# Fallon Community Health Plan

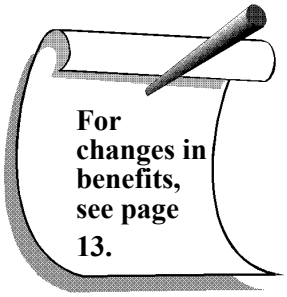
www.fchp.org

# 2011

## A Health Maintenance Organization (basic option)

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

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




**Enrollment code for this Plan:**

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

***Special Notice:*** *Enrollment codes JV4 and JV5 are not offered for the 2011 plan year*

Authorized for distribution by the:

**United States**
**Office of Personnel Management**

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

**RI 73-090**

**Important Notice from Fallon Community Health Plan About**

**Our Prescription Drug Coverage and Medicare**

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

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

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

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Please be advised

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If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

**Medicare's Low Income Benefits**

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

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

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

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# 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, Inc.
10 Chestnut Street
Worcester, MA 01608

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2011, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2011, and changes are summarized on page 13. 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, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Operations, Program Planning & Evaluation, 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:

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

- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

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

If the provider does not resolve the matter, call us at 1-800-868-5200 (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 age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- 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 if you are no longer enrolled in the Plan.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

## Preventing Medical Mistakes

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

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

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

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

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

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

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

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

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

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

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

**Patient Safety Links**

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

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

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

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

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

- www.quic.gov/report/toc.htm**.** 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.

**Never Events**

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

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

We have a benefit payment policy that will encourage hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs neither your FEHB plan or you will incur cost to correct the medical error.

# Section 1. Facts about this HMO Plan

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

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

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

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

Questions regarding what protections apply and what protections do not apply to a grandfathered health plan, and what might cause a plan to change status from grandfathered to non-grandfathered may be directed to us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) x69297**.** You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

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

Questions regarding what protections apply may be directed to us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) x69297**.** You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

**General features of our Basic Option**

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

**How we pay providers**

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

**Your rights**

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/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.
- We have been awarded an "Excellent" status for our HMO plans by the National Committee for Quality Assurance (NCQA).
- As a Fallon Community Health Plan member, you have certain rights and responsibilities:

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

- Be informed about Fallon Community Health Plan and covered services.
- Receive information about the managed care organization, its services, its practitioners and providers, and members' rights and responsibilities.
- Be informed about how medical treatment decisions are made by the contracted medical group or Fallon Community Health Plan, including payment structure.
- Choose a qualified contracted primary care physician and contracted hospital.
- You have the right to timely access to your prescriptions at any network pharmacy.
- Know the names and qualifications of physicians and health care professionals involved in your medical treatment.
- Receive information about an illness, the course of treatment and prospects for recovery in terms that you can understand.
- Actively participate in decisions regarding your own health and treatment options, including the right to refuse treatment.
- Receive emergency services when you, as a prudent layperson acting reasonably, would have believed that an emergency medical condition existed.
- Candidly discuss appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage, presented by your provider in a manner appropriate to your condition and ability to understand.
- Be treated with dignity and respect, and to have your privacy recognized.
- Keep your personal health information private as protected under federal and state laws—including oral, written and electronic information across the organization. Unauthorized people do not see or change your records. You have the right to review and get a copy of certain personal health information (there may be a fee for photocopies).
- Make complaints and appeals without discrimination about the managed care organization or the care provided, and expect problems to be fairly examined and appropriately addressed.
- Exercise these rights regardless of your race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or your national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care. Expect these rights to be upheld by both Fallon Community Health Plan and its contracted providers.
- You have the right to ask someone such as a family member or friend to help you with decisions about your health care. You can use a special form (such as a health care proxy, living will, or a power of attorney) to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself.
- Make recommendations regarding Fallon Community Health Plan's members' rights and responsibilities policies.

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

- Get familiar with your coverage and the rules you must follow to get care as a member. You can use this Brochure to learn about your coverage, what you have to pay, and the rules you need to follow. Call Customer Service, 1-800-868-5200 (TDD/TTY: 1-877-608-7677), if you have questions.
- Provide, to the extent possible, information that Fallon Community Health Plan, your physician or other care providers need in order to care for you.
- Do your part to improve your health condition by following the treatment plan, instruction and care that you have agreed on with your physician(s).
- Understand your health problems, and participate in developing mutually agreed-upon treatment goals.

If you have any questions about your rights and responsibilities, or 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 1-508-831-0912 or visit our Web site at www.fchp.org.

For information about a physician, including physician profiling information, call 1-617-654-9800, or write to the Commonwealth of Massachusetts, Board of Registration in Medicine, 560 Harrison Avenue, Suite G4, Boston, MA 02118.

**Your medical and claims records are confidential**

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

**Service Area**

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area includes towns in the following Counties: Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester.

Abington
Acton
Amesbury
Andover
Arlington
Arlington Heights
Ashburnham
Ashby
Ashland
Auburn
Auburndale
Avon
Ayer
Babson Park
Baldwinville
Barre
Bedford
Bellingham
Belmont
Berlin
Beverly
Billerica
Blackstone
Bolton
Bondsville
Boxboro
Boxford
Boylston
Braintree
Bridgewater
Brimfield
Brockton
Brookfield
Brookline
Brookline Village
Burlington
Byfield
Cambridge
Canton
Carlisle
Charlton
Charlton City
Charlton Depot
Chelmsford
Chelsea
Cherry Valley
Clinton
Cohasset
Concord
Danvers
Dedham
Devens
Douglas
Dover
Dracut
Dudley
Dunstable
Duxbury
East Bridgewater
East Brookfield
East Princeton
East Taunton
East Templeton
East Walpole
Easton
Essex
Everett
Fayville
Fiskdale
Fitchburg
Foxboro
Framingham
Franklin
Gardner
Georgetown
Gilbertville
Gloucester
Grafton
Groton
Groveland
Halifax
Hamilton
Hanover
Hanscom AFB
Hanson
Hardwick
Harvard
Haverhill
Hingham
Holbrook
Holden
Holland
Holliston
Hopedale
Hopkinton
Hubbardston
Hudson
Hull
Ipswich
Jefferson
Kingston
Lancaster
Lawrence
Leicester
Leominster
Lexington
Lincoln
Linwood

Littleton
Lowell
Lunenburg
Lynn
Lynnfield
Malden
Manchaug
Manchester
Mansfield
Marblehead
Marlborough
Marshfield
Marshfield Hills
Maynard
Medfield
Medford
Medway
Melrose
Mendon
Merrimac
Methuen
Middleton
Milford
Millbury
Millis
Millville
Milton
Monson
Nahant
Natick
Needham
Needham Heights
New Braintree
Newbury
Newburyport
Newton
Newton Center
Newton Highlands
Newton Lower Falls
Newton Upper Falls
Newtonville
Norfolk
North Andover
North Billerica
North Brookfield
North Chelmsford
North Dighton
North Easton
North Grafton
North Marshfield
North Reading
North Scituate
North Uxbridge
North Waltham
Northborough
Northbridge
Norton
Norwell
Norwood
Oakdale
Oakham
Oxford
Palmer
Paxton
Peabody
Pembroke
Pepperell
Petersham
Phillipston
Plainville
Plympton
Princeton
Quincy
Randolph
Raynham
Reading
Revere
Rochdale
Rockland
Rockport
Rowley
Rutland
Salem
Salisbury
Saugus
Scituate
Sharon
Sheldenville
Sherborn
Shirley
Shrewsbury
Somerville
South Barre
South Easton
South Grafton
South Hamilton
South Lancaster
Southborough
Southbridge
Spencer
Sterling
Still River
Stoneham
Stow
Sturbridge
Sudbury
Sutton
Swampscott
Taunton
Templeton
Tewksbury
Thorndike
Topsfield
Townsend
Tyngsboro
Upton
Uxbridge
Village of Nagog Woods
Waban
Wakefield
Wales
Walpole
Waltham
Ware
Warren
Watertown
Wayland
Webster
Wellesley
Wellesley Hills
Wenham
West Boxford
West Boylston
West Bridgewater
West Brookfield
West Groton
West Medford
West Millbury
West Newbury
West Newton
West Townsend
West Warren
Westboro
Westford
Westminster
Weston
Westwood
Weymouth
Wheelwright
Whitinsville
Wilkinsonville
Wilmington
Winchendon
Winchendon Springs
Winchester
Winthrop
Woburn
Woodville
Worcester
Wrentham

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

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), we provide coverage for a limited number of services when authorized in advance by the Plan. See Section 5(g) *Special features*. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

# Section 2. How we change for 2011

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

**Program Wide Change**

- Several provisions of the Affordable Care Act (ACA) affect eligibility and benefits under the FEHB Program and FSAFEDS beginning January 1, 2011. For instance, children up to age 26 will be covered under a self and Family enrollment. Please read the information in Sections 11 and 12 carefully.
- We have reorganized organ and tissue transplant benefit information to clarify coverage.
- We have reorganized Mental health and substance abuse benefits to clarify coverage.

