



# FALLON COMMUNITY HEALTH PLAN

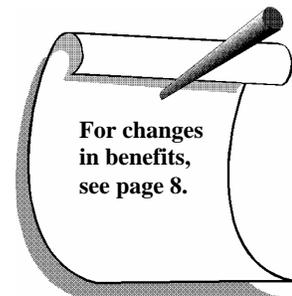
<http://www.fchp.org>

## 2005

### A Health Maintenance Organization

**Serving:** Central and Eastern Massachusetts, including the Worcester metropolitan area

**Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.**



*This Plan has Excellent accreditation from NCQA.  
See the 2005 Guide for more information on NCQA.*

**Enrollment code for this Plan:**

- JV1 High Option—Self Only**
- JV2 High Option—Self and Family**
- JV4 Standard Option—Self Only**
- JV5 Standard Option—Self and Family**

Special notice: This Plan is offering a Standard Option for the first time under the Federal Employees Health Benefits Program during the 2004 Open Season.

Authorized for distribution by the:



**United States  
Office of Personnel Management**

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



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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at [www.healthierfeds.opm.gov](http://www.healthierfeds.opm.gov) for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, [www.hhs.gov/safety/index.html](http://www.hhs.gov/safety/index.html), which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Website at [www.opm.gov/insure](http://www.opm.gov/insure). I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

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

Kay Coles James

Director



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

---

## Table of Contents

---

Introduction .....	3
Plain Language .....	3
Stop Health Care Fraud!.....	3
Preventing medical mistakes .....	4
Section 1. Facts about this HMO plan.....	6
How we pay providers.....	6
Your Rights .....	6
Service Area .....	6
Section 2. How we change for 2005.....	8
Program-wide changes .....	8
Changes to this Plan .....	8
Section 3. How you get care.....	9
Identification cards.....	9
Where you get covered care .....	9
• Plan providers .....	9
• Plan facilities .....	9
What you must do to get covered care .....	9
• Primary care.....	10
• Specialty care.....	10
• Hospital care .....	12
Circumstances beyond our control .....	12
Services requiring preauthorization.....	12
Section 4. Your costs for covered services.....	14
Copayments .....	14
Deductible .....	14
Coinsurance.....	14
Your catastrophic protection out-of-pocket maximum.....	14
Section 5. Benefits – OVERVIEW ( <i>See page 8 for how our benefits changed this year and pages 70 to 71 for a benefits summary.</i> ).....	15
Section 5(a) Medical services and supplies provided by physicians and other health care professionals .....	17
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals .....	29
Section 5(c) Services provided by a hospital or other facility, and ambulance services .....	34
Section 5(d) Emergency services/accidents .....	37
Section 5(e) Mental health and substance abuse benefits.....	39
Section 5(f) Prescription drug benefits.....	41
Section 5(g) Special features.....	44
• Flexible benefits option .....	44
• Out-of-area student coverage.....	44
• Services for deaf and hearing impaired .....	45
• Clinical trials .....	45
• Interpreter services .....	45
• Peace of Mind Program™ .....	45
Section 5(h) Dental benefits .....	46
Section 5(i) Non-FEHB benefits available to Plan members .....	48

Section 6. General exclusions – things we don’t cover .....	49
Section 7. Filing a claim for covered services .....	50
Section 8. The disputed claims process .....	51
Section 9. Coordinating benefits with other coverage .....	53
When you have other health coverage .....	53
What is Medicare? .....	53
• Should I enroll in Medicare? .....	53
• The Original Medicare Plan (Part A or Part B) .....	53
• Medicare Advantage .....	56
TRICARE and CHAMPVA .....	56
Workers’ Compensation .....	56
Medicaid .....	57
When other Government agencies are responsible for your care .....	57
When others are responsible for injuries .....	57
Section 10. Definitions of terms we use in this brochure .....	58
Section 11. FEHB Facts .....	59
Coverage information .....	59
• No pre-existing condition limitation .....	59
• Where you can get information about enrolling in the FEHB Program .....	59
• Types of coverage available for you and your family .....	59
• Children’s Equity Act .....	60
• When benefits and premiums start .....	60
• When you retire .....	60
When you lose benefits .....	60
• When FEHB coverage ends .....	60
• Spouse equity coverage .....	61
• Temporary Continuation of Coverage (TCC) .....	61
• Converting to individual coverage .....	61
• Getting a Certificate of Group Health Plan Coverage .....	61
Section 12. Two Federal Programs complement FEHB benefits .....	62
The Federal Flexible Spending Account Program – <i>FSAFEDS</i> .....	62
The Federal Long Term Care Insurance Program .....	65
Index .....	66
Summary of benefits for the Fallon Community Health Plan - 2005 High Option .....	70
Summary of benefits for the Fallon Community Health Plan – 2005 Standard Option .....	71
2005 Rate Information for Fallon Community Health Plan .....	72

---

## 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. The address for Fallon Community Health Plan administrative offices is:

Fallon Community Health Plan  
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, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 8. Rates are shown at the end of this brochure.

---

## Plain Language

---

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

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at [www.opm.gov/insure](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

---

## Stop Health Care Fraud!

---

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

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

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

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

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

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

If the provider does not resolve the matter, call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) and explain the situation.

If we do not resolve the issue:

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

**OR WRITE TO:**

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

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

---

## **Preventing medical mistakes**

---

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

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

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

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

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

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

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

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

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

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

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

Want more information on patient safety?

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

---

## Section 1. Facts about this HMO plan

---

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

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

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

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

### How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and they have agreed not to bill you for more than your share of the cost for covered services. See Section 4, *Your costs for covered services*, for more information on your cost-sharing responsibilities.

### Your Rights

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

- 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.

If you want more information about us, call 1-800-868-5200 (TDD/TTY: 1-877-608-7677), or write to Fallon Community Health Plan, 10 Chestnut Street, Worcester, MA 01608. You may also contact us by fax at 508-831-0912 or visit our Web site at [www.fchp.org](http://www.fchp.org).

### Service Area

To enroll in this Plan, you must live in or work in our Select Care service area. This is where our providers practice. Our service area includes all of Essex, Middlesex, Norfolk, Suffolk and Worcester Counties, and parts of Bristol, Franklin, Hampden, Hampshire and Plymouth Counties. The following is a list of the cities and towns in the Select Care service area:

Abington	Barre	Brimfield	Danvers
Acton	Bedford	Brockton	Dedham
Allston	Bellingham	Brookfield	Dighton
Amesbury	Belmont	Brookline	Dorchester
Andover	Berkley	Burlington	Douglas
Arlington	Berlin	Cambridge	Dover
Ashburnham	Beverly	Canton	Dracut
Ashby	Billerica	Carlisle	Dudley
Ashland	Blackstone	Charlestown	Dunstable
Assonet	Bolton	Charlton	Duxbury
Athol	Boston	Chelmsford	East Boston
Attleboro	Boxborough	Chelsea	East Bridgewater
Auburn	Boxford	Cherry Valley	East Brookfield
Auburndale	Boylston	Chestnut Hill	East Douglas
Avon	Braintree	Clinton	East Taunton
Ayer	Bridgewater	Cohasset	East Walpole
Baldwinville	Brighton	Concord	Easton

Erving	Manchester	Palmer	Swansea
Essex	Mansfield	Paxton	Taunton
Everett	Marblehead	Peabody	Templeton
Fall River	Marlborough	Pembroke	Tewksbury
Fiskdale	Marshfield	Pepperell	Three Rivers
Fitchburg	Mattapan	Petersham	Topsfield
Foxborough	Maynard	Phillipston	Townsend
Framingham	Medfield	Plainville	Tyngsborough
Franklin	Medford	Plympton	Upton
Freetown	Medway	Princeton	Uxbridge
Gardner	Melrose	Quincy	Waban
Georgetown	Mendon	Randolph	Wakefield
Gilbertville	Merrimac	Raynham	Wales
Gloucester	Methuen	Reading	Walpole
Grafton	Middleborough	Rehoboth	Waltham
Groton	Middleton	Revere	Ware
Groveland	Milford	Rochdale	Warren
Halifax	Millbury	Rockland	Warwick
Hamilton	Millis	Rockport	Watertown
Hanover	Millville	Roslindale	Wayland
Hanson	Milton	Rowley	Webster
Hardwick	Monson	Roxbury	Wellesley
Harvard	Nahant	Royalston	Wendell
Haverhill	Natick	Rutland	Wenham
Hingham	Needham	Salem	West Boylston
Holbrook	New Braintree	Salisbury	West
Holden	New Salem	Saugus	Bridgewater
Holland	Newbury	Scituate	West
Holliston	Newburyport	Seekonk	Brookfield
Hopedale	Newton	Sharon	West Newbury
Hopkinton	Norfolk	Sherborn	West Newton
Hubbardston	North Andover	Shirley	West Roxbury
Hudson	North	Shrewsbury	West
Hull	Attleborough	Somerset	Townsend
Hyde Park	North Billerica	Somerville	Westborough
Ipswich	North Brookfield	South Boston	Westford
Jamaica Plain	North	South Easton	Westminster
Jefferson	Chelmsford	South Grafton	Weston
Kingston	North Dighton	South Hamilton	Westwood
Lakeville	North Easton	South Walpole	Weymouth
Lancaster	North Grafton	Southborough	Whitinsville
Lawrence	North Oxford	Southbridge	Whitman
Leicester	North Reading	Spencer	Wilmington
Leominster	Northborough	Sterling	Winchendon
Lexington	Northbridge	Stoneham	Winchester
Lincoln	Norton	Stoughton	Winthrop
Littleton	Norwell	Stow	Woburn
Lunenburg	Norwood	Sturbridge	Worcester
Lynn	Oakham	Sudbury	Wrentham
Lynnfield	Orange	Sutton	
Malden	Oxford	Swampscott	

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 moves outside of our service area, you can enroll in another plan. If you or a family member moves, you do not have to wait until open season to change plans. Contact your employing or retirement office. 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*.

