of-pocket maximum.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PLAN APPROVAL FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require plan approval.
- This Plan does not have a deductible.

Benefit Description	You pay
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and x-rays • Dressings, splints, casts and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts and sterile tray services	$100 per day up to $500 per admission. Authorization required.

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
Note: We cover hospital services and supplies related to dental procedures when necessitated by a nondental physical impairment. We do not cover the dental procedures.	$100 per day up to $500 per admission. Authorization required.
Not covered: • *Custodial care* • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery and other treatment rooms • Prescribed drugs and medications • 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 • Presurgical testing • Dressings, casts and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a nondental physical impairment. We do not cover the dental procedures.	$200 copay for outpatient surgical procedures when performed in an outpatient facility setting
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Skilled nursing care facility benefits	**High Option**
Skilled nursing facility (SNF): 730 days if the patient meets criteria	Nothing
Not covered: Custodial care	*All charges*
Hospice care	**High Option**
• In the home • In a skilled nursing facility	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
End of life care	**High Option**
No benefits	All charges
Ambulance	**High Option**
• Nonemergency ground and air transport when preauthorized (See Section 5 (d) for *Emergency services/accidents*.)	$100 for each transport Authorization required
Not covered: • Services provided by an emergency responder that do not include medical care or transportation are not covered.	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- There is an out-of-pocket maximum of $6,350 Self/$12,700 Self and Family. Medical and prescription copayments and coinsurance count toward this annual out-of-pocket maximum.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- This Plan does not have a deductible.

What is a medical emergency?

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

What to do in case of emergency

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

If you are hospitalized in a non-Plan facility and a Plan physician believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

We pay reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers. Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

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

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

Benefit Description	You pay
Emergency within and outside of our service area	**High Option**
• Emergency care at an urgent care center	$50 per visit or 50% of the approved amount, whichever is less
• Emergency care in a hospital emergency room or as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted as an inpatient to the hospital.	$100 per visit
Not covered: Elective care or nonemergency care	*All charges*

Benefit Description	You pay
Ambulance	**High Option**
• Emergency ground and air transport when medically appropriate. Note: See 5(c) for nonemergency service.	$100 for each transport Authorization required
Not covered: • *Services provided by an emergency responder that do not include medical care or transportation are not covered.*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- There is an out-of-pocket maximum of $6,350 Self/$12,700 Self and Family. Medical and prescription copayments and coinsurance count toward this annual out-of-pocket maximum.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- This Plan does not have a deductible.

Benefit Description	You pay
Professional Services	**High**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Nothing
Diagnostics	**High**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing

Benefit Description	You pay
Inpatient hospital or other covered facility	**High**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$100 per day up to $500 per admission. Authorization required.
Outpatient hospital or other covered facility	**High**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	Nothing

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- Federal law prevents the pharmacy from accepting unused medications.
- This Plan does not have a deductible.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- 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
- Specialty drugs are covered when obtained from a pharmacy in the BCN Exclusive Pharmacy Network for Specialty Drugs
- **The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria** only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). **We do not exclude coverage for entire classes of pharmaceuticals,** e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You may have your prescription filled at over 2,400 participating retail pharmacies in the state and 68,000 nationwide or through OptumRx Home Delivery, our mail order pharmacy.
- **We use a drug list.** For a complete list of formulary exclusions to the Blue Care Network pharmacy program you can go to www.bcbsm.com/pharmacy and click on Drug Lists. For a complete list of covered drugs and coverage requirements, go to www.bcbsm.com/pharmacy and click Drug Lists. Or find the drug list and cost estimates, and any special requirements for coverage, by logging in to your online account at bcbsm.com.

BCN has also established quantity limits on certain medications based on clinical criteria and generally acceptable use.

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

- **A generic equivalent will be dispensedif it is available**, unless your physician specifically requires a name brand. Generic substitution is mandatory where appropriate. If you receive a brand-name drug when a FDA approved generic drug is available, you have to pay the difference in cost between the brand-name drug and the generic in addition to your copayment. The difference in cost between the brand name drug and its generic equivalent does not apply to the out-of-pocket maximum.
- Why use generic drugs? Generic drugs are lower-priced drugs that contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. You can save money by using generic drugs.