**Changes to this Plan**

- Standard Option "Select Care," Codes JV4&JV5 will be eliminated.
- For Preventive Care, adult, the cost to the enrollee will be Nothing.
- For Preventive Care, children, the cost to the enrollee will be Nothing.
- Dependents will be covered to age 26.
- The PCP/Specialist copay will be $25 PCP and $35 Specialist.
- Human leukocyte antigen (HLA) or histocompatibility locus antigen testing will be included in the list of covered services.
- The Plan will provide for testing for up to four bone marrow transplant donors per year from family members and/or unrelated individuals.
- Inpatient Hospital/Office visit copayment, the cost to the enrollee will be $150 per day up to $750.
- The plan will remove short term inpatient care from the hospice benefit. It it an inpatient benefit.
- For Outpatient Hospital/Office visit copayment, the cost to the enrollee will be $100 per admission after the deductible is met.
- For Extended Care/Skilled nursing facility/Inpatient copayment, the cost to the enrollee will be $150 per day up to $750 per admission.
- For Emergency within our Service Area/copayments, the cost to the enrollee will be $100.
- For Emergency outside our Service Area/copayments, the cost to the enrollee will be $100.
- The Basic Option service area has been expanded to include eleven (11) additional cities and towns as follows: Cohasset, Duxbury, Hingham, Hull, Marshfield, Marshfield Hills, North Marshfield, North Scituate, Plympton, Scituate, Kingston.

# Section 3. How you get care

**Identification cards**

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

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

**Where you get covered care**

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

- **Plan providers**

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

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

- **Plan facilities**

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

**What you must do to get covered care**

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

Once you become a Plan member, we will generally only pay for services that you receive from Plan providers. However, there are certain circumstances in which we will temporarily pay for services that you receive from a non-Plan provider if you had been receiving care from that provider 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 a nurse practitioner. Your primary care provider will provide most of your health care, or give you a referral to see a specialist.

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

  If your primary care provider leaves the Plan, we will notify you 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**

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

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

  - If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get prior authorization beforehand).
  - If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
  - If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
  - If you have a chronic and disabling condition and lose access to your specialist because we:
  - Terminate our contract with your specialist for other than cause; or
  - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
  - Reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

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

**If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Service department immediately at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

- **Circumstances beyond our control**

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

**Services requiring our prior authorization**

For certain types of specialist visits and for certain specialty services, your PCP will need to get prior authorization from the Plan before giving you a referral. A prior authorization is an assurance by the Plan to pay for medically necessary covered services provided by an FCHP Select Care network provider to an eligible Plan member.

**Services that need prior authorization from the Plan**

- Admissions to a hospital or other inpatient facility
- Some same-day surgery (outpatient) and ambulatory procedures
- Services with a non-network provider
- Organ transplant evaluation and procedures
- Reconstructive surgery
- Infertility/assisted reproductive technology services
- Oral surgery (with the exception of the extraction of impacted teeth)
- Genetic testing
- Neuropsychological testing
- Prosthetics/orthotics and durable medical equipment
- Home health care and hospice care
- Nonemergency ambulance
- MRI, CT, PET and nuclear cardiology scans
- Growth hormone therapy (GHT)
- Speech therapy

When a service needs prior authorization, your PCP will send a request for services to the Plan. We will review the request and make an authorization decision within two business days of receipt of all the necessary information. For the purposes of this section, "necessary information" may include the results of any face-to-face clinical evaluation or second opinion that may be required.

We will tell your PCP of our decision within 24 hours of the time that we make the decision. If we authorize the service, we will send you and your PCP an authorization letter within two business days thereafter. When you get the letter, you can call a Plan specialist to make an appointment. The authorization letter will state the services the Plan has approved for coverage. Make sure that you have this authorization letter before any services requiring authorization are furnished to you. If the specialist feels you need services beyond those authorized, the specialist will ask for preauthorization directly from the Plan. If we approve the request for additional services, we will send both you and your PCP an authorization letter.

If we do not authorize a service, we will send you and your PCP a denial letter within one business day of the decision. The denial letter will explain the reasons for our decision and your right to file a grievance. Pending the outcome of the grievance process, in certain circumstances, such as for immediate or urgently needed services, the Plan will provide for an automatic reversal of a denial of coverage for services or durable medical equipment, within 48 hours, or sooner for durable medical equipment, if your PCP tells us that in his or her opinion the provision of such service or durable medical equipment should not await the outcome of the normal grievance process and that the service or durable medical equipment is medically necessary and that immediate and severe harm will result if you do not receive the service within 48 hours or sooner for durable medical equipment. The Plan will provide the coverage until we notify you of the outcome of your grievance.

**Please note:**

If a physician or other health care provider discusses treatment options with you, this does not necessarily make that treatment a covered service. Physicians and other health care providers are freely able to discuss treatment options without restraint from the Plan. Services or supplies that are not described as covered in Section 5, *Benefits*, and that did not receive any necessary prior authorization from the Plan are not covered services. Services that are not medically necessary are not covered services. Services and supplies you receive from providers who are not network providers are not covered services, unless you received prior authorization from the Plan to go to that provider.

# Section 4. Your costs for covered services

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

**Copayments**

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

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

**Cost-sharing**

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

**Deductible**

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

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

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

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

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the calendar year deductible of your old option to the calendar year deductible of your new option.

| | |
|---|---|
| **Coinsurance** | Your share of the allowed charges for certain covered benefits, expressed as a percentage. For example, if your coinsurance is 20%, you pay 20% of the allowed charges for the services you received, and we pay the remaining 80%. |
| **Your catastrophic protection out-of-pocket maximum** | We do not have a catastrophic protection out-of-pocket maximum. There is a dollar limit to the number of copayments you must pay in each calendar year for inpatient admissions and outpatient surgery combined.<br><br>Inpatient admissions include admissions to hospitals and skilled nursing or rehabilitation facilities. Outpatient surgery includes same-day surgery in a hospital outpatient department or ambulatory care facility.<br><br>You are responsible for a copayment maximum of $1,000 per member/$2,000 per family for inpatient admissions, outpatient surgery and prosthetic limbs combined in each calendar year. Each member must meet the per-member copayment maximum unless the family copayment maximum applies. The family copayment maximum is considered met when any combination of family members reaches the copayment maximum. No individual family member will pay more than the per-member copayment maximum in a calendar year. After you have met your copayment maximum, you will no longer pay a copayment for inpatient admissions or outpatient surgery.<br><br>The plan will keep track of the copayments that apply to your copayment maximum. When you reach the copayment maximum, we will send you a letter that indicates that you have reached your copayment maximum and that no further copayments will be required for inpatient admissions or outpatient surgery.<br><br>If you pay any copayments that you are not responsible for, please contact Customer Service, or you may send a letter to Fallon Community Health Plan, Customer Service, 10 Chestnut St., Worcester, MA 01608. Include your name, address, member ID, proof of payment and an address to which the reimbursement should be sent. You must submit a claim for reimbursement within one year of the date of service. |
| **Carryover** | If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.<br><br>Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option. |
| **When Government Facilities bill us** | Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information. |

# Section 5. Basic Option Benefits

See page 13 for how our benefits changed this year. Page 82 is a benefits summary. Make sure that you review the benefits that are available under this option.


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## Section 5. Basic Option Benefits Overview

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

The Basic Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the *General exclusions* in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about Basic Option benefits, contact us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) or at our Web site at www.fchp.org.

