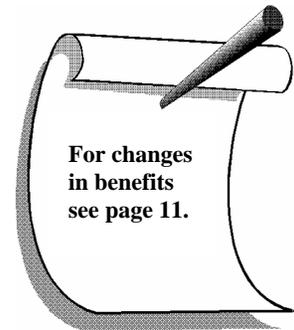


A Health Maintenance Organization (high and standard option) and a high deductible health plan

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

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 8 for requirements.



Enrollment code for this Plan:

- JV1 High Option – Self Only
- JV2 High Option – Self and Family
- JV4 Standard Option – Self Only
- JV5 Standard Option - Self and Family
- DV1 High Deductible Health Plan (HDHP) – Self Only
- DV2 High Deductible Health Plan (HDHP) – Self and Family

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Important Notice from 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, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

You can get more information about Medicare prescription drug plans and 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 users should call 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, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 11. 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 fehbwcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 800-868-5200 (TDD/TTY: 877-608-7677) and explain the situation.
 - If we do not resolve the issue:

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

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

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

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

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

3. Get the results of any test or procedure.

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

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

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

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

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

Want more information on patient safety?

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

Section 1 Facts about this HMO plan

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

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

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

General features of our High and Standard Options

High Option offers you the richest level of benefits. With High Option, you get comprehensive coverage without a deductible—you pay only the stated copayment for covered services. See Section 4 *Your costs for covered services* for more information.

Standard 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 they have agreed not to bill you for more than your share of the cost for covered services. See Section 4, *Your costs for covered services*, for more information on your cost-sharing responsibilities.

General features of our High Deductible Health Plan (HDHP)

HDHPs were established by the Medicare Prescription Drug, Improvement and Modernization Act, which was signed into law on December 3, 2003. To qualify as an HDHP, a health plan must meet certain specific requirements, including the requirement that it pay no benefits for any year, other than benefits for preventive care services, until the calendar year deductible for that year is satisfied.

HDHPs have higher calendar year deductibles and annual out-of-pocket maximum limits than other types of FEHB plans.

When you enroll in this HDHP, you become eligible for either a health savings account (HSA) or a health reimbursement account (HRA). See below for more information on these types of accounts.

Preventive care services

Preventive care services are generally paid as first dollar coverage or after a small calendar year deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year.

Calendar year deductible

The calendar year deductible must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA)

HSAs are accounts established to receive tax-favored contributions by or on behalf of eligible individuals.

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the calendar year deductible, copayments, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. In addition, your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA because you are enrolled in Medicare, or become ineligible to continue an HSA because you enroll in Medicare, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including calendar year deductibles and copayments, cannot exceed \$3,000 for Self Only enrollment, or \$6,000 family coverage.

Health education resources and accounts management tools

Fallon Community Health Plan's Web site, www.fchp.org, offers members a place to learn more about their health, as well as a convenient and secure way of communicating with us. Among other things, members can use the site to:

- Search our regularly updated provider directories
- Request a new membership card
- Request plan literature
- Change your address or phone number
- Change your primary care provider
- Contact Customer Service

The site also includes our *Preventive Health Care Guidelines*; issues of *Healthy Communities*, our quarterly member health guide; and an online health encyclopedia and reference guide to get answers to health questions.

Your Rights

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

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

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

- Be informed about Fallon Community Health Plan and covered services.

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

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

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

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

- For information about a physician, including physician profiling information, call 617-654-9800, or write to the Commonwealth of Massachusetts, Board of Registration in Medicine, 560 Harrison Avenue, Suite G4, Boston, MA 02118.
- For information about a hospital, call 617-753-8000, or write to the Commonwealth of Massachusetts, Department of Public Health, Division of Health Care Quality, 10 West Street, 5th Floor, Boston, MA 02111.
- For information about nurses, dentists, chiropractors and other non-physician health care professionals, call 617-727-3074 (TDD/TTY: 716-727-2099), or write to the Commonwealth of Massachusetts, Division of Professional Licensure, 239 Causeway Street, 5th Floor, Boston, MA 02114.

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 all of Essex, Middlesex, Norfolk, Suffolk and Worcester Counties, and parts of Bristol, Franklin, Hampden, Hampshire and Plymouth Counties. The following is a list of the cities and towns in the FCHP Select Care service area:

| | | | |
|------------|--------------|------------|-------------|
| Abington | Athol | Belmont | Boylston |
| Acton | Attleboro | Berkley | Braintree |
| Allston | Auburn | Berlin | Bridgewater |
| Amesbury | Auburndale | Beverly | Brighton |
| Andover | Avon | Billerica | Brimfield |
| Arlington | Ayer | Blackstone | Brockton |
| Ashburnham | Baldwinville | Bolton | Brookfield |
| Ashby | Barre | Boston | Brookline |
| Ashland | Bedford | Boxborough | Burlington |
| Assonet | Bellingham | Boxford | Cambridge |

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

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

Section 2 How we change for 2006

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

Changes to High Option only

- Inpatient mental health and substance abuse services no longer require a copayment. See page 46.
- You now have an annual out-of-pocket copayment maximum of \$1,000 for Self Only and \$2,000 for Self and Family. This copayment maximum applies to hospital, skilled nursing facility and rehabilitation admissions, and inpatient and outpatient surgery services. See page 18.

Changes to both High and Standard Options

- Routine physical exams with your primary care provider no longer require a copayment. See page 24.
- Well-child care visits no longer require a copayment. See page 25.
- Routine annual gynecological exams no longer require a copayment. See page 24.
- Routine immunizations administered during a routine physical examination with your PCP no longer require a copayment. See page 25.
- Short-term inpatient care in a hospice or skilled nursing facility is covered for as many days as are medically necessary. Previously this benefit was limited to 5 consecutive days. See pages 42 to 43.
- A one-time Abdominal Aortic Aneurysm screening (ultrasound) is covered for men between the ages of 65 and 75 with a history of smoking. See page 24.
- The administration of the Meningococcal Conjugate Vaccine is covered for children at risk as indicated by the American Academy of Pediatrics. See page 26.
- Pancreas transplants are now covered. See page 39.
- We removed the exclusion on travel related vaccines. See pages 25 and 26.
- We eliminated the option to choose a Physician Assistant or a Nurse Practitioner as a Primary Care Physician.

Section 3 How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-868-2500 (TDD/TTY: 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 and calendar year deductibles.

• Plan providers

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

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

• Plan facilities

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

What you must do to get covered care

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

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

If your prior primary care provider is not a participating provider in any health plan offered by the FEHB Program, we will pay for services from that provider for 30 days from your effective date.

If you are receiving an ongoing course of treatment from a provider who is not a participating provider in any health insurance plan that the FEHB Program offers, we will pay for services from that provider for 30 days from your effective date.

If you are in the second or third trimester of pregnancy and you are receiving services related to your pregnancy from a provider who is not a participating provider in any health insurance plan that the FEHB Program offers, we will pay for services from that provider through your postpartum period.

If you are terminally ill and you are receiving ongoing treatment from a provider who is not a participating provider in any other health insurance plan that the FEHB Program offers, we will pay for services from that provider until your death.

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

• Primary care

Your primary care physician can be a family practitioner, internist or pediatrician. 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

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

If you and your primary care provider decide that a visit with a specialist is medically necessary your primary care provider will make the arrangements for you. For some services your primary care provider is authorized to give you a referral to see a specialist. See *PCP referral* on page 14. For other services, your primary care provider must get preauthorization from the Plan before giving you a referral. See *Services requiring preauthorization* on page 16. If you get services from any physician, hospital or other health care provider without getting a referral from your primary care provider you will have to pay for those services yourself, with the exception of those services listed under *Self-referral* below.

Self-referral

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

provider, but you must see a Plan provider.

Services you can self-refer for:

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

PCP referral

In some instances your PCP can refer you to a specialist without preauthorization from the Plan. Your PCP can provide you with a copy of the referral form and then you can make an appointment with the specialist for services. You do not need to do anything further and you will not get a letter from the Plan.

Services that need a PCP referral but do not need preauthorization from the Plan include:

- Office visits with a specialist, with the exception of office visits with a Fallon Clinic specialist if you have a Fallon Clinic PCP. In some instances, your PCP may give you a “standing referral” to a specialist for covered services. Standing referrals are valid for up to a maximum of 12 visits within a 12-month period—your PCP has the discretion to allow fewer visits.
- Initial evaluation with a podiatrist for podiatry services. The podiatrist must obtain preauthorization from the Plan for all subsequent visits.
- Chiropractic care. Your PCP will give you a referral to a chiropractor which may cover up to five visits, if medically necessary. The chiropractor must obtain preauthorization from the Plan for all subsequent visits.
- Physical, occupational and speech therapy. Your PCP will give you a written order to take to a physical, occupational or speech therapist. The written order covers up to six visits, if medically necessary. The therapist must obtain preauthorization from the Plan for all subsequent visits.

If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. Your primary care provider will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan. (See below for a list of circumstances in which we will temporarily pay for services with a non-Plan provider.)

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

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

- If you are terminally ill and our contract with a provider from whom you are receiving treatment related to your terminal illness ends, you may continue to receive treatment from that provider.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan, you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.
- If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

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.

• Hospital care

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

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

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

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 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 preauthorization

For certain types of specialist visits and for certain specialty services, your PCP will need to get preauthorization from the Plan before giving you a referral. An 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 preauthorization 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
- PET scans

When a service needs preauthorization, 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 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 authorization from the Plan to go to that provider.

Section 4 Your cost for covered services

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

Copayments

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

- With both High Option and Standard Option, you have no copayment for routine physical examinations or well-child care with your PCP.
- Under High Option, you pay a \$15 copayment per office visit with your primary care provider and certain other providers, and a \$25 copayment per office visit with a specialist. After you pay your copayment, the Plan pays the remainder of the cost for the office visit and any covered services you receive during the office visit. See Section 5 (c) for your copayments for services provided in a hospital or other facility, Section 5 (d) for your copayments for emergency services and Section 5 (f) for your copayments for prescription drugs.
- Under Standard Option, you pay a \$20 copayment per office visit and the Plan pays the remainder of the amount billed by the physician or other health care professional for the office visit. Covered services you receive during the office visit, such as labs, X-rays and other diagnostic tests, or medical or surgical care are subject to your 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.

Calendar year 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.

- Under High Option, there is no calendar year deductible.
- Under Standard Option, for Self Only coverage, the calendar year deductible is \$600.
- Under Standard Option, for Self and Family coverage, the calendar year deductible is \$1,200. The Self and Family calendar year deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for all family members reach \$1,200. No individual family member must pay more than \$600 per calendar year deductible.
- Under the HDHP option, the calendar year deductible is \$1,500 for Self Only enrollment. For Self and Family enrollment the 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 reaches \$3,000.

Note: For the Standard Option, 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.

And, 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

We do not have coinsurance.

Your catastrophic protection out-of-pocket maximum

- We do not have a catastrophic protection out-of-pocket maximum for High Option and Standard Option. However, under High Option, you have an annual out-of-pocket copayment maximum. This is 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.

You are responsible for a copayment maximum of \$1,000 per member/\$2,000 per family for inpatient admissions and outpatient surgery 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.

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.

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.

- Under the HDHP option, after your copayments and calendar year deductibles total \$3,000 for Self Only enrollment or \$6,000 for Self and Family enrollment in any calendar year, you do not have to pay any more for covered services.

Carryover

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

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

High and Standard Option Benefits

See page 11 for how our benefits changed this year. Pages 119 and 121 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Summary of benefits for the Standard Option of Fallon Community Health Plan - 2006 121

Section 5 High and Standard Option Benefits Overview

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

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

Each option offers unique features.

