Fallon Community Health Plan

http://www.fchp.org

fallon community health plan

2014

A Health Maintenance Organization (basic option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 15 for details.

Basic Option Serving: Central, and portions of Eastern, Massachusetts.

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

IMPORTANT
- Rates: Back Cover
- Changes for 2014: Page 15
- Summary of benefits: Page 81

Enrollment code for this Plan:

JG1 Basic Option/Direct Care network - Self Only
JG2 Basic Option/Direct Care network - Self and Family

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 73-090

Important Notice from Fallon Community Health Plan About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

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

Table of Contents

Introduction

This brochure describes the benefits of Fallon Community Health Plan under our contract (CS 1917) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1-800-868-5200 (TTY users please call TRS Relay 711) or through our website: www.fchp.org. The address for Fallon Community Health Plan administrative offices is:

Fallon Community Health Plan, Inc.
10 Chestnut Street
Worcester, MA 01608

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2014, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2014, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. 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 requirements for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

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 or family member, "we" means Fallon Community Health Plan, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that 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 1-800-868-5200 (TTY users please call TRS Relay 711), and explain the situation.

- If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/oig

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); or

  Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coveragefor yourself or for someone who is not 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 for services received directly by by 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 is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines 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 medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

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

Patient Safety Links

- www.ahrq.gov/consumer**.** The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

- www.npsf.org**.** The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

- www.leapfroggroup.org**.** The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org**.** The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

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

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

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

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 (MEC) and satisfies the ACA's individual shared responsibility requirement. 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

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health for enrollment information as well as:

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

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

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

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

Types of coverage available for you and your family

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

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

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 (include a valid common law marriage) and children as described in the chart below.

Children	**Coverage**
Natural, adopted children, and stepchildren	Natural and adopted children are covered until their 26th birthday.
Foster children	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 our foster child meets all of the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources officer or retirement system for additional information.
Married Children	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	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Children's Equity Act

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

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

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

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

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2014 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2013 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 divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

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, if you are a covered dependent child and you turn 26, etc.

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, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

We also want to inform you that the Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules.

Converting to individual coverage

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

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

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

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

Health Insurance Market Place

If you would like to purchase health insurance through the Affordable Care Act'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.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/healthcare-insurance; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 1. How this plan works

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

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

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

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

General features of our Basic Option

Basic Option has a calendar year deductible for certain covered services. You must meet that deductible before we will begin to pay for those services. See Section 4 *Your costs for covered services* for more information.

How we pay providers

We contract with individual physicians, medical groups, hospitals and ancillary providers to provide care to members. These plan providers accept a negotiated payment for their services. When you obtain a covered service, the only payment that a provider will collect from you for a covered service is the copayment, coinsurance or deductible amounts shown in this brochure.

Your rights

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

- Fallon Community Health Plan is licensed in the Commonwealth of Massachusetts as an HMO. We also qualify under Federal law as an HMO.
- We have been in existence since 1977.
- Fallon Community Health Plan is a not-for-profit organization.
- We have been awarded an "Excellent" status for our HMO plans by the National Committee for Quality Assurance (NCQA).
- As a Fallon Community Health Plan member, you have certain rights and responsibilities.

As a Fallon Community Health Plan member, you have the right to …

- Be informed about Fallon Community Health Plan and covered services.
- Receive information about the managed care organization, its services, its practitioners and providers, and members' rights and responsibilities.
- Be informed about how medical treatment decisions are made by the contracted medical group or Fallon Community Health Plan, including payment structure.
- Choose a qualified contracted primary care physician and contracted hospital.
- Know the names and qualifications of physicians and health care professionals involved in your medical treatment.
- Receive information about an illness, the course of treatment and prospects for recovery in terms that you can understand.

- Actively participate in decisions regarding your own health and treatment options, including the right to refuse treatment.
- Receive emergency services when you, as a prudent layperson acting reasonably, would have believed that an emergency medical condition existed.
- Candidly discuss appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage, presented by your provider in a manner appropriate to your condition and ability to understand.
- Be treated with dignity and respect, and to have your privacy recognized.
- Keep your personal health information private as protected under federal and state laws—including oral, written and electronic information across the organization. Unauthorized people do not see or change your records. You have the right to review and get a copy of certain personal health information (there may be a fee for photocopies).
- Make complaints and appeals without discrimination about the managed care organization or the care provided, and expect problems to be fairly examined and appropriately addressed.
- Exercise these rights regardless of your race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or your national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care. Expect these rights to be upheld by both Fallon Community Health Plan and its contracted providers.
- Make recommendations regarding Fallon Community Health Plan's members' rights and responsibilities policies.

A*s a Fallon Community Health Plan member, you have the responsibility to …*

- Provide, to the extent possible, information that Fallon Community Health Plan, your physician or other care providers need in order to care for you.
- Do your part to improve your health condition by following the treatment plan, instruction and care that you have agreed on with your physician(s).
- Understand your health problems, and participate in developing mutually agreed-upon treatment goals to the degree possible.

If you have any questions about your rights and responsibilities, or want more information about us, call 1-800-868-5200 (TTY users please call TRS Relay 711), or write to Fallon Community Health Plan, 10 Chestnut Street, Worcester, MA 01608. You may also visit our Web site at www.fchp.org.

For information about a physician, including physician profiling information, call 1-781-876-8200, or write to the Commonwealth of Massachusetts, Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01881. You may also visit their Web site at www.mass.gov/massmedboard.

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 or work in our Service Area. This is where our providers practice. Our service area includes all cities and towns in the following counties: Bristol, Essex, Middlesex, Norfolk, Plymouth and Suffolk. The service area includes all cities and towns in Worcester County with the exception of Athol and Royalston. The service area includes the following town in Hampshire County: Ware. The service area includes the following towns in Hampden County: Brimfield, Holland, Monson, Palmer and Wales.

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

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), we provide coverage for a limited number of services when authorized in advance by the Plan. See Section 5(g) *Special features*. 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.

Section 2. Changes for 2014

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 *Benefits*. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

Changes to this Plan

- Your catastrophic protection out-of pocket maximum, the cost to the enrollee, will be $1,200 self and $2,400 family. This will include deductible, coinsurance and all copayments. See page 24.
- In vitro fertilization and embryo placement (IVF-EP), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT) services will be covered with a $100 copayment per procedure after the deductible. See page 33.
- Scalp and hair prosthesis (wigs) are covered at no charge after the deductible. See page 36.
- Hearing aids for individuals, age 21 or younger for the cost of one (1) hearing aid per hearing impaired ear up to $2,000 for each hearing aid device only, every 36 months are covered at 20% coinsurance after the deductible. Related services and supplies for hearing aids are not subject to the $2,000 limit. See page 36.
- Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms are covered at no charge after the deductible. See page 43.
- Habilitative/rehabilitative services (physical, occupational, and speech therapy) up to 60 visits per illness or injury per calendar year are covered at $25 copayment per office visit after the deductible. See page 34.
- Food products modified to be low in protein for individuals that have been diagnosed with phenylketonuria and other inherited diseases of amino acids and organ acids are covered. You may be required to purchase these products over-the-counter and submit claims to the Plan for reimbursement. See page 56.
- Your plan now includes coverage for Healthy Health Plan. See page 62.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-868-5200 (TTY users please call TRS Relay 711) or write to us at Fallon Community Health Plan, Customer Service Department, 10 Chestnut Street, Worcester, MA 01608. You may also request replacement cards through our Web site at www.fchp.org.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles and/or coinsurance.

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care provider. This decision is important since your primary care provider provides or arranges for most of your health care.