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

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

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

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

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.** | |
| **Diagnostic and treatment services** | **Basic Option** |
| Professional services of physicians or other health care professionals<br>• In physician's office<br>• Second surgical opinion<br>• Office medical consultations<br>• Minute clinics (mini-clinics)<br>• At home<br><br>Note: See Section 5(d), *Emergency services*, for care of a minor emergency in a doctor's office or urgent care center. | $25 copayment per office visit to your primary care provider or obstetrician/gynecologist<br><br>$35 copayment per associated office visit to a specialist<br><br>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<br>• During a hospital stay<br>• In a skilled nursing facility | Nothing |
| **Lab, X-ray and other diagnostic tests** | **Basic Option** |
| Tests, such as:<br>• Blood tests<br>• Urinalysis<br>• Non-routine Pap tests<br>• Pathology<br>• X-rays<br>• Non-routine mammograms<br>• CAT Scans/MRI<br>• Ultrasound | Nothing for lab, X-ray and other diagnostic tests after you meet your calendar year deductible<br><br>$25 copayment per office visit to your primary care provider or obstetrician/gynecologist<br><br>$35 copayment per associated office visit to a specialist |

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

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Lab, X-ray and other diagnostic tests (cont.)** | **Basic Option** |
| • Electrocardiogram and EEG<br>• Human leukocyte antigen (HLA) or histocompatibility locus antigen testing for A, B, or DR antigens, or any combination thereof, necessary to establish bone marrow transplant donor suitability of a member | Nothing for lab, X-ray and other diagnostic tests after you meet your calendar year deductible<br>$25 copayment per office visit to your primary care provider or obstetrician/gynecologist<br>$35 copayment per associated office visit to a specialist |
| **Preventive care, adult** | **Basic Option** |
| Routine physical examinations and related services with your PCP, such as:<br>• History and risk assessment<br>• Urinalysis<br>• CBC<br>• Total blood cholesterol<br>• Colorectal Cancer Screening, including:<br>- Fecal occult blood test<br>- Sigmoidoscopy screening - every five years starting at age 50<br>- Double contrast barium enema - every five years starting at age 50<br>- Colonoscopy screening - every ten years starting at age 50<br>• Osteoporosis screening for women age 65 and older (beginning at age 60 for women at increased risk)<br>• Abdominal Aortic Aneurysm screening (ultrasound) - one time test for men age 65 to 75 with a history of smoking | Nothing |
| Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older | Nothing |
| Routine Pap test | Nothing |
| Routine mammogram – covered for women age 35 and older, as follows:<br>• From age 35 through 39, one during this five year period<br>• From age 40 and older, one every calendar year<br>• At age 65 and older, one every two consecutive calendar years | Nothing |
| Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) | Nothing |
| Travel-related immunizations | Nothing<br>(No deductible) |
| *Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp.* | *All charges* |

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Preventive care, children** | **Basic Option** |
| Well-child care charges for routine examsinations, immunizations and care (up to age 22), which include:<br>• History and physical examination, measurements, sensory screening, neuropsychiatric evaluations, development screening and assessment.<br>• Screening of all children under six years of age for the presence of lead poisoning<br>• 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.<br>• Examinations, such as:<br>- Vision screening through age 22 to determine the need for vision correction<br>- Hearing screening through age 22 to determine the need for hearing correction<br>- Examinations done on the day of immunizations (up to age 22) | Nothing<br>(No deductible) |
| • Childhood immunizations recommended by the American Academy of Pediatrics including Hepatitis A for infants 12 to 23 months of age, and tetanus, diptheria, and pertussis<br>• Meningococcal Conjugate Vaccine for children at risk as indicated by the American Academy of Pediatrics | Nothing<br>(No deductible) |
| Travel-related immunizations | Nothing<br>(No deductible) |
| *Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, or attending schools or camp* | *All charges* |
| **Maternity care** | **Basic Option** |
| Complete maternity (obstetrical) care, such as:<br>• Prenatal care<br>• Delivery<br>• Postnatal care<br><br>Note: Here are some things to keep in mind:<br>• You do not need to precertify your normal delivery; see page 14 for other circumstances, such as extended stays for you or your baby. | Nothing for prenatal care or the first postpartum visit; $25 copayment per office visit for all postpartum care visits thereafter.<br>Nothing for inpatient professional delivery services |

*Maternity care - continued on next page*

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Maternity care (cont.)** | **Basic Option** |
| • 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.<br>• We cover routine nursery care including examination, newborn hearing screening and circumcision, of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision.<br>• We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).<br>• We pay non-routine maternity care the same as for illness and injury. See Medical services and supplies provided by physicians and other health care professionals (Section 5(a)). | Nothing for prenatal care or the first postpartum visit; $25 copayment per office visit for all postpartum care visits thereafter.<br><br>Nothing for inpatient professional delivery services |
| **Family planning** | **Basic Option** |
| A range of voluntary family planning services, limited to:<br>• Consultations, examinations, procedures and medical services related to the use of all contraceptive methods<br>• Contraceptives furnished by a Plan provider during a covered office visit, such as:<br>- Surgically implanted contraceptives<br>- Intrauterine devices (IUDs)<br>- Diaphragms<br>- Cervical caps<br>• Voluntary sterilization (See *Surgical procedures* Section 5 (b)).<br><br>Note: We cover oral contraceptives and certain other contraceptives, such as Depo-Provera and the contraceptive patch, under the prescription drug benefit. | Nothing for family planning services<br><br>(No deductible)<br><br>$25 copayment per associated office visit to your primary care provider or obstetrician/ gynecologist<br><br>$35 copayment per associated office visit to a specialist |
| *Not covered:*<br>• *Reversal of voluntary surgical sterilization*<br>• *Genetic counseling*<br>• *Over-the-counter contraceptive drugs or devices* | *All charges* |

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Infertility services** | **Basic Option** |
| Diagnosis and treatment of infertility such as:<br>• Evaluation and diagnosis of infertility<br>• The following procedures for the treatment of infertility<br>- Artificial insemination (AI)<br>*Intravaginal insemination (IVI)*<br>*Intrauterine insemination (IUI)*<br>• In vitro fertilization and embryo placement (IVF-EP)<br>• Gamete intrafallopian transfer (GIFT)<br>• Zygote intrafallopian transfer (ZIFT)<br>• Intracytoplasmic sperm injection (ICSI)<br>• Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated egg<br>To be eligible, you must be an individual who:<br>(1) is unable to conceive or produce conception during a period of one year; and<br>(2) should expect fertility as a natural state; or<br>(3) is a premenopausal female or a female who is experiencing menopause at a premature age<br>Approval for Assisted Reproductive Technology (ART) is continegent upon review of your medical history by the Plan medical director. A benefits pamphlet is available by contacting Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).<br>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. | Nothing for infertility procedures after you meet your deductible<br>$25 copayment per office visit to your primary care provider or obstetrician/gynecologist<br>$35 copayment per associated office visit to a specialist |
| *Not covered:*<br>• *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.*<br>• *Donor egg transfer or harvesting for women who are menopausal (except as stated above) or have genetic oocyte defects.*<br>• *Chromosome studies of a donor (sperm or egg).*<br>• *Pre-implant Genetic Diagnosis (PGD) or testing (genetic testing on the embryo before it is inserted into the uterus).*<br>• *Charges for the storage of donor sperm, eggs or embryo that remain in storage after the completion of an approved infertility cycle.* | *All charges* |

*Infertility services - continued on next page*

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Infertility services (cont.)** | **Basic Option** |
| • *Supplies that may be purchased without a physician's written order, such as ovulation test kits.*<br>• *Services which are necessary due to a voluntary sterilization, such as tubal ligation or vasectomy.*<br>• *Surrogacy or gestational carrier services.*<br>• *Transportation costs to or from the medical facility.*<br>• *Services that are covered by another insurer.*<br>• *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.)* | *All charges* |
| **Allergy care** | **Basic Option** |
| • Testing and treatment<br>• Allergy injections | Nothing for allergy testing and treatment<br>$25 copayment per associated office visit to your primary care provider<br>$35 copayment per associated office visit to a specialist |
| • Allergy serum | Nothing |
| *Not covered:*<br>• *Provocative food testing*<br>• *Sublingual allergy desensitization* | *All charges* |
| **Treatment therapies** | **Basic Option** |
| • Chemotherapy and radiation therapy<br>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 36. We cover prescription chemotherapy drugs purchased at a pharmacy under the prescription drug benefit, with the applicable copayments.<br>• Respiratory and inhalation therapy<br>Note: Drug therapies for the treatment of respiratory diseases are covered under the prescription drug benefit.<br>• Dialysis – hemodialysis and peritoneal dialysis<br>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy<br>• Growth hormone therapy (GHT)<br>Note: Growth hormone is covered under the prescription drug benefit. | Nothing for treatment therapies after you meet your calendar year deductible<br>$25 copayment per associated office visit to your primary care provider<br>$35 copayment per associated office visit to a specialist |

*Treatment therapies - continued on next page*

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Treatment therapies (cont.)** | **Basic Option** |
| Note: We only cover GHT when we give prior authorization for the treatment. Your Plan provider will submit a request for prior authorization 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 *Services requiring preauthorization* in Section 3. | Nothing for treatment therapies after you meet your calendar year deductible<br><br>$25 copayment per associated office visit to your primary care provider<br><br>$35 copayment per associated office visit to a specialist |
| **Physical and occupational therapies** | **Basic Option** |
| Up to 60 visits per illness or injury per calendar year for:<br>• qualified physical therapists, and<br>• occupational therapists<br><br>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. | $25 copayment per office visit after you meet your calendar year deductible |
| • Cardiac rehabilitation for persons with documented cardiovascular disease, initiated within 26 weeks after the diagnosis of cardiovascular disease | $25 copayment per office visit after you meet your calendar year deductible |
| • Early intervention services delivered by certified early intervention specialists according to operational standards developed by the Department of Public Health, for children from birth to their 3rd birthday. | Nothing |
| *Not covered:*<br>• *Long-term rehabilitative therapy*<br>• *Exercise programs* | *All charges* |
| **Speech therapy** | **Basic Option** |
| Medically necessary services, up to 60 visits per condition, for the diagnosis and treatment of speech, hearing and language disorders when services are provided by a Plan provider who is a speech-language pathologist or audiologist; at a Plan facility or provider's office. | $25 copayment per office visit after you meet your calendar year deductible |
| **Hearing services (testing, treatment, and supplies)** | **Basic Option** |
| • Hearing testing for children through age 17, as shown in *Preventive care, children.*<br>• Hearing aids, as shown in *Orthotic and prosthetic devices* | Nothing |