- **When do you have to file a claim?** Prescriptions for covered medications filled at non-network pharmacies will be reimbursed based on our negotiated rate, less your copayment in urgent or emergency situations. Prescriptions filled at non-network pharmacies for nonemergency situations are not covered. You must submit proof of payment for prescription services to Customer Service. Visit www.bcbsm.com/billform for the Member Reimbursement Form.
- **BCN Specialty Drug Program.** Specialty drugs are covered **only** when obtained through a Walgreens Specialty Pharmacy in the BCN Exclusive Pharmacy Network for Specialty Drugs. Walgreens Specialty Pharmacy, an independent company, provides specialty pharmacy services to Blue Cross Blue Shield of Michigan and Blue Care Network members. You can find additional information regarding the specialty drug program along with the member guide located at www.bcbsm.com/specialtydrug. As noted within the Specialty Drug Program Rx Benefit Member Guide (PDF), Walgreens Specialty Pharmacy can assist members with questions that they may have regarding the process of filling their specialty medications. They can be reached at 1-866-515-1355 or visit the website at WalgreensSpecialtyRx.com*. For questions regarding your coverage, call BCN Customer Service at 800-662-6667.

  *Blue Cross Blue Shield of Michigan and Blue Care Network do not control this website or endorse its general content.

Benefit Description	You pay
Covered medications and supplies	**High Option**
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: - Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as not covered - Insulin - Diabetic supplies limited to: Disposable needles and syringes for the administration of covered medications, lancets, select glucometers and testing strips. - First time opiate prescriptions are limited to a five-day supply and members are responsible to pay the lesser of the contracted amount, Usual and Customary or copay for the generic or brand-name drug; whichever is less. - Medications prescribed to treat obesity	**In-network:** **Retail and Mail Order (30-day supply)** • Tier 1 (Generics) $10 • Tier 2 (Preferred Brands and Non-Preferred generics) $30 • Tier 3 (Non-Preferred Brands) $60 **Retail and Mail Order (90-day supply)** • Tier 1 (Generics) $20 • Tier 2 (Preferred Brands and Non-Preferred generics) $60 • Tier 3 (Non-Preferred Brands) $120 **Retail and Mail Order Specialty Drugs (30-day supply)** • Tier 4 (Preferred Specialty Drugs) 20% coinsurance up to a maximum of $100 • Tier 5 (Non-Preferred Specialty Drugs) 20% coinsurance up to a maximum of $200 Notes: • Certain select Specialty Drugs are limited to a 15-day supply for the first prescription, reducing your copayment by half. • If there is no generic equivalent available and a brand-name drug is dispensed, you must pay the applicable brand copayment.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
	• Specialty Drugs must be filled through a Walgreens Specialty Pharmacy that's part of the BCN Exclusive Pharmacy Network for Specialty Drugs. **Out-of-network: All charges**
• Drugs to treat sexual dysfunction. - Contact Blue Care Network at 800-662-6667 for dose limits	50% coinsurance up to the dose limit; all charges thereafter
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • For contraceptive exception requests, fill out the form at the following link: https://www.bcbsm.com/individuals/help/pharmacy/cover-prescription-drug-contraceptive/coverage-request-form/. For a 24-hour turnaround time, do NOT check “This is a standard request." If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. • Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a).	Nothing for Tier 1 generics
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription from any in-network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA’s National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications unless specifically indicated elsewhere* • *Drugs prescribed in connection with Sex-Trait Modification for treatment of gender dysphoria*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care. Our exception process is as follows: The exception process will be applied on a case-by-case basis. In order to apply for an exception to the exclusion of sex-trait medical interventions/transgender services call our customer service office at 1-800-662-6667. You will also find more information on our member website at bcbsm.com/fep/bcn. If you disagree with this information, please contact our customer service at 1-800-662-6667 to speak to a representative. *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*
Preventive medications	**High Option**
The following are covered: Preventive Medications with USPSTF A and B recommendation. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications*	*All charges*
Over-the-counter COVID-19 test kits	**High Option**
Members receive 8 over-the-counter COVID-19 test kits, per member, per 30 days	$10 generic tier copay

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- There is an out-of-pocket maximum of $6,350 Self/$12,700 Self and Family. Medical and prescription copayments and coinsurance count toward this annual out-of-pocket maximum.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We cover hospitalization for dental procedures only when a nondental physical condition exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- This Plan does not have a deductible.

Benefit Description	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. To be payable, services have to be provided within 72 hours of the injury.	$25 per specialist visit

Dental benefits

We have no other dental benefits.