---

## Section 2. How we change for 2005

---

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

### Program-wide changes

- In Section 9, we revised the **Medicare Primary Payer Chart** and updated the language regarding Medicare Advantage plans (formerly called Medicare Advantage plans).
- In Section 12, we revised the language regarding the Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program.

### Changes to this Plan

- Your share of the non-Postal premium will decrease by 0.5% for Self Only or increase by 1.0% for Self and Family.
- FCHP now offers two options: a High Option and, new for 2005, a Standard Option.
- If you were a Fallon Community Health Plan member in 2004, and you make no changes during open season, you will be enrolled in High Option for 2005.
- Under High Option, you will pay a \$15 copayment for each primary care physician office visit, and for office visits with the following specialists: mental health and substance abuse providers, chiropractors, physical and occupational therapists, speech-language pathologists and audiologists, early intervention specialists, obstetricians and gynecologists, podiatrists, nurse midwives and nurse practitioners who bill independently. You will also pay a \$15 copayment for the following specialty services: urgent care visits, diabetes outpatient self-management training and routine eye exams.
- Under High Option, you will pay a \$25 copayment for each specialist office visit.
- Under High Option, your dependent children under the age of 22 will pay nothing for preventive care office visits (well-child care).
- Under High Option, you will pay a \$250 copayment for each inpatient admission to a hospital or other inpatient facility.
- Under High Option, you will pay a \$50 outpatient surgery copayment.
- Under High Option, your copayments for prescription drugs have increased. You will pay \$25 for up to a 30-day supply of a Tier-2 medication, and \$50 for up to a 30-day supply of a Tier-3 medication.
- Under High Option, when you refill your prescription through our mail-order program, you will pay a \$50 copayment for up to a 90-day supply of a Tier-2 medication, and a \$150 copayment for up to a 90-day supply of a Tier-3 medication.
- The benefit for early intervention services has increased to \$5,200 per calendar year and an aggregate of \$15,600 lifetime for children from birth to age three.
- The Plan no longer requires notification for emergency services.

---

## Section 3. How you get care

---

### Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) or write to us at Fallon Community Health Plan, Customer Service Department, 10 Chestnut St., Worcester, MA 01608. You may also request replacement cards through our website at [www.fchp.org](http://www.fchp.org).

### Where you get covered care

You get care from “Plan providers” and “Plan facilities.” Under High Option, you will only pay copayments, and you will not have to file claims. Under Standard Option, you will only pay copayments and deductibles, and you will not have to file claims.

#### • Plan providers

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

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

#### • Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site. If there is a specific hospital or other facility you want to use, you should check the provider directory or our Web site to make sure that the primary care physician you have chosen has admitting privileges to that hospital.

### 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 physician 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 before becoming a member of the Plan:

- 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 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, pediatrician (or, in some cases, a physician assistant or nurse practitioner who works under the supervision of a physician). 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](http://www.fchp.org).

If your primary care provider leaves the Plan, we will notify you in writing, either 30 days prior to the date of termination 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**

When you have health care concerns, a good place to start is by contacting your primary care provider. Much of the time, your primary care provider can provide the care that you need. Sometimes, however, you may need specialty care or services that your primary care provider does not provide.

*Self-referral*

In some instances, you can self-refer to a specialist. This means that you can call the specialist and make the appointment yourself. You do not need to have a referral from your primary care provider, but you must see a plan provider.

Services you can self-refer for:

- Office visits with a Fallon Clinic specialist (physician, physician assistant, nurse midwife or nurse practitioner only) if you have a Fallon Clinic primary care provider
- Services with an obstetrician, gynecologist, certified nurse midwife or family practitioner, for an annual gynecological examination, including any subsequent obstetric or gynecological services determined to be medically necessary, including, but not limited to, Pap smear or mammogram; services for acute or emergent gynecological conditions; and maternity care. It does not include inpatient admissions or infertility treatment (unless provided by a Fallon Clinic specialist and you have a Fallon Clinic primary care provider); see page 22 for more information on “Infertility/assisted reproductive technology services”).
- Office visits to an oral surgeon for extraction of impacted teeth. Visits to an oral surgeon for any other procedure require a referral and authorization. See page 31 for more information on covered oral surgery services.
- Routine eye examinations with an ophthalmologist or optometrist
- Routine dental care
- Outpatient mental health and substance abuse services. For assistance in finding a network provider, call 1-888-421-8861 (TDD/TTY: 781-994-7660).

*PCP referral*

For certain other specialist visits and specialty services, your primary care provider will refer you to a specialist for needed care. When you receive a referral from your primary care provider, you must return to the primary care physician after the consultation. Do not go to the specialist for return visits unless your primary care

provider has authorized a certain number of visits without additional referrals.

Services that need a referral from your primary care provider:

- Office visits with a specialist (if you have a Fallon Clinic primary care provider you may self-refer to a Fallon Clinic specialist). The specialist must obtain preauthorization from the Plan for all specialty services.
- Initial evaluation with a podiatrist for podiatric services. The podiatrist must obtain preauthorization from the Plan for all subsequent visits.
- Chiropractic care. Your primary care provider will give you a referral to a chiropractor for up to five visits, if medically necessary. The chiropractor must obtain preauthorization from the Plan for all subsequent visits.
- Physical, occupational and speech therapy. Your primary care provider will give you a written order to take to a physical, occupational or speech therapist. The written order covers up to six visits if medically necessary. The therapist must obtain preauthorization from the Plan for all subsequent visits.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care provider will give you a standing referral that allows you to see the specialist for a certain number of visits without additional referrals. Your primary care provider may give you a referral for up to a maximum of 12 visits in a 12-month period. Your primary care provider has the discretion to allow fewer visits. Your primary care provider will work with the specialist to develop a treatment plan for you and the specialist will keep your primary care provider up-to-date on your treatment. For certain specialist visits and for certain specialty services, your primary care provider will have to get preauthorization from the Plan before giving you a referral.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. Your primary care provider will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan. (See below for a list of circumstances in which we will temporarily pay for services with a non-Plan provider.)
- We will provide coverage of pediatric specialty care, including mental health care, to a child requiring such care, when provided by a provider with recognized expertise in specialty pediatrics.

We cannot guarantee that any one physician, hospital or other provider will remain under contract with us. We reserve the right at any time to end our contract with any Plan provider who may be furnishing you with care. If this occurs, we will generally no longer pay for services provided to you by that provider, except in the circumstances listed below.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you are terminally ill and our contract with a provider from whom you are receiving treatment related to your terminal illness ends, you may continue to receive treatment from that provider.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - Terminate our contract with your specialist for other than cause; or

- Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
- Reduce our service area and you enroll in another FEHB Plan, you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.
- If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

• **Hospital care**

Your Plan primary care 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 in the hospital when your enrollment in our Plan begins, call Customer Service immediately at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

**Circumstances beyond our control**

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

**Services requiring preauthorization**

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

We call this review and approval process preauthorization. Your provider must obtain preauthorization for the following services:

- Elective admissions to a hospital or other inpatient facility.
- Covered services with a non-Plan provider
- Organ transplant evaluation and services
- Reconstructive surgery
- Infertility/assisted reproductive technology services
- Oral surgery services (with the exception of the extraction of impacted teeth)
- Genetic testing
- Neuropsychological testing
- Prosthetics/orthotics and durable medical equipment
- Home health and hospice care
- Non-emergency ambulance

- PET scans

When your primary care provider needs preauthorization from the Plan, he or she will send a “*Request for Services*” to the Plan. We will review the request and make a preauthorization decision within two business days of receipt of the medical information. We will tell your primary care provider of our decision within 24 hours thereafter.

If we authorize the service, we will send you and your primary care provider confirmation within two business days of the decision. When you get the authorization letter you can call the specialist to make the appointment. The authorization letter will state the services the Plan has approved for coverage. If the specialist feels you need services beyond those we have approved, he or she will ask for authorization directly from the Plan. If we approve the request for additional services, we will send you and your primary care provider an authorization letter.

If we do not authorize a service, we will send you and your primary care provider a denial letter within one business day of the decision. The denial letter will explain our reasons for the decision and your right to file a grievance. If we do not authorize the service, you will be financially responsible.

---

## Section 4. Your costs for covered services

---

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

### **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 services. The amount of the copayment varies, depending on the type of provider or service.

Under Standard Option, you pay a \$15 copayment per office visit with your primary care provider and certain other providers, and a \$25 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. 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.

Under High Option, you pay a \$20 copayment per office visit and the Plan pays the remainder of the amount billed by the physician or other health care professional for 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 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 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 deductible. When a covered service or supply is subject to your deductible, only the Plan allowance that you pay for that service or supply goes toward your deductible. The 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.

Under Standard Option, for Self Only coverage, the calendar year deductible is \$600.

Under Standard Option, 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.

Under High Option, there is no calendar year deductible.

Note: Any deductible amounts paid during the last three months of the calendar year may be applied to your 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.

### **Coinsurance**

We do not have coinsurance.

### **Your catastrophic protection out-of-pocket maximum**

We do not have a catastrophic protection out-of-pocket maximum.

---

## Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and pages 70 to 71 for a benefits summary.)