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Vision services (testing, treatment, and supplies)** | **Basic Option** |
| • Diagnosis and treatment of diseases or injuries to the eye<br>• Annual eye refractions<br><br>Note: See *Preventive care, children* for eye exams for children. | Nothing for treatment of diseases or injuries to the eye after you meet your calendar year deductible<br><br>$25 copayment per associated office visit to your primary care provider<br><br>$35 copayment per associated office visit to a specialist |
| *Not covered:*<br>• *Eye exercises and orthoptics*<br>• *Radial keratotomy and other refractive surgery* | *All charges* |
| **Foot care** | **Basic Option** |
| • Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.<br>• Non-routine foot care, including but not limited to : treatment of bunions, ganglion, heel spurs, plantar fasciitis, osteoarthritis and plantar warts.<br><br>Note: See *Orthotic and prosthetic devices* for information on podiatric shoe inserts on page 30. | $25 copayment per office visit to your primary care provider<br><br>$35 copayment per associated office visit to a specialist |
| *Not covered:*<br>• *Routine foot care for members unless specified above* | *All charges* |
| **Orthotic and prosthetic devices** | **Basic Option** |
| Prosthetic limbs, which replace in whole or in part, an arm or leg.<br>• Orthotic devices (devices that support part of the body and/or eliminate motion) such as neck collars for cervical support, molded body jacket for curvature of the spine and braces with rigid support.<br>• Prosthetic devices (not including dental) such as artificial eyes, implanted corrective lenses following cataract surgery and electric speech aids.<br>• Corrective orthotic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.<br><br>Note: All orthotic and prosthetic devices must be ordered by a Plan provider and authorized by the Plan. | 20% coinsurance<br><br>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.<br><br>Orthotic and prosthetic devices and durable medical equipment are subject to a combined benefit limit. |
| Scalp and hair prosthesis (wigs) for individuals who have suffered hair loss as a result of the treatment of any form of cancer or leukemia. | Nothing, up to the benefit limit of $350 per calendar year, after you meet your calendar year deductible. You pay all charges beyond the benefit limit. |

*Orthotic and prosthetic devices - continued on next page*

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Orthotic and prosthetic devices (cont.)** | **Basic Option** |
| • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy<br>• 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. | Nothing after you meet your calendar year deductible. |
| *Not covered:*<br>• *Orthotic and corrective shoes (except when part of a brace or for diabetic foot care)*<br>• *Arch supports*<br>• *Foot orthotics*<br>• *Heel pads and heel cups*<br>• *Lumbosacral supports*<br>• *Adjustable shoe-styling positioning devices, sucha as Bebax™ Shoe*<br>• *Corsets, trusses, elastic stockings, support hose, and other supportive devices* | *All charges* |
| **Durable medical equipment (DME)** | **Basic Option** |
| We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:<br>• Oxygen and oxygen equipment;<br>• Hospital beds;<br>• Wheelchairs;<br>• Crutches and canes;<br>• Walkers;<br>• Audible prescription reading devices;<br>• Speech generating devices;<br>• Blood glucose monitors;<br>• Visual magnifying aids for use by the legally blind;<br>• Voice synthesizers for blood glucose monitors; and<br>• Insulin pumps and insulin pump supplies.<br><br>Note: Insulin and insulin pump supplies are covered under the prescription drug benefit. All durable medical equipment must be ordered by a Plan provider and preauthorized by the Plan. | Nothing, up to the benefit limit of $1,500 per calendar year, after you meet your calendar year deductible. You pay all charges beyond the benefit limit. |

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

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Durable medical equipment (DME) (cont.)** | **Basic Option** |
| Note: Call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at a discounted rates and will tell you more about this service when you call. | Nothing, up to the benefit limit of $1,500 per calendar year, after you meet your calendar year deductible. You pay all charges beyond the benefit limit. |
| *Not covered:*<br>• *Items that are not covered include, but are not limited to, air conditioners, air purifiers, arch supports, ear plugs (to prevent fluid from entering the ear canal during water activities), foot orthotics, orthopedic shoes (except when part of a brace) or other supportive devices for the feet, articles of special clothing, compression garments (such as Jobst® stockings), bed-pans, raised toilet seats, dehumidifiers, dentures, elevators, safety grab bars, car seats, seizure helmets, hearing aids, heating pads, hot water bottles, tinnitus maskers, exercise equipment or similar equipment.*<br>• *Oxygen and related equipment when received from a non-Plan provider. This includes oxygen and related equipment that you are supplied with while you are out of our service area.* | *All charges* |
| **Home health services** | **Basic Option** |
| Home health care ordered by a Plan provider and authorized by the Plan, including part-time or intermitent skilled nursing care and physical therapy, medical social services, home health aid services, medical and surgical supplies, durable medical equipment and nutritional consultations are covered to the extent that they are determined to be a medically necessary component of covered skilled nursing care and physical therapy.<br>Note: Durable medical equipment and physical and occupational therapy provided as a medically necessary component of home health care are not subject to the benefit limits. | Nothing after you meet your calendar year deductible |
| *Not covered:*<br>• *Nursing care requested by, or for the convenience of, the patient or the patient's family*<br>• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* | *All charges* |

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Chiropractic** | **Basic Option** |
| Chiropractic services for acute musculoskeletal conditions. The condition must be new or an exacerbation of a previous condition. Coverage is provided for up to 12 office visits in each calendar year, when medically necessary. | $25 copayment per office visit<br><br>(No deductible) |
| **Alternative treatments** | **Basic Option** |
| *No benefit* | *All charges* |
| **Educational classes and programs** | **Basic Option** |
| Coverage is provided for:<br>• Smoking cessation programs, including individual/group/ telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. | Nothing for counseling for up to two quit attempts per calendar year, four counseling sessions per quit attempt.<br><br>Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence. |
| • Diabetes self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider. | $25 copayment per office visit<br><br>(No deductible) |
| • Childhood obesity education | Nothing |

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan providers must provide or arrange your care.
- You have an annual out-of-pocket copayment maximum of $1,000 per person or $2,000 per family for inpatient admissions and outpatient surgery combined.
- The calendar year deductible is $600 per person or $1,200 per family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- You pay a copayment for each office visit to a physician or other health care professional. Services provided to you during the office visit, such as diagnostic tests and medical or surgical procedures, are subject to the calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

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

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

*Surgical procedures - continued on next page*

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Surgical procedures (cont.)** | **Basic Option** |
| - Have no untreated metabolic cause for obesity (e.g. adrenal or thyroid disorders)<br>- Have a history of failure with two or more nonsurgical measures, supervised, over at least a one year period<br>• Insertion of internal prosthetic devices. See Section 5(a) - *Orthotic and prosthetic devices* for device coverage information.<br>• Voluntary sterilization (e.g., tubal ligation, vasectomy)<br>• Treatment of burns<br><br>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for a pacemaker and surgery benefits for insertion of the pacemaker. | Nothing for surgical procedure after you meet your calendar year deductible<br><br>$25 copayment per associated office visit to your primary care provider or obstetrician/ gynecologist<br><br>$35 copayment per associated office visit to a specialist<br><br>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). |
| *Not covered:*<br>• *Reversal of voluntary sterilization.*<br>• *Routine treatment of conditions of the foot; see Foot care.* | *All charges* |
| **Reconstructive surgery** | **Basic Option** |
| • Surgery to correct a functional defect<br>• Surgery to correct a condition caused by injury or illness if:<br>- the condition produced a major effect on the member's appearance and<br>- the condition can reasonably be expected to be corrected by such surgery<br>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes.<br>• All stages of breast reconstruction surgery following a mastectomy, such as:<br>- Reconstruction of the breast on which the mastectomy was performed;<br>- Surgery to produce a symmetrical appearance on the other breast;<br>- Treatment of any physical complications, such as lymphedemas.<br><br>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. | Nothing for reconstructive surgery after you meet your calendar year deductible<br><br>$25 copayment per associated office visit to your primary care provider or obstetrician/ gynecologist<br><br>$35 copayment per associated office visit to a specialist |
| Breast prostheses and surgical bras and replacements (see Section 5 (a) *Orthotic and prosthetic devices)* | Nothing after you meet your calendar year deductible |
| | *All charges* |