High Option

High Option offers you the richest level of benefits. It has no deductible—you pay only the stated copayment for covered services. See Section 4 *Your cost for covered services* for more information.

Standard Option

Standard 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 cost 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 physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The Standard Option 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 |
|---------------------|---------|
|---------------------|---------|

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say “(No deductible)” when it does not apply.

| Diagnostic and treatment services | High Option | Standard Option |
|--|--|---|
| Professional services of physicians or other health care professionals <ul style="list-style-type: none"> • In physician’s office • Second surgical opinion • Office medical consultations • At home Note: See Section 5(d), <i>Emergency services</i> , for care of a minor emergency in a doctor’s office or urgent care center. | \$15 copayment per office visit to your primary care provider or obstetrician/gynecologist \$25 copayment per office visit to a specialist | \$20 copayment per office visit Services provided to you during the office visit, such as diagnostic tests and medical or surgical procedures are subject to the calendar year deductible. |
| Professional services of physicians or other health care professionals <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility | Nothing | Nothing after you meet your calendar year deductible |
| Lab, X-ray and other diagnostic tests | | |
| Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays | Nothing for lab, X-ray and other diagnostic tests \$15 copayment per associated office visit to your primary care provider or obstetrician/gynecologist \$25 copayment per associated office visit to a specialist | Nothing for lab, X-ray and other diagnostic tests after you meet your calendar year deductible \$20 copayment per associated office visit |

| Labs, X-ray and other diagnostic tests <i>(continued)</i> | You pay | |
|--|--|---|
| | High Option | Standard Option |
| <ul style="list-style-type: none"> • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG | | |
| Preventive care, adult | | |
| Routine physical examinations and related services with your PCP, such as: <ul style="list-style-type: none"> • History and risk assessment • Urinalysis • CBC • Total blood cholesterol • Fecal occult blood test | Nothing | Nothing |
| Routine screenings, such as: <ul style="list-style-type: none"> • Colorectal cancer screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 – Double contrast barium enema – every five years starting at age 50 – Colonoscopy screening – every ten years starting at age 50 • Osteoporosis screening for women age 65 and older (beginning at age 60 for women at increased risk) • Abdominal Aortic Aneurysm screening (ultrasound) – one time test for men age 65 to 75 with a history of smoking | Nothing for routine screenings \$15 copayment per associated office visit to your primary care provider \$25 copayment per associated office visit to a specialist | Nothing for routine screenings (No deductible) \$20 copayment per associated office visit |
| Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older | Nothing for PSA test \$15 copayment per associated office visit to your primary care provider \$25 copayment per associated office visit to a specialist | Nothing for PSA test (No deductible) \$20 copayment per associated office visit |
| Routine Pap test | Nothing for Pap test Nothing for routine annual gynecological exam \$25 copayment per associated office visit to a specialist | Nothing for Pap test Nothing for routine annual gynecological exam (No deductible) |

Preventive care, adult – continued on next page.

| Preventive care, adult <i>(continued)</i> | You pay | |
|--|--|---|
| | High Option | Standard Option |
| Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 and older, one every calendar year | Nothing for mammogram | Nothing for mammogram (No deductible) |
| Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older | Nothing for immunizations \$15 copayment per associated office visit to your primary care provider (unless provided during a routine examination with your primary care provider) \$25 copayment per associated office visit to a specialist | Nothing for immunizations (No deductible) \$20 copayment per associated office visit (unless provided during a routine examination with your primary care provider) |
| Travel-related immunizations | Nothing for immunizations \$15 copayment per associated office visit to your primary care provider (unless provided during a routine examination with your primary care provider) \$25 copayment per associated office visit to a specialist | Nothing for immunizations (No deductible) \$20 copayment per associated office visit (unless provided during a routine examination with your primary care provider) |
| <i>Not covered: Physical exams required for obtaining or continuing employment or insurance, or attending schools or camp</i> | <i>All charges.</i> | <i>All charges.</i> |
| Preventive care, children | | |
| <ul style="list-style-type: none"> • Well-child care (up to age 22) including: <ul style="list-style-type: none"> ○ History and physical examination, measurements, sensory screening, neuropsychiatric evaluations, development screening and assessment. ○ Screening of all children under six years of age for the presence of lead poisoning ○ Hereditary and metabolic screening at birth, newborn hearing screening, tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the provider. • Childhood immunizations recommended by the American Academy of Pediatrics | Nothing | Nothing (No deductible) |

Preventive care, children – continued on next page.

| Preventive care, children <i>(continued)</i> | You pay | |
|--|--|---|
| | High Option | Standard Option |
| <ul style="list-style-type: none"> • Meningococcal Conjugate Vaccine for children at risk as indicated by the American Academy of Pediatrics • Examinations, such as: <ul style="list-style-type: none"> – Vision screening to age 22 to determine the need for vision correction – Hearing screening to age 22 to determine the need for hearing correction – Examinations done on the day of immunizations (up to age 22) | | |
| Travel-related immunizations | Nothing for immunizations \$15 copayment per associated office visit to your primary care provider (unless provided during a routine examination with your primary care provider) \$25 copayment per associated office visit to a specialist | Nothing for immunizations (No deductible) \$20 copayment per associated office visit (unless provided during a routine examination with your primary care provider) |
| <i>Not covered:</i> <ul style="list-style-type: none"> • Physical exams required for obtaining or continuing employment or insurance, or attending schools or camp | <i>All charges.</i> | <i>All charges.</i> |
| Maternity care | | |
| Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need preauthorization for your normal delivery; see page 13 for other circumstances. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean 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. | \$15 copayment for the first prenatal office visit. All other prenatal office visits covered in full \$15 copayment per postnatal office visit | \$20 copayment for the first prenatal office visit. All other prenatal office visits covered in full \$20 copayment per postnatal office visit (No deductible) |

Maternity care – continued on next page.

| Maternity care (continued) | You pay | |
|---|---|--|
| | High Option | Standard Option |
| <ul style="list-style-type: none"> • 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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See <i>Hospital benefits</i> (Section 5(c)) and <i>Surgery benefits</i> (Section 5(b)). • We pay non-routine maternity care the same as for illness and injury. See <i>Medical services and supplies provided by physicians and other health care professionals</i> (Section 5(a)). | | |
| <i>Not covered: Routine sonograms to determine fetal age, size or sex</i> | <i>All charges.</i> | <i>All charges.</i> |
| Family planning | | |
| <p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Consultations, examinations, procedures and medical services related to the use of all contraceptive methods • Contraceptives furnished by a Plan provider during a covered office visit, such as: <ul style="list-style-type: none"> – Surgically implanted contraceptives – Intrauterine devices (IUDs) – Diaphragms – Cervical caps • Voluntary sterilization (See <i>Surgical procedures</i> Section 5 (b).) <p>Note: We cover oral contraceptives and certain other contraceptives, such as Depo-Provera and the contraceptive patch, under the prescription drug benefit.</p> | <p>Nothing for family planning services</p> <p>\$15 copayment per associated office visit to your primary care provider or obstetrician/ gynecologist</p> <p>\$25 copayment per associated office visit to a specialist</p> | <p>Nothing for family planning services</p> <p>(No deductible)</p> <p>\$20 copayment per associated office visit</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> • <i>Over-the-counter contraceptive drugs or devices</i> | <i>All charges.</i> | <i>All charges.</i> |

| Infertility services | You pay | |
|---|--|--|
| | High Option | Standard Option |
| <p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Evaluation and diagnosis of infertility • The following procedures for the treatment of infertility <ul style="list-style-type: none"> – Artificial insemination (AI) – In vitro fertilization and embryo placement (IVF-EP) – Gamete intrafallopian transfer (GIFT) – Zygote intrafallopian transfer (ZIFT) – Intracytoplasmic sperm injection (ICSI) – Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated egg <p>To be eligible, you must be an individual who:</p> <ol style="list-style-type: none"> (1) is unable to conceive or produce conception during a period of one year; and (2) should expect fertility as a natural state; or (3) is a premenopausal female or a female who is experiencing menopause at a premature age <p>Approval for Assisted Reproductive Technology (ART) is contingent upon review of your medical history by the Plan medical director. Initial approval covers four ART cycles, if you wish to continue beyond four cycles, further medical review by the Plan medical director is required.</p> <p>A benefits pamphlet is available by contacting Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).</p> <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p> | <p>Nothing for infertility procedures</p> <p>\$15 copayment per associated office visit to your primary care provider or obstetrician/gynecologist</p> <p>\$25 copayment per associated office visit to a specialist</p> | <p>Nothing for infertility procedures after you meet your calendar year deductible</p> <p>\$20 copayment per associated office visit</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Treatments, services and supplies which have not been determined to be medically necessary by a Plan specialist in fertility and the Plan medical director or when the member has a medical contraindication or when there is no diagnosis of infertility</i> • <i>Donor egg transfer or harvesting for women who are menopausal (except as stated above) or have genetic oocyte defects</i> • <i>Chromosome studies of a donor (sperm or egg)</i> | <p><i>All charges.</i></p> | <p><i>All charges.</i></p> |

Infertility services – continued on next page.

| Infertility services (continued) | You pay | |
|---|--|---|
| | High Option | Standard Option |
| <ul style="list-style-type: none"> • Pre-implant Genetic Diagnosis (PGD) or testing (genetic testing on the embryo before it is inserted into the uterus) • Charges for the storage of donor sperm, eggs or embryo that remain in storage after the completion of an approved infertility cycle • Supplies that may be purchased without a physician’s written order, such as ovulation test kits • Services which are necessary due to a voluntary sterilization, such as tubal ligation or vasectomy • Surrogacy or gestational carrier services • Transportation costs to or from the medical facility • Services that are covered by another insurer • 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.) | | |
| Allergy care | | |
| <p>Allergy testing and treatment, including:</p> <ul style="list-style-type: none"> • Allergy serum • Allergy injections | <p>Nothing for allergy testing and treatment</p> <p>\$15 copayment per associated office visit with your primary care provider</p> <p>\$25 copayment per associated office visit with a specialist</p> | <p>Nothing for allergy testing and treatment</p> <p>(No deductible)</p> <p>\$20 copayment per associated office visit</p> |
| <p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p> | <p><i>All charges.</i></p> | <p><i>All charges.</i></p> |
| Treatment therapies | | |
| <ul style="list-style-type: none"> • Chemotherapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 39. We cover prescription chemotherapy drugs purchased at a pharmacy under the prescription drug benefit, with the applicable copayments.</p> <ul style="list-style-type: none"> • Radiation therapy • Respiratory and inhalation therapy <p>Note: Drug therapies for the treatment of respiratory diseases are covered under the prescription drug benefit.</p> | <p>Nothing for treatment therapies</p> <p>\$15 copayment per associated office visit with your primary care provider</p> <p>\$25 copayment per associated office visit with a specialist</p> | <p>Nothing for treatment therapies after you meet your calendar year deductible</p> <p>\$20 copayment per associated office visit</p> |

Treatment therapies – continued on next page.