---

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) or at our Web site at [www.fchp.org](http://www.fchp.org).

Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	17
Diagnostic and treatment services.....	17
Lab, X-ray and other diagnostic tests.....	18
Preventive care, adult.....	18
Preventive care, children.....	19
Maternity care.....	20
Family planning.....	21
Infertility services.....	22
Allergy care.....	23
Treatment therapies.....	23
Speech therapy.....	24
Hearing services.....	24
Vision services.....	25
Foot care.....	25
Durable medical equipment (DME).....	26
Home health services.....	27
Chiropractic.....	27
Alternative treatments.....	28
Educational classes and programs.....	28
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	29
Surgical procedures.....	29
Reconstructive surgery.....	30
Oral and maxillofacial surgery.....	31
Organ/tissue transplants.....	31
Anesthesia.....	33
Section 5(c) Services provided by a hospital or other facility, and ambulance services.....	34
Inpatient hospital.....	34
Outpatient hospital or ambulatory surgical center.....	35
Skilled nursing care facility benefits.....	35
Hospice care.....	36
Ambulance.....	36
Section 5(d) Emergency services/accidents.....	37
Emergency within our service area.....	38
Ambulance.....	38
Section 5(e) Mental health and substance abuse benefits.....	39
Mental health and substance abuse benefits.....	39
Section 5(f) Prescription drug benefits.....	41
Covered medications and supplies.....	42
Section 5(g) Special features.....	44
Flexible benefits option.....	44
Out-of-area student coverage.....	44
Services for deaf and hearing impaired.....	45
Clinical trials.....	45
Interpreter services.....	45
Peace of Mind Program.....	45

Section 5(h) Dental benefits.....46

    Accidental injury benefit.....46

    Out-of-area dental care .....46

    Dental benefits .....46

Section 5(i) Non-FEHB benefits available to Plan members.....48

Summary of benefits for the Fallon Community Health Plan – 2005 High Option.....70

Summary of benefits for the Fallon Community Health Plan – 2005 Standard Option.....71

2005 Rate Information for Fallon Community Health Plan.....72

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

**Here are some important things you should keep in mind about these benefits:**

**I  
M  
P  
O  
R  
T  
A  
N  
T**

- 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 your care.
- Under Standard Option, your calendar year deductible is \$600 per person or \$1,200 per family. The calendar year deductible applies to almost all Standard Option benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Under Standard Option, 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.
- Under High Option, there is no calendar year deductible.
- Be sure to read Section 3, *How you get care*, for important information on accessing specialty care and 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.

**I  
M  
P  
O  
R  
T  
A  
N  
T**

Benefit Description	You pay	
<p><b>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” when it does not apply. There is no calendar year deductible under High Option.</b></p>		
Diagnostic and treatment services	You Pay High Option	You Pay Standard Option
Professional services of physicians or other health care professionals <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• Second surgical opinion</li> <li>• Office medical consultations</li> <li>• At home</li> </ul> Note: See Section 5(d), <i>Emergency services</i> , for care of a minor emergency in a doctor’s office or urgent care center.	\$15 copayment per office visit to your primary care provider or obstetrician/gynecologist  \$25 copayment per office visit to a specialist	\$20 copayment per office visit  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 <ul style="list-style-type: none"> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> </ul>	Nothing	Nothing after you meet your calendar year deductible

<b>Lab, X-ray and other diagnostic tests</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> <li>• CAT Scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	Nothing for lab, X-ray and other diagnostic tests  \$15 copayment per associated office visit to your primary care provider or obstetrician/gynecologist  \$25 copayment per associated office visit to a specialist	Nothing for lab, X-ray and other diagnostic tests after you meet your calendar year deductible  \$20 copayment per associated office visit
<b>Preventive care, adult</b>		
Routine screenings, such as: <ul style="list-style-type: none"> <li>• Total blood cholesterol</li> <li>• Colorectal cancer screening, including               <ul style="list-style-type: none"> <li>– Fecal occult blood test</li> <li>– Sigmoidoscopy, screening – every five years starting at age 50</li> <li>– Double contrast barium enema – every five years starting at age 50</li> <li>– Colonoscopy screening – every ten years starting at age 50</li> </ul> </li> <li>• Osteoporosis screening for women age 65 and older (beginning at age 60 for women at increased risk)</li> </ul>	Nothing for routine screenings  \$15 copayment per associated office visit to your primary care provider  \$25 copayment per associated office visit to a specialist	Nothing for routine screenings (No deductible)  \$20 copayment per associated office visit
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing for PSA test  \$15 copayment per associated office visit to your primary care provider  \$25 copayment per associated office visit to a specialist	Nothing for PSA test (No deductible)  \$20 copayment per associated office visit
Routine Pap test	Nothing for Pap test  \$15 copayment per associated office visit to your primary care provider or obstetrician/gynecologist  \$25 copayment per associated office visit to a specialist	Nothing for Pap test (No deductible)  \$20 copayment per associated office visit

*Preventive care, adult – continued on next page*

<b>Preventive care, adult - (continued)</b>	<b>You Pay High Option</b>	<b>You Pay Standard Option</b>
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• From age 40 and older, one every calendar year</li> </ul>	Nothing for mammogram	Nothing for mammogram (No deductible)
Routine immunizations, limited to: <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza vaccine, annually</li> <li>• Pneumococcal vaccine, age 65 and older</li> </ul>	Nothing for immunizations \$15 copayment per associated office visit to your primary care provider \$25 copayment per associated office visit to a specialist	Nothing for immunizations (No deductible) \$20 copayment per associated office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel</li> <li>• Travel related immunizations, such as Malaria or Yellow fever</li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Preventive care, children</b>		
<ul style="list-style-type: none"> <li>• Well-child care (up to age 22) including:               <ul style="list-style-type: none"> <li>– History and physical examination, measurements, sensory screening, neuropsychiatric evaluations, development screening and assessment.</li> <li>– Screening of all children under six years of age for the presence of lead poisoning</li> <li>– 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.</li> </ul> </li> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> <li>• Examinations, such as:               <ul style="list-style-type: none"> <li>– Vision screening to age 22 to determine the need for vision correction</li> <li>– Hearing screening to age 22 to determine the need for hearing correction</li> <li>– Examinations done on the day of immunizations (up to age 22)</li> </ul> </li> </ul>	Nothing	Nothing for well-child care, immunizations or examinations (No deductible) \$20 copayment per associated office visit

<b>Maternity care</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need preauthorization for your normal delivery; see page 12 for other circumstances.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. 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.</li> <li>• 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.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See <i>Hospital benefits</i> (Section 5(c)) and <i>Surgery benefits</i> (Section 5(b)).</li> <li>• We pay non-routine maternity care the same as for illness and injury. See <i>Medical services and supplies provided by physicians and other health care professionals</i> (Section 5(a)).</li> </ul>	<p>\$15 copayment for the first prenatal office visit. All other prenatal office visits covered in full</p> <p>\$15 copayment per postnatal office visit</p>	<p>\$20 copayment for the first prenatal office visit. All other prenatal office visits covered in full</p> <p>\$20 copayment per postnatal office visit</p> <p>(No deductible)</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

<b>Family planning</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Consultations, examinations, procedures and medical services related to the use of all contraceptive methods</li> <li>• Contraceptives furnished by a Plan provider during a covered office visit, such as: <ul style="list-style-type: none"> <li>– Surgically implanted contraceptives</li> <li>– Intrauterine devices (IUDs)</li> <li>– Diaphragms</li> <li>– Cervical caps</li> </ul> </li> <li>• Voluntary sterilization (See Surgical procedures Section 5 (b))</li> </ul> <p>Note: We cover oral contraceptives and certain other contraceptives, such as Depo-Provera and the contraceptive patch, under the prescription drug benefit.</p>	<p>Nothing for family planning services</p> <p>\$15 copayment per associated office visit to your primary care provider or obstetrician/gynecologist</p> <p>\$25 copayment per associated office visit to a specialist</p>	<p>Nothing for family planning services</p> <p>(No deductible)</p> <p>\$20 copayment per associated office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary surgical sterilization</i></li> <li>• <i>Genetic counseling</i></li> <li>• <i>Over-the-counter contraceptive drugs or devices</i></li> </ul>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Infertility services	You pay High Option	You Pay Standard Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> <li>• Evaluation and diagnosis of infertility</li> <li>• The following procedures for the treatment of infertility <ul style="list-style-type: none"> <li>– Artificial insemination (AI)</li> <li>– In vitro fertilization and embryo placement (IVF-EP)</li> <li>– Gamete intrafallopian transfer (GIFT)</li> <li>– Zygote intrafallopian transfer (ZIFT)</li> <li>– Intracytoplasmic sperm injection (ICSI)</li> <li>– Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated egg</li> </ul> </li> </ul> <p>To be eligible, you must be an individual who:</p> <ol style="list-style-type: none"> <li>(1) is unable to conceive or produce conception during a period of one year; and</li> <li>(2) should expect fertility as a natural state; or</li> <li>(3) is a premenopausal female or a female who is experiencing menopause at a premature age</li> </ol> <p>Approval for Assisted Reproductive Technology (ART) is contingent upon review of your medical history by the Plan medical director. Initial approval covers four ART cycles, if you wish to continue beyond four cycles, further medical review by the Plan medical director is required.</p> <p>A benefits pamphlet is available by contacting Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).</p> <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	<p>Nothing for infertility procedures</p> <p>\$15 copayment per associated office visit to your primary care provider or obstetrician/gynecologist</p> <p>\$25 copayment per associated office visit to a specialist</p>	<p>Nothing for infertility procedures after you meet your deductible</p> <p>\$20 copayment per associated office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Treatments, services and supplies which have not been determined to be medically necessary by a Plan specialist in fertility and the Plan medical director or when the member has a medical contraindication or when there is no diagnosis of infertility</i></li> <li>• <i>Donor egg transfer or harvesting for women who are menopausal (except as stated above) or have genetic oocyte defects</i></li> <li>• <i>Chromosome studies of a donor (sperm or egg)</i></li> <li>• <i>Pre-implant Genetic Diagnosis (PGD) or testing (genetic testing on the embryo before it is inserted into the uterus)</i></li> <li>• <i>Charges for the storage of donor sperm, eggs or embryo that remain in storage after the completion of an approved infertility cycle</i></li> <li>• <i>Supplies that may be purchased without a physician's written order, such as ovulation test kits</i></li> <li>• <i>Services which are necessary due to a voluntary sterilization, such as tubal ligation or vasectomy</i></li> <li>• <i>Surrogacy or gestational carrier services</i></li> </ul>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