Section 5(h). Wellness and Other Special Features

Feature	Description
Travel benefits	One of the many benefits of Blue Care Network of Michigan is coverage that travels with you. You can receive benefits when you're outside Michigan, but still in the U.S. You have access to a nationwide network of Blue Plan providers. Call your primary care provider before you travel to arrange for coordinated care and required authorizations. Always carry your BCN member ID card for access to service. For more information, call 1-800-810-2583.
24-hour Customer Service	Any time, day or night, you have 24-hour phone access to coverage information. Our interactive voice response system provides answers to questions about coverage, eligibility and claims status. Of course, you can always reach us during our regular business hours (8 a.m. to 5:30 p.m. Monday through Friday).
Blue365®	Blue Care Network of Michigan members can score big savings on a variety of healthy products and services from businesses in Michigan and across the United States. Member discounts with Blue365 offers exclusive deals on things like: • Fitness and wellness: Health magazines, fitness gear and gym memberships • Healthy eating: Cookbooks, cooking classes and weight-loss programs • Lifestyle: Travel and recreation • Personal care: Lasik and eye care services, dental care and hearing aids Show your Blue Care Network of Michigan ID card at participating local retailers or use an offer code online to take advantage of these savings. You can view all savings in one place through your member account at **www.bcbsm.com.**
Online resources	Our website is a valuable resource for health information that can help you get the most from your coverage. Here's some of what you can do: • Complete a health assessment and develop a personal action plan. • Verify eligibility for everyone on your contract. • Order ID cards. • View and print claim summaries. • View your benefits. • Change your primary care provider. • Use our Coverage Advisor™ to compare health plans and their costs. To access all these features, login to your account at www.bcbsm.com.
Blue Cross Well-Being	Blue Cross Well-Being offers well-being resources to improve your health and build healthy habits. Members can access a variety of free online tools when they log in to their member account at bcbsm.com. Or visit bcbsm.com/wellbeing for more information. Blue Care Network of Michigan reminds members through various media (blog; online health information; phone calls) to get important health screenings or services. The preventive recommendations include: screening tests for members with diabetes, breast cancer screenings, cervical cancer screenings, childhood and adolescent immunizations, flu vaccines and annual checkups. Blue Care Network of Michigan members can also order self-help guides about nutritious eating, exercise, depression, high blood pressure, stress management, losing weight, back pain, cholesterol or quitting smoking.

Health Assessment	You can get a picture of your health by taking the health assessment at bcbsm.com. To get started: 1. Log in to your member account at bcbsm.com. 2. Click on the *Programs & Services* tab. 3. Click on *Take Your Health Assessment.* Your results will include: • A health score based on an analysis of your health risks • A list of your highest-risk areas • A list of the next steps you can take to improve your health The assessment takes about 10 minutes to complete. After you complete your health assessment, you'll receive recommendations for the Digital Health Assistant online coaching programs that are best for you. The Digital Health Assistant programs help you set small, achievable goals that you commit to for one week. You can choose activities, create a plan and track your progress.
Virtual Care	When you use Virtual Care, you'll have access to online medical and behavioral health services anywhere in the U.S. You can your covered family members can see and talk to a doctor for minor illnesses such as cold, flu or sore throat when their primary care doctor isn't available, or a behavioral health clinician or psychiatrist to help work through different challenges such as anxiety, depression and grief. To use Virtual Care, download the Teladoc Health® app, visit bcbsm.com/virtualcare or call **855-636-1578**.
24-hour Nurse Advice Line	Get answers to health care questions anytime, anywhere with support from registered nurses. Call **855-624-5214** to reach the 24-hour nurse advice line.

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). These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact the Plan at 800-662-6667 or visit their website at www.bcbsm.com.

Medicare prepaid plan

Blue Care Network of Michigan offers Medicare recipients the opportunity to enroll in this Plan through Medicare. Annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join the Medicare prepaid Plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join this Plan, ask whether this Plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Call us at 800-529-8360 for information on the Medicare prepaid Plan and the cost of that enrollment.

Section 6. General Exclusions – Services, Drugs and Supplies We Don't Cover

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs or supplies you receive while you are not enrolled in this Plan.
- Services, drugs or supplies not medically necessary.
- Services, drugs or supplies not required according to accepted standards of medical, dental or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.
- Services, drugs or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs or supplies you receive without charge while in active military service.
- Costs related to conducting a clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
- Services or supplies we are prohibited from covering under the Federal Law.
- Any benefits or services required solely for your employment are not covered by this Plan.
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include "gender transition" services), other than mid-treatment exceptions, see Section 3. How You Get Care.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-Plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file a claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file HIPAA compliant electronic claims for you. In cases where a paper claim must be used, the provider must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 800-662-6667, or our website at www.bcbsm.com/individuals/help/claims/claim-forms.