Once you become a Plan member, we will generally only pay for services that you receive from Plan providers. However, there are certain circumstances in which we will temporarily pay for services that you receive from a non-Plan provider if you had been receiving care from that provider prior to becoming a member:

- If your prior primary care provider is not a participating provider in any health plan offered by the FEHB Program, we will pay for services from that provider for 30 days from your effective date.
- If you are receiving an ongoing course of treatment from a provider who is not a participating provider in any health insurance plan that the FEHB Program offers, we will pay for services from that provider for 30 days from your effective date.
- If you are in the second or third trimester of pregnancy and you are receiving services related to your pregnancy from a provider who is not a participating provider in any health insurance plan that the FEHB Program offers, we will pay for services from that provider through your postpartum period.
- If you are terminally ill and you are receiving ongoing treatment from a provider who is not a participating provider in any other health insurance plan that the FEHB Program offers, we will pay for services from that provider until your death.

In all cases, the provider must agree to accept reimbursement for services at our rates, and adhere to our quality assurance standards and other policies and procedures such as obtaining appropriate referrals and prior authorizations. You will be eligible for benefits as if the provider was under contract with us.

- **Primary care**

Your primary care provider can be a family practitioner, internist (for members over 18), pediatrician (for members under 18), geriatrician, doctor of adolescent medicine, physician assistant, or a nurse practitioner. Your primary care provider will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care providers, call us. We will help you select a new one. You can also notify us when you want to change your primary care provider on our Web site at www.fchp.org.

If your primary care provider leaves the Plan, we will notify you of the change either 30 days prior to the date the contract ends, or as soon as we are notified of the termination, whichever is later. You may continue to receive treatment from your primary care provider for 30 days beyond the date of termination of our contract (except in the case where the provider is terminated for reasons involving fraud, patient safety or quality of care). You will be required to choose a new primary care provider.

- **Specialty care**

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

- A network obstetrician, gynecologist, certified nurse midwife, physician assistant, or family practitioner, including annual preventive gynecological health examination and any subsequent gynecological services determined to be necessary as a result of such examination; services for acute or emergent gynecological conditions and maternity care. This does not include inpatient admissions or infertility treatment (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP).
- A Reliant Medical Group specialist (physician, physician assistant, nurse midwife or nurse practitioner only) *if you have a Reliant Medical Group PCP.*
- A network oral surgeon for the extraction of impacted teeth. (Visits to an oral surgeon for any other procedure require prior authorization from the plan).
- A network ophthalmologist or optometrist for routine eye exams.
- Outpatient mental health and substance abuse services with plan providers. For assistance in finding a plan provider call: 1-888-421-8861 (TDD/TTY: 1-781-994-7660). Prior authorization is required after eight visits.
- A contracted limited service clinic (appointments not required).

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist.

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

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

If you have a chronic and disabling condition and lose access to your specialist because we:

- terminate our contract with your specialist for other than cause;
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
- reduce our Service Area and you enroll in another FEHB plan;

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

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

- **Hospital care**

Your Plan primary care 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 1-800-868-5200 (TTY users please call TRS Relay 711). 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
- the 92nd day after you become a member of this Plan, whichever happens first

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

You need prior Plan approval for certain services

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

- **Inpatient hospital admissions**

Precertification is the process by which - prior to your 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. You must obtain prior authorization for:

- Transplants
- Some same-day surgery (outpatient) and ambulatory procedures
- Services with a non-network provider
- Reconstructive and restorative services
- Infertility/assisted reproductive technology services
- Oral surgery (with the exception of impacted teeth)
- Genetic testing
- Neuropsychological testing
- Prosthetics/orthotics and durable medical equipment
- Hospice care
- Non-emergency ambulance
- High-tech radiology, including, but not limited to, MRI/MRA, CT/CTA, PET scans and nuclear cardiology imaging studies
- Sleep study and/or sleep therapy
- Oxygen
- Outpatient mental health services (including intermediate care), beyond eight sessions
- Speech therapy
- Injections and injectables that are included on the formulary, that are for covered medical benefits, and that are ordered, supplied and administered by a plan provider
- Pulmonary rehabilitation services for chronic obstructive pulmonary disease (COPD)
- Habilitative or rehabilitative care, including but not limited to ABA therapy, for the treatment of autism
- Therapeutic care for the treatment of autism
- Enteral formulas and special medical formulas
- Intensity modulated radiation therapy (IMRT) of the breast
- Proton beam therapy
- Stereotactic radiosurgery and stereotactic body radiotherapy
- Treatment of cleft lip and cleft palate

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

First, your physician, your hospital, you, or your representative, must call us at 1-800-868-5200 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours 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 1-800-868-5200 (TTY users please call TRS Relay 711). 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 1-800-868-5200 (TTY users please call TRS Relay 711). 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, then we will make a decision within 24 hours after we receive the claim.

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

- **Maternity care** — The plan covers maternity and obstetrical care in accordance with the General Laws of Massachusetts. Routine obstetrical and maternity care does not require a referral or prior authorization, but you need to see a plan provider who is an obstetrician, certified nurse midwife or family practice physician.

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

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

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 described below.

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

- **To reconsider a non-urgent care claim** — Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

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

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

  3. Write to you and maintain our denial.

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

Subject to a request for additional information, we will notify you of our decision with 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 telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

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

Section 4. Your cost 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., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the physician or other health care provider, facility, pharmacy, etc., when you receive certain services. The amount of the copayment varies, depending on the type of provider or service.

- You have no copayment for routine physical examinations or well-child care with your PCP.
- You pay a $25 copayment per office visit with your primary care provider and certain other providers, and a $35 copayment per office visit with a specialist. After you pay your copayment, the Plan pays the remainder of the cost for the office visit and any covered services you receive during the office visit. Covered services you receive during the office visit, such as labs, X-rays and other diagnostic tests, or medical or surgical care are subject to your calendar year deductible. See Section 5 (c) for your copayments for services provided in a hospital or other facility, Section 5 (d) for your copayments for emergency services and Section 5 (f) for your copayments for prescription drugs.

Deductible

A calendar year deductible is a fixed expense you must incur for certain covered services and supplies before the Plan starts paying benefits for them. Copayments do not count toward your calendar year deductible. When a covered service or supply is subject to your calendar year deductible, only the Plan allowance that you pay for that service or supply goes toward your calendar year deductible. The calendar year deductible does not apply to preventive care office visits for adults and children, including immunizations, mammograms, cytological exams and other tests associated with preventive care; prenatal maternity care, well-child care (from birth to age 22) including vision and auditory screening; voluntary family planning; or nutrition and health education.

- For Self Only coverage, the calendar year deductible is $600.
- For Self and Family coverage, the calendar year deductible is $1,200. The Self and Family calendar year deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for all family members reach $1,200. No individual family member must pay more than $600 per calendar year deductible.

Note: Any calendar year deductible amounts paid during the last three months of the calendar year may be applied to your calendar year deductible for the next calendar year. We call this the deductible carryover. In order for the deductible carryover to apply you must have had continuous coverage under the Plan at the time the charges for the prior year were incurred.

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: In our plan, you pay 30% of our allowance for durable medical equipment.

Your catastrophic protection out-of-pocket maximum

Your catastrophic protection out-of-pocket maximum, the cost to the enrollee, will be $1,200 self and $2,400 family. This will include deductibles, coinsurance and all copayments.

For other covered services, such as inpatient care, you must meet a per-member deductible before the plan will begin paying benefits. Each member must meet the per-member deductible amount, unless the family deductible applies. The family deductible is considered met when any combination of members in a family reaches the family deductible amount. No individual family member will pay more than the per-member deductible in a calendar year. After you have met your deductible, some services will be covered in full by the plan. For other services, you will be responsible for a copayment when you receive these services. Your costs for all covered services are described in this brochure. Copayments do not count toward your deductible.

Your deductible is $600 per member/$1,200 per family per calendar year for certain services. Once you have met your deductible, you may still be responsible for a copayment when you receive certain services.