*Infertility services – continued on next page*

<b>Infertility services – <i>continued</i></b>	<b>You pay High Option</b>	<b>You Pay Standard Option</b>
<ul style="list-style-type: none"> <li>• <i>Transportation costs to or from the medical facility</i></li> <li>• <i>Services that are covered by another insurer</i></li> <li>• <i>Service fees, charges or compensation for a donated egg. (This does not include charges related to the medical procedure of removing an egg for the purpose of donation when the recipient is a member of the plan.)</i></li> </ul>		
<b>Allergy care</b>		
<p>Allergy testing and treatment, including:</p> <ul style="list-style-type: none"> <li>• Allergy serum</li> <li>• Allergy injections</li> </ul>	<p>Nothing for allergy testing and treatment</p> <p>\$15 copayment per associated office visit with your primary care provider</p> <p>\$25 copayment per associated office visit with a specialist</p>	<p>Nothing for allergy testing and treatment</p> <p>(No deductible)</p> <p>\$20 copayment per associated office visit</p>
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges.</i>	<i>All charges.</i>
<b>Treatment therapies</b>		
<ul style="list-style-type: none"> <li>• Chemotherapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 31.</p> <ul style="list-style-type: none"> <li>• Radiation therapy</li> <li>• Respiratory and inhalation therapy</li> </ul> <p>Note: Drug therapies for the treatment of respiratory diseases are covered under the prescription drug benefit.</p> <ul style="list-style-type: none"> <li>• Dialysis – hemodialysis and continuous ambulatory peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: Growth hormone is covered under the prescription drug benefit. We only cover GHT when we authorize the treatment. Your Plan provider will submit a request for preauthorization before you begin treatment. If your Plan provider does not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring preauthorization</i> in Section 3.</p>	<p>Nothing for treatment therapies</p> <p>\$15 copayment per associated office visit with your primary care provider</p> <p>\$25 copayment per associated office visit with a specialist</p>	<p>Nothing for treatment therapies after you meet your deductible</p> <p>\$20 copayment per associated office visit</p>

<b>Physical and occupational therapies</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<ul style="list-style-type: none"> <li>Up to 60 consecutive visits or 20 nonconsecutive visits (whichever is greater) per illness or injury per calendar year for: <ul style="list-style-type: none"> <li>physical therapy</li> <li>occupational therapy</li> </ul> </li> </ul> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p>	\$15 copayment per office visit	\$20 copayment per office visit after you meet your deductible
<ul style="list-style-type: none"> <li>Cardiac rehabilitation for persons with documented cardiovascular disease, initiated within 26 weeks after the diagnosis of cardiovascular disease.</li> <li>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. Benefits are limited to a maximum of \$5,200 per year per child and an aggregate of \$15,600 over the term of the child's Plan membership.</li> </ul>	Nothing	\$20 copayment per office visit after you meet your deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Long-term rehabilitative therapy</li> <li>Exercise programs</li> <li>Acupuncture, aquatic or massage therapy</li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Speech therapy</b>		
Medically necessary services 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.	\$15 copayment per office visit	\$20 copayment per visit after you meet your deductible
<b>Hearing services</b>		
<ul style="list-style-type: none"> <li>Hearing screening for children to age 22 to determine the need for hearing correction (see <i>Preventive care, children</i>)</li> </ul>	Nothing	Nothing for hearing screening (No deductible) \$20 copayment per associated office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>All other hearing testing</li> <li>Hearing aids, testing and examinations for them</li> </ul>	<i>All charges.</i>	<i>All charges.</i>

<b>Vision services</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<ul style="list-style-type: none"> <li>• Diagnosis and treatment of diseases or injuries to the eye</li> </ul>	\$15 copayment per office visit with your primary care provider \$25 copayment per office visit with a specialist	Nothing for treatment of diseases or injuries to the eye after you meet your deductible \$20 copayment per associated office visit
<ul style="list-style-type: none"> <li>• Annual eye exam</li> </ul> Note: See <i>Preventive care, children</i> for vision screening for children to age 22	\$15 copayment per office visit	\$20 copayment per office visit (No deductible)
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Eye exercises and orthoptics</li> <li>• Radial keratotomy and other refractive surgery</li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Foot care</b>		
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.  Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.	\$15 copayment per office visit	Nothing for routine foot care after you meet your deductible \$20 copayment per associated office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</li> <li>• Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Orthopedic and prosthetic devices</b>		
<ul style="list-style-type: none"> <li>• Orthopedic 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.</li> <li>• Prosthetic devices (devices that replace all or part of an organ or body part, not including dental) such as artificial limbs and eyes, implanted corrective lenses following cataract surgery and electric speech aids.</li> <li>• Corrective orthopedic appliances for nondental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</li> </ul> Note: All orthopedic and prosthetic devices must be ordered by a Plan provider and authorized by the Plan.	Nothing up to the benefit limit of \$1,500 per calendar year. You pay all charges beyond the benefit limit.  Orthopedic and prosthetic devices and durable medical equipment are subject to a combined benefit limit.	Nothing, up to the benefit limit of \$1,500 per calendar year, after you meet your deductible. You pay all charges beyond the benefit limit.  Orthopedic and prosthetic devices and durable medical equipment are subject to a combined benefit limit.

*Orthopedic and prosthetic devices – continued on next page*

<b>Orthopedic and prosthetic devices – <i>continued</i></b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<ul style="list-style-type: none"> <li>Scalp hair prosthesis (wigs) for individuals who have suffered hair loss as a result of the treatment of any form of cancer or leukemia.</li> </ul>	Nothing up to the benefit limit of \$350 per calendar year. You pay all charges beyond the benefit limit.	Nothing, up to the benefit limit of \$350 per calendar year, after you meet your deductible. You pay all charges beyond the benefit limit.
<ul style="list-style-type: none"> <li>Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy.</li> <li>Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. See Section 5(b) for coverage of the surgery to insert the device.</li> </ul>	Nothing	Nothing after you meet your deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Orthopedic and corrective shoes</li> <li>Arch supports</li> <li>Foot orthotics</li> <li>Heel pads and heel cups</li> <li>Lumbosacral supports</li> <li>Corsets, trusses, elastic stockings, support hose, and other supportive devices</li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Durable medical equipment (DME)</b>		
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan provider, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> <li>Hospital beds</li> <li>Wheelchairs</li> <li>Crutches</li> <li>Walkers</li> <li>Blood glucose monitors</li> <li>Insulin pumps</li> <li>Visual magnifying aids and voice synthesizers for blood glucose monitors for use by the legally blind</li> <li>Therapeutic/molded shoes and shoe inserts for the treatment of severe diabetic foot disease</li> </ul> <p>Note: Insulin pumps and insulin pump supplies are covered under the prescription drug benefit. All durable medical equipment must be ordered by a Plan provider and preauthorized by the Plan.</p>	<p>Nothing up to the benefit limit of \$1,500 per calendar year. You pay all charges beyond the benefit limit.</p> <p>Orthopedic and prosthetic devices and durable medical equipment are subject to a combined benefit limit.</p>	<p>Nothing, up to the benefit limit of \$1,500 per calendar year, after you meet your deductible. You pay all charges beyond the benefit limit.</p> <p>Orthopedic and prosthetic devices and durable medical equipment are subject to a combined benefit limit.</p>

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

<b>Durable medical equipment (DME) – <i>continued</i></b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<ul style="list-style-type: none"> <li>Oxygen and oxygen equipment</li> </ul>	Nothing	Nothing after you meet your deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>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, exercise equipment or similar equipment.</li> <li>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.</li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Home health services</b>		
<p>Home health care ordered by a Plan provider and authorized by the Plan, including part-time or intermittent skilled nursing care and physical therapy. Additional services such as occupational and speech therapy, oxygen and intravenous therapy, medical social services, home health aide 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.</p> <p>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.</p>	Nothing	Nothing after you meet your deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Nursing care requested by, or for the convenience of, the patient or the patient's family</li> <li>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Chiropractic</b>		
<p>Chiropractic services for acute musculoskeletal conditions. The condition must be new or an exacerbation of a previous condition. Coverage is provided for up to 20 visits in each calendar year.</p>	\$15 copayment per office visit	\$20 copayment per office visit (No deductible)

Alternative treatments	You pay High Option	You pay Standard Option
<i>No benefit</i>	<i>All charges.</i>	<i>All charges.</i>
Educational classes and programs		
Coverage is limited to: <ul style="list-style-type: none"> <li>Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.</li> </ul>	Nothing	Nothing (No deductible)
<ul style="list-style-type: none"> <li>Diabetes self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider.</li> </ul>	\$15 copayment per office visit	\$20 copayment per office visit (No deductible)

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

**Here are some important things you should keep in mind about these benefits:**

**I  
M  
P  
O  
R  
T  
A  
N  
T**

- 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 your care.
- Under Standard Option, 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.
- Under Standard Option, 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.
- Under High Option, there is no 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 PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization and identify which surgeries require preauthorization.