| Treatment therapies <i>(continued)</i> | You pay | |
|---|---------------------------------|--|
| | High Option | Standard Option |
| <ul style="list-style-type: none"> • Dialysis – hemodialysis and continuous ambulatory peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit. We only cover GHT when we authorize the treatment. Your Plan provider will submit a request for preauthorization before you begin treatment. If your Plan provider does not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring preauthorization</i> in Section 3.</p> | | |
| Physical and occupational therapies | | |
| <ul style="list-style-type: none"> • Up to 60 consecutive visits or 20 nonconsecutive visits (whichever is greater) per illness or injury per calendar year for: <ul style="list-style-type: none"> – physical therapy – occupational therapy <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> | \$15 copayment per office visit | \$20 copayment per office visit after you meet your calendar year deductible |
| <ul style="list-style-type: none"> • Cardiac rehabilitation for persons with documented cardiovascular disease, initiated within 26 weeks after the diagnosis of cardiovascular disease. • Early intervention services delivered by certified early intervention specialists according to operational standards developed by the Department of Public Health, for children from birth to their 3rd birthday. Benefits are limited to a maximum of \$5,200 per year per child and an aggregate of \$15,600 over the term of the child's Plan membership. | Nothing | \$20 copayment per office visit after you meet your calendar year deductible |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> • <i>Acupuncture, aquatic or massage therapy</i> | <i>All charges.</i> | <i>All charges.</i> |

| Speech therapy | You pay | |
|--|--|---|
| | High Option | Standard Option |
| Medically necessary services for the diagnosis and treatment of speech, hearing and language disorders when services are provided by a Plan provider who is a speech-language pathologist or audiologist; at a Plan facility or provider's office. | \$15 copayment per office visit | \$20 copayment per visit after you meet your calendar year deductible |
| Hearing services (testing, treatment and supplies) | | |
| <ul style="list-style-type: none"> Hearing screening for children to age 22 to determine the need for hearing correction (See <i>Preventive care, children.</i>) | Nothing | Nothing for hearing screening (No deductible) \$20 copayment per associated office visit |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> All other hearing testing Hearing aids, testing and examinations for them | <i>All charges.</i> | <i>All charges.</i> |
| Vision services (testing, treatment, and supplies) | | |
| <ul style="list-style-type: none"> Diagnosis and treatment of diseases or injuries to the eye | \$15 copayment per office visit with your primary care provider \$25 copayment per office visit with a specialist | Nothing for treatment of diseases or injuries to the eye after you meet your calendar year deductible \$20 copayment per associated office visit |
| <ul style="list-style-type: none"> Annual eye exam <p>Note: See <i>Preventive care, children</i> for vision screening for children to age 22.</p> | \$15 copayment per office visit | \$20 copayment per office visit (No deductible) |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eye exercises and orthoptics Radial keratotomy and other refractive surgery | <i>All charges.</i> | <i>All charges.</i> |
| Foot care | | |
| <ul style="list-style-type: none"> Routine foot care for members with diabetes that is complicated by peripheral vascular disease. Non-routine foot care, including but not limited to: treatment of bunions, ganglion, heel spurs, plantar fasciitis, osteoarthritis and plantar warts. <p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts on page 32.</p> | \$15 copayment per office visit | \$20 copayment per associated office visit |

Foot care – continued on next page.

| Foot care (continued) | You pay | |
|--|--|---|
| | High Option | Standard Option |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Routine foot care for members unless specified above.</i> | <i>All charges.</i> | <i>All charges.</i> |
| Orthopedic and prosthetic devices | | |
| <ul style="list-style-type: none"> Orthopedic devices (devices that support part of the body and/or eliminate motion) such as neck collars for cervical support, molded body jacket for curvature of the spine and braces with rigid support. Prosthetic devices (devices that replace all or part of an organ or body part, not including dental) such as artificial limbs and eyes, implanted corrective lenses following cataract surgery and electric speech aids. Corrective orthopedic appliances for nondental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. <p>Note: All orthopedic and prosthetic devices must be ordered by a Plan provider and authorized by the Plan.</p> | <p>Nothing up to the benefit limit of \$1,500 per calendar year. You pay all charges beyond the benefit limit.</p> <p>Orthopedic and prosthetic devices and durable medical equipment are subject to a combined benefit limit.</p> | <p>Nothing, up to the benefit limit of \$1,500 per calendar year, after you meet your deductible. You pay all charges beyond the benefit limit.</p> <p>Orthopedic and prosthetic devices and durable medical equipment are subject to a combined benefit limit.</p> |
| <ul style="list-style-type: none"> Scalp 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. You pay all charges beyond the benefit limit. | 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. |
| <ul style="list-style-type: none"> Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: 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 | Nothing after you meet your calendar year deductible |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Orthopedic and corrective shoes</i> <i>Arch supports</i> <i>Foot orthotics</i> <i>Heel pads and heel cups</i> <i>Lumbosacral supports</i> <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> | <i>All charges.</i> | <i>All charges.</i> |

| Durable medical equipment (DME) | You pay | |
|--|--|---|
| | High Option | Standard Option |
| <p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan provider, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors • Insulin pumps • Visual magnifying aids and voice synthesizers for blood glucose monitors for use by the legally blind • Therapeutic/molded shoes and shoe inserts for the treatment of severe diabetic foot disease <p>Note: Insulin pumps and insulin pump supplies are covered under the prescription drug benefit. All durable medical equipment must be ordered by a Plan provider and preauthorized by the Plan.</p> | <p>Nothing up to the benefit limit of \$1,500 per calendar year. You pay all charges beyond the benefit limit.</p> <p>Orthopedic and prosthetic devices and durable medical equipment are subject to a combined benefit limit.</p> | <p>Nothing, up to the benefit limit of \$1,500 per calendar year, after you meet your calendar year deductible. You pay all charges beyond the benefit limit.</p> <p>Orthopedic and prosthetic devices and durable medical equipment are subject to a combined benefit limit.</p> |
| <ul style="list-style-type: none"> • Oxygen and oxygen equipment | <p>Nothing</p> | <p>Nothing after you meet your calendar year deductible</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Items that are not covered include, but are not limited to, air conditioners, air purifiers, arch supports, ear plugs (to prevent fluid from entering the ear canal during water activities), foot orthotics, orthopedic shoes (except when part of a brace) or other supportive devices for the feet, articles of special clothing, compression garments (such as Jobst® stockings), bed-pans, raised toilet seats, dehumidifiers, dentures, elevators, safety grab bars, car seats, seizure helmets, hearing aids, heating pads, hot water bottles, exercise equipment or similar equipment.</i> • <i>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.</i> | <p><i>All charges.</i></p> | <p><i>All charges.</i></p> |

| Home health services | You pay | |
|--|--|---|
| | High Option | Standard Option |
| <p>Home health care ordered by a Plan provider and authorized by the Plan, including part-time or intermittent skilled nursing care and physical therapy. Additional services such as occupational and speech therapy, oxygen and intravenous therapy, medical social services, home health aide services, medical and surgical supplies, durable medical equipment and nutritional consultations are covered to the extent that they are determined to be a medically necessary component of covered skilled nursing care and physical therapy.</p> <p>Note: Durable medical equipment and physical and occupational therapy provided as a medically necessary component of home health care are not subject to the benefit limits.</p> | Nothing | Nothing after you meet your calendar year deductible |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> | <i>All charges.</i> | <i>All charges.</i> |
| Chiropractic | | |
| <p>Chiropractic services for acute musculoskeletal conditions. The condition must be new or an exacerbation of a previous condition. Coverage is provided for up to 20 visits in each calendar year.</p> | \$15 copayment per office visit | \$20 copayment per office visit (No deductible) |
| Alternative treatments | | |
| <i>No benefit</i> | <i>All charges.</i> | <i>All charges.</i> |
| Educational classes and programs | | |
| <p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. | <p>Nothing</p> <p>You pay all charges above \$100 maximum.</p> | <p>Nothing</p> <p>(No deductible)</p> <p>You pay all charges above \$100 maximum.</p> |
| <ul style="list-style-type: none"> • Diabetes self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider. | \$15 copayment per office visit | \$20 copayment per office visit (No deductible) |

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

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.
- Under High Option, there is no calendar year deductible.
- Under High Option, 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.
- Under Standard Option, the calendar year deductible is \$600 per person or \$1,200 per family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Under Standard Option, you pay a copayment for each office visit to a physician or other health care professional. Services provided to you during the office visit, such as diagnostic tests and medical or surgical procedures, are subject to the calendar year deductible.
- 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 PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

| Benefit Description | You pay |
|---------------------|---------|
|---------------------|---------|

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when it does not apply.

| Surgical procedures | High Option | Standard Option |
|--|--|--|
| A comprehensive range of services, such as: <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) | \$15 copayment per associated office visit with your primary care provider or obstetrician/gynecologist \$25 copayment per associated office visit with a specialist See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). | Nothing for surgical procedure after you meet your calendar year deductible \$20 copayment per associated office visit See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). |

Surgical procedures - continued on next page.

| Surgical procedures (continued) | You pay | |
|---|---------------------|------------------------|
| | High Option | Standard Option |
| <ul style="list-style-type: none"> • Surgical treatment of morbid obesity (bariatric surgery). Candidates must: <ul style="list-style-type: none"> ○ Meet the definition of morbid obesity ○ Have been morbidly obese for at least five years ○ Be at least 18 years old ○ Have no untreated metabolic cause for obesity (e.g. adrenal or thyroid disorders) ○ Have a history of failure with two or more nonsurgical measures, supervised, over at least a one year period • Insertion of internal prosthetic devices. See 5(c) – for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns | | |
| <p><i>Not covered:</i></p> <p><i>Reversal of voluntary sterilization</i></p> <p><i>Routine treatment of conditions of the foot; see Foot care</i></p> | <i>All charges.</i> | |

| Reconstructive surgery | | |
|---|--|--|
| <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – the condition produced a major effect on the member’s appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – reconstruction of the breast on which the mastectomy was performed; – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas. <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p> | <p>\$15 copayment per associated office visit with your primary care provider or obstetrician/gynecologist</p> <p>\$25 copayment per associated office visit with a specialist</p> | <p>Nothing for reconstructive surgery after you meet your calendar year deductible</p> <p>\$20 copayment per associated office visit</p> |

Reconstructive surgery – continued on next page.

| Reconstructive surgery (continued) | You pay | |
|--|---|--|
| | High Option | Standard Option |
| Breast prostheses and surgical bras and replacements (see Section 5 (a) Orthopedic and prosthetic devices) on page 32. | Nothing | Nothing after you meet your calendar year deductible |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> | <i>All charges.</i> | <i>All charges.</i> |
| Oral and maxillofacial surgery | | |
| <p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. | <p>\$15 copayment per associated office visit with your primary care provider</p> <p>\$25 copayment per associated office visit with a specialist</p> <p>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)</p> | <p>Nothing for oral and maxillofacial surgery after you meet your calendar year deductible</p> <p>\$20 copayment per associated office visit</p> <p>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> | <i>All charges.</i> | <i>All charges.</i> |

| Organ/tissue transplants | You pay | |
|---|---|---|
| | High Option | Standard Option |
| <p>The Plan covers human solid organ, bone marrow and stem cell transplants, such as:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung for patients under age 60 with end-stage primary or secondary pulmonary hypertension • Kidney • Liver • Lung transplant for patients under age 60 with end-stage obstructive or restrictive pulmonary disease • Pancreas only • Allogenic (donor) bone marrow transplants for leukemia, aplastic anemia, severe combined immunodeficiency disease, or Wiskott-Aldrich Syndrome; for patients with high-risk lymphoblastic lymphoma in remission; or for patients under age 60 with myelodysplasia • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; resistant or advanced non-Hodgkin's lymphoma; recurrent or refractory neuroblastoma; for patients diagnosed with breast cancer that has progressed to metastatic disease; for patients under age 65 with chemo-responsive multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Human Leukocyte Antigen (HLA) or histocompatibility locus antigen testing for A, B, or DR antigens, or any combination thereof, to establish bone marrow transplant donor suitability <p>The transplant must be performed at an affiliated transplant facility, subject to your acceptance into the program. The Plan will work with the transplant facility to coordinate your care during the evaluation and transplant process and help to arrange your discharge and follow-up care.</p> | <p>\$15 copayment per associated office visit with your primary care provider</p> <p>\$25 copayment per associated office visit with a specialist</p> <p>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)</p> | <p>\$20 copayment per associated office visit (No deductible)</p> <p>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)</p> |