There is a limit to your out-of-pocket costs each calendar year. This is called your out-of-pocket maximum. The out-of-pocket maximum includes your deductible, coinsurance and copayments you pay. Your out-of-pocket maximum is $1,200 per member or $2,400 per family. Each member must meet the per-member out-of-pocket maximum, unless the family out-of-pocket maximum applies. The family out-of-pocket maximum is considered met when any combination of members in a family reaches the family out-of-pocket maximum. Please note that once any one member in a family accumulates $1,200 in out-of-pocket costs, that family member's out-of-pocket maximum is considered met, and that family member will have no additional out-of-pocket costs for the remainder of the year.

If you pay any amounts that you are not responsible for, please contact Customer Service, or you may send a letter to Fallon Community Health Plan, Customer Service, 10 Chestnut St., Worcester, MA 01608. Include your name, address, member ID, proof of payment and an address to which the reimbursement should be sent. You must submit a claim for reimbursement within one year of the date of service.

Carryover

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

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

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.

Section 5. Basic Option Benefits

See page 15 for how our benefits changed this year. Page 81 is a benefits summary. Make sure that you review the benefits that are available under this option.

Section 5. Basic Option Benefits Overview

This Plan offers a Basic Option. This benefit package is described in Section 5. Make sure that you review the benefits that are available under this option.

The Basic Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Basic Option benefits, contact us at 1-800-868-5200 (TTY users please call TRS Relay 711) or on our Web site at www.fchp.org.

• **Basic Option**	Basic Option has a calendar year deductible for certain covered services. You must meet that deductible before we will begin to pay for those services. See Section 4 *Your costs for covered services* for more information.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan providers must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is: $600 per person ($1,200 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	**Basic Option**
Professional services of physicians or other health care professionals • In physician's office • Second surgical opinion • Office medical consultations • At home Note: See Section 5(d), *Emergency services*, for care of a minor emergency in a doctor's office or urgent care center.	$25 copayment per office visit to your primary care provider and certain other providers $35 copayment per associated office visit to a specialist Services provided to you during the office visit, such as diagnostic tests and medical or surgical procedures, are subject to the calendar year deductible.
Professional services of physicians or other health care professionals • In a hospital	Nothing
Professional services of physicians or other health care professionals • In a skilled nursing facility	Nothing
Minute clinics (mini-clinics)	$25 copayment per visit (No deductible)

Benefit Description	You pay After the calendar year deductible…
Lab, X-ray and other diagnostic tests	**Basic Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG • Human leukocyte antigen (HLA) or histocompatibility locus antigen testing for A, B, or DR antigens, or any combination thereof, necessary to establish bone marrow transplant donor suitability of a member	Nothing for lab, X-ray and other diagnostic tests after you meet your calendar year deductible $25 copayment per office visit to your primary care provider and certain other providers $35 copayment per associated office visit to a specialist
High-tech imaging services (including MRI, CT, PET, and nuclear cardiology imaging)	$75 copayment per MRI, CT, PET and nuclear cardiology imaging study after you meet your deductible
Preventive care, adult	**Basic Option**
Routine physical examinations every 12 months and related services with your PCP, such as: • History and risk assessment • Urinalysis • CBC Routine screenings, such as: • Total blood cholesterol • Colorectal Cancer Screening, including: - Fecal occult blood test - Sigmoidoscopy screening - every five years starting at age 50 - Colonoscopy screening - every ten years starting at age 50 • Osteoporosis screening for women age 65 and older (beginning at age 60 for women at increased risk) • Abdominal Aortic Aneurysm screening (ultrasound) - one time test for men age 65 to 75 with a history of smoking	Nothing (No deductible)
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing (No deductible)
Well woman care, including, but not limited to: • Routine pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections	Nothing (No deductible)

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible…
Preventive care, adult (cont.)	**Basic Option**
• Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing (No deductible)
Routine mammogram - covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive years	Nothing (No deductible)
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing (No deductible)
Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	
Travel-related immunizations	Nothing (No deductible)
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp.	*All charges*
Preventive care, children	**Basic Option**
• Well-child care charges for routine examinations, immunizations and care (up to age 22), which include: - History and physical examination, measurements, sensory screening, neuropsychiatric evaluations, development screening and assessment - Screening of all children under six years of age for the presence of lead poisoning - Hereditary and metabolic screening at birth, newborn hearing screening, tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the provider. • Examinations, such as: - Eye exams through age 22 to determine the need for vision correction - Hearing exams through age 22 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	Nothing (No deductible)

Preventive care, children - continued on next page

Benefit Description	You pay After the calendar year deductible…
Preventive care, children (cont.)	**Basic Option**
• Childhood immunizations recommended by the American Academy of Pediatrics including Hepatitis A for infants 12 to 23 months of age, and tetanus, diptheria, and pertussis • Meningococcal Conjugate Vaccine for children at risk as indicated by the American Academy of Pediatrics	Nothing (No deductible)
Travel-related immunizations	Nothing (No deductible)
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, or attending schools or camp	*All charges*
Maternity care	**Basic Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 19 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. If you are discharged sooner (the mother must decide to accept an early discharge), you are covered for one home visit by a registered nurse, physician or certified nurse midwife. • We cover routine nursery care including examination, newborn hearing screening and circumcision, of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). • We pay non-routine maternity care the same as for illness and injury. See Medical services and supplies provided by physicians and other health care professionals (Section 5(a)).	Nothing for prenatal care or the first postpartum visit; $25 copayment per office visit for all postpartum care visits thereafter. Nothing for inpatient professional delivery services

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Maternity care (cont.)	**Basic Option**
Breastfeeding support, supplies and counseling for each birth	Nothing
Family planning	**Basic Option**
Contraceptive counseling on an annual basis	Nothing (No deductible)
A range of voluntary family planning services, limited to: • Consultations, examinations, procedures and medical services related to the use of all contraceptive methods • Contraceptives furnished by a Plan provider during a covered office visit, such as: - Surgically implanted contraceptives - Intrauterine devices (IUDs) - Diaphragms - Cervical caps • Voluntary sterilization (See *Surgical procedures* Section 5 (b)) Note: We cover oral contraceptives and certain other contraceptives, such as Depo-Provera and the contraceptive patch, under the prescription drug benefit.	Nothing (No deductible)
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	**Basic Option**
Diagnosis and treatment of infertility such as: • Evaluation and diagnosis of infertility • The following procedures for the treatment of infertility - Artificial insemination (AI) - Intravaginal insemination (IVI) - Intrauterine insemination (IUI) • Intracytoplasmic sperm injection (ICSI) • Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated egg To be eligible, you must be an individual who: (1) is unable to conceive or produce conception during a period of one year; and (2) should expect fertility as a natural state; or (3) is a premenopausal female or a female who is experiencing menopause at a premature age	Nothing for infertility procedures after you meet your deductible $25 copayment per office visit to your primary care provider and certain other providers $35 copayment per associated office visit to a specialist