*Reconstructive surgery - continued on next page*

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Reconstructive surgery (cont.)** | **Basic Option** |
| *Not covered:*<br>• *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*<br>• Surgeries related to sex transformation | *All charges* |
| **Oral and maxillofacial surgery** | **Basic Option** |
| Oral surgical procedures, limited to:<br>• Reduction of fractures of the jaws or facial bones;<br>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;<br>• Removal of stones from salivary ducts;<br>• Excision of leukoplakia or malignancies;<br>• Excision of cysts and incision of abscesses when done as independent procedures; and<br>• Other surgical procedures that do not involve the teeth or their supporting structures. | Nothing for oral and maxillofacial surgery after you meet your calendar year deductible.<br>$25 copayment per associated office visit to your primary care provider<br>$35 copayment per associated office visit to a specialist<br>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.) |
| *Not covered:*<br>• *Oral implants and transplants*<br>• *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* | *All charges* |
| **Organ/tissue transplants** | **Basic Option** |
| These **solid organ transplants** are covered. Solid organ transplants are limited to:<br>• Cornea<br>• Heart<br>• Heart/lung<br>• Intestinal transplants<br>- Small intestine<br>- Small intestine with the liver<br>- Small intestine with multiple organs, such as the liver, stomach, and pancreas<br>• Kidney<br>• Liver<br>• Lung: single/bilateral/lobar<br>• Pancreas<br>• Autologus pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis | Nothing |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Organ/tissue transplants (cont.)** | **Basic Option** |
| These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures.<br>• Autologous tandem transplants for:<br>- AL Amyloidosis<br>- Multiple myeloma (de novo and treated)<br>- Recurrent germ cell tumors (including testicular cancer) | Nothing |
| **Blood or marrow stem cell transplants** limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.<br>• Allogenic transplants for:<br>- Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia<br>- Advanced Hodgkin's lymphoma with reoccurence (relapsed)<br>- Advanced non-Hodgkin's lymphoma with reoccurence (relapsed)<br>- Acute myeloid leukemia<br>- Advanced Myeloproliferative Disorders (MPDs)<br>- Advanced neuroblastoma<br>- Amyloidosis<br>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)<br>- Hemoglobinopathy<br>- Infantile malignant osteoporosis<br>- Kostmann's syndrome<br>- Leukocyte adhesion deficiencies<br>- Marrow failure and related disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia)<br>- Mucidolipidosis (e.g. Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)<br>- Mucopolysaccharidosis (e.g. Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)<br>- Myelodysplasia/Myelodysplastic syndromes<br>- Paroxysmal Nocturnal Hemoglobinuria<br>- Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)<br>- Severe combined immunodeficiency<br>- Severe or very severe aplastic anemia<br>- Sickle cell anemia | Nothing |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Organ/tissue transplants (cont.)** | **Basic Option** |
| - X-linked lymphoproliferative syndrome<br>• Autologous transplants for<br>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia<br>- Advanced Hodgkin's lymphoma with reoccurrence (relapsed)<br>- Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)<br>- Amyloidosis<br>- Breast Cancer<br>- Ependymoblastoma<br>- Epithelial ovarian cancer<br>- Ewing's sarcoma<br>- Multiple myeloma<br>- Medulloblastoma<br>- Pineoblastoma<br>- Neuroblastoma<br>- Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors | Nothing |
| **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan.<br><br>Refer to *Other services* in Section 3 for prior authorization procedures:<br>• Allogeneic transplants for<br>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia<br>- Advanced Hodgkin's lymphoma with reoccurrence (relapsed)<br>- Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)<br>- Acute myeloid leukemia<br>- Advanced Myeloproliferative Disorders (MPDs)<br>- Amyloidosis<br>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)<br>- Hemoglobinopathy<br>- Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia)<br>- Myelodysplasia/Myelodysplastic syndromes<br>- Paroxysmal Nocturnal Hemoglobinuria<br>- Severe combined immunodeficiency | Nothing |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Organ/tissue transplants (cont.)** | **Basic Option** |
| - Severe or very severe aplastic anemia<br>• Autologous transplants for<br>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia<br>- Advanced Hodgkin's lymphoma with reoccurrence (relapsed)<br>- Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)<br>- Amyloidosis<br>- Neuroblastoma | Nothing |
| These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.<br><br>If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.<br>• Allergenic transplants for<br>- Advanced Hodgkin's lymphoma<br>- Advanced non-Hodgkin's lymphoma<br>- Beta Thalassemia Major<br>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma<br>- Multiple myeloma<br>- Multiple sclerosis<br>- Sickle Cell anemia<br>• Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for<br>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia<br>- Advanced Hodgkin's lymphoma<br>- Advanced non-Hodgkin's lymphoma<br>- Breast cancer<br>- Chronic lymphocytic leukemia<br>- Chronic myelogenous leukemia<br>- Colon cancer<br>- Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) | Nothing |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Organ/tissue transplants (cont.)** | **Basic Option** |
| - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma<br>- Multiple myeloma<br>- Multiple sclerosis<br>- Myeloproliferative disorders (MSDs)<br>- Non-small cell lung cancer<br>- Ovarian cancer<br>- Prostate cancer<br>- Renal cell carcinoma<br>- Sarcomas<br>- Sickle cell anemia<br>• Mini-transplants (non-myeloblative autologous, reduced intensity conditioning or RIC) for<br>- Advanced Hodgkin's lymphoma<br>- Advanced non-Hodgkin's lymphoma<br>- Chronic myelogenous leukemia<br>- Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)<br>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma<br>- Multiple sclerosis<br>- Small cell lung cancer<br>- Systemic lupus erythematosus<br>- Systemic sclerosis<br>- Scleroderma<br>- Scleroderma-SSc (severe, progressive) | Nothing |
| National Transplant Program (NTP) | Nothing |
| *Note: We cover related medical and hospital expenses of the donor when we cover the recipient.* We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members. | Nothing |
| *Not covered:*<br>• *Donor screening tests and donor search expenses, except as shown above*<br>• *Implants of artificial organs*<br>• *Transplants not listed as covered* | *All charges* |

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Anesthesia** | **Basic Option** |
| Professional services provided in –<br>• Hospital (inpatient) | Nothing for anesthesia services after you meet your calendar year deductible |
| Professional services provided in –<br>• Hospital outpatient department<br>• Skilled nursing facility<br>• Ambulatory surgical center<br>• Office | Nothing for anesthesia services after you meet your calendar year deductible<br>$25 copayment per associated office visit to your primary care provider<br>$35 copayment per associated office visit to a specialist |

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan providers must provide or arrange your care and you must be hospitalized in a Plan facility.
- You have an annual out-of-pocket copayment maximum of $1,000 per person or $2,000 per family for inpatient admissions and outpatient surgery combined.
- The calendar year deductible is $600 per person or $1,200 per family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).

**YOUR PROVIDER MUST GET PRIOR AUTHORIZATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require prior authorization.**

| Benefit Description | You pay |
|---|---|
| **Note: The calendar year deductible applies only when we say below: "(calendar year deductible applies)".** | |
| **Inpatient hospital** | **Basic Option** |
| Room and board, such as<br>• Ward, semiprivate, or intensive care accommodations;<br>• General nursing care; and<br>• Meals and special diets.<br><br>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. | $150 copayment per day up to $750 per admission after you meet your calendar year deductible |
| Other hospital services and supplies, such as:<br>• Operating, recovery, maternity, and other treatment rooms<br>• Prescribed drugs and medicines<br>• Diagnostic laboratory tests and X-rays<br>• Dressings, splints, casts, and sterile tray services<br>• Medical supplies and equipment, including oxygen | $150 copayment per day up to $750 per admission after you meet your calendar year deductible |
| • Anesthetics, including nurse anesthetist services<br>• Take-home items<br>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) | $150 copayment per day up to $750 per admission after you meet your calendar year deductible |
| *Not covered:*<br>• *Custodial care* | *All charges* |

*Inpatient hospital - continued on next page*

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

| Benefit Description | You pay |
|---|---|
| **Hospice care** | **Basic Option** |
| Hospice care is a method of caring for the terminally ill that helps those individuals continue their lives with as little disruption as possible. This type of care emphasizes supportive services, such as home care and pain control, rather than the cure-oriented services that are provided in hospitals. To be eligible for hospice care, you must be terminally ill with a life expectancy of less than six months.<br>• Hospice services are provided, as necessary, to maintain the terminally ill individual at home such as:<br>- Physicians' services, nursing care and medical social services<br>- Medical appliances and supplies including drugs and biologicals (prescription copayments may apply) | Nothing after you meet your calendar year deductible |
| *Not covered: Independent nursing, homemaker services* | *All charges* |
| **Ambulance** | **Basic Option** |
| • Ambulance service when medically appropriate<br>Note: See Section 5(d) for coverage of emergency ambulance. | Nothing after you meet your calendar year deductible |