Organ/tissue transplants – continued on next page.

| Organ/tissue transplants (continued) | You pay | |
|---|---------------------------------|--|
| | High Option | Standard Option |
| <p>Note: If you are the recipient of a transplant the services of the donor are covered including the evaluation and preparation and the surgery and recovery directly related to the donation with the exception of those services covered by another insurer. If you are the donor and the transplant recipient is not a member of the Plan no coverage is provided for either the recipient or the donor with the exception of human leukocyte antigen or histocompatibility locus antigen testing.</p> | | |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Transplants not listed as covered or investigational or experimental procedures</i> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Bioartificial transplantation, such as the transplantation of a total artificial heart</i> • <i>Xenotransplantation, such as the transplantation of animal tissues or organs into a human</i> • <i>Services for the organ donor that are covered by another insurance plan</i> • <i>Services for an organ donor if the recipient is not a Plan member</i> • <i>Transportation, housing or home cleaning services incurred by either the donor or the recipient</i> | <i>All charges.</i> | <i>All charges.</i> |
| Anesthesia | | |
| <p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center | Nothing | Nothing for anesthesia services after you meet your calendar year deductible |
| <p>Professional services provided in –</p> <ul style="list-style-type: none"> • Office | \$25 copayment per office visit | Nothing for anesthesia services after you meet your calendar year deductible \$20 copayment per associated office visit |

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan providers must provide or arrange your care and you must be hospitalized in a Plan facility.
- Under High Option, there is no calendar year deductible.
- Under High Option, 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.
- Under Standard Option, the calendar year deductible is \$600 per person or \$1,200 per family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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 PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

| Benefit Description | You pay | |
|--|--|--|
| Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. | | |
| Inpatient hospital | High Option | Standard Option |
| Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs • Diagnostic laboratory tests and X-rays • Blood and blood products • Administration of blood and blood products • Dressings, splints, casts, and sterile tray services • Internal prosthetic devices | \$250 copayment per admission until you meet your annual out-of-pocket maximum | Nothing after you meet your calendar year deductible |

Inpatient hospital - continued on next page.

| Inpatient hospital <i>(continued)</i> | You pay | |
|--|--|--|
| | High Option | Standard Option |
| <ul style="list-style-type: none"> • Medical supplies, appliances and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items | | |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care | <i>All charges.</i> | <i>All charges.</i> |
| Outpatient hospital or ambulatory surgical | | |
| <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p> | \$50 copayment per outpatient surgery until you meet your annual out-of-pocket maximum | Nothing after you meet your calendar year deductible |
| Skilled nursing care facility benefits | | |
| <p>Skilled nursing facility (SNF): The Plan covers inpatient services in a SNF for up to 100 days in each calendar year. You may be admitted to a SNF if, based on your medical condition, you need daily skilled nursing care, skilled rehabilitation services or other medical services that may require access to 24-hour medical care but does not require the specialized care of an acute care hospital.</p> | \$250 copayment per admission until you meet your annual out-of-pocket maximum | Nothing after you meet your calendar year deductible |

Skilled nursing care facility benefits - continued on next page.

| Skilled nursing care facility benefits <i>(continued)</i> | You pay | |
|--|--|--|
| | High Option | Standard Option |
| <p>Services provided are:</p> <ul style="list-style-type: none"> • Room and board in a semiprivate room (or private room if medically necessary) • The services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, nursing services, physical, speech and occupational therapy, medical supplies and equipment. • Drugs, biologicals, equipment and supplies ordinarily provided or arranged by the skilled nursing facility, when prescribed by a Plan provider | | |
| <i>Not covered: Custodial care or personal comfort items such as telephone, radio or television</i> | <i>All charges.</i> | <i>All charges.</i> |
| Hospice care | | |
| <p>Hospice care is a method of caring for the terminally ill that helps those individuals continue their lives with as little disruption as possible. This type of care emphasizes supportive services, such as home care and pain control, rather than the cure-oriented services that are provided in hospitals. To be eligible for hospice care, you must be terminally ill with a life expectancy of less than six months.</p> <ul style="list-style-type: none"> • Hospice services are provided, as necessary, to maintain the terminally ill individual at home such as: <ul style="list-style-type: none"> – Physicians services, nursing care and medical social services – Medical appliances and supplies including drugs and biologicals (prescription copayments may apply) | Nothing | Nothing after you meet your calendar year deductible |
| – Short-term inpatient care for the control of pain and management of acute and severe clinical problems that cannot be managed in a home setting. | \$250 copayment per admission until you meet your annual out-of-pocket maximum | Nothing after you meet your calendar year deductible |
| <i>Not covered: Independent nursing, homemaker services</i> | <i>All charges.</i> | <i>All charges.</i> |
| Ambulance | | |
| <p>Ambulance service when medically appropriate</p> <p>Note: See Section 5 (d) for coverage of emergency ambulance.</p> | Nothing | 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.
- Under High Option, there is no calendar year deductible.
- Under Standard Option, the calendar year deductible is \$600 per person or \$1,200 per family. The calendar year deductible applies to some Standard Option benefits in this section. We say “(No deductible)” to indicate that the calendar year deductible does not apply to that particular service.
- Under Standard Option, you pay a copayment for each office visit to a physician or other health care professional. Services provided to you during the office visit, such as diagnostic tests and medical or surgical procedures, are subject to the calendar year deductible.
- 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 preauthorization, but after receiving emergency care, you should notify your primary care provider, who will arrange for any follow-up or continuing care that is medically necessary for you.

Urgent care

Sometimes you may need care for minor medical emergencies such as cuts that require stitches or a sprained ankle. If you are within the Plan service area, call your primary care provider’s office for information on how and where to seek treatment. If your primary care provider is not available, a provider on call will make arrangements for your care. Providers’ telephones are answered 24 hours a day, seven days a week. Explain the medical situation to the provider and state where you are calling from so that the provider can refer you to the most appropriate facility.

If you are outside the Plan service area, go to the nearest medical facility for care. You do not need a referral or preauthorization, but you should notify your primary care provider, who will arrange for any follow-up or continuing care that is medically necessary for you.

| Benefit Description | You pay | |
|--|---|--|
| Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. | | |
| Emergency care | High Option | Standard Option |
| <ul style="list-style-type: none"> • Emergency care in an emergency room | \$50 copayment per visit (waived if admitted) | \$75 copayment per visit (waived if admitted) (No deductible) |

Emergency care - continued on next page.

| Emergency care (continued) | You pay | |
|--|--------------------------|--|
| | High Option | Standard Option |
| <ul style="list-style-type: none"> Urgent care at an urgent care center or a doctors' office | \$15 copayment per visit | \$20 copayment per visit (No deductible) |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective or non-emergency care received in an emergency room</i> <i>Follow-up care, unless provided by your primary care provider or authorized by the Plan. This includes follow-up care provided in an emergency room or urgent care facility.</i> | <i>All charges.</i> | <i>All charges.</i> |
| Ambulance | | |
| <p>Emergency ambulance service when medically appropriate</p> <p>Note: See Section 5(c) for non-emergency ambulance service.</p> | Nothing | Nothing after you meet your calendar year deductible |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Air ambulance when not appropriate to medical condition or geographic location</i> <i>Transfers between hospitals when the patient's medical condition does not warrant that he or she be transported to another facility</i> <i>Commercial airline transportation</i> | <i>All charges.</i> | <i>All charges.</i> |

Section 5(e) Mental health and substance abuse benefits

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under High Option, 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 Standard Option calendar year deductible does not apply to benefits in this section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.
- **YOUR PROVIDER MUST GET PREAUTHORIZATION FOR INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.** See the instructions after the benefits description below.

| Benefit Description | You pay |
|---------------------|---------|
|---------------------|---------|

Note: The Standard Option calendar year deductible does not apply to benefits in this Section.

| Mental health and substance abuse benefits | High Option | Standard Option |
|--|--|--|
| <p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p> | <p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p> | <p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p> |
| <p>Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</p> <p>Medication management</p> | <p>\$15 copayment per office visit</p> | <p>\$20 copayment per office visit</p> |
| <p>Note: See Section 5 (a) for coverage of labs, X-rays and other diagnostic tests.</p> | | |
| <p>Services provided by a hospital or other facility</p> | <p>Nothing</p> | <p>Nothing</p> |

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

| Mental health and substance abuse benefits <i>(continued)</i> | You pay | |
|--|---------------------|---------------------|
| | High Option | Standard Option |
| Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment | Nothing | Nothing |
| <i>Not covered: Services we have not approved.</i> <i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i> | <i>All charges.</i> | <i>All charges.</i> |

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

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

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

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

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

Section 5(f) Prescription drug benefits

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.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under High Option there is no calendar year deductible.
- Under Standard Option, the calendar year deductible is \$600 per person or \$1,200 per family. The calendar year deductible applies to some benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- 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” on page 49 for information on submitting proof of payment for reimbursement.
- **We use a formulary.** Our formulary is a list of medications that shows the copayment tier and preauthorization requirements for each medication. We have chosen the tiers and determined the criteria for preauthorization based on cost and efficacy. Coverage of certain drugs is based on medical necessity. They are designated on the formulary as “MN”. Your provider must get authorization from the Plan before giving you a prescription for one of these medications.
- **These are the dispensing limitations.** When you fill a covered prescription at a Plan pharmacy, you pay one copayment for up to a 30-day supply. Occasionally, for safety reasons or as directed by your provider, the length of therapy may be less than 30 days. We follow FDA dispensing guidelines. You generally cannot refill a prescription until most of the previous supply has been used.

A generic drug is a drug that meets the approval of the FDA and is equivalent to a brand name drug in terms of quality and performance. You will generally receive a generic drug from a Plan pharmacy anytime one is available, unless your prescriber has directed the pharmacist to only dispense a specific brand name drug. However, some drugs do not have a generic equivalent. In this case, you will receive the brand name drug and you will be responsible for the appropriate copayment for that drug.

- **Mail-order program.** When you fill or refill your prescription through our mail-order program, you may order up to a 90-day supply of most medications. You have a fixed copayment for each tier of medication through our mail-order program. The copayment for up to a 90-day supply of Tier-1 and Tier-2 medications is equal to the cost of two pharmacy (30-day supply) copayments. The Tier-3 mail-order copayment is equal to three pharmacy (30-day supply) copayments.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you -- and us -- less than a name brand prescription.
- **If you are called to active duty or need medication during a national or other emergency** you can get up to a 90-day supply of a maintenance medication at a participating pharmacy or through our mail-order program. If you need assistance with the process, call Customer Service at 800-868-5200.