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	**Basic Option**
Approval for Assisted Reproductive Technology (ART) is continegent upon review of your medical history by the Plan medical director. A benefits pamphlet is available by contacting Customer Service at 1-800-868-5200 (TTY users please call TRS Relay 711). Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	Nothing for infertility procedures after you meet your deductible $25 copayment per office visit to your primary care provider and certain other providers $35 copayment per associated office visit to a specialist
Diagnosis and treatment of infertility such as: • In vitro fertilization and embryo placement (IVF-EP) • Gamete intrafallopian transfer (GIFT) • Zygote intrafallopian transfer (ZIFT)	$100 copayment per procedure after you meet your deductible
Not covered: Services include, but are not limited to the following list. For more information please contact Customer Service at 1-800-828-5200 (TTY users please call TRS Relay 711). • *Treatments, services and supplies which have not been determined to be medically necessary by a Plan specialist in fertility and the Plan medical director.* • *Donor egg transfer or harvesting for women who are menopausal (except as stated above) or have genetic oocyte defects.* • *Chromosome studies of a donor (sperm or egg).* • *Pre-implant Genetic Diagnosis (PGD) or testing (genetic testing on the embryo before it is inserted into the uterus).* • *Surrogacy or gestational carrier services.*	*All charges*
Allergy care	**Basic Option**
• Testing and treatment • Allergy injections	Nothing for allergy testing and treatment $25 copayment per associated office visit to your primary care provider and certain other providers $35 copayment per associated office visit to a specialist
• Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Treatment therapies	**Basic 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 41. We cover prescription chemotherapy drugs purchased at a pharmacy under the prescription drug benefit, with the applicable copayments. • Respiratory and inhalation therapy Note: Drug therapies for the treatment of respiratory diseases are covered under the prescription drug benefit. • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: 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 18.	Nothing for treatment therapies after you meet your calendar year deductible $25 copayment per associated office visit to your primary care provider and certain other providers $35 copayment per associated office visit to a specialist
Pulmonary rehabilitation services for chronic obstructive pulmonary disease (COPD) are covered for up to two one-hour sessions per day, for up to 36 lifetime sessions.	Nothing
Autism services: Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder	$25 copayment per visit (No deductible)
Physical and occupational therapies	**Basic Option**
Habilitative/rehabilitative services (physical, occupational and speech therapy) up to 60 visits per illness or injury per calendar year for: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a provider: • orders the care. Cardiac rehabilitation for persons with documented cardiovascular disease, initiated within 26 weeks after the diagnosis of cardiovascular disease	$25 copayment per office visit after you meet your calendar year deductible

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies (cont.)	**Basic Option**
• Early intervention services delivered by certified early intervention specialists according to operational standards developed by the Department of Public Health, for children from birth to their 3rd birthday.	Nothing (No deductible)
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	**Basic Option**
Habilitative and rehabilitative medically necessary services, up to 60 visits per condition, for the diagnosis and treatment of speech, hearing and language disorders when services are provided by a Plan provider who is a speech-language pathologist or audiologist; at a Plan facility or provider's office.	$25 copayment per office visit after you meet your calendar year deductible
Hearing services (testing, treatment, and supplies)	**Basic Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist. • Hearing aids, as shown in *Orthotic and prosthetic devices.* Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	Nothing
Not covered: • *Hearing services that are not shown as covered.*	*All charges*
Vision services (testing, treatment, and supplies)	**Basic Option**
• Annual eye refractions	Nothing (No deductible)
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**Basic Option**
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. • Non-routine foot care, including but not limited to : treatment of bunions, ganglion, heel spurs, plantar fasciitis, osteoarthritis and plantar warts. Note: See *Orthotic and prosthetic devices* for information on podiatric shoe inserts on page 36.	$25 copayment per office visit to your primary care provider and certain other providers $35 copayment per associated office visit to a specialist
Not covered:	*All charges*

Foot care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Foot care (cont.)	**Basic Option**
• *Routine foot care for members unless specified above*	*All charges*
Orthotic and prosthetic devices	**Basic Option**
Prosthetic limbs, which replace in whole or in part, an arm or leg. • Orthotic devices (devices that support part of the body and/or eliminate motion) such as neck collars for cervical support, molded body jacket for curvature of the spine and braces with rigid support. • Prosthetic devices (not including dental) such as artificial eyes, implanted corrective lenses following cataract surgery and electric speech aids. • Corrective orthotic appliances for non-dental treatment of temporomandibular (TMJ) pain dysfunction syndrome. • Externally worn breast prostheses and surgical bras, including replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	20% coinsurance after you meet your calendar year deductible
Scalp and hair prosthesis (wigs) for individuals who have suffered hair loss as a result of the treatment of any form of cancer or leukemia.	Nothing after you meet your calendar year deductible
Hearing aids for individuals age 21 or younger for the cost of one (1) hearing aid per hearing impaired ear up to $2,000 for each hearing aid device only, every 36 months • Related services and supplies for hearing aids (not subject to the $2,000 limit)	20% coinsurance after you meet your calendar year deductible
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbrosacral supports* • *Adjustable shoe-styling positioning devices, such as Bebax™ Shoe* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME)	**Basic Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen and oxygen equipment • Hospital beds • Wheelchairs • Crutches and canes • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Visual magnifying aids for use by the legally blind • Voice synthesizers for blood glucose monitors • Insulin pumps and insulin pump supplies Note: Insulin and insulin pump supplies are covered under the prescription drug benefit. All durable medical equipment must be ordered by a Plan provider and require prior authorization by the Plan. Note: Call us at 1-800-868-5200 (TTY users please call TRS Relay 711) as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at a discounted rates and will tell you more about this service when you call.	30% coinsurance after you meet your calendar year deductible
Not covered: • *Items that are not covered include, but are not limited to, air conditioners, air purifiers, arch supports, ear plugs (to prevent fluid from entering the ear canal during water activities), foot orthotics, orthopedic shoes (except when part of a brace) or other supportive devices for the feet, articles of special clothing, compression garments (such as Jobst® stockings), bed-pans, raised toilet seats, dehumidifiers, dentures, elevators, safety grab bars, car seats, seizure helmets, hearing aids, heating pads, hot water bottles, tinnitus maskers, exercise equipment or similar equipment.* • *Oxygen and related equipment when received from a non-Plan provider. This includes oxygen and related equipment that you are supplied with while you are out of our service area.*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Home health services	**Basic Option**
Home health care ordered by a Plan provider and authorized by the Plan, including part-time or intermitent skilled nursing care and physical therapy, medical social services, home health aid services, medical and surgical supplies, durable medical equipment and nutritional consultations are covered to the extent that they are determined to be a medically necessary component of covered skilled nursing care and physical therapy. Note: Durable medical equipment and physical and occupational therapy provided as a medically necessary component of home health care are not subject to the benefit limits.	Nothing after you meet your calendar year deductible
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*	*All charges*
Chiropractic	**Basic Option**
Chiropractic services for acute musculoskeletal conditions. The condition must be new or an exacerbation of a previous condition. Coverage is provided for up to 12 office visits in each calendar year, when medically necessary.	$25 copayment per office visit (No deductible)
Alternative treatments	**Basic Option**
No benefit	*All charges*
Educational classes and programs	**Basic Option**
Coverage is provided for: • Tobacco cessation programs, including individual/group/ telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per calendar year, four counseling sessions per quit attempt. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
• Diabetes self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider.	$25 copayment per office visit (No deductible)
• Childhood obesity education	Nothing