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

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

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

**What is a medical emergency?**

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

**What to do in case of emergency:**

**Emergency care**

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

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

**Urgent care**

Sometimes you may need care for minor medical emergencies such as cuts that require stitches 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 prior authorization, 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<br>After the calendar year deductible… |
|---|---|
| **Emergency within our service area** | **Basic Option** |
| • Emergency care in an emergency room | $100 copayment per visit (waived if admitted)<br>(No deductible) |
| • Emergency care at a doctor's office<br>• Emergency care at an urgent care center<br>• Emergency care as an outpatient at a hospital, including doctors' services<br>*Note: We waive the ER copay if you are admitted to the hospital.* | $25 copayment per visit<br>(No deductible) |
| Urgent care at an urgent care center or a doctors' office | $25 copayment per visit<br>(No deductible) |
| *Not covered:*<br>• *Elective or non-emergency care received in an emergency room*<br>• *Follow-up care, unless provided by your primary care provider or authorized by the Plan. This includes follow-up care provided in an emergency room or urgent care facility.* | *All charges* |
| **Emergency outside our service area** | **Basic Option** |
| • Emergency care in an emergency room | $100 copayment per visit (waived if admitted)<br>(No deductible) |
| • Emergency care at a doctor's office<br>• Emergency care at an urgent care center<br>• Emergency care as an outpatient at a hospital, including doctors' services<br>*Note: We waive the ER copay if you are admitted to the hospital.* | $25 copayment per visit<br>(No deductible) |
| • Urgent care at an urgent care center or a doctors' office | $25 copayment per visit<br>(No deductible) |
| *Not covered:*<br>• *Elective or non-emergency care received in an emergency room*<br>• *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 center.* | *All charges* |

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Ambulance** | **Basic Option** |
| Emergency ambulance service when medically appropriate. Emergency ambulance services do not require prior authorization<br><br>Note: See 5(c) for non-emergency ambulance service. | Nothing after you meet your calendar year deductible |
| *Not covered:*<br>• *Air ambulance when not appropriate to medical condition or geographic location*<br>• *Transfers between hospitals when the patient's medical condition does not warrant that he or she be transported to another facility*<br>• *Commercial airline transportation* | *All charges* |

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

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost - sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR AUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the prior authorization process and get Plan approval of your treatment plan:

We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

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

*Professional services - continued on next page*

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

## Section 5(f). Prescription drug benefits

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

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

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

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

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Note: The calendar year deductible applies to almost all benefits in this Section.<br>We say "(No deductible)" when it does not apply.** | |
| **Covered medications and supplies** | **Basic Option** |
| We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail-order program:<br>• Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.*<br>• 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<br>• Oral medications that influence blood sugar levels<br>• Self-administered injectable agents<br>• Hormone replacement therapy for peri- and post- menopausal women<br>• Disposable needles and syringes for the administration of covered medications<br>• Fertility drugs<br>• Drugs for sexual dysfunction<br>• Contraceptive drugs and devices<br>• Off-label use of covered drugs in the treatment of HIV, AIDS or cancer<br><br>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. Certain fertility medications also require prior authorization; some may have a quantity limit for each prescription as well. | *At a Plan pharmacy:* up to a 30-day supply<br>Tier 1: $10<br>Tier 2: $30<br>Tier 3: $60<br>*Mail-order:* up to a 90-day supply<br>Tier 1: $20<br>Tier 2: $60<br>Tier 3: $120<br>Note: If there is no generic equivalent available, you will still have to pay the brand name copayment.<br>(No deductible) |
| Note: Injectables furnished and administered in a provider's office or under professional supervision are generally covered under the medical benefit. | Nothing after you pay your calendar year deductible |
| The Plan covers the special medical formulas and food products limited to those listed below. Prior authorization is required.<br>• 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.<br>• 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. | Nothing after you pay your calendar year deductible |

*Covered medications and supplies - continued on next page*

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Covered medications and supplies (cont.)** | **Basic Option** |
| • 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 $5,000 per calendar year. You may be required to purchase these products over-the-counter and submit claims to the Plan for reimbursement. | Nothing after you pay your calendar year deductible |
| *Not covered:*<br>• *Bio-identical hormone replacement therapy.*<br>• *Drugs and supplies for cosmetic purposes.*<br>• *Drugs to enhance athletic performance.*<br>• *Drugs for appetite suppression.*<br>• *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies.*<br>• *Vitamins, nutrients and food supplements even if a physician prescribes or administers them.*<br>• *Nonprescription medicines, over-the-counter preparations, devices and medical supplies such as antiseptics.*<br>• *Drugs that are investigational or that have not been approved for general sale and distribution by the U.S. Food and Drug Administration.*<br>• *Nicotine patches and gum or other smoking cessation products, unless supplied to you as part of an approved smoking cessation program.*<br>• *Medications and products for noncovered dental conditions.*<br>• *Prescription drugs that are a combination of a covered prescription item and an item that is specifically excluded, such as vitamins, minerals, medical foods or formulas.*<br><br>Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Smoking cessation benefit. (See page 56.) | *All charges* |

## Section 5(g). Dental benefits

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

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

| Benefit Desription | You Pay |
|---|---|
| **Accidental injury benefit** | **Basic Option** |
| The Plan covers emergency medical care, such as to relieve pain and stop bleeding as a result of an accidental injury to sound natural teeth or tissues, when provided as soon as medically possible in the office of a physician or dentist. You do not need a referral or prior authorization for emergency care needed as a result of dental trauma. Go to the closest provider.<br><br>Note: This accidental injury benefit does not include restorative or other dental services. | $25 copayment per office visit |
| **Out-of-area dental care** | **Basic Option** |
| 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. | $10 per office visit<br><br>Coverage is provided for up to $50 per incident. |

**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, 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 $19 to $51.

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(j), *Non-FEHB benefits available to Plan members*, for more information about discounted dental services.

| Dental Benefits | You Pay |
|---|---|
| **Diagnostic exams** | **Basic Option** |
| D0120 Periodic oral examination (every six months) | $10 |
| D0140 Limited oral evaluation (problem focused) | $10 |
| D0150 Comprehensive oral evaluation | $10 |
| D0170 Reevaluation limited (problem focused, not post-op visit) | $10 |
| D0220 Intraoral (periapical, first film) | $10 |
| D0230 Intraoral (periapical, each additional film) | $10 |
| D0240 Intraoral (occlusal film) | $10 |
| D0270 Bitewing (single film) | $10 |
| D0272 Bitewings (two films) | $10 |
| D0273 Bitewings (three films) | $10 |
| D0274 Bitewings (four films) | $10 |
| D0460 Pulp vitality tests | $10 |
| D0470 Diagnostic casts | $10 |
| **Preventive (cleanings)** | **Basic Option** |
| D1110 Prophylaxis (adult, every six months) | $10 |
| D1120 Prophylaxis (child, every six months) | $10 |
| D1203 Topical application fluoride excluding prophylaxis – ages 0-11 (every six months) | $10 |
| D1204 Topical application fluoride excluding prophylaxis – ages 0-11 (every six months) ages 12 and up (every six months) - adult | $10 |
| D1205 Topical fluoride varnish – for patients at moderate risk for caries | $10 |
| **Minor restorative (fillings)** | **Basic Option** |
| D2140 Amalgam (one surface) | $19 |
| D2150 Amalgam (two surfaces) | $25 |
| D2160 Amalgam (three surfaces) | $27 |
| D2161 Amalgam (four or more surfaces) | $36 |
| D2330 Resin (one surface, anterior) | $24 |
| D2331 Resin (two surfaces, anterior) | $27 |

*Minor restorative (fillings) - continued on next page*

| Dental Benefits | You Pay |
|---|---|
| **Minor restorative (fillings) (cont.)** | **Basic Option** |
| D2332 Resin (three surfaces, anterior) | $36 |
| D2335 Resin (four or more surfaces, or involving incisal angle – anterior) | $42 |
| D2391 Resin-based composite (one surface, posterior) | $24 |
| D2392 Resin-based composite (two surfaces, posterior) | $32 |
| D2393 Resin-based composite (three surfaces, posterior) | $44 |
| D2394 Resin-based composite (four or more surfaces, posterior) | $51 |
| *Not covered: Procedures not shown are not covered.* | *All charges.* |