Prescription drugs (continued)

- **When you have to file a claim.** If you need an emergency prescription as part of an approved emergency treatment while

| Benefit Description | You pay | |
|---|--|---|
| Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. | | |
| Covered medications and supplies | High Option | Standard Option |
| <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail-order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Diabetic supplies and medications limited to insulin, insulin syringes, blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, insulin pumps, insulin pump supplies and insulin pens • Oral medications that influence blood sugar levels • Self-administered injectable agents • Hormone replacement therapy • Disposable needles and syringes for the administration of covered medications • Fertility drugs • Drugs for sexual dysfunction • Contraceptive drugs and devices • Off-label use of covered drugs in the treatment of HIV, AIDS or cancer • Contraceptive drugs and devices <p>Note: Injectables furnished and administered in a provider’s office or under professional supervision are generally covered under the medical benefit.</p> | <p><i>At a Plan pharmacy:</i> up to a 30-day supply</p> <p>Tier 1: \$5 Tier 2: \$25 Tier 3: \$50</p> <p><i>Mail-order:</i> up to a 90-day supply</p> <p>Tier 1: \$10 Tier 2: \$50 Tier 3: \$150</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copayment.</p> | <p><i>At a Plan pharmacy:</i> up to a 30-day supply</p> <p>Tier 1: \$10 Tier 2: \$30 Tier 3: \$60</p> <p><i>Mail-order:</i> up to a 90-day supply</p> <p>Tier 1: \$20 Tier 2: \$60 Tier 3: \$180</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copayment. (No deductible)</p> |

Covered medications and supplies – continued on next page.

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

Section 5(g) Special features

| Feature | Description |
|--|--|
| <p>Flexible benefits option</p> | <p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. |
| <p>Out-of-area student coverage</p> | <p>Students attending school outside the Plan service area may not have easy access to a Plan provider. They are covered for a limited number of services while out-of-area, if authorized in advance by the Plan.</p> <p>With the exception of emergency care, all out-of-area student services must be preauthorized by the plan. This includes post-stabilization care or follow-up care needed as a result of an emergency.</p> <p>Services that are covered for students while out of the Plan service area include:</p> <ul style="list-style-type: none"> • Non-routine medical office visits • Diagnostic lab and X-ray connected with a non-routine office visit • 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 • Outpatient services to diagnose and/or treat mental conditions • Short-term rehabilitation services, including physical, occupational and speech therapy. Coverage for physical and occupational therapy is provided for up to 60 consecutive days or 20 nonconsecutive visits (whichever is greater) per illness or injury in each calendar year (combined with any in-area visits). Coverage for speech therapy is determined by medical necessity. <p><i>Aside from emergency care, the services listed above are the only services that are covered for students on an out-of-network basis. To be covered, all other services must be obtained when they return to the Plan service area.</i></p> <p>Services that are not covered for students while out of the Plan service area include:</p> <ul style="list-style-type: none"> • Routine physical, gynecological exams, vision screening and hearing screening • Routine preventive care • Non-emergency prescription medication. You may use the prescription medication mail-order program to fill medication refills. (See pages 48-50.) • Second opinion • Preventive dental care or minor restorative care (e.g., fillings) • Chiropractic care services • Home health care • Outpatient surgical procedures that could be delayed until return to the Plan service area |

Out-of-area student coverage – continued on next page.

| | |
|---|---|
| <p>Out-of-area student coverage <i>(continued)</i></p> | <ul style="list-style-type: none"> • Maternity care or delivery • Durable medical equipment (e.g., wheelchairs), including maintenance or replacement |
| <p>Services for deaf and hearing impaired</p> | <p>You may access our TDD/TTY equipment at 877-608-7677.</p> |
| <p>Clinical trials</p> | <p>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.</p> |
| <p>Interpreter services</p> | <p>The Plan will, upon request, provide members with interpreter and translation services related to our administrative procedures.</p> |
| <p>Peace of Mind Program™</p> | <p>Our <i>Peace of Mind Program™</i> provides access to specialty services at specified Boston area medical centers. You may access <i>Peace of Mind Program™</i> providers at your request if you meet the following conditions:</p> <ul style="list-style-type: none"> • Care is for covered services as described in this brochure. The same copayments, calendar year deductibles and benefit limits apply. • You have seen a Plan specialist for this condition within the past three months. • A referral to a specific <i>Peace of Mind Program™</i> physician is made by your primary care provider and notification is given to the Plan that you are accessing that specialist through the <i>Peace of Mind Program™</i>. • The specialist to whom you are referred is on staff at one of the five medical centers listed below: <ul style="list-style-type: none"> – Massachusetts General Hospital – Brigham and Women’s Hospital – Children’s Hospital (Boston) – Dana-Farber Cancer Institute – 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. If you see a provider through the <i>Peace of Mind Program™</i> and that provider recommends or arranges services to be performed at a hospital that is not listed above, these services will not be covered unless the provider has obtained preauthorization from the Plan. You must have a copy of the authorization from the Plan; do not rely on assurances by the <i>Peace of Mind Program™</i> provider regarding your coverage. |

Peace of Mind Program™ - continued on next page.

Peace of Mind Program™
(continued)

Once the Plan has been notified of the *Peace of Mind Program™* referral, you may arrange an appointment to see this specialist for a consultation. You may continue treatment with this specialist or you may return to a Plan provider for care at any time, so long as you obtain appropriate preauthorization. If you wish to see any other *Peace of Mind Program™* provider, you must get a new referral from your primary care physician, the Plan must be notified of your request, and the request must meet the conditions listed above.

You may use the *Peace of Mind Program™* for all specialty care except mental health, substance abuse, chiropractic services, obstetrics or dental care. You may not use the *Peace of Mind Program™* for any primary care services, including internal medicine, family practice or pediatrics. If you have not met the conditions listed above, the services will not be covered by the Plan, and the *Peace of Mind Program™* provider may hold you financially responsible.

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- The Standard Option calendar year deductible does not apply to dental benefits.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.

| Benefit Description | You pay |
|---------------------|---------|
|---------------------|---------|

Note: The Standard Option calendar year deductible does not apply to benefits in this Section.

| Accidental injury benefit | High Option | Standard Option |
|--|---|---|
| <p>The Plan covers emergency medical care, such as to relieve pain and stop bleeding as a result of an accidental injury to sound natural teeth or tissues, when provided as soon as medically possible in the office of a physician or dentist. You do not need a referral or preauthorization for emergency care needed as a result of dental trauma. Go to the closest provider.</p> <p>Note: This accidental injury benefit does not include restorative or other dental services.</p> | \$15 copayment per office visit | \$20 copayment per office visit |
| Out-of-area dental care | | |
| While you are out of the Plan service area, we will cover | <p>\$10 per office visit</p> <p>Coverage is provided for up to \$50 per incident.</p> | <p>\$10 per office visit</p> <p>Coverage is provided for up to \$50 per incident.</p> |

Dental benefits

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

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

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

Additional dental benefits are available from participating Plan dentists at discounted rates. These discounted services are not to be considered Plan benefits and are not covered under this contract. See Section 6, *Non-FEHB benefits available to Plan members*, for more information about discounted dental services.

Dental benefits – continued on next page.

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

High Deductible Health Plan Benefits

See page 11 for how our benefits changed this year and page 123 for a benefits summary.

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Section 5 High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 800-868-5200 (TDD/TTY: 877-608-7677) or at our Web site at www.fchp.org.

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or HRA based upon your eligibility.

With this Plan, preventive care is not subject to the deductible. Routine physical exams, per Massachusetts Health Quality Partners, are covered in full. See page 110 for a definition of routine physical exams. As you receive non-preventive medical care, you must meet the Plan's calendar year deductible before we pay benefits according to the benefits described on page 70. You can choose to use funds available in your HSA to make payments toward the calendar year deductible or you can pay toward your calendar year deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: preventive care; traditional medical coverage health care that is subject to the calendar year deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

Preventive care

The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. *You do not have to meet the calendar year deductible before using these services.*

Traditional medical coverage

After you have paid the Plan's calendar year deductible, we pay benefits under traditional medical coverage described in Section 5.

Covered services include:

- Medical services and supplies provided by physicians and other health care professionals
- Surgical and anesthesia services provided by physicians and other health care professionals
- Hospital services; other facility or ambulance services
- Emergency services/accidents
- Mental health and substance abuse benefits
- Prescription drug benefits

Savings

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 59 for more details).

Health Savings Accounts (HSA)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2006, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$62.50 per month for a Self Only enrollment or \$125.00 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which for this plan is \$750 for Self Only enrollment and \$1,500 for Self and Family enrollment. See maximum contribution information on page 62. You can use funds in your HSA to help pay your health plan calendar year deductible. You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Your HSA is administered by Sovereign Bank
- Your contributions to the HSA are tax deductible
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it for qualified medical expenses, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Health Care Flexible Spending Account: If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a health care flexible spending account (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA.

Health Reimbursement Arrangements (HRA)

You must notify us that you are enrolled in Medicare and therefore ineligible for an HSA. We will administer and provide an HRA instead.

In 2006, we will give you an HRA credit of \$750 per year for a Self Only enrollment and \$1,500 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan calendar year deductible and/or for certain expenses that don't count toward the calendar year deductible.

HRA features include:

- For our HDHP option, the HRA is administered by WageWorks
- HRA credits are available following receipt of plan premium. Eligibility for contributions will be determined on the first day of the month. There are no prorated contributions.
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest

- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.

An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSAs). However, you must meet FSAFEDS eligibility requirements. See *Who is eligible to enroll?* in Section 12 under The Federal Flexible Spending Account Program – FSAFEDS.

Catastrophic protection for out-of-pocket expenses

When you use network providers, your annual maximum for out-of-pocket expenses (calendar year deductibles and copayments) for covered services is limited to \$3,000 per person or \$6,000 per family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s allowable amount or benefit maximum). Refer to Section 4 *Your catastrophic protection out-of-pocket maximum* and HDHP Section 5 *Traditional medical coverage subject to the calendar year deductible* for more details.

Health education resources and account management tools

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5 Savings – HSAs and HRAs

| Feature Comparison | Health Savings Account (HSA) | Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA |
|-----------------------------|---|--|
| Administrator | The Plan will establish an HSA for you with | TD Banknorth is the HRA fiduciary for this Plan. |
| Fees | None. | None. |
| Eligibility | <p>You are eligible for an HSA if you:</p> <ul style="list-style-type: none"> • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Are not enrolled in Medicare Part A or Part B • Can not be claimed as a dependent on someone else's tax return • Have not received VA benefits in the last three months • Complete and return all banking paperwork. <p>Eligibility for contributions is determined on the first day of the month following your effective date of enrollment and will be prorated for length of enrollment.</p> <p>You are no longer eligible for an HSA once you</p> | <p>You are eligible for an HRA if you:</p> <ul style="list-style-type: none"> • Enroll in this HDHP • Are enrolled in Medicare Part A or Part B <p>Eligibility for contributions is determined on the first day of the month following your effective day of enrollment and will be prorated for the remainder of the calendar year.</p> |
| Funding | <p>If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month.</p> <p>If you join this plan during Open Season, you will receive \$750 annually for Self Only coverage or \$1,500 annually for Self and Family coverage.</p> <p>If you join at any other time of the year, your HSA funding is prorated based on the number of</p> | <p>Eligibility for the annual credit will be determined on the first day of the month.</p> <p>If you join this plan during Open Season, you will receive \$750 annually for Self Only coverage or \$1,500 annually for Self and Family coverage.</p> <p>If you join at any other time of the year, your HRA funding is prorated based on the number of full months you are enrolled in the HDHP.</p> |
| Self Only enrollment | For 2006, a monthly premium pass through of | For 2006, your HRA annual credit is \$750. This amount will be prorated for length of enrollment. Your annual credit is not considered taxable income. |