**I  
M  
P  
O  
R  
T  
A  
N  
T**

Benefit Description	You pay	
<p><b>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” when it does not apply. There is no calendar year deductible under High Option.</b></p>		
Surgical procedures	You pay High Option	You pay Standard Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see Reconstructive surgery)</li> <li>• Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over.</li> </ul>	<p>\$15 copayment per associated office visit with your primary care provider or obstetrician/gynecologist</p> <p>\$25 copayment per associated office visit with a specialist</p> <p>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).</p>	<p>Nothing for surgical procedure after you meet your deductible</p> <p>\$20 copayment per associated office visit</p> <p>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).</p>

*Surgical procedures - continued on next page*

<b>Surgical procedures</b> <i>(continued)</i>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<ul style="list-style-type: none"> <li>• Insertion of internal prosthetic devices. See 5(c) – for device coverage information</li> <li>• Voluntary sterilization (e.g., tubal ligation, vasectomy)</li> <li>• Treatment of burns</li> </ul>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Reconstructive surgery</b>		
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member’s appearance and</li> <li>– the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>– reconstruction of the breast on which the mastectomy was performed;</li> <li>– surgery to produce a symmetrical appearance on the other breast;</li> <li>– treatment of any physical complications, such as lymphedemas;</li> </ul> </li> </ul> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$15 copayment per associated office visit with your primary care provider or obstetrician/gynecologist</p> <p>\$25 copayment per associated office visit with a specialist</p>	<p>Nothing for reconstructive surgery after you meet your deductible</p> <p>\$20 copayment per associated office visit</p>
<ul style="list-style-type: none"> <li>• Breast prostheses and surgical bras and replacements (see Section 5 (a) Orthopedic and prosthetic devices)</li> </ul>	Nothing	Nothing after you meet your deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>

Oral and maxillofacial surgery	You pay High Option	You pay Standard Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> </ul>	<p>\$15 copayment per associated office visit with your primary care provider</p> <p>\$25 copayment per associated office visit with a specialist</p> <p>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)</p>	<p>Nothing for oral and maxillofacial surgery after you meet your deductible</p> <p>\$20 copayment per associated office visit</p> <p>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> </ul>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Organ/tissue transplants		
<p>The Plan covers human solid organ, bone marrow and stem cell transplants, such as:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung for patients under age 60 with end-stage primary or secondary pulmonary hypertension</li> <li>• Kidney</li> <li>• Liver</li> <li>• Lung transplant for patients under age 60 with end-stage obstructive or restrictive pulmonary disease</li> <li>• Allogenic (donor) bone marrow transplants for leukemia, aplastic anemia, severe combined immunodeficiency disease, or Wiskott-Aldrich Syndrome; for patients with high-risk lymphoblastic lymphoma in remission; or for patients under age 60 with myelodysplasia</li> <li>• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; resistant or advanced non-Hodgkin's lymphoma; recurrent or refractory neuroblastoma; for patients diagnosed with breast cancer that has progressed to metastatic disease; for patients under age 65 with chemo-responsive multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors</li> </ul>	<p>\$15 copayment per associated office visit with your primary care provider</p> <p>\$25 copayment per associated office visit with a specialist</p> <p>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)</p>	<p>\$20 copayment per associated office visit (No deductible)</p> <p>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)</p>

*Organ/tissue transplants- continued on next page*

Organ/tissue transplants <i>(continued)</i>	You pay High Option	You pay Standard Option
<ul style="list-style-type: none"> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> <li>• Human Leukocyte Antigen (HLA) or histocompatibility locus antigen testing for A, B, or DR antigens, or any combination thereof, to establish bone marrow transplant donor suitability</li> </ul> <p>The transplant must be performed at an affiliated transplant facility, subject to your acceptance into the program. The Plan will work with the transplant facility to coordinate your care during the evaluation and transplant process and help to arrange your discharge and follow-up care.</p> <p>Note: If you are the recipient of a transplant the services of the donor are covered including the evaluation and preparation and the surgery and recovery directly related to the donation with the exception of those services covered by another insurer. If you are the donor and the transplant recipient is not a member of the Plan no coverage is provided for either the recipient or the donor with the exception of human leukocyte antigen or histocompatibility locus antigen testing.</p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Transplants not listed as covered or investigational or experimental procedures, including, but not limited to, transplantation of partial pancreatic tissue or islet cells and a pancreatic transplant that does not follow a kidney transplant or that is not part of a combined pancreas-kidney transplant</i></li> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li>• <i>Bioartificial transplantation, such as the transplantation of a total artificial heart</i></li> <li>• <i>Xenotransplantation, such as the transplantation of animal tissues or organs into a human</i></li> <li>• <i>Services for the organ donor that are covered by another insurance plan</i></li> <li>• <i>Services for an organ donor if the recipient is not a Plan member</i></li> <li>• <i>Transportation, housing or home cleaning services incurred by either the donor or the recipient</i></li> </ul>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

<b>Anesthesia</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
Professional services provided in – <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory surgical center</li> </ul>	Nothing	Nothing for anesthesia services after you meet your deductible
Professional services provided in – <ul style="list-style-type: none"> <li>• Office</li> </ul>	\$25 copayment per office visit	Nothing for anesthesia services after you meet your deductible \$20 copayment per associated office visit

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

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

**I  
M  
P  
O  
R  
T  
A  
N  
T**

- 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 your care and you must be hospitalized in a Plan facility.
- Under Standard Option, 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.
- Under High Option, there is no calendar year deductible.
- 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 PREAUTHORIZATION FOR INPATIENT ADMISSIONS.** Please refer to Section 3 to be sure which services require preauthorization.

**I  
M  
P  
O  
R  
T  
A  
N  
T**

Benefit Description	You pay	
<p>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when it does not apply. There is no calendar year deductible under High Option.</p>		
Inpatient hospital	You pay High Option	You pay Standard Option
<p>Room and board, such as</p> <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Blood and blood products</li> <li>• Administration of blood and blood products</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Internal prosthetic devices</li> <li>• Medical supplies, appliances and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> </ul>	<p>\$250 copayment per admission</p>	<p>Nothing after you meet your deductible</p>

*Inpatient hospital - continued on next page.*

<b>Inpatient hospital (continued)</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Non-covered facilities, such as nursing homes, schools</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>• Private nursing care</li> </ul>	All charges.	All charges.
<p><b>Outpatient hospital or ambulatory surgical center</b></p> <ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$50 copayment per outpatient surgery	Nothing after you meet your deductible
<p><b>Skilled nursing care facility benefits</b></p>		
<p>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.</p> <p>Services provided are:</p> <ul style="list-style-type: none"> <li>• Room and board in a semiprivate room (or private room if medically necessary)</li> <li>• 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.</li> <li>• Drugs, biologicals, equipment and supplies ordinarily provided or arranged by the skilled nursing facility, when prescribed by a Plan provider</li> </ul>	\$250 copayment per admission	Nothing after you meet your deductible
<p><i>Not covered: Custodial care or personal comfort items such as telephone, radio or television</i></p>	All charges.	All charges.

<b>Hospice care</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<p>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.</p> <ul style="list-style-type: none"> <li>• Hospice services are provided, as necessary, to maintain the terminally ill individual at home such as: <ul style="list-style-type: none"> <li>– Physicians services, nursing care and medical social services</li> <li>– Medical appliances and supplies including drugs and biologicals (prescription copayments may apply)</li> </ul> </li> </ul>	Nothing	Nothing after you meet your deductible
<ul style="list-style-type: none"> <li>• Inpatient respite care in a Plan-affiliated facility (hospice or skilled nursing) for up to five consecutive days</li> </ul>	\$250 copayment per admission	Nothing after you meet your deductible
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges.</i>	<i>All charges.</i>
<b>Ambulance</b>		
<ul style="list-style-type: none"> <li>• Ambulance service when medically appropriate</li> </ul> <p>Note: See Section 5 (d) for coverage of emergency ambulance.</p>	Nothing	Nothing after you meet your deductible

---

## Section 5(d) Emergency services/accidents

---

I  
M  
P  
O  
R  
T  
A  
N  
T

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under Standard Option, the calendar year deductible is \$600 per person or \$1,200 per family. The calendar year deductible applies to some Standard Option benefits in this section. We say “(No deductible)” to indicate that the calendar deductible does not apply to that particular service.
- Under Standard Option, 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.
- Under High Option, there is no 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.

I  
M  
P  
O  
R  
T  
A  
N  
T

---

### 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).

Emergency services do not require referral or preauthorization, 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 or a sprained ankle. 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 primary care provider is not available, a provider on call will make arrangements for your care. Providers’ telephones are answered 24 hours a day, seven days a week. Explain the medical situation to the provider and state where you are calling from so that the provider 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 preauthorization, but you should notify your primary care provider, who will arrange for any follow-up or continuing care that is medically necessary for you.