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan providers must provide or arrange your care.
- You have an annual out-of-pocket maximum of $1,200 per person or $2,400 per family.
- The calendar year deductible is $600 per person or $1,200 per family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- You pay a copayment for each office visit to a physician or other health care professional. Services provided to you during the office visit, such as diagnostic tests and medical or surgical procedures, are subject to the calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR PROVIDER MUST GET PRIOR AUTHORIZATION FOR SOME SURGICAL PROCEDURES. Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require prior authorization.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	**Basic Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery). Candidates must: - Meet the definition of morbid obesity - Be at least 18 years old - Have no untreated metabolic cause for obesity (e.g. adrenal or thyroid disorders)	Nothing for surgical procedure after you meet your calendar year deductible $25 copayment per associated office visit to your primary care provider and certain other providers $35 copayment per associated office visit to a specialist See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**Basic Option**
- Have a history of failure with two or more nonsurgical measures, supervised, over at least a one year period • Insertion of internal prosthetic devices. See Section 5(a) - *Orthotic and prosthetic devices* for device coverage information. • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns 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.	Nothing for surgical procedure after you meet your calendar year deductible $25 copayment per associated office visit to your primary care provider and certain other providers $35 copayment per associated office visit to a specialist See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
Not covered: • *Reversal of voluntary sterilization.* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges*
Reconstructive surgery	**Basic 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; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Reconstruction of the breast on which the mastectomy was performed; - Surgery to produce a symmetrical appearance on the other breast; - Treatment of any physical complications, such as lymphedemas. 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.	Nothing for reconstructive surgery after you meet your calendar year deductible $25 copayment per associated office visit to your primary care provider and certain other providers $35 copayment per associated office visit to a specialist
Breast prostheses and surgical bras and replacements (see Section 5 (a) *Orthotic and prosthetic devices)*	Nothing after you meet your calendar year deductible
Not covered:	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	**Basic Option**
• *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* • Surgeries related to sex transformation	*All charges*
Oral and maxillofacial surgery	**Basic 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.	Nothing for oral and maxillofacial surgery after you meet your calendar year deductible. $25 copayment per associated office visit to your primary care provider and certain other providers $35 copayment per associated office visit to a specialist See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**Basic Option**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - 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 • Autologus pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**Basic Option**
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 limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogenic 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) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphicytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteoporosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Mucidolipidosis (e.g. Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g. Hunter's syndrome, Hurler's syndrome, Sanfilippo'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	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**Basic Option**
- 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) - Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeolma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	Nothing
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	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**Basic Option**
- 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 reccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reccurrence (relapsed) - Amyloidosis - Neuroblastoma	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. • Allogenic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - 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 - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**Basic Option**
- 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) - 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 - Breast cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian cancer - Mantle cell (non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	Nothing
National Transplant Program (NTP)	Nothing
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 as shown above*	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**Basic Option**
• *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**Basic Option**
Professional services provided in – • Hospital (inpatient)	Nothing for anesthesia services after you meet your calendar year deductible
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing for anesthesia services after you meet your calendar year deductible $25 copayment per associated office visit to your primary care provider and certain other providers $35 copayment per associated office visit to a specialist

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan providers must provide or arrange your care and you must be hospitalized in a Plan facility.
- You have an annual out-of-pocket copayment maximum of $1,200 per person or $2,400 per family.
- The calendar year deductible is $600 per person or $1,200 per family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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 PROVIDER MUST GET PRIOR AUTHORIZATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require prior authorization.

Benefit Description	You pay
Note: The calendar year deductible applies only when we say below: "(calendar year deductible applies)".	
Inpatient hospital	**Basic 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.	$150 copayment per day up to $750 per admission after you meet your calendar year deductible
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	$150 copayment per day up to $750 per admission after you meet your calendar year deductible
• 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 (Note: calendar year deductible applies.)	$150 copayment per day up to $750 per admission after you meet your calendar year deductible
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**Basic Option**
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**Basic Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$100 copayment per outpatient surgery after you meet your calendar year deductible
Extended care benefits/Skilled nursing care facility benefits	**Basic Option**
Skilled nursing facility (SNF): The plan covers inpatient services in a SNF for up to 100 days in each calendar year. You may be admitted to a SNF if, based on your medical condition, you need daily skilled nursing care, skilled rehabilitation services or other medical services that may require access to 24-hour medical care but does not require the specialized care of an acute care hospital. Services require referral and prior authorization. Services provided are: • Room and board in a semiprivate room (or private room if medically necessary) • The services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, nursing services, physical, speech and occupational therapy, medical supplies and equipment • Drugs, biologicals, equipment and supplies ordinarily provided or arranged by the skilled nursing facility, when prescribed by a plan provider	$150 copayment per day up to $750 per admission after you meet your calendar year deductible
Not covered: • *Custodial care or personal comfort items such as telephone, radio or television* • *Rest care or long-term care*	*All charges*

Benefit Description	You pay
Hospice care	**Basic Option**
Hospice care is a method of caring for the terminally ill that helps those individuals continue their lives with as little disruption as possible. This type of care emphasizes supportive services, such as home care and pain control, rather than the cure-oriented services that are provided in hospitals. To be eligible for hospice care, you must be terminally ill with a life expectancy of less than six months. • Hospice services are provided, as necessary, to maintain the terminally ill individual at home, in the community and in facilities, such as: - Physicians' services, nursing care and medical social services - Medical appliances and supplies including drugs and biologicals (prescription copayments may apply)	Nothing (No deductible)
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**Basic Option**
• Ambulance service when medically appropriate Note: See Section 5(d) for coverage of emergency ambulance.	Nothing after you meet your calendar year deductible

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $600 per person or $1,200 per family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergency care

The Plan covers emergency care worldwide. When you have a medical emergency (as described above) you should go to the nearest emergency room for care or call your local emergency communications system (e.g., police or fire department, or 911) to request ambulance transportation.

Emergency services do not require referral or prior authorization, but after receiving emergency care, you should notify your primary care provider, who will arrange for any follow-up or continuing care that is medically necessary for you.

Urgent care

Sometimes you may need care for minor medical emergencies such as cuts that require stitches, a sprained ankle or stomach pain. These situations may not pose as much of a threat as the emergency situations discussed above, but they still require fast treatment to prevent serious deterioration of your health.

If you are within the Plan service area, call your primary care provider's office for information on how and where to seek treatment. If your doctor is not available, an on-call doctor will make arrangements for your care. Telephones are answered 24 hours a day, seven days a week. Explain the medical situation to the doctor and state where you are calling from so that the doctor can refer you to the most appropriate facility.

If you are outside the Plan service area, go to the nearest medical facility for care. You do not need a referral or prior authorization, but you should notify your primary care provider for assistance.

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	**Basic Option**
• Emergency care in an emergency room *Note: We waive the ER copay if you are admitted to the hospital.*	$100 copayment per visit (No deductible)
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services • Urgent care at an urgent care center or doctors' office	$25 copayment per visit (No deductible)
Not covered: • *Elective or non-emergency care received in an emergency room* • *Follow-up care, unless provided by your primary care provider or authorized by the Plan. This includes follow-up care provided in an emergency room or urgent care facility.*	*All charges*
Emergency outside our service area	**Basic Option**
• Emergency care in an emergency room *Note: We waive the ER copay if you are admitted to the hospital.*	$100 copayment per visit (No deductible)
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services • Urgent care at an urgent care center or a doctors' office	$25 copayment per visit (No deductible)
Not covered: • *Elective or non-emergency care received in an emergency room* • *Follow-up care, unless provided by your primary care provider or authorized by the Plan, including follow-up care provided in an emergency room or urgent care center.*	*All charges*
Ambulance	**Basic Option**
Emergency ambulance service when medically appropriate. (Prior authorization is not required.) Note: See 5(c) for non-emergency ambulance service.	Nothing after you meet your calendar year deductible
Not covered: • *Air ambulance when not appropriate to medical condition or geographic location* • *Transfers between hospitals when the patient's medical condition does not warrant that he or she be transported to another facility* • *Commercial airline transportation*	*All charges*

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR AUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the prior authorization process and get Plan approval of your treatment plan:
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Professional services	**Basic Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. 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 (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Professional services (cont.)	**Basic Option**
• Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnostics	**Basic Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse 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	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Note: See Section 5 (a) for coverage of labs, X-rays and other diagnostic tests.	
Inpatient hospital or other covered facility	**Basic Option**
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	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Outpatient hospital or other covered facility	**Basic Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Not covered: Services that are not part of a prior authorized approved treatment plan.	