| | | |
|--|---|--|
| <p>Self and Family enrollment</p> | <p>For 2006, a monthly premium pass through of</p> | <p>For 2006, your HRA annual credit is \$1,500. This amount will be prorated for length of enrollment. Your annual credit is not considered taxable income.</p> |
| <p>Contributions/credits</p> | <p>The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the amount of the calendar year deductible, which is \$1,500 for Self Only or \$3,000 for Self and Family. This amount is reduced by $\frac{1}{12}$ for any month you were ineligible to contribute to an HSA.</p> <p>For each month that you are eligible for HSA contributions, if you choose to contribute to your HSA,</p> <ul style="list-style-type: none"> – The maximum allowable contribution is a combination of employee and employer funds up to the amount of the calendar year deductible of \$1,500 for Self Only or \$3,000 for Self and Family. To determine the maximum allowable contribution, take the amount of your calendar year deductible divided by 12, times the number of full months enrolled in the HDHP. Subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution to determine the amount you may contribute. – You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). – HSAs earn tax-free interest (does not affect your annual maximum contribution). – Catch-up contributions are discussed on | <p>HRA credits are available following receipt of plan premium. Eligibility for contributions will be determined on the first day of the month. There are no prorated contributions.</p> |
| <p>• Self Only enrollment</p> | <p>You may make an annual maximum contribution of \$750.</p> <p>You can make contributions monthly or you can make a lump sum contribution at any time during the tax year, up to the filing deadline of April 15, 2007, as long as you remain enrolled in this</p> | <p>You cannot contribute to the HRA.</p> |

| | | |
|--|--|--|
| <ul style="list-style-type: none"> • Self and Family enrollment | <p>You may make an annual maximum contribution of \$1,500.</p> <p>You can make contributions monthly or you can make a lump sum contribution at any time during the tax year, up to the filing deadline of April 15, 2007, as long as you remain enrolled in this</p> | <p>You cannot contribute to the HRA.</p> |
| <p>Access funds</p> | <p>You can access your HSA funds from Sovereign Bank by the following methods:</p> <ul style="list-style-type: none"> • Debit cards • Checks • Direct transfer of funds from the HSA account to your checking or savings account • By direct request to Sovereign for you to receive a check or direct deposit | <p>For qualified medical expenses under your HDHP, you can be reimbursed when claims are submitted to WageWorks in the following methods:</p> <ul style="list-style-type: none"> • Debit cards • Direct provider payment • Paper claims <p>Submit your requests for reimbursement to: WageWorks Processing Center 4129 E. Van Buren St., Suite 220A Phoenix, AZ 85008</p> |
| <p>Distributions/withdrawals</p> <ul style="list-style-type: none"> • Medical | <p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.</p> <p>Medical expenses are not allowable if they occur before the first full month your enrollment is effective, and they are not reimbursable from the HSA until the first of the month following the effective date of your enrollment in this HDHP and the date the HSA account is established.</p> <p>For most Federal employees (those not paid on a monthly basis), the earliest date medical expenses will be allowable is February 1, 2006.</p> <p>See IRS Publication 302 for a list of eligible medical expenses, including over-the-counter</p> | <p>You can pay the out-of-pocket expenses for eligible medical expenses for individuals covered under the HDHP.</p> <p>Eligible medical expenses are not covered by the plan can be reimbursed if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> on page 64 for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.</p> |
| <ul style="list-style-type: none"> • Non-medical | <p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.</p> <p>When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary</p> | <p>Not applicable – distributions will not be made for anything other than eligible medical expenses.</p> |

| | | |
|-------------------------------------|--|--|
| <p>Availability of funds</p> | <p>Funds are not available until:</p> | <p>Funds are not available until: The member's enrollment in the FCHP Qualified HDHP is completed and the Plan's first medical plan premiums are received. The earliest date funds would be available is February 1, 2006.</p> |
| <p>Account owner</p> | <p>FEHB enrollee</p> | <p>Employer</p> |
| <p>Portable</p> | <p>You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA.</p> | <p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.</p> |
| <p>Annual rollover</p> | <p>Yes, accumulates without a maximum cap.</p> | <p>Yes, accumulates without a maximum cap.</p> |

If you have an HSA

Contributions

All contributions are aggregated and cannot exceed the annual maximum contribution. You may contribute your own money to your account through payroll deductions (if available), or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. You receive tax advantages in any case. You have until April 15 of the following year to make HSA contributions for the current year.

IRS contribution rules reduce the total annual maximum contribution if you are not eligible for the HDHP during the whole month. For instance, if your enrollment in this Plan was effective after January 1, 2006, you would need to deduct $\frac{1}{12}$ of the annual maximum contribution. Contact Sovereign Bank's Customer Service Department at 877-HSA-7800, Monday through Friday from 8 a.m. to 8 p.m. Eastern, for more details.

Catch-up contributions

If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. In 2006, you may contribute up to \$700 in catch-up contributions. Catch-up contributions in later years increase up to a maximum of \$1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.

If you die

If you do not have a named beneficiary, if you are married, it becomes your spouse's HSA; otherwise, it becomes part of your taxable estate.

Qualified expenses

You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase any health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at www.irs.gov and click on "Forms and Publications." Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

Non-qualified expenses

You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.

Tracking your HSA balance

You will receive a periodic statement that shows the deposits ("premium pass through"), withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.

Minimum reimbursements from your HSA

You can request reimbursement in any amount.

If you have an HRA**Why an HRA is established**

You must notify us that you are enrolled in Medicare and therefore ineligible for an HSA. We will administer and provide an HRA instead.

HRA credits are available following receipt of plan premium. Eligibility for contributions will be determined on the first day of the month. There are no prorated contributions.

How an HRA differs

Please review the chart on pages 61-64 which details the differences between an HRA and an HSA. The major differences are:

- You cannot make contributions to an HRA
- Funds are forfeited if you leave the HDHP
- An HRA does not earn interest, and
- HRAs can only pay for eligible medical expenses, such as deductibles and copayments, for individuals covered by the HDHP.

Section 5 Preventive care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the calendar year deductible. You only owe your copay for covered preventive care services.
- You must use providers that are part of our network.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the calendar year deductible.*

| Benefit Description | You pay |
|--|--|
| Preventive care, adult | |
| Routine physicals | Nothing (No deductible) |
| Routine screenings, such as: <ul style="list-style-type: none"> • Total blood cholesterol • Colorectal cancer screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 – Double contrast barium enema – every five years starting at age 50 – Colonoscopy screening – every ten years starting at age 50 • Osteoporosis screening for women age 65 and older (beginning at age 60 for women at increased risk) • Abdominal Aortic Aneurysm screening – ultrasonography, one between the age of 65 and 75 for men with smoking history | Nothing for routine screenings \$20 copayment per associated office visit, unless provided by your primary care provider at the time of your routine physical exam (No deductible) |
| Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older | Nothing for PSA test \$20 copayment per associated office visit, unless provided by your primary care provider at the time of your routine physical exam (No deductible) |
| Routine Pap test | Nothing (No deductible) |
| Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 and older, one every calendar year | Nothing (No deductible) |

Preventive care, adult – continued on next page.

| Preventive care, adult <i>(continued)</i> | You pay |
|---|---|
| Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older | Nothing for immunizations \$20 copayment per associated office visit, unless provided by your primary care provider at the time of your routine physical exam (No deductible) |
| Travel-related immunizations | Nothing for immunizations \$20 copayment per associated office visit, unless provided by your primary care provider at the time of your routine physical exam (No deductible) |
| <i>Not covered:</i> <i>Physical exams required for obtaining or continuing employment or insurance, or attending schools or camp</i> | <i>All charges.</i> |
| Preventive care, children | |
| <ul style="list-style-type: none"> • Well-child care (up to age 22) including: <ul style="list-style-type: none"> – History and physical examination, measurements, sensory screening, neuropsychiatric evaluations, development screening and assessment. – Screening of all children under six years of age for the presence of lead poisoning – Hereditary and metabolic screening at birth, newborn hearing screening, tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the provider. • Childhood immunizations recommended by the American Academy of Pediatrics, including Meningococcal Conjugate Vaccine for children at risk. • Examinations, such as: <ul style="list-style-type: none"> – Vision screening to age 22 to determine the need for vision correction – Hearing screening to age 22 to determine the need for hearing correction – Examinations done on the day of immunizations (up to age 22) | Nothing (No deductible) |
| Travel-related immunizations | Nothing for immunizations \$20 copayment per associated office visit, unless provided by your primary care provider at the time of your routine physical exam (No deductible) |

Preventive care, children – continued on next page.

| Preventive care, children <i>(continued)</i> | You pay |
|--|----------------------------|
| <p><i>Not covered:</i> <i>Physical exams required for obtaining or continuing employment or insurance, or attending schools or camp</i></p> | <p><i>All charges.</i></p> |
| Dental Preventive Care | |
| <ul style="list-style-type: none"> • See Section 5(h) <i>Dental benefits</i> | |

Section 5 Traditional medical coverage subject to the calendar year deductible

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.
- Preventive care is not subject to the calendar year deductible. Traditional medical coverage is subject to the calendar year deductible.
- The calendar year deductible is \$1,500 per person or \$3,000 per family enrollment. The family calendar year deductible can be satisfied by one or more family members. The calendar year deductible applies to almost all benefits under Traditional medical coverage. You must pay your calendar year deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your copayments for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your copayments and calendar year deductibles total \$3,000 per person or \$6,000 per family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum).
- 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 |
|--|---|
| Calendar year deductible before Traditional medical coverage begins | |
| The calendar year deductible applies to almost all benefits in this Section. In the You pay column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the calendar year deductible. | 100% of allowable charges until you meet the calendar year deductible of \$1,500 per person or \$3,000 per family enrollment |
| After you meet the calendar year deductible, we pay the allowable charge (less your copayment) until you meet the annual catastrophic out-of-pocket maximum. | After you meet the calendar year deductible, you pay the indicated copayments for covered services. You may choose to pay the copayments from your HSA or HRA, or you can pay for them out-of-pocket. |

**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.
- This plan has a calendar year deductible. The calendar year deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family calendar year deductible can be satisfied by one or more family members. The calendar year deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your calendar year deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your copayments for eligible medical expenses and prescriptions.
- 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 |
|---|--|
| Diagnostic and treatment services | |
| Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • In an urgent care center • Office medical consultations • Second surgical opinion Note: See Section 5(d), <i>Emergency services</i> , for care of a minor emergency in a doctor’s office or urgent care center | \$20 copayment per office visit after you meet your calendar year deductible |
| Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility | Nothing after you meet your calendar year deductible |

| Lab, X-ray and other diagnostic tests | You pay |
|--|--|
| <p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG | <p>Nothing for lab, X-ray and other diagnostic tests after you meet your calendar year deductible</p> <p>\$20 copayment per associated office visit after you meet your calendar year deductible</p> |
| Maternity care | You pay |
| <p>Prenatal maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need preauthorization for your normal delivery; see page 13 for other circumstances. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. We will extend your inpatient stay if medically necessary. If you are discharged sooner (the mother must decide to accept an early discharge), you are covered for one home visit by a registered nurse, physician or certified nurse midwife. • We cover routine nursery care, including examination, newborn hearing screening and circumcision, of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See <i>Hospital benefits</i> (Section 5(c)) and <i>Surgery benefits</i> (Section 5(b)). • We pay non-routine maternity care the same as for illness and injury. See <i>Medical services and supplies provided by physicians and other health care professionals</i> (Section 5(a)). | <p>\$20 copayment for the first prenatal office visit.</p> <p>All other prenatal office visits covered in full (No deductible)</p> |
| <ul style="list-style-type: none"> • Postnatal maternity (obstetrical) care | <p>\$20 copayment per office visit after you meet your calendar year deductible</p> |
| <p><i>Not covered: Routine sonograms to determine fetal age, size or sex</i></p> | <p><i>All charges.</i></p> |