---

Benefit Description	You pay	
<p><b>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.</b>                      We say “(No deductible)” when it does not apply.                      There is no calendar year deductible under High Option.</p>		
Emergency care	You pay High Option	You pay Standard Option
<ul style="list-style-type: none"> <li>Emergency care in an emergency room</li> </ul>	\$50 copayment per visit (waived if admitted)	\$75 copayment per visit (waived if admitted) (No deductible)
<ul style="list-style-type: none"> <li>Urgent care at an urgent care center or a doctors’ office</li> </ul>	\$15 copayment per visit	\$20 copayment per visit (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Elective or non-emergency care received in an emergency room</i></li> <li><i>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.</i></li> </ul>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Ambulance		
Emergency ambulance service when medically appropriate Note: See Section 5(c) for non-emergency ambulance service.	Nothing	Nothing after you meet your deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Air ambulance when not appropriate to medical condition or geographic location</i></li> <li><i>Transfers between hospitals when the patient’s medical condition does not warrant that he or she be transported to another facility</i></li> <li><i>Commercial airline transportation</i></li> </ul>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

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

**I  
M  
P  
O  
R  
T  
A  
N  
T**

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

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

- 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 Standard Option calendar year deductible does not apply to benefits in this section.
- 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.
- **YOUR PROVIDER MUST GET PREAUTHORIZATION FOR INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.** See the instructions after the benefits description below.

**I  
M  
P  
O  
R  
T  
A  
N  
T**

Benefit Description	You pay	
<p>Note: The Standard Option calendar year deductible does not apply to benefits in this Section. There is no calendar year deductible under High Option.</p>		
Mental health and substance abuse benefits	You pay High Option	You pay Standard Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	<p>\$15 copayment per office visit</p>	<p>\$20 copayment per office visit</p>
<p>Note: See Section 5 (a) for coverage of labs, X-rays and other diagnostic tests.</p>		
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> </ul>	<p>\$250 copayment per admission</p>	<p>Nothing</p>
<ul style="list-style-type: none"> <li>• Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	<p>Nothing</p>	<p>Nothing</p>

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

<b>Mental health and substance abuse benefits</b> <i>(continued)</i>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<p><i>Not covered: Services we have not approved</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges.</i>	<i>All charges.</i>

**Preauthorization**

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

You may self-refer for outpatient mental health and substance abuse services with a Plan provider. For assistance in finding a Plan provider, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660).

Inpatient mental health and substance abuse services require preauthorization. Call 1- 888-421-8861 (TDD/TTY: 1-781-994-7660).

For mental health and substance abuse emergencies, follow the same procedures as for any other medical emergency. See Section 5(d), Emergency services.

**Limitation**

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

---

## Section 5(f) Prescription drug benefits

---

I  
M  
P  
O  
R  
T  
A  
N  
T

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under Standard Option, 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.
- Under High Option there is no 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.

I  
M  
P  
O  
R  
T  
A  
N  
T

### 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 can write your prescription.
- **Where you can obtain them.** You may fill your prescription at a Plan pharmacy or through our mail-order program. 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 applicable 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 preauthorization requirements for each medication. We have chosen the tiers and determined the criteria for preauthorization 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 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 drug is a drug that meets the approval of the FDA and is equivalent to a brand name drug in terms of quality and performance. You will generally receive a generic drug from a Plan pharmacy any time one is available, unless your prescriber has directed the pharmacist to only dispense a specific brand name drug. However, some drugs do not have a generic equivalent. In this case, you will receive the brand name drug and you will be responsible for the appropriate copayment for that drug.

- **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 Tier-1 and Tier-2 medications is equal to the cost of two pharmacy (30-day supply) copayments. The Tier-3 mail-order copayment is equal to three 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, P.O. Box 15121, Worcester, MA 01615-0121.

Benefit Description	You pay	
<p><b>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.</b>  <b>We say “(No deductible)” when it does not apply.</b>  <b>There is no calendar year deductible under High Option.</b></p>		
Covered medications and supplies	You pay High Option	You pay Standard Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail-order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>.</li> <li>• 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</li> <li>• Oral medications that influence blood sugar levels</li> <li>• Self-administered injectable agents</li> <li>• Hormone replacement therapy</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Fertility drugs</li> <li>• Drugs for sexual dysfunction</li> <li>• Contraceptive drugs and devices</li> <li>• Off-label use of covered drugs in the treatment of HIV, AIDS or cancer</li> <li>• Contraceptive drugs and devices</li> </ul> <p>Note: Injectables furnished and administered in a provider’s office or under professional supervision are generally covered under the medical benefit.</p>	<p><i>At a Plan pharmacy:</i> up to a 30-day supply</p> <p>Tier 1: \$5 Tier 2: \$25 Tier 3: \$50</p> <p><i>Mail-order:</i> up to a 90-day supply</p> <p>Tier 1: \$10 Tier 2: \$50 Tier 3: \$150</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copayment.</p>	<p><i>At a Plan pharmacy:</i> up to a 30-day supply</p> <p>Tier 1: \$10 Tier 2: \$30 Tier 3: \$60</p> <p><i>Mail-order:</i> up to a 90-day supply</p> <p>Tier 1: \$20 Tier 2: \$60 Tier 3: \$180</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copayment. (No deductible)</p>
<p>The Plan covers the special medical formulas and food products limited to those listed below. Preauthorization is required.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul>	<p>Nothing</p>	<p>Nothing after you meet your deductible</p>

*Covered medications and supplies – continued on next page*

Covered medications and supplies <i>(continued)</i>	You pay High Option	You pay Standard Option
<ul style="list-style-type: none"> <li>• 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. Coverage is provided for up to \$2,500 per calendar year. You may be required to purchase these products over-the-counter and submit claims to the Plan for reimbursement.</li> </ul>	<p>Nothing up to a maximum of \$2,500 per calendar year</p>	<p>Nothing, up to a maximum of \$2,500 per calendar year, after you meet your calendar year deductible.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Drugs for appetite suppression</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i></li> <li>• <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i></li> <li>• <i>Nonprescription medicines, over-the-counter preparations, devices and medical supplies such as antiseptics.</i></li> <li>• <i>Drugs that are investigational or that have not been approved for general sale and distribution by the U.S. Food and Drug Administration.</i></li> <li>• <i>Nicotine patches and gum or other smoking cessation products, unless supplied to you as part of an approved smoking cessation program.</i></li> </ul>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

## Section 5(g) Special features

Feature	Description
<b>Flexible benefits option</b>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.</li> <li>• Alternative benefits are subject to our ongoing review.</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>• The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.</li> <li>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</li> </ul>
<b>Out-of-area student coverage</b>	<p>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.</p> <p>With the exception of emergency care, all out-of-area student services must be preauthorized by the plan. This includes post-stabilization care or follow-up care needed as a result of an emergency.</p> <p>Services that are covered for students while out of the Plan service area include:</p> <ul style="list-style-type: none"> <li>• Non-routine medical office visits</li> <li>• Diagnostic lab and X-ray connected with a non-routine office visit</li> <li>• Non-elective inpatient services if the Plan is notified within 48 hours of admission</li> <li>• Outpatient services to treat the abuse of or addiction to alcohol or drugs, while out of the Plan service area</li> <li>• Outpatient services to diagnose and/or treat mental conditions</li> <li>• Short-term rehabilitation services, including physical, occupational and speech therapy. Coverage for physical and occupational therapy is provided for up to 60 consecutive days or 20 nonconsecutive visits (whichever is greater) per illness or injury in each calendar year (combined with any in-area visits). Coverage for speech therapy is determined by medical necessity.</li> </ul> <p><i>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.</i></p> <p>Services that are not covered for students while out of the Plan service area include:</p> <ul style="list-style-type: none"> <li>• Routine physical, gynecological exams, vision screening and hearing screening</li> <li>• Routine preventive care</li> <li>• Non-emergency prescription medication. You may use the prescription medication mail-order program to fill medication refills. (See pages 41-43.)</li> <li>• Second opinion</li> <li>• Preventive dental care or minor restorative care (e.g., fillings)</li> <li>• Chiropractic care services</li> <li>• Home health care</li> <li>• Outpatient surgical procedures that could be delayed until return to the Plan service area</li> <li>• Maternity care or delivery</li> <li>• Durable medical equipment (e.g., wheelchairs), including maintenance or replacement</li> </ul>

<b>Services for deaf and hearing impaired</b>	You may access our TDD/TTY equipment at 1-877-608-7677.
<b>Clinical trials</b>	The Plan covers the costs for services furnished to members enrolled in certain qualified clinical trials. 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. Treatment must be consistent with the usual and customary standard of care for someone with the same diagnosis. Coverage is limited to those services covered by the Plan and subject to all the terms and requirements of the Plan, including, but not limited to, provisions requiring the use of Plan providers.
<b>Interpreter services</b>	The Plan will, upon request, provide members with interpreter and translation services related to our administrative procedures.
<b>Peace of Mind Program™</b>	<p>Our 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:</p> <ul style="list-style-type: none"> <li>• Care is for covered services as described in this brochure. The same copayments, deductibles and benefit limits apply.</li> <li>• You have seen a Plan specialist for this condition within the past three months.</li> <li>• A referral to a specific Peace of Mind Program™ physician is made by your primary care provider and notification is given to the Plan that you are accessing that specialist through the Peace of Mind Program.™</li> <li>• The specialist to whom you are referred is on staff at one of the six medical centers listed below: <ul style="list-style-type: none"> <li>– Massachusetts General Hospital</li> <li>– Brigham and Women’s Hospital</li> <li>– Children’s Hospital (Boston)</li> <li>– Dana-Farber Cancer Institute</li> <li>– New England Medical Center</li> <li>– Boston IVF (for infertility services only)</li> </ul> </li> <li>• 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. If you see a provider through the Peace of Mind Program™ and that provider recommends or arranges services to be performed at a hospital that is not listed above, these services will not be covered unless the provider has obtained preauthorization from the Plan. You must have a copy of the authorization from the Plan; do not rely on assurances by the Peace of Mind Program™ provider regarding your coverage.</li> </ul> <p>Once the Plan has been notified of the Peace of Mind Program™ referral, you may arrange an appointment to see this specialist for a consultation. You may continue treatment with this specialist or you may return to a Plan provider for care at any time, so long as you obtain appropriate preauthorization. If you wish to see any other Peace of Mind Program™ provider, you must get a new referral from your primary care physician, the Plan must be notified of your request, and the request must meet the conditions listed above.</p> <p>You may use the Peace of Mind Program™ for all specialty care except mental health, substance abuse, chiropractic services, obstetrics or dental care. 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, the services will not be covered by the Plan, and the Peace of Mind Program™ provider may hold you financially responsible.</p>

## Section 5(h) Dental benefits

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

**I  
M  
P  
O  
R  
T  
A  
N  
T**

- 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 dentists must provide your care.
- The calendar year does not apply to dental benefits.
- 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.