## Section 5(h). Special features

| Feature | Description |
|---|---|
| **Flexible benefits option** | Under the flexible benefits option, we determine the most effective way to provide services.<br>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue.<br>• Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process.<br>• By approving an alternative benefit, we cannot guarantee you will get it in the future.<br>• The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits.<br>• If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request.<br>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. |
| **24 hour nurse line** | For any of your health concerns, 24 hours a day, 7 days a week, you may call and talk with a registered nurse who will discuss treatment options and answer your health questions. |
| **Services for deaf and hearing impaired** | You may access our TDD/TTY equipment at 1-877-608-7677. |
| **Clinical trials** | 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.<br>*Exclusion: All clinical trials with the exception of clinical trials for the treatment of cancer.* |
| **Interpreter services** | The Plan will, upon request, provide members with interpreter and translation services related to our administrative procedures. |
| **Out-of-area student coverage** | Students attending school outside the Plan service area may not have easy access to a Plan provider. They are covered for a limited number of services while out-of-area, if authorized in advance by the Plan.<br>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.<br>Services that are covered for students while out of the Plan service area include:<br>• Non-routine medical office visits<br>• Diagnostic lab and X-ray connected with a non-routine office visit<br>• Non-elective inpatient services if the Plan is notified within 48 hours of admission |

| | |
|---|---|
| | • Outpatient services to treat the abuse of or addiction to alcohol or drugs, while out of the Plan service area<br>• Outpatient services to diagnose and/or treat mental conditions<br>• Short-term rehabilitation services, including physical, occupational and speech therapy. Coverage for physical and occupational therapy is provided for up to 60 visits per illness or injury in each calendar year (combined with any in-area visits). Coverage for speech therapy is determined by medical necessity.<br><br>*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.*<br><br>Services that are not covered for students while out of the Plan service area include:<br>• Routine physical, gynecological exams, vision screening and hearing screening<br>• Routine preventive care<br>• Non-emergency prescription medication. You may use the prescription medication mail-order program to fill medication refills. (See page 55.)<br>• Second opinion<br>• Preventive dental care or minor restorative care (e.g., fillings)<br>• Chiropractic care services<br>• Home health care<br>• Outpatient surgical procedures that could be delayed until return to the Plan service area<br>• Maternity care or delivery<br>• Durable medical equipment (e.g., wheelchairs), including maintenance or replacement |
| **Peace of Mind Program™** | FCHP's Peace of Mind Program provides access to specialty services at specified Boston area medical centers. You may access Peace of Mind Program providers at your request if you meet the following conditions:<br>• The specialty service is ordinarily available in our network<br>• Care is for covered services as described in this brochure. The same copayments and benefit limits apply.<br>• You have seen a plan specialist for this same condition within the past three months.<br>• A referral to a specific Peace of Mind Programphysician is made by your PCP and notification of the referral is given to the plan.<br>• The provider to whom you are referred is on staff at one of the five medical centers listed below:<br><br>— Massachusetts General Hospital<br>— Brigham and Women's Hospital<br>— Children's Hospital (Boston)<br>— Dana-Farber Cancer Institute<br>— New England Medical Center |

| | |
|---|---|
| | • If you receive any hospital-based services such as surgery, lab or X-rays, these services must be performed at one of the above hospitals or at another FCHP Select Care network hospital. If you see a specialist through the Peace of Mind Program, and the specialist recommends or arranges services to be performed at a hospital that is not listed above, these services will not be covered unless the physician has obtained authorization from the plan. You must have a copy of the written authorization from the plan; do not rely on assurances by the physician regarding plan coverage.<br><br>Once the plan has been notified of the Peace of Mind Program referral to a Peace of Mind Program specialist, you may see this specialist for a period of one year or until treatment for the presenting condition is complete, whichever comes first. When your course of treatment is complete, or for care for any non-related condition, you should return to your PCP for care.<br><br>If your Peace of Mind Program specialist wants you to see another specialist at the same facility for the same condition, your PCP must submit a separate referral to the plan before you see the other specialist.<br><br>If you want to see a Peace of Mind Program specialist for a different condition, the request must meet Peace of Mind Program conditions described above for the second condition, your PCP must submit a referral to the plan and you must receive prior authorization from the plan in order for the services related to the second condition to be covered.<br><br>Please note: For the period of time that you are authorized treatment with the Peace of Mind Program provider for a particular condition, the Peace of Mind Program provider may order X-rays, laboratory tests and other tests to evaluate that condition without prior authorization if these services would normally be covered and would require no prior authorization when ordered by a plan provider. All inpatient care or inpatient, outpatient, or office-based surgery requires prior authorization from the plan. For a complete list of services requiring prior authorization, see obtaining specialty care and services. Note that all PET scans and genetic testing require prior authorization.<br><br>If you need physical therapy or occupational therapy for the same condition for which your Peace of Mind Program specialist is treating you, your Peace of Mind Program specialist may refer you for such physical therapy or occupational therapy without prior authorization at the Peace of Mind Program facility, or you may return to a plan therapist if you want.<br><br>You may use the Peace of Mind Program for all specialty care except mental health, substance abuse, dental care, chiropractic services, obstetrics, speech therapy and infertility services. You may not use the Peace of Mind Program for any primary care services, including internal medicine, family practice or pediatrics. If you have not met the conditions listed above, or if you or your physician have not obtained plan authorization for a Peace of Mind Program service, the services will not be covered by the plan and the Peace of Mind Program provider may hold you financially responsible. |

## Section 5(i). Health education resources and account management tools

| Special Feature | Description |
|---|---|
| **Health education reources** | Visit our Web site at www.fchp.org for:<br>• Healthwise Knowledgebase : one of the nation's leading online resources for helping people become informed about their health and health care in active partnership with their doctors. This comprehensive tool features a user-friendly format, hundreds of helpful illustrations and powerful search functions—all of which increase the usefulness of the in-depth medical content.<br>• Preventive Healthcare Guidelines: access preventive health care guidelines and prenatal recommendations from the Massachusetts Health Quality Partners and the Massachusetts Department of Public Health's guidelines for adult diabetes care.<br>• Leapfrog Group: learn more about the Leapfrog Group, which encourages large employers to recognize and reward health plans and hospitals that make "big leaps" in patient safety and quality.<br>• Healthy Communities : FCHP's member magazine provides you with information about hot health topics plus interesting articles on how to improve your general health and well-being. |
| **Care support (Patient Safety)** | *Leapfrog Group* - FCHP works in collaboration with the Mass Leapfrog Coalition to enhance patient safety for members treated at our contracted hospitals. We work with the Massachusetts Hospital Association to effectively prioritize and implement the Leapfrog project. FCHP publishes articles in the member magazine, which address information specific to Leapfrog compliance.<br>We also report the following progress with our outpatient safety programs:<br>*Web-based Health Education Program* - FCHP has implemented Web-based education modules in nutrition, fitness, stress, smoking, and weight loss.<br>*Public Report Card on Quality* - FCHP is in the process of developing a physician report card on quality. These report cards will be based on statewide rates and offer you information to help you make health care choices. |
| **Care Management** | At FCHP, we focus on selected complex medical and psychological needs of members and their families. Our Care Management Nurses identify, assess, plan, coordinate, implement, monitor and evaluate options and services to meet your health care needs. This approach gives you access to the appropriate resources and services which can improve your quality of life.<br>In addition to the general Care Management Program, FCHP has developed several disease care programs which identify, case manage, and provide educational resources for members with Congestive Heart Failure, Coronary Artery Disease, Asthma, Diabetes, High Risk Program, and Depression.<br>Our specially trained Care Managers empower you to take a more active role in your health care, and give you the tools you need to manage your disease. This is done by coaching over the phone and by mailing appropriate educational packages to you. Care Managers may also refer you to local support groups, classes and rehabilitation programs. |

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

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB calendar year deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact the plan at 800-868-5200 (TDD/TTY: 877-608-7677) or visit their website at www.fchp.org.

**Eyewear discounts**

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

***It Fits!***

Fallon Community Health Plan's wellness feature, gives you family up to $400 ($200 for self-only contract) to use toward a variety of healthy activities, like membership at local fitness centers, aerobics, Pilates and yoga classes when taught by a certified instructor), Weight Watchers ® programs, aw well as and local, town and school sports programs for all ages when they include an aerobic and instructional component. With *It Fits!,* Plan members decide what type of health and fitness program best fits their lifestyle. For more information, contact Customer Service at 800-868-5200 (TDD/TTY: 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 69, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid Plan if one is available in their area. They may then later re-enroll in the FEHB program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid program but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid Plan. Contact Customer Service at 800-868-5200 (TDD/TTY: 877-608-7677) for information on benefits available under the Medicare HMO.

**Health education and wellness programs**

FCHP offers a variety of health education and wellness programs, such as smoking cessation and worksite wellness. Fees for these programs vary and many are provided at no cost. Call Customer Service at 800-868-5200 (TDD/TTY: 877-608-7677) for more information.

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants).

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.
- All clinical trials with the exception of clinical trials for the treatment of cancer. We do not cover extra care costs related to taking part in a clinical trial, or research costs related to conducting the clinical trial.

# Section 7. Filing a claim for covered services

There are four types of claims. Three of the four types - Urgent care claims, Pre-service claims, and Concurrent review claims - usually involve access to care where you need to request and receive our advance approval to receive coverage for a particular service or supply covered under this Brochure. See Section 3 for more information on these claims/requests and Section 10 for the definitions of these three types of claims.