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

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

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| Allergy care | |
| <p>Allergy testing and treatment, including:</p> <ul style="list-style-type: none"> • Allergy serum • Allergy injections | <p>Nothing for allergy testing and treatment after you meet your calendar year deductible</p> <p>\$20 copayment per associated office visit after you meet your calendar year deductible</p> |
| <p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p> | <p><i>All charges.</i></p> |
| Treatment therapies | You pay |
| <ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 82.</p> <ul style="list-style-type: none"> • Radiation therapy • Respiratory and inhalation therapy • Note: Drug therapies for the treatment of respiratory diseases are covered under the prescription drug benefit. • Dialysis – hemodialysis and continuous ambulatory peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. Your Plan provider will submit a request for preauthorization before you begin treatment. If your Plan provider does not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring preauthorization</i> in Section 3.</p> | <p>Nothing for treatment therapies after you meet your calendar year deductible</p> <p>\$20 copayment per associated office visit after you meet your calendar year deductible</p> |
| Physical and occupational therapies | |
| <ul style="list-style-type: none"> • Up to 60 consecutive visits or 20 nonconsecutive visits (whichever is greater) per illness or injury per calendar year for: <ul style="list-style-type: none"> – physical therapy – occupational therapy <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> | <p>\$20 copayment per office visit after you meet your calendar year deductible</p> |
| <ul style="list-style-type: none"> • Cardiac rehabilitation for persons with documented cardiovascular disease, initiated within 26 weeks after the diagnosis of cardiovascular disease. • Early intervention services delivered by certified early intervention specialists according to operational standards developed by the Department of Public Health, for children from birth to their 3rd birthday. Benefits are limited to a maximum of \$5,200 per year per child and an aggregate of \$15,600 over the term of the child’s Plan membership. | <p>Covered in full after you meet your calendar year deductible</p> |

Physical and occupational therapies – continued on next page.

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| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs • Acupuncture, aquatic or massage therapy | <p><i>All charges.</i></p> |
| Speech therapy | You pay |
| <p>Medically necessary services for the diagnosis and treatment of speech, hearing and language disorders when services are provided by a Plan provider who is a speech-language pathologist or audiologist; at a Plan facility or provider's office.</p> | <p>\$20 copayment per visit after you meet your calendar year deductible</p> |
| Hearing services (testing, treatment, and supplies) | |
| <p>Hearing screening for children to age 22 to determine the need for hearing correction (see <i>Preventive care, child</i>).</p> | <p>Nothing for hearing screening (No deductible)</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing and examinations for them | <p><i>All charges.</i></p> |
| Vision services (testing, treatment, and supplies) | |
| <ul style="list-style-type: none"> • Diagnosis and treatment of diseases or injuries to the eye | <p>Nothing for treatment of diseases or injuries to the eye after you meet your calendar year deductible</p> <p>\$20 copayment per associated office visit after you meet your calendar year deductible</p> |
| <ul style="list-style-type: none"> • Annual eye exam <p>Note: See <i>Preventive care, children</i> for vision screening for children to age 22</p> | <p>\$20 copayment per office visit (No deductible)</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery | <p><i>All charges.</i></p> |
| Foot care | |
| <p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p> | <p>Nothing for routine foot care after you meet your calendar year deductible</p> <p>\$20 copayment per associated office visit after you meet your calendar year deductible</p> |
| <p><i>Not covered:</i></p> <p><i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i></p> <p><i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></p> | <p><i>All charges.</i></p> |

| Orthopedic and prosthetic devices | |
|---|---|
| <ul style="list-style-type: none"> • Orthopedic devices (devices that support part of the body and/or eliminate motion) such as neck collars for cervical support, molded body jacket for curvature of the spine and braces with rigid support. • Prosthetic devices (devices that replace all or part of an organ or body part, not including dental) such as artificial limbs and eyes, implanted corrective lenses following cataract surgery and electric speech aids. • Corrective orthopedic appliances for nondental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. <p>Coverage for orthopedic and prosthetic devices and durable medical equipment is subject to a combined benefit limit of \$1,500 per calendar year.</p> <p>Note: All orthopedic and prosthetic devices must be ordered by a Plan provider and authorized by the Plan.</p> | Nothing after you meet your calendar year deductible. |
| <ul style="list-style-type: none"> • Scalp hair prosthesis (wigs) for individuals who have suffered hair loss as a result of the treatment of any form of cancer or leukemia. Coverage is limited to \$350 per calendar year. | Nothing after you meet your calendar year deductible. |
| <ul style="list-style-type: none"> • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. <p>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.</p> | Nothing after you meet your calendar year deductible |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> | <i>All charges.</i> |

| Durable medical equipment (DME) | You pay |
|---|--|
| <p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; • Visual magnifying aids and voice synthesizers for blood glucose monitors for use by the legally blind • Therapeutic/molded shoes and shoe inserts for the treatment of severe diabetic foot disease • Coverage for orthopedic and prosthetic devices and durable medical equipment is subject to a combined benefit limit of \$1,500 per calendar year <p>Note: Insulin pumps and insulin pump supplies are covered under the prescription drug benefit. All durable medical equipment must be ordered by a Plan provider and preauthorized by the Plan.</p> | <p>Nothing after you meet your calendar year deductible.</p> |
| <ul style="list-style-type: none"> • Oxygen and oxygen equipment | <p>Nothing after you meet your calendar year deductible</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Items that are not covered include, but are not limited to, air conditioners, air purifiers, arch supports, ear plugs (to prevent fluid from entering the ear canal during water activities), foot orthotics, orthopedic shoes (except when part of a brace) or other supportive devices for the feet, articles of special clothing, compression garments (such as Jobst® stockings), bed-pans, raised toilet seats, dehumidifiers, dentures, elevators, safety grab bars, car seats, seizure helmets, hearing aids, heating pads, hot water bottles, exercise equipment or similar equipment.</i> • <i>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.</i> | <p><i>All charges.</i></p> |

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| Home health services | |
| <p>Home health care ordered by a Plan provider and authorized by the Plan, including part-time or intermittent skilled nursing care and physical therapy. Additional services such as occupational and speech therapy, oxygen and intravenous therapy, medical social services, home health aide services, medical and surgical supplies, durable medical equipment and nutritional consultations are covered to the extent that they are determined to be a medically necessary component of covered skilled nursing care and physical therapy.</p> <p>Note: Durable medical equipment and physical and occupational therapy provided as a medically necessary component of home health care are not subject to the benefit limits.</p> | Nothing after you meet your calendar year deductible |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> | <i>All charges.</i> |
| Chiropractic | |
| <p>Chiropractic services for acute musculoskeletal conditions. The condition must be new or an exacerbation of a previous condition. Coverage is provided for up to 20 visits in each calendar year.</p> | \$20 copayment per office visit after you meet your calendar year deductible |
| Alternative treatments | |
| <i>No benefit</i> | <i>All charges.</i> |
| Educational classes and programs | You pay |
| <p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. | Nothing (No deductible) |
| <ul style="list-style-type: none"> • Diabetes self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider. | \$20 copayment per office visit after you meet your calendar year deductible |

**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.
- The calendar year deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family calendar year deductible can be satisfied by one or more family members. The calendar year deductible applies to almost all benefits in this Section.
- After you have satisfied your calendar year deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for copayments for eligible medical expenses and prescriptions.
- 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 PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- When you enroll in this Plan, we establish either an HSA or an HRA for you based on your eligibility. See Section 6(a) *Health Savings Accounts* and Section 6(b) *Health Reimbursement Accounts* for important information about these accounts.

| Benefit Description | You pay |
|---|---|
| Surgical procedures | |
| <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) | <p>Nothing for surgical procedures after you meet your calendar year deductible</p> <p>\$20 copayment per associated office visit after you meet your calendar year deductible</p> <p>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).</p> |

Surgical procedures – continued next page.

| Surgical procedures <i>(continued)</i> | You pay |
|---|---|
| <ul style="list-style-type: none"> • Surgical treatment of morbid obesity (bariatric surgery). Candidates must: <ul style="list-style-type: none"> ○ Meet the definition of morbid obesity ○ Have been morbidly obese for at least five years ○ Be at least 18 years old ○ Have no untreated metabolic cause for obesity (e.g. adrenal or thyroid disorders) ○ Have a history of failure with two or more nonsurgical measures, supervised, over at least a one year period • Insertion of internal prosthetic devices. See 5(c) – for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns | |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Reversal of voluntary sterilization • Routine treatment of conditions of the foot; see Foot care | <i>All charges.</i> |
| Reconstructive surgery | |
| <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – the condition produced a major effect on the member’s appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – reconstruction of the breast on which the mastectomy was performed; – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p> | <p>Nothing for reconstructive surgery after you meet your calendar year deductible.</p> <p>\$20 copayment per associated office visit after you meet your calendar year deductible.</p> |
| <ul style="list-style-type: none"> • Breast prostheses and surgical bras and replacements (see Section 5 (a) <i>Orthopedic and prosthetic devices</i>) | Nothing after you meet your calendar year deductible |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury • Surgeries related to sex transformation | <i>All charges.</i> |

| Oral and maxillofacial surgery | |
|--|---|
| <p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. | <p>Nothing for oral and maxillofacial surgery after you meet your calendar year deductible</p> <p>\$20 copayment per associated office visit after you meet your calendar year deductible</p> <p>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> | <p><i>All charges.</i></p> |
| Organ/tissue transplants | You pay |
| <p>The Plan covers human solid organ, bone marrow and stem cell transplants, such as:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung for patients under age 60 with end-stage primary or secondary pulmonary hypertension • Kidney • Liver • Lung transplant for patients under age 60 with end-stage obstructive or restrictive pulmonary disease • Pancreas transplants • Allogenic (donor) bone marrow transplants for leukemia, aplastic anemia, severe combined immunodeficiency disease, or Wiskott-Aldrich Syndrome; for patients with high-risk lymphoblastic lymphoma in remission; or for patients under age 60 with myelodysplasia • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; resistant or advanced non-Hodgkin's lymphoma; recurrent or refractory neuroblastoma; for patients diagnosed with breast cancer that has progressed to metastatic disease; for patients under age 65 with chemo-responsive multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors | <p>Nothing for organ/tissue transplants after you meet your calendar year deductible</p> <p>\$20 copayment per associated office visit after you meet your calendar year deductible</p> <p>See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)</p> |

Organ/tissue transplants – continued on next page.

| Organ/tissue transplants <i>(continued)</i> | You pay |
|---|--|
| <ul style="list-style-type: none"> • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Human Leukocyte Antigen (HLA) or histocompatibility locus antigen testing for A, B, or DR antigens, or any combination thereof, to establish bone marrow transplant donor suitability <p>The transplant must be performed at an affiliated transplant facility, subject to your acceptance into the program. The Plan will work with the transplant facility to coordinate your care during the evaluation and transplant process and help to arrange your discharge and follow-up care.</p> <p>Note: If you are the recipient of a transplant the services of the donor are covered including the evaluation and preparation and the surgery and recovery directly related to the donation with the exception of those services covered by another insurer. If you are the donor and the transplant recipient is not a member of the Plan no coverage is provided for either the recipient or the donor with the exception of human leukocyte antigen or histocompatibility locus antigen testing.</p> | |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Transplants not listed as covered or investigational or experimental procedures, including, but not limited to, transplantation of partial pancreatic tissue or islet cells</i> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Bioartificial transplantation, such as the transplantation of a total artificial heart</i> • <i>Xenotransplantation, such as the transplantation of animal tissues or organs into a human</i> • <i>Services for the organ donor that are covered by another insurance plan</i> • <i>Services for an organ donor if the recipient is not a Plan member</i> • <i>Transportation, housing or home cleaning services incurred by either the donor or the recipient</i> | <i>All charges.</i> |
| Anesthesia | |
| <p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center | Nothing for anesthesia services after you meet your calendar year deductible |
| <p>Professional services provided in –</p> <ul style="list-style-type: none"> • Office | <p>Nothing for anesthesia services after you meet your calendar year deductible</p> <p>\$20 copayment per associated office visit after you meet your calendar year deductible</p> |