**I  
M  
P  
O  
R  
T  
A  
N  
T**

<b>Accidental injury benefit</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<p>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 preauthorization for emergency care needed as a result of dental trauma. Go to the closest provider.</p> <p>Note: This accidental injury benefit does not include restorative or other dental services.</p>	<p>\$15 copayment per office visit</p>	<p>\$20 copayment per office visit</p>
<b>Out-of-area dental care</b>		
<p>While you are out of the Plan service area, we will cover some limited urgent dental care services for minor ailments such as a toothache or loose filling. Go to the closest provider and notify the Plan within 48 hours of receiving urgent dental care.</p>	<p>\$10 per office visit</p> <p>Coverage is provided for up to \$50 per incident.</p>	<p>\$10 per office visit</p> <p>Coverage is provided for up to \$50 per incident.</p>

### **Dental benefits**

The Plan covers diagnostic, preventive and minor restorative dental services. Services not listed are not covered. You do not need Plan authorization for these services, but you must see a Plan dentist. Refer to our website, [www.fchp.org](http://www.fchp.org), for a list of Plan dentists, or call Customer Service at 1-800-868-5200 and we will help you find a Plan dentist.

Preventive care is covered once every six months. You are responsible for one copayment per visit for any visit in which exam, cleaning and X-rays (except full mouth series and panoramic) are performed.

The Plan covers minor restorative dental care such as metal or composite fillings. Copayments for these services vary from \$16 to \$49.

Additional dental benefits are available from participating Plan dentists at discounted rates. These discounted services are not to be considered Plan benefits and are not covered under this contract. See Section 5(i), *Non-FEHB benefits available to Plan members*, for more information about discounted dental services.

*Dental benefits- continued on next page*

<b>Dental benefits</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<b>Diagnostic (exams)</b>		
120 Periodic oral examination	\$10	\$10
140 Limited oral evaluation (problem focused)	\$10	\$10
150 Comprehensive oral evaluation	\$10	\$10
170 Reevaluation limited (problem focused)	\$10	\$10
220 Intraoral: (periapical, first film)	\$10	\$10
230 Intraoral: (periapical, each additional film)	\$10	\$10
240 Intraoral: (occlusal film)	\$10	\$10
270 Bitewing (single film)	\$10	\$10
272 Bitewings (two films)	\$10	\$10
274 Bitewings (four films)	\$10	\$10
460 Pulp vitality tests	\$10	\$10
470 Diagnostic casts	\$10	\$10
<b>Preventive (cleanings)</b>		
1110 Prophylaxis (adult, every six months)	\$10	\$10
1120 Prophylaxis (child, every six months)	\$10	\$10
1201 Topical application fluoride (includes prophylaxis–under age 14)	\$10	\$10
1203 Topical application fluoride (excludes prophylaxis–under age 14)	\$10	\$10
1205 Topical application fluoride (includes prophylaxis–age 14 and over)	\$10	\$10
<b>Minor restorative (fillings)</b>		
2110 Amalgam (one surface, primary)	\$16	\$16
2120 Amalgam (two surfaces, primary)	\$22	\$22
2130 Amalgam (three surfaces, primary)	\$26	\$26
2131 Amalgam (four or more surfaces, primary)	\$34	\$34
2140 Amalgam (one surface, permanent)	\$18	\$18
2150 Amalgam (two surfaces, permanent)	\$24	\$24
2160 Amalgam (three surfaces, permanent)	\$26	\$26
2161 Amalgam (four or more surfaces, permanent)	\$34	\$34
2330 Resin (one surface, anterior)	\$23	\$23
2331 Resin (two surfaces, anterior)	\$26	\$26
2332 Resin (three surfaces, anterior)	\$34	\$34
2335 Resin (four or more surfaces, or involving incisal angle – anterior)	\$40	\$40
2380 Resin (one surface, posterior primary)	\$22	\$22
2381 Resin (two surfaces, posterior primary)	\$31	\$31
2382 Resin (three or more surfaces, posterior primary)	\$38	\$38
2385 Resin (one surface, posterior permanent)	\$23	\$23
2386 Resin (two surfaces, posterior permanent)	\$30	\$30
2387 Resin (three surfaces, posterior permanent)	\$42	\$42
2388 Resin (four or more surfaces, posterior permanent)	\$49	\$49
<i>Not covered: Procedures not shown are not covered.</i>	<i>All charges.</i>	<i>All charges.</i>

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

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

### **Discounted dental services**

Plan members are eligible for discounts on non-covered dental services, such as sealants, crowns, inlays, bridges, root canals, gingivectomies and dentures when performed by participating Plan dentists. For a listing of discounted dental services, call Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

### **Eyewear discounts**

The Plan has arranged for discounts on eyeglass frames, prescription lenses, non-prescription sunglasses and complete contact lens packages. For more information, contact Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

### **Hearing aid discounts**

The Plan has arranged for discounts off the regular price of hearing aids. Contact Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) for a list of providers.

### ***It Fits!***

With *It Fits!*, Plan members can get reimbursed up to \$200 per family (\$100 per individual) for membership at their local fitness center, in Weight Watchers<sup>®</sup>, or both. 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 (TDD/TTY: 1-877-608-7677).

### ***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 (TDD/TTY: 1-877-608-7677).

### **Medicare prepaid Plan enrollment**

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 56, 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 our Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) for information on benefits available under the Medicare HMO.

### **Health education and wellness programs**

Fallon Foundation offers many health education and wellness programs and classes at the Lifetime Center, located in the atrium of the Worcester Medical Center, in Worcester, MA, for those who want to take a more active role in their health care. (Similar classes and programs may be available in other locations through Plan-affiliated hospitals.) In addition, the Lifetime Center offers a variety of free brochures and booklets that provide information about wellness, prevention and coping with various illnesses. Fees for these programs vary; many are provided at no cost to members. Call the Lifetime Center at 1-800-891-2300 for details.

---

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

---

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan provider determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed in *Services requiring preauthorization* on page 12.**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see Emergency benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service; or
- Services, drugs, or supplies you receive for non-covered conditions.

---

## Section 7. Filing a claim for covered services

---

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

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

### **Medical, hospital and drug benefits**

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

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

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

**Submit your claims to:** 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.

### **When we need more information**

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

---

## Section 8. The disputed claims process

---

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

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none"><li>Write to us within 6 months from the date of our decision; and</li><li>Send your request to us at: Fallon Community Health Plan, Consumer Affairs Department, 10 Chestnut St., Worcester, MA 01608, or fax it to us at: 1-508-755-7393; and</li><li>Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ol>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none"><li>Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>Write to you and maintain our denial – go to step 4; or</li><li>Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.</li></ol>
<b>3</b>	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
<b>4</b>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"><li>90 days after the date of our letter upholding our initial decision; or</li><li>120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or</li><li>120 days after we asked for additional information.</li></ul> <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

### The disputed claims process (*continued*)

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You may call OPM's Health Insurance Group 3 at 1-202-606-0755 between 8 a.m. and 5 p.m. eastern time.

---

## Section 9. Coordinating benefits with other coverage

---

### When you have other health coverage

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

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

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

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

### What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

### • Should I enroll in Medicare?

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

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various 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. Some things are not covered under Original Medicare, such as prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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

**Claims process when you have the Original Medicare Plan** – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) or visit us at [www.fchp.org](http://www.fchp.org).

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

(Primary Payer chart is on next page.)

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

<b>Primary Payer Chart</b>		
<b>A. When you - or your covered spouse - are age 65 or over and have Medicare and you...</b>	<b>The primary payer for the individual with Medicare is...</b>	
	<b>Medicare</b>	<b>This Plan</b>
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and ... You have FEHB coverage on your own or through your spouse who is also an active employee		✓
You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal Employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
<b>B. When you or a covered family member...</b>		
1) Have Medicare solely based on end stage renal disease (ESRD) and... • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
<b>C. When either you or a covered family member are eligible for Medicare solely due to disability and you...</b>		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
<b>D. When you are covered under the FEHB Spouse Equity provision as a former spouse</b>		
	✓	

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

## • Medicare Advantage

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare Advantage plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare Advantage plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare Advantage plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at [www.medicare.gov](http://www.medicare.gov).

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

**This Plan and our Medicare Advantage plan:** You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we do not waive cost-sharing for your FEHB coverage.