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.
- The calendar year deductible is $600 per person or $1,200 per family. The calendar year deductible applies to some benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed Plan provider or a provider who you have seen on an authorized referral must write the prescription.
- **Where you can obtain them.** You may fill your prescription at a Plan pharmacy or by mail. In emergencies, when you are out of the Plan service area and cannot fill your prescription at a Plan pharmacy, we will provide coverage for up to a 14-day supply. You may fill the prescription at any location and submit the receipt for reimbursement. You will be reimbursed the cost of a 14-day supply, less the appropriate copayment. See “When you have to file a claim” below for information on submitting proof of payment for reimbursement.
- **We use a formulary.** Our formulary is a list of medications that shows the copayment tier and prior authorization requirements for each medication. We have chosen the tiers and determined the criteria for prior authorization based on cost and efficacy. Coverage of certain drugs is based on medical necessity. They are designated on the formulary as “MN”. Your provider must get prior authorization from the Plan before giving you a prescription for one of these medications.
- **These are the dispensing limitations.** When you fill a covered prescription at a Plan pharmacy, you pay one copayment for up to a 30-day supply. Occasionally, for safety reasons or as directed by your provider, the length of therapy may be less than 30 days. We follow FDA dispensing guidelines. You generally cannot refill a prescription until most of the previous supply has been used.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Mail-order program.** When you fill or refill your prescription through our mail-order program, you may order up to a 90-day supply of most medications. You have a fixed copayment for each tier of medication through our mail-order program. The copayment for up to a 90-day supply of covered prescription medications is equal to the cost of two pharmacy (30-day supply) copayments.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you - and us - less than a name brand prescription.
- **If you are called to active duty or need medication during a national or other emergency** you can get up to a 90-day supply of a maintenance medication at a participating pharmacy or through our mail-order program. If you need assistance with the process, call Customer Service at 1-800-868-5200.
- **When you have to file a claim.** If you need an emergency prescription as part of an approved emergency treatment while you are out of the Plan service area, the Plan will reimburse you for the cost of a 14-day supply of medication, less the appropriate copayment. Submit proof of payment to: Fallon Community Health Plan, Claims Department, PO Box 15121, Worcester, MA 01615-0121.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	**Basic Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail-order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Diabetic supplies and medications limited to insulin, insulin syringes, blood glucose monitoring strips, urine glucose strips, Ketone strips, lancets, insulin pumps, insulin pump supplies and insulin pens • Oral medications that influence blood sugar levels • Self-administered injectable agents • Hormone replacement therapy for peri- and post- menopausal women • Disposable needles and syringes for the administration of covered medications • Fertility drugs • Drugs for sexual dysfunction • Off-label use of covered drugs in the treatment of HIV, AIDS or cancer Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. Certain fertility medications also require prior authorization; some may have a quantity limit for each prescription as well.	*At a Plan pharmacy:* up to a 30-day supply Tier 1: $10 Tier 2: $30 Tier 3: $60 *Mail-order:* up to a 90-day supply Tier 1: $20 Tier 2: $60 Tier 3: $120 Note: If there is no generic equivalent available, you will still have to pay the brand name copayment. (No deductible)
Women's contraceptive drugs and devices Note: Over-the-counter emergency contraceptive drugs (morning after pill) are covered at no cost when prescribed by a physician and purchased at a network pharmacy.	Nothing (No deductible)
Injectables furnished and administered in a provider's office or under professional supervision are covered as a medical benefit.	Nothing after you pay your calendar year deductible
The Plan covers the special medical formulas and food products limited to those listed below. Prior authorization is required. • Special medical formulas for the treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria.	Nothing after you pay your calendar year deductible

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	**Basic Option**
• Enteral formulas for home use for which a physician has issued a written order and which are necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids. • Food products modified to be low in protein for individuals that have been diagnosed with phenylketonuria and other inherited diseases of amino acids and organic acids. You may be required to purchase these products over-the-counter and submit claims to the Plan for reimbursement.	Nothing after you pay your calendar year deductible
We cover Vitamin D for adults age 65 and over.	Nothing (No deductible)
Not covered: • *Bio-identical hormone replacement therapy.* • *Drugs and supplies for cosmetic purposes.* • *Drugs to enhance athletic performance.* • *Drugs for appetite suppression.* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies.* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them, except for Vitamin D.* • *Nonprescription medicines, over-the-counter preparations, devices and medical supplies such as antiseptics.* • *Drugs that are investigational or that have not been approved for general sale and distribution by the U.S. Food and Drug Administration.* • *Nicotine patches and gum or other smoking cessation products, unless supplied to you as part of an approved smoking cessation program.* • *Medications and products for noncovered dental conditions.* • *Prescription drugs that are a combination of a covered prescription item and an item that is specifically excluded, such as vitamins, minerals, medical foods or formulas.* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 38.)	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental /Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- The calendar year deductible is: $600 per person ($1,200 per family). The calendar year deductible applies to all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay
Accidental injury benefit	**Basic Option**
The Plan covers emergency medical care, such as to relieve pain and stop bleeding as a result of an accidental injury to sound natural teeth or tissues, when provided as soon as medically possible in the office of a physician or dentist. You do not need a referral or prior authorization for emergency care needed as a result of dental trauma. Go to the closest provider. Note: This accidental injury benefit does not include restorative or other dental services.	$25 copayment per office visit

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	You may access our TTY equipment at TRS Relay 711.
Clinical trials	The Plan covers the costs for services furnished to members enrolled in certain qualified clinical trials to the same extent as they would be covered if the member did not receive care in a qualified clinical trial. To be eligible for coverage, you must have been diagnosed with cancer and the clinical trial must be one that is intended to treat cancer. Coverage for services provided to you while you are enrolled in the clinical trial is subject to all the terms and conditions of the plan, including, but not limited to, provisions requiring the use of plan providers. *Exclusion: All clinical trials with the exception of clinical trials for the treatment of cancer.*
Interpreter services	The Plan will, upon request, provide members with interpreter and translation services related to our administrative procedures.
Out-of-area student coverage	Students attending school outside the Plan service area may not have easy access to a Plan provider. They are covered for a limited number of services while out-of-area, if authorized in advance by the Plan. You must work with your PCP to get prior authorization. These services include: • Non-routine medical office visits • Diagnostic lab and X-ray connected with a non-routine office visit • Non-elective inpatient services

	• Outpatient services to treat mental conditions • Speech therapy • Short-term rehabilitation services, including physical and occupational are covered for up to 60 visits combined in each calendar year (combined with any in-area visits). *Aside from emergency care, the services listed above are the only services that are covered for students on an out-of-network basis. To be covered, all other services must be obtained when they return to the Plan service area.* Services that are not covered for students while out of the Plan service area include: • Routine physical, gynecological exams, vision screening and hearing screening • Routine preventive care • Non-emergency prescription medication. Students may use a network pharmacy or the prescription medication mail-order program to fill medication refills. (See page 54.) • Second opinion • Chiropractic care services • Home health care • Outpatient surgical procedures that could be delayed until return to the Plan service area • Maternity care or delivery • Durable medical equipment (e.g., wheelchairs), including maintenance or replacement
Peace of Mind Program™	FCHP's Peace of Mind Program provides access to specialty services at specified Boston area medical centers. You may access Peace of Mind Program providers at your request if you meet the following conditions: • The specialty service is ordinarily available in the Plan network • Care is for covered services as described in this brochure. The same copayments and benefit limits apply. • You have seen a plan specialist for this same condition within the past three months. • A referral to a specific Peace of Mind Programphysician is made by your PCP and notification of the referral is given to the plan. • The provider to whom you are referred is on staff at one of the six medical centers listed below: - Beth Israel Deaconess Medical Center - Brigham and Women's Hospital - Children's Hospital - Dana Farber Cancer Institute - Massachusetts General Hospital - Tufts New England Medical Center • If you receive any hospital-based services such as surgery, lab or X-rays, these services must be performed at one of the above hospitals or at another plan facility. If you see a specialist through the Peace of Mind Program, and the specialist recommends or arranges services to be performed at a hospital that is not listed above, these services will not be covered unless the physician has obtained prior authorization from the plan. You must have a copy of the written authorization from the plan; do not rely on assurances by the physician regarding plan coverage.