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

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

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

Submit your claims through your member account at bcbsm.com or to:

Blue Care Network of Michigan

PO Box 68767

Grand Rapids, MI 49516-8753

Prescription drugs

If a Member gets covered drugs, needles and syringes, or insulin from a nonparticipating pharmacy in an urgent situation or when out of area and a participating pharmacy is not available, Blue Care Network of Michigan will reimburse the amount specified on Blue Care Network of Michigan's fee schedule or the actual charge, whichever is less, minus the copayment. Complete a Prescription Drug Reimbursement Form that is available online at www.bcbsm.com/billform or by calling Customer Service at 800-662-6667.

Deadline for filing your claim

Send us all 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. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a three year limitation on the re-issuance of uncashed checks.

Post-service claims procedures	We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Records	Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.
Overseas claims	For covered services you receive by providers and hospitals outside the United States and Puerto Rico, send a completed Overseas Claim Form and the itemized bills to: BCBS Global Core P.O. Box 2048 Southeastern, PA 19399 Obtain Overseas Claim Forms from: bcbsglobalcore.com. If you have questions about the processing of overseas claims, contact 804-673-1177 or claims@bcbsglobalcore.com.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Blue Care Network of Michigan, P.O. Box 68767, Grand Rapids, MI 49516-8767, or calling 800-662-6667.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within six months from the date of our decision; and b) Send your request to us at: Appeals and Grievances Blue Care Network of Michigan PO Box 44200 Detroit, MI 48244-0191 c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure. d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2

In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim, or

b) Write to you and maintain our denial, or

c) Ask you or your provider for more information

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

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

3

If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim appeals and the exchange of information by telephone, electronic mail, facsimile, or other methods.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

4

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

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

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

- If you are covered under our Plan as a dependent, any group health insurance you have from your employer will pay primary and we will pay secondary.
- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.
- When you are entitled to the payment of health care expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payor and we are the secondary payor.

For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.bcbsm.com/fep

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

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

TRICARE and CHAMPVA

TRICARE is the healthcare 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 or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this Plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this Plan or by OWCP.

We do not cover services that:

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

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 or employing 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

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.gov, or by phone 877-888-3337, TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

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

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by Blue Care Network of Michigan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. Blue Care Network of Michigan covers some of these costs, providing we determine the services are medically necessary. Please contact Blue Care Network of Michigan to discuss specific services if you participate in a clinical trial.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. Blue Care Network of Michigan does not cover these costs.

When you have Medicare

- **When you have Medicare**

For more detailed information on "When you have Medicare" and "Should I Enroll in Medicare?" please contact Medicare at 1- 800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-662-6667 or visit our website at www.bcbsm.com.

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

Please review the following examples which illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible
High Option You Pay Without Medicare: N/A
High Option You Pay With Medicare Part B: N/A

Benefit Description: Out-of-Pocket-Maximum
High Option You Pay Without Medicare: $6,350 self only/$12,700 family
High Option You Pay With Medicare Part B: $6,350 self only/$12,700 family

Benefit Description: Part B Premium Reimbursement Offered
High Option You Pay Without Medicare: N/A
High Option You Pay With Medicare Part B: N/A

Benefit Description: Primary Care Provider
High Option You Pay Without Medicare: $25 office copay
High Option You Pay With Medicare Part B: $25 office copay

Benefit Description: Specialist
High Option You Pay Without Medicare: $50 office copay
High Option You Pay With Medicare Part B: $50 office copay

Benefit Description: Inpatient Hospital
High Option You Pay Without Medicare: Nothing
High Option You Pay With Medicare Part B: Nothing

Benefit Description: Outpatient Hospital
High Option You Pay Without Medicare: Nothing
High Option You Pay With Medicare Part B: Nothing

Benefit Description: Prescription drugs: Retail and Mail order (90-day supply) Note: Specialty drugs are limited to a 30-day supply
High Option You Pay Without Medicare: 2x retail copay
High Option You Pay With Medicare Part B: 2x retail copay

You can find more information about how our plan coordinates benefits with Medicare online at www.bcbsm.com/medicare.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare 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), TTY 800-486-2048 or at www.medicare.gov.

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments and coinsurance. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

	Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.
• **Medicare prescription drug coverage (Part D)**	When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.
• **Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP)**	This Plan does not offer a Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP).

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓*
9) Are a Federal employee receiving disability benefits for six months or more	✓	
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 payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
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.

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Assisted Reproductive Technology (ART)

Refers to medical procedures other than artificial insemination used primarily to address infertility with the aim of achieving pregnancy. ART procedures specifically involve surgically removing eggs from an individual's ovaries, combining them with sperm in the laboratory, and returning them to the individual's body.

Blue Cross Well-Being

Blue Cross Well-Being is a digital platform comprising of online well-being tools, encouraging small steps and healthy habits, to help members stay healthy, get better or improve their quality of life. This resource provides members with the information and tools they need to make informed health care choices.