**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.

## TRICARE and CHAMPVA

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

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

## Workers' Compensation

We do not cover services that:

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

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

## **Medicaid**

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

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

## **When other Government agencies are responsible for your care**

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

## **When others are responsible for injuries**

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

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

---

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

---

<b>Calendar year</b>	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 14.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	Care furnished to meet non-medically necessary needs such as assistance in mobility, dressing, bathing, eating, preparation of special diets and taking medications. Custodial care that lasts 90 days or more is sometimes known as long-term care. Custodial care is not covered by the Plan.
<b>Deductible</b>	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 14.
<b>Experimental or investigational services</b>	Our Benefits & 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.
<b>Group health coverage</b>	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.
<b>Medical necessity</b>	A service which is rendered for the diagnosis or treatment of an illness or injury, not furnished primarily for the convenience of the member or provider, and is in accordance with professionally recognized medical standards and Plan medical criteria.
<b>Provider</b>	A person, agency or facility that may furnish health care to you under the terms of this contract. This includes, but is not limited to, doctors of medicine, osteopathy and podiatry, registered nurse anesthetists and nurse practitioners.
<b>Us/we</b>	Us and we refer to Fallon Community Health Plan (FCHP).
<b>You</b>	You refers to the enrollee and each covered family member.

---

## Section 11. FEHB Facts

---

### Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

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

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

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

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

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

- **Children’s Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan’s Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Benefit Service 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 2005 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 2004 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

### **When you lose benefits**

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

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

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

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

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

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

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

---

## Section 12. Two Federal Programs complement FEHB benefits

---

### Important information

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

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

#### • What is an FSA?

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

There are two types of FSAs offered by FSAFEDS:

#### Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

#### Dependent Care Flexible Spending Account (DCFSA)

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

#### • Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

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

#### What is SHPS?

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

## Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

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

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

## • How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006 to submit claims for eligible expenses.

The FSAFEDS Calculator at [www.FSAFEDS.com](http://www.FSAFEDS.com) will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

## • What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 14 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the High Option of this plan, typical out-of-pocket expenses include: office visit, prescription and inpatient hospital copayments; hearing aids; eyeglasses; and orthodontia.

Under the Standard Option of this plan, typical out-of-pocket expenses include: deductible, office visit and prescription copayments; hearing aids; eyeglasses; and orthodontia.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at [www.FSAFEDS.com/fsafeds/eligibleexpenses.asp](http://www.FSAFEDS.com/fsafeds/eligibleexpenses.asp). If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

## • Tax savings with an FSA

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

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

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

- **Tax credits and deductions**

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

- **Health care expenses**

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

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

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

- **Dependent care expenses**

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

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

- **Does it cost me anything to participate in FSAFEDS?**

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

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at [www.FSAFEDS.com](http://www.FSAFEDS.com), or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

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

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

- **It's important protection** Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later. In order to qualify for coverage under the FLTCIP,** you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an Open Season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To find out more and to request an application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

---

## Index

---

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

Accidental injury .....	24, 31, 50
Allergy tests.....	23
Ambulance.....	35, 38
Anesthesia .....	5, 29
Autologous bone marrow transplant.....	23
Biopsy.....	30
Blood and blood plasma .....	37
Casts .....	36, 37
<i>Catastrophic protection out-of-pocket</i> <i>maximum</i> .....	14
<b>Changes for 2005</b> .....	8
Chemotherapy .....	23
Cholesterol tests.....	18
Claims.....	15, 54, 55, 59, 64, 66
Coinsurance.....	6, 14, 60, 67
Colorectal cancer screening.....	18
Congenital anomalies .....	30, 31
Contraceptive drugs and devices .....	45
Copayments.....	14
Covered charges .....	58
Crutches.....	26
Deductible .....	6, 14, 17, 43, 54, 60, 67, 74
Definitions... ..	17, 29, 35, 39, 41, 43, 50, 62, 70, 71
Diagnostic services.....	17, 36, 41
Disputed claims review .....	47, 55
Dressings .....	36
Educational classes and programs .....	28
Effective date of enrollment .....	12
Emergency .....	6, 39, 40, 53, 54
Experimental or investigational .....	53
Family planning.....	21
Fecal occult blood test .....	18
Fraud.....	3, 4
General exclusions.....	53
General Exclusions.....	15
Hospital ... ..	4, 5, 6, 9, 12, 26, 29, 31, 34, 35, 36, 37, 42, 50, 54, 57, 60, 61
Immunizations .....	6, 19
Infertility.....	22
Inpatient hospital benefits.....	36
Magnetic Resonance Imagings (MRIs) ..	18
Mammograms.....	18
Maternity benefits.....	20
Medicaid.....	61
Medically necessary .....	17, 20, 29, 35, 39, 41, 43, 50, 53
Medicare.....	41, 57, 59
Medicare Advantage .....	60
Original .....	57, 60
Members	
Associate .....	72
Family .....	63
Plan .....	9, 30
Mental Health/Substance Abuse Benefits .....	41
Newborn care .....	20
Nurse	
Nurse Anesthetist (NA).....	36
Office visits .....	6
Oral and maxillofacial surgical.....	32
Out-of-pocket expenses .....	14, 57, 67
Oxygen .....	26, 36, 37
Pap test .....	18
Physician .....	29
Preauthorization .....	12, 23, 29, 35, 41, 42, 55, 56
Prescription drugs.....	23, 54, 60
Preventive care, adult .....	18
Preventive care, children .....	19
Preventive services.....	6
Prosthetic devices .....	25, 30
Psychologist .....	42
Room and board .....	36
Second surgical opinion .....	17
Skilled nursing facility care.....	12, 17, 34
Smoking cessation .....	28
Social worker .....	42
Splints.....	36
Subrogation .....	61
Surgery .....	5, 20, 29, 30, 31, 32
Anesthesia .....	37
Oral .....	32
Outpatient.....	37
Reconstructive.....	30, 31
Syringes.....	45
Temporary Continuation of Coverage (TCC).....	64
Transplants .....	23, 32
Treatment therapies .....	23
Wheelchairs.....	26
Workers Compensation .....	60
X-rays.....	18, 36, 37

---

## Notes

---

---

## Notes

---

---

## Notes

---

## Summary of benefits for the Fallon Community Health Plan - 2005 High Option

- **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 by Plan providers, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Preventive care for children to age 22 .....	Nothing	19
• Diagnostic and treatment services provided in the office .....	\$15 copayment per office visit with your primary care physician or obstetrician or gynecologist	17
	\$25 copayment per office visit with a specialist	17
Services provided by a hospital:		
• Inpatient.....	\$250 copayment per admission	34
• Outpatient .....	\$50 copayment per surgery	35
Emergency benefits		
• Emergency room .....	\$50 copayment per emergency room visit	38
• Doctor's office or urgent care facility .....	\$15 copayment per urgent care visit	38
Mental health and substance abuse treatment.....	Regular cost sharing	39
Prescription drugs .....	Tier 1, 2 and 3: up to a 30-day supply \$5/\$25/\$50 copayment	41
	Tier 1, 2, and 3: up to a 90-day supply \$10/\$50/\$150 copayment	
Dental care .....	\$10 per office visit for preventive care; copayments vary from \$16 to \$49 for minor restorative care	46
Vision services:		
Diagnosis and treatment of disease of the eye .....	\$25 copayment per office visit with a specialist	25
• Annual eye exam .....	\$15 copayment	25
Special features:	Flexible benefits option Out-of-area student benefits Clinical trials Services for the hearing impaired Interpreter services Peace of Mind Program™	44
Protection against catastrophic costs (Your catastrophic protection out-of-pocket maximum).....	We do not have a catastrophic out-of-pocket maximum.	14

## Summary of benefits for the Fallon Community Health Plan – 2005 Standard Option

- **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 by Plan providers, except in emergencies.
- An asterisk (\*) means the item is subject to the \$600 per member or \$1,200 per family calendar year deductible.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Preventive care for children to age 22 .....	\$20 copayment per office visit	19
• Diagnostic and treatment services provided in the office* .....	\$20 copayment per 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 your deductible.	17 17
Services provided by a hospital:		
• Inpatient* .....	Nothing after you meet your deductible	34
• Outpatient* .....	Nothing after you meet your deductible	35
Emergency benefits		
• Emergency room .....	\$75 copayment per emergency room visit	38
• Doctor's office or urgent care facility* .....	\$20 copayment per urgent care visit	38
Mental health and substance abuse treatment .....	Regular cost sharing	39
Prescription drugs .....	Tier 1, 2 and 3: up to a 30-day supply \$10/\$30/\$60 copayment  Tier 1, 2, and 3: up to a 90-day supply \$20/\$60/\$180 copayment	41
Dental care .....	\$10 per office visit for preventive care; copayments vary from \$16 to \$49 for minor restorative care	46
Vision services:		
• Diagnosis and treatment of disease of the eye* .....	\$25 copayment per office visit with a specialist	25
• Annual eye exam .....	\$15 copayment	25
Special features:	Flexible benefits option Out-of-area student benefits Clinical trials Services for the hearing impaired Interpreter services Peace of Mind Program™	44
Protection against catastrophic costs (Your catastrophic protection out-of-pocket maximum).....	We do not have a catastrophic out-of-pocket maximum.	14

## 2005 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 FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

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

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	JV1	\$131.08	\$56.97	\$284.01	\$123.43	\$154.74	\$33.31
High Option Self & Family	JV2	\$298.23	\$158.83	\$646.17	\$344.13	\$352.08	\$104.98
Standard Option Self Only	JV4	\$121.68	\$40.56	\$263.64	\$87.88	\$143.99	\$18.25
Standard Option Self & Family	JV5	\$295.73	\$98.58	\$640.76	\$213.58	\$349.95	\$44.36