The fourth type - Post-service claims - is the claim for payment of benefits after services or supplies have been received.

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or 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 CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 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 CMS-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 payor – 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.

**Urgent care claims procedure**

If you have an urgent care claim, please contact our Customer Service department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) . Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) the end of the time frame whichever is earlier.

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

**Concurrent care claims procedures**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

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

**Pre-service claims procedures**

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

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

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

**Post-service claims procedures**

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

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

**When we need more information**

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

**Authorized Representative**

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

## Section 8. The disputed claims process

Please 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 prior authorization required by Section 3. You may be able to appeal to the U.S. Office of Personnel Management (OPM) immediately if we do not follow the particular requirements of this disputed claims process. For more information about situations in which you are entitled to immediately appeal and how to do so, please visit www.fchp.org.

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

| Step | Description |
|---|---|
| **1** | Ask us in writing to reconsider our initial decision. You must:<br>a) Write to us within 6 months from the date of our decision; and<br>b) Send or bring your request to us at: Fallon Community Health Plan, Member Appeals and Grievances Department, 10 Chestnut St., Worcester, MA 01608, fax it to us at: 1-508-755-7393, e-mail it to us at grievance@fchp.org, or call us at 1-800-333-2535, extension 69950; and<br>c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and<br>d) Include copies of documents that support your claim, such as physician's letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.<br>e) Include your email address (optional for member), if you would like to receive OPM's decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. |
| **2** | We have 30 days from the date we receive your request to:<br>a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or<br>b) Write to you and maintain our denial - go to step 4; or<br>c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request - go to step 3. |
| **3** | 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.<br>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.<br>We will write to you with our decision.<br>In the case of an appeal of an urgent care claim, we will notify you of our decision not later than 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods. |
| **4** | If you do not agree with our decision, you may ask OPM to review it.<br>You must write to OPM within<br>• 90 days after the date of our letter upholding our initial decision; or<br>• 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or<br>• 120 days after we asked for additional information.<br>Write to OPM at: United States Office of Personnel Management, Insurance Operations, Health Insurance Group 3, Room 3451, 1900 E Street, NW, Washington, DC 20415-3630. |

Send OPM the following information:

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

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

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

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

**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 prior authorization. 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 you did not indicate that your claim was for urgent care, then call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance Group 3 at (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 has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

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

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

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

**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; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

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

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

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

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

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) or visit us at www.fchp.org.

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

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

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

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

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

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

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

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

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

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

**TRICARE and CHAMPVA**

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

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

**Workers' Compensation**

We do not cover services that:

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

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

**Medicaid**

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

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

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

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

**When others are responsible for injuries**

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

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

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

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

**Clinical Trials**

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

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

*Note: This plan follows M.G.L. 176G § 4P which requires us to cover qualified clinical trials intended to treat cancer. We do not cover clinical trials with the exception of clinical trials for the treatment of cancer.*

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

**Calendar year**

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

**Coinsurance**

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 18.

**Clinical Trials Cost Categories**

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes

**Copayment**

A copayment is a fixed amount of money you pay when you receive covered services. See page 18.

**Cost-sharing**

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

**Covered services**

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

**Custodial care**

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.

**Deductible**

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 18.

**Experimental or investigational service**

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.

**Group health coverage**

Health care coverage through a partnership, association or corporation that has an agreement to pay the Plan or its agent the Plan premium for a group of subscribers. FEHB is an example of a group.

**Health care professional**

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

**Medical necessity**

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.

**Out-of-pocket maximum** A dollar limit to the number of copayments you must pay in each calendar year for inpatient admissions and outpatient surgery combined. Inpatient admissions include admissions to hospitals and skilled nursing or rehabilitation facilities. Outpatient surgery includes same-day surgery in a hospital outpatient department or ambulatory care facility.

**Plan allowance** Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

**Post-service claims** Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

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

**Us/We** Us and We refer to Fallon Community Health Plan (FCHP).

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

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

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

# Section 11. FEHB Facts

**Coverage information**

**No pre-existing condition limitation**

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

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

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

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

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

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; 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. For information on your premium deductions, you must also contact your employing or retirement office.

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

Several provisions of the Affordable Care Act (ACA) affect the eligibility of family members under the FEHB Program effective January 1, 2011.

| Children | Coverage |
|---|---|
| Between ages 22 and 26 | Children between the ages of 22 and 26 are covered under their parent's Self and Family enrollment up to age 26. |
| Married Children | Married children (but NOT their spouse or their own children) are covered up to age 26. This is true even if the child is currently under age 22. |
| Children with or eligible for employer-provided health insurance | Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26. |
| Stepchildren | Stepchildren do not need to live with the enrollee in a parent–child relationship to be eligible for coverage up to age 26. |
| Children Incapable of Self-Support | Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information. |
| Foster Children | Foster children are eligible for coverage up to age 26. |

You can find additional information at www.opm.gov/insure.

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 26 turns 26.

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

**Children's Equity Act**

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

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

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

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

**When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2011 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 2010 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

**When you retire**

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

## When you lose benefits

**When FEHB coverage ends**

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

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

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

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

**Upon divorce**

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

**Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26, etc.

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

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

**Converting to individual coverage**

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

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

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

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

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

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

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

# Section 12. Three Federal Programs complement FEHB benefits

**Important information**

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

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

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

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

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

**What is an FSA?**

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

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

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

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

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

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

**Important Information**

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

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

**Dental Insurance**

Dental plans provide a comprehensive range of services, including all the following:

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

**Vision Insurance**

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

**Additional Information**

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

**How do I enroll?**

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

## The Federal Long Term care Insurance Program - FLTCIP

**It's important protection**

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

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# Summary of benefits for the Basic Option of the Fallon Community Health Plan - 2011

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

| Basic Option Benefits | You Pay | Page |
|---|---|---|
| **Medical services provided by physicians:** | | |
| • Routine physical examinations and related services with your PCP | Nothing | 24 |
| • Preventive care for children to age 22 | Nothing | 25 |
| • Diagnostic and treatment services provided in the office* | $25 copayment per associated office visit to your primary care provider.<br>$35 copayment per associated office visit to a specialist.<br>Services provided to you during the office visit, such as diagnostic tests and medical or surgical procedures are subject to the calendar year deductible. | 23 |
| **Services provided by a hospital:** | | |
| • Inpatient * | $150 copayment per day up to $750 per admission after you meet your calendar year deductible. | 42 |
| • Outpatient * | $100 copayment per outpatient surgery after you meet your calendar year deductible. | 43 |
| **Emergency benefits:** | | |
| • Emergency room | $100 copayment per visit (waived if admitted). (No deductible) | 46 |
| • Doctor's office or urgent care facility* | $25 copayment per visit. (No deductible) | 46 |
| **Mental health and substance abuse treatment:** | Your cost-sharing responsibilities are no greater than for other illnesses or conditions. | 48 |

| Basic Option Benefits | You Pay | Page |
|---|---|---|
| **Prescription drugs:** | | |
| • Retail pharmacy | *At a Plan pharmacy:* up to a 30-day supply<br>Tier 1, 2, and 3<br>$10/$30/$60 copayment | 51 |
| • Mail order | Tier 1, 2, and 3: up to a 90-day supply<br>$20/$60/$120 copayment | 51 |
| **Vision care:** | | |
| • Diagnosis and treatment of disease of the eye* | Nothing for treatment of diseases or injuries to the eye after you meet your calendar year deductible<br>$25 copayment per associated office visit to your primary care provider<br>$35 copayment per associated office visit to a specialist | 30 |
| • Annual eye exam | $25 copayment | 30 |
| **Special features:** | 24 hour nurse line<br>Flexible benefits option<br>Services for deaf and hearing impaired<br>Clinical trials<br>Interpreter services<br>Out-of-area student coverage<br>Peace of Mind Program™ | 56 |
| **Protection against catastrophic costs** (out-of-pocket maximum)**:** | We do not have a catastrophic out-of-pocket maximum. | 19 |

# 2011 Rate Information for Fallon Community Health Plan

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

**Postal rates** apply to career Postal Service employees.Most employees should refer to the Guide to Benefits *for Career* United States Postal Service Employees, RI 70-2, and to the rates shown below.

The rates shown below do not apply to *Postal* Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI-2NU).

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

| Type of Enrollment | Enrollment Code | Non-Postal Premium | | | | Postal Premium | |
|---|---|---|---|---|---|---|---|
| | | Biweekly | | Monthly | | Biweekly | |
| | | Gov't Share | Your Share | Gov't Share | Your Share | USPS Share | Your Share |
| **Basic Option Self Only** | JG1 | $180.66 | $102.81 | $391.43 | $222.76 | $203.24 | $80.23 |
| **Basic Option Self and Family** | JG2 | $403.98 | $284.94 | $875.29 | $617.37 | $454.48 | $234.44 |