	Once the plan has been notified of the Peace of Mind Program referral to a Peace of Mind Program specialist, you may see this specialist for a period of one year or until treatment for the presenting condition is complete, whichever comes first. When your course of treatment is complete, or for care for any non-related condition, you should return to your PCP for care. If your Peace of Mind Program specialist wants you to see another specialist at the same facility for the same condition, your PCP must submit a separate referral to the plan before you see the other specialist. If you want to see a Peace of Mind Program specialist for a different condition, the request must meet Peace of Mind Program conditions described above for the second condition, your PCP must submit a referral to the plan and you must receive prior authorization from the plan in order for the services related to the second condition to be covered. Please note: For the period of time that you are authorized treatment with the Peace of Mind Program provider for a particular condition, the Peace of Mind Program provider may order X-rays, laboratory tests and other tests to evaluate that condition without prior authorization if these services would normally be covered and would require no prior authorization when ordered by a plan provider. All inpatient care or inpatient, outpatient, or office-based surgery requires prior authorization from the plan. For a list of services requiring prior authorization, see Section 3 *How you get care*. Note that all MRIs, CT scans, PET scans, nuclear cardiology imaging and genetic testing require prior authorization. If you need physical therapy or occupational therapy for the same condition for which your Peace of Mind Program specialist is treating you, your Peace of Mind Program specialist may refer you for such physical therapy or occupational therapy up to the benefit maximum without prior authorization at the Peace of Mind Program facility, or you may return to a plan therapist if you want. You may use the Peace of Mind Program for all specialty care except mental health, substance abuse, chiropractic services, obstetrics, speech therapy and infertility services. You may not use the Peace of Mind Program for any primary care services, including internal medicine, family practice or pediatrics. If you have not met the conditions listed above, or if you or your physician have not obtained prior authorization for a Peace of Mind Program service, the services will not be covered by the plan and the Peace of Mind Program provider may hold you financially responsible.
Health education resources	Visit our Web site at www.fchp.org for: • Healthwise Knowledgebase : one of the nation's leading online resources for helping people become informed about their health and health care in active partnership with their doctors. This comprehensive tool features a user-friendly format, hundreds of helpful illustrations and powerful search functions—all of which increase the usefulness of the in-depth medical content. • Preventive Healthcare Guidelines: access preventive health care guidelines and prenatal recommendations from the Massachusetts Health Quality Partners and the Massachusetts Department of Public Health's guidelines for adult diabetes care. • Leapfrog Group: learn more about the Leapfrog Group, which encourages large employers to recognize and reward health plans and hospitals that make "big leaps" in patient safety and quality. • Healthy Communities : FCHP's member magazine provides you with information about hot health topics plus interesting articles on how to improve your general health and well-being.

Care support (Patient Safety)	*Leapfrog Group* - FCHP works in collaboration with the Mass Leapfrog Coalition to enhance patient safety for members treated at our contracted hospitals. We work with the Massachusetts Hospital Association to effectively prioritize and implement the Leapfrog project. FCHP publishes articles in the member magazine, which address information specific to Leapfrog compliance. We also report the following progress with our outpatient safety programs: *Web-based Health Education Program* - FCHP has implemented Web-based education modules in nutrition, fitness, stress, smoking, and weight loss. *Public Report Card on Quality* - FCHP is in the process of developing a physician report card on quality. These report cards will be based on statewide rates and offer you information to help you make health care choices.
Care Management	At FCHP, we focus on selected complex medical and psychological needs of members and their families. Our Care Management Nurses identify, assess, plan, coordinate, implement, monitor and evaluate options and services to meet your health care needs. This approach gives you access to the appropriate resources and services which can improve your quality of life. In addition to the general Care Management Program, FCHP has developed several disease care programs which identify, case manage, and provide educational resources for members with Congestive Heart Failure, Coronary Artery Disease, Asthma, Diabetes, High Risk Program, and Depression. Our specially trained Care Managers empower you to take a more active role in your health care, and give you the tools you need to manage your disease. This is done by coaching over the phone and by mailing appropriate educational packages to you. Care Managers may also refer you to local support groups, classes and rehabilitation programs.

Section 5(i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB calendar year 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 1-800-868-5200 (TTY users please call TRS Relay 711) or visit their website at www.fchp.org.

Eyewear discounts

The Plan has arranged for discounts on eyeglass frames, prescription lenses, non-prescription sunglasses and complete contact lens packages from contracted vendors. For more information, contact Customer Service at 1-800-868-5200 (TTY users please call TRS Relay 711).

Hearing aid discounts

The Plan has arranged for discounts off the regular price of hearing aids. Contact Customer Service at 1-800-868-5200 (TTY users please call TRS Relay 711) for a list of providers.

It Fits!

Fallon Community Health Plan's wellness feature, gives your family up to $400 ($200 for self-only contract) to use toward a variety of healthy activities: membership at local fitness centers, aerobics, Pilates and yoga classes when taught by a certified instructor, Weight Watchers ® programs, as well as and local, town and school sports programs for all ages when they include an aerobic and instructional component. Aerobic activities for the whole family include: baseball, softball, soccer, football, dance classes, ski lessons, golf lessons, swimming lessons, tennis and sports camps. With *It Fits!,* Plan members decide what type of health and fitness program best fits their lifestyle. For more information, contact Customer Service at 1-800-868-5200 (TTY users please call TRS Relay 711).

Oh, Baby!

Oh, Baby! is a health and wellness program for birth, baby and beyond. Whether expecting or planning to adopt, the *Oh Baby!* program gives you information and resources to help you take care of the "little things" in your life. Eligible participants receive useful and important items at no cost. For more information, contact Customer Service at 1-800-868-5200 (TTY users please call TRS Relay 711).

Medicare prepaid Plan enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 71, 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 if one is available in their area. They may then later re-enroll in the FEHB program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid program but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid Plan. Contact Customer Service at 1-800-868-5200 (TTY users please call TRS Relay 711) for information on benefits available under the Medicare HMO.

Health education and wellness programs

FCHP offers a variety of health education and wellness programs, such as tobacco cessation and worksite wellness. Fees for these programs vary and many are provided at no cost. Call Customer Service at 1-800-868-5200 (TTY users please call TRS Relay 711) for more information.

Healthy Health Plan

The FCHP Healthy Health Plan program is designed to allow eligible subscribers to take an active role in their health care. The Program is designed to help eligible subscribers achieve or maintain a healthy lifestyle through a health assessment, online self-learning modules, personalized action plans and professional health coaching.

Requirements for Incentive Payment:

Eligible subscribers that log onto FCHP's Healthy Health Plan portal and complete an HRA are eligible for a $50 incentive payment.

If a subscriber receives a health risk score of between 80% - 100% they are considered healthy and will be paid an additional incentive of $150. – These subscribers may choose to participate in any wellness challenges available within the online wellness portal.

If a subscriber receives a health risk score of between 60% - 79% they are considered to have moderate risk and will be required to participate in an on-line action plan created specifically for them through the portal based on their answers and their readiness to engage in certain areas. If the subscriber completes the action plan before the end of their plan year, they will be paid an additional incentive of $150.

If a subscriber receives a health risk score of between 0% - 59% they will be considered high risk and will be required to participate in Health Coaching which will include an on-line action plan created specifically for them through the portal with the Health Coach and based on their individual risks and readiness to engage in certain areas. If the subscriber completes the coaching (minimum of 4 sessions) and their personal action plan before the end of their plan year, they will be paid an additional incentive of $150.

Incentives will take the form of a check reimbursement. Eligible subscribers are eligible for the incentive payments once per plan year. Only eligible subscribers are eligible to receive the incentive. However, adults 18 and older covered under a subscriber's contract may participate in the FCHP Healthy Health Plan program, but will be ineligible for incentive payments.

FCHP is committed to helping you achieve your best health status. Rewards for participating in a wellness program are available to all eligible subscribers. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact our Customer Service Department at 1-800-868-5200 and we will work with you to find a wellness program with the same reward that is right for you in light of your health status.