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.

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

Coinsurance

See Section 4, *Your Costs for Covered Services*

Copayment

See Section 4, *Your Costs for Covered Services*

Cost-sharing

See Section 4, *Your Costs for Covered Services*

Covered services

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

Deductible	See Section 4, *Your Costs for Covered Services*
Experimental or investigational services	A product or procedure is considered not experimental or investigational if it meets all of the following conditions: • It has final approval from the appropriate government regulatory bodies; • The scientific evidence permits conclusions concerning the effect of the technology on health outcomes; • The technology improves the net health outcome; and • The technology is as beneficial as any established alternatives. The investigational setting may be eliminated if the research and experimental stage of development is completed and the improvement in net health outcome is attainable outside the investigational settings. Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you would be able to accept treatment or procedures that may be recommended by this Plan's providers.
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Infertility	BCN defines infertility as the result of a disease (an interruption, cessation, or disorder of body functions, systems, or organs) involving the reproductive system, which prevents conception. The American Society for Reproductive Medicine defines infertility as a failure to achieve pregnancy after 12 months of more of unprotected intercourse or egg-sperm contact for individuals under age 35 and 6 months for individuals aged 35 and older or due to an impairment of an individual's capacity to reproduce either as an individual or with a partner due to medical history and diagnostic testing.
Out-of-pocket maximum	The out-of-pocket amount is the limit on total member medical and pharmacy copayments and coinsurance under a benefit contract.
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. You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Surprise bill

An unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for

air ambulance services furnished by nonparticipating providers of air ambulance services.

Urgent care claims

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

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

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

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

Us/We

Us and We refer to Blue Care Network of Michigan.

You

You refers to the enrollee and each covered family member.

Index

Summary of Benefits for Blue Care Network of Michigan High Option — 2026

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.bcbsm.com/fep.
- 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.
- There is no annual deductible for this benefit.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$25 copay per primary care provider visit $50 copay per specialist visit	28
Home health care service visits	$50	39
Services provided by a hospital: Inpatient	$100 per day up to $500 per admission. Authorization required.	49
Outpatient hospital or ambulatory surgical center	$200 copay for outpatient surgical procedures when performed in an outpatient facility setting. Authorization required.	50
Emergency in a hospital emergency room or as an outpatient at a hospital, including doctors' services	$100 per visit	51
Mental health and substance use disorder treatment	Regular cost-sharing	53
Prescription drugs: Mail Order or Retail (30-day supply)	• Tier 1 (Generics) $10 • Tier 2 (Preferred Brands and Non-Preferred generics) $30 • Tier 3 (Non-Preferred Brands) $60	56
Prescription drugs: Retail and Mail Order (90-day supply)	• Tier 1 (Generics) $20 • Tier 2 (Preferred Brands and Non-Preferred generics) $60 • Tier 3 (Non-Preferred Brands) $120 Specialty drugs are limited to a 30-day supply.	56
Prescription drugs: Retail and Mail Order Specialty Drugs (30-day supply)	• Tier 4 (Preferred Specialty Drugs) 20% coinsurance up to a maximum of $100 • Tier 5 (Non-Preferred Specialty Drugs) 20% coinsurance up to a maximum of $200 Note: Certain select Specialty Drugs are limited to a 15-day supply for the first prescription, reducing your copayment by half.	56
Dental care: Accidental injury only	$25 copay	59

High Option Benefits	You pay	Page
Vision Care • Annual eye exams • Lenses and contact lenses • Frames	$5 copay per eye exam $7.50 copay All charges above $150.00	37
Protection against catastrophic costs: (out-of-pocket maximum)	Out-of-pocket copayment maximum of $6,350 for Self Only, $12,700 for Self Plus One or $12,700 per Self and Family includes medical and prescription copayments and coinsurance	22
Hearing services (testing, treatment, and supplies)	• Up to two hearing aids in the TruHearing formulary will be covered in full every 36 months regardless of age. Members may choose any hearing aid available through the TruHearing formulary at no out-of-pocket cost. • $25 per primary care provider visit • $50 per specialist visit	37
Urgent Care (Diagnostic and Treatment Services/Emergency Services/Accidents)	$50 per visit or 50% of the approved amount, whichever is less	28 51

Notes

Notes

Notes

2026 Rate Information for Blue Care Network of Michigan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare**.**

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Michigan					
High Option Self Only	LX1	$324.76	$249.57	$703.65	$540.73
High Option Self Plus One	LX3	$711.17	$609.80	$1,540.87	$1,321.23
High Option Self and Family	LX2	$778.03	$623.35	$1,685.73	$1,350.59