Section 6. General exclusions – services, drugs and supplies we do not 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 related to sex transformations
- 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
- All clinical trials with the exception of clinical trials for the treatment of cancer. We do not cover extra care costs related to taking part in a clinical trial, or research costs related to conducting the clinical trial

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

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

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

Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 1-800-868-5200 (TTY users please call TRS Relay 711) or at our Web site at www.fchp.org.

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

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

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

Submit your claims to:

Fallon Community Health Plan
Claims Department
P. O. Box 15121
Worcester, MA 01615-0121

Deadline for filing your claim

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

Post-service claims procedures

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

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

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

Authorized Representative

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

Notice Requirements

If you live in a county where at least 10 percent 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 telephone 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 health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

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

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 Fallon Community Health Plan, 10 Chestnut Street, Worcester, MA, 01608 or calling 1-800-868-5200 (TTY users please call TRS relay 711).

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 health care 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 decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

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 6 months from the date of our decision; and b) Send or bring your request to us at: Fallon Community Health Plan, Member Appeals and Grievances Department, 10 Chestnut St., Worcester, MA 01608, fax it to us at: 1-508-755-7393, e-mail it to us at grievance@fchp.org, or call us at 1-800-333-2535, extension 69950 (TTY users call TRS Relay 711); and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physician's letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive OPM's 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, with 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 make our decision on the information we already have. We will write to you with our decision.

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

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You must write to OPM within:

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

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 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 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.

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

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

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

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

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

You may not sue until you have completed the disputed claim 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 1-800-868-5200 (TTY users please call TRS Relay 711). We will hasten 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 dependent 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 coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC web site at http://www.NAIC.org.

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

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

- **TRICARE and CHAMPVA**

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

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

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

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

Clinical Trials

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, this health plan 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 this plan.
- 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. This plan does not cover these costs.
- 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.

When you have Medicare

- **What is Medicare?**

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.

- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

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

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

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call Customer Service at 1-800-868-5200 (TTY users please call TRS Relay 711) or visit us at www.fchp.org.

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

You can find more information about how our plan coordinates benefits with Medicare at www.fchp.org.

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) 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), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

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 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

Calendar year	The 12 month period beginning on January 1 and ending December 31. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Your share of the allowed charges for certain covered benefits expressed as a percentage. You may also be responsible for additional amounts. See page 23.
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. If you are a participant in a clinical trial, this health plan 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 • 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
Copayment	The amount you are responsible to pay for covered services. See page 23.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Health care services or supplies that are covered by the Plan, as described in this brochure.
Custodial care	A level of care which: (1) is chiefly designed to assist a person with the activities of daily life; and (2) cannot reasonably be expected to improve a medical condition. Custodial care is not covered by the plan.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 23.
Experimental or investigational service	Our Technology Assessment Committee determines what procedures, devices and services are considered experimental or investigational, using FDA guidelines and long-term clinical studies. Clinical studies are used to ensure that the procedure, device or service has proven to be more effective than currently accepted procedures, devices or services.
Group health coverage	Health care coverage through a partnership, association or corporation that has an agreement to pay the Plan or its agent the Plan premium for a group of subscribers. FEHB is an example of a group.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medically necessary (service)	A service or supply that is consistent with generally accepted principles of professional medical practice, as determined by whether or not: (1) the service is the most appropriate available supply or level of service for the member in question, considering potential benefits and harms to the individual; (2) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; (3) for services and interventions not in widespread use, is based on scientific evidence.
Out-of-pocket maximum	A dollar limit to the number of copayments you must pay in each calendar year for inpatient admissions, outpatient surgery and prosthetic limbs combined. Inpatient admissions include admissions to hospitals and skilled nursing or rehabilitation facilities. Outpatient surgery includes same-day surgery in a hospital outpatient department or ambulatory care facility.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services.
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 prior authorization or a referral and (2) where failure to obtain prior authorization or a referral results in a reduction of benefits.
Us/We	Us and We refer to Fallon Community Health Plan (FCHP).
You	You refers to the enrollee and each covered family member.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service department at 1-800-868-5200 (TTY users please call TRS Relay 711). 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.
Usual, customary and reasonable charge	An amount that is consistent with the normal range of charges for the same or similar services in the geographical area where the service was provided, as determined by the plan.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

  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.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents, including children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- If you are new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

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

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

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

Dental Insurance

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

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. Beginning in 2014, most plans cover adult orthodontia. Review your plan's brochure for information on this benefit.

Vision Insurance

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

Additional Information

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

How do I enroll?

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

The Federal Long Term care Insurance Program - FLTCIP

It's important protection

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

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Summary of benefits for the Basic Option of the Fallon Community Health Plan - 2014

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan providers, except in emergencies.
- Below, an asterisk (*) means the item is subject to the $600 per member/$1,200 per family calendar year deductible.

Basic Option Benefits	You Pay	Page
Medical services provided by physicians:		
• Routine physical examinations and related services with your PCP	Nothing	29
• Preventive care for children to age 22	Nothing	30
• Diagnostic and treatment services provided in the office*	$25 copayment per associated office visit to your primary care provider and certain other providers. $35 copayment per associated office visit to a specialist. Services provided to you during the office visit, such as diagnostic tests and medical or surgical procedures are subject to the calendar year deductible.	28
Services provided by a hospital:		
• Inpatient*	$150 copayment per day up to $750 per admission after you meet your calendar year deductible.	47
• Outpatient *	$100 copayment per outpatient surgery after you meet your calendar year deductible.	48
Emergency benefits:		
• Emergency room	$100 copayment per visit (waived if admitted)	50
• Doctor's office or urgent care facility*	$25 copayment per visit	50
Mental health and substance abuse treatment	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	52
Prescription drugs:		
• Retail pharmacy	*At a Plan pharmacy:* up to a 30-day supply Tier 1, 2, and 3 $10/$30/$60 copayment	54
• Mail order	Tier 1, 2, and 3: up to a 90-day supply	54

	$20/$60/$120 copayment	
Vision care:		
• Diagnosis and treatment of disease of the eye	Nothing for treatment of diseases or injuries to the eye after you meet your calendar year deductible $25 copayment per associated office visit to your primary care provider and certain other providers $35 copayment per associated office visit to a specialist	35
• Annual eye refraction	Nothing	35
Special features:	24 hour nurse line Flexible benefits option Services for deaf and hearing impaired Interpreter services Out-of-area student coverage Peace of Mind Program™	58
Protection against catastrophic costs (out-of-pocket maximum)**:**	We do have a catastrophic protection out-of-pocket maximum for certain covered services: $1,200/member or $2,400/family.	24

Notes

Notes

2014 Rate Information for Fallon Community Health Plan

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

Postal rates apply to Postal Service employees. They are shown in special Guides published for APWU (including Material Distribution Center and Operating Services) NALC, NPMHU and NRLCA Career Postal Employees (see RI 70-2A); Information Technology/Accounting Services employees (see RI 70-21T); Nurses (see RI 70-2N); Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees and Postal Career Executive Service employees (see RI 70-21N); and non-career employees (see RI-70-8PS).

Postal Category 1 rates apply to career bargaining unit employees covered by the Postal Police contract.

Postal Category 2 rates apply to career non-bargaining unit, non-executive, non-law enforcement employees, and non-law enforcement Inspection Service and Forensics employees.

For further assistance, Postal Service employees should call:
Human Resources Shared Service Center
1-877-477-3273, option 5
TTY: 1-866-260-7507

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

Premiums for Tribal employees are shown under the monthly non-postal column. The amount shown under employee contribution 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	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Basic Option Self Only	JG1	196.68	135.40	426.14	293.37	113.54	127.20
Basic Option Self and Family	JG2	437.62	369.43	948.18	800.43	320.81	351.20