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.
- The calendar year deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family calendar year deductible can be satisfied by one or more family members. The calendar year deductible applies to all benefits in this Section.
- After you have satisfied your calendar year deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for copayments for eligible medical expenses and prescriptions.
- 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 PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.
- When you enroll in this Plan, we establish either an HSA or an HRA for you based on your eligibility. See Section 6(a) *Health Savings Accounts* and Section 6(b) *Health Reimbursement Accounts* for important information about these accounts.

| Benefit Description | You pay |
|---|---|
| <p>Inpatient hospital</p> <p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs • Diagnostic laboratory tests and X-rays • Blood and blood products • Administration of blood and blood products • Dressings, splints, casts, and sterile tray services • Internal prosthetic devices | <p>Nothing after you meet your calendar year deductible</p> |

Inpatient hospital - continued on next page.

| Inpatient hospital <i>(continued)</i> | You pay |
|---|--|
| <ul style="list-style-type: none"> • Medical supplies, appliances and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items | |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care | <i>All charges.</i> |
| Outpatient hospital or ambulatory surgical center | |
| <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p> | Nothing after you meet your calendar year deductible |
| Skilled nursing care facility benefits | You pay |
| <p>Skilled nursing facility (SNF): The Plan covers inpatient services in a SNF for up to 100 days in each calendar year. You may be admitted to a SNF if, based on your medical condition, you need daily skilled nursing care, skilled rehabilitation services or other medical services that may require access to 24-hour medical care but does not require the specialized care of an acute care hospital.</p> <p>Services provided are:</p> <ul style="list-style-type: none"> • Room and board in a semiprivate room (or private room if medically necessary) • The services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, nursing services, physical, speech and occupational therapy, medical supplies and equipment. • Drugs, biologicals, equipment and supplies ordinarily provided or arranged by the skilled nursing facility, when prescribed by a Plan provider | Nothing after you meet your calendar year deductible |

Skilled nursing care facility benefits – continued on next page.

| Skilled nursing care facility benefits <i>(continued)</i> | You pay |
|--|--|
| <i>Not covered: Custodial care or personal comfort items such as telephone, radio or television</i> | <i>All charges.</i> |
| <p>Hospice care</p> <p>Hospice care is a method of caring for the terminally ill that helps those individuals continue their lives with as little disruption as possible. This type of care emphasizes supportive services, such as home care and pain control, rather than the cure-oriented services that are provided in hospitals. To be eligible for hospice care, you must be terminally ill with a life expectancy of less than six months.</p> <ul style="list-style-type: none"> • Hospice services are provided, as necessary, to maintain the terminally ill individual at home such as: <ul style="list-style-type: none"> - Physicians' services, nursing care and medical social services - Medical appliances and supplies including drugs and biologicals (prescription copayments may apply) • Short-term inpatient care for the control of pain and management of acute and severe clinical problems that cannot be managed in a home setting. | Nothing after you meet your calendar year deductible |
| <i>Not covered: Independent nursing, homemaker services</i> | <i>All charges.</i> |
| Ambulance | |
| <p>Ambulance service when medically appropriate</p> <p>Note: See Section 5(d) for coverage of emergency ambulance.</p> | 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 \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family calendar year deductible can be satisfied by one or more family members. The calendar year deductible applies to all benefits in this Section.
- After you have satisfied your calendar year deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for copayments for eligible medical expenses and prescriptions.
- 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.
- When you enroll in this Plan, we establish either an HSA or an HRA for you based on your eligibility. See Section 6(a) *Health Savings Accounts* and Section 6(b) *Health Reimbursement Accounts* for important information about these accounts.

What is a medical emergency?

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

What to do in case of emergency:

Emergency care

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

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

Urgent care

Sometimes you may need care for minor medical emergencies such as cuts that require stitches or a sprained ankle. If you are within the Plan service area, call your primary care provider’s office for information on how and where to seek treatment. If your primary care provider is not available, a provider on call will make arrangements for your care. Providers’ telephones are answered 24 hours a day, seven days a week. Explain the medical situation to the provider and state where you are calling from so that the provider can refer you to the most appropriate facility.

If you are outside the Plan service area, go to the nearest medical facility for care. You do not need a referral or preauthorization, but you should notify your primary care provider, who will arrange for any follow-up or continuing care that is medically necessary for you.

| Benefit Description | You pay |
|--|---|
| Emergency care | |
| <ul style="list-style-type: none"> Emergency care in an emergency room. | \$75 copayment per visit after you meet your calendar year deductible (waived if admitted) |
| <ul style="list-style-type: none"> Urgent care at an urgent care center or a doctors' office. | \$20 copayment per visit after you meet your calendar year deductible |
| <i>Not covered:</i> <ul style="list-style-type: none"> Elective or non-emergency care received in an emergency room Follow-up care, unless provided by your primary care provider or authorized by the Plan. This includes follow-up care provided in an emergency room or urgent care facility. | <i>All charges.</i> |
| Ambulance | |
| <ul style="list-style-type: none"> Emergency ambulance service when medically appropriate. Note: See Section 5(c) for non-emergency ambulance service. | Nothing after you meet your calendar year deductible |
| <i>Not covered:</i> <ul style="list-style-type: none"> Air ambulance when not appropriate to medical condition or geographic location Transfers between hospitals when the patient's medical condition does not warrant that he or she be transported to another facility Commercial airline transportation | <i>All charges.</i> |

Section 5(e) Mental health and substance abuse benefits

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

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

- Plan providers must provide your care and you must be hospitalized in a Plan facility.
- 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 \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family calendar year deductible can be satisfied by one or more family members. The calendar year deductible applies to all benefits in this Section.
- After you have satisfied your calendar year deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.
- **YOUR PROVIDER MUST GET PREAUTHORIZATION FOR INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.** See the instructions after the benefits description below.
- When you enroll in this Plan, we establish either an HSA or an HRA for you based on your eligibility. See Section 6(a) *Health Savings Accounts* and Section 6(b) *Health Reimbursement Accounts* for important information about these accounts.

| Benefit Description | You pay |
|--|--|
| Mental health and substance abuse benefits | |
| <p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p> | <p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p> |
| <ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers. • Medication management. <p>Note: See Section 5 (a) for coverage of labs, X-rays and other diagnostic tests.</p> | <p>\$20 copayment per office visit after you meet your calendar year deductible</p> |
| <ul style="list-style-type: none"> • Services provided by a hospital or other facility. | <p>Nothing after you meet your calendar year deductible</p> |

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

| Mental health and substance abuse benefits <i>(continued)</i> | You pay |
|---|---|
| <ul style="list-style-type: none"> Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment | Nothing after you meet your calendar year deductible |
| <p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p> | <i>All charges.</i> |
| <p>Preauthorization</p> | <p>To be eligible to receive these benefits, you must obtain a treatment plan and follow all of the following authorization processes:</p> <p>You may self-refer for outpatient mental health and substance abuse services with a Plan provider. For assistance in finding a Plan provider, call 888-421-8861 (TDD/TTY: 781-994-7660).</p> <p>Inpatient mental health and substance abuse services require preauthorization. Call 888-421-8861 (TDD/TTY: 781-994-7660).</p> <p>For mental health and substance abuse emergencies, follow the same procedures as for any other medical emergency. See Section 5(d), <i>Emergency services</i>.</p> |
| <p>Limitation</p> | <p>We may limit your benefits if you do not obtain a treatment plan.</p> |

Section 5(f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family calendar year deductible can be satisfied by one or more family members. The calendar year deductible applies to all benefits in this Section.
- After you have satisfied your calendar year deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for copayments for eligible prescriptions.
- 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.
- When you enroll in this Plan we establish either an HSA or an HRA for you based on your eligibility. See Section 6(a) *Health Savings Accounts* and Section 6(b) *Health Reimbursement Accounts* for important information about these accounts.

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” on page 92 for information on submitting proof of payment for reimbursement.
- **We use a formulary.** A formulary is a list of medications that shows the copayment tier and preauthorization requirements for each medication. We have chosen the tiers and determined the criteria for preauthorization based on cost and efficacy. Coverage of certain drugs is based on medical necessity. They are designated on the formulary as “PA”. Your provider must get prior authorization from the Plan before giving you a prescription for one of these medications.
- **These are the dispensing limitations.** When you fill a covered prescription at a Plan pharmacy, you pay one copayment for up to a 30-day supply. Occasionally, for safety reasons or as directed by your provider, the length of therapy may be less than 30 days.
- We follow FDA dispensing guidelines. You generally cannot refill a prescription until most of the previous supply has been used.
- A generic drug is a drug that meets the approval of the FDA and is equivalent to a brand name drug in terms of quality and performance. You will generally receive a generic drug from a Plan pharmacy any time one is available, unless your prescriber has directed the pharmacist to only dispense a specific brand name drug. However, some drugs do not have a generic equivalent. In this case, you will receive the brand name drug and you will be responsible for the appropriate copayment for that drug.
- **Mail-order program.** When you fill or refill your prescription through our mail-order program, you may order up to a 90-day supply of most medications. You have a fixed copayment for each tier of medication through our mail-order program. The copayment for up to a 90-day supply of Tier-1 and Tier-2 medications is equal to the cost of two pharmacy (30-day supply) copayments. The Tier-3 mail-order copayment is equal to three pharmacy (30-day supply) copayments.

Prescription drug benefits begin on the next page.

- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you -- and us -- less than a name brand prescription.
- **If you are called to active duty or need medication during a national or other emergency** you can get up to a 90-day supply of a maintenance medication at a participating pharmacy or through our mail-order program. If you need assistance with the process, call Customer Service at 1-800-868-5200.
- **When you have to file a claim.** If you need an emergency prescription as part of an approved emergency treatment while you are out of the Plan service area, the Plan will reimburse you for the cost of a 14-day supply of medication, less the appropriate copayment. Submit proof of payment to: Fallon Community Health Plan, Claims Department, P.O. Box 15121, Worcester, MA 01615-0121.

| Benefit Description | You pay |
|---|---|
| Covered medications and supplies | |
| <p>We cover the following medications and supplies prescribed by a Plan provider and obtained from a Plan pharmacy or through our mail-order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as Not covered. • Diabetic supplies and medications limited to insulin, insulin syringes, blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, insulin pumps, insulin pump supplies and insulin pens • Oral medications that influence blood sugar levels • Self-administered injectable agents • Hormone replacement therapy for perimenopausal and postmenopausal women • Disposable needles and syringes for the administration of covered medications • Fertility drugs • Drugs for sexual dysfunction • Contraceptive drugs and devices • Off-label use of covered drugs in the treatment of HIV, AIDS or cancer • Contraceptive drugs and devices <p>Note: Injectables furnished and administered in a provider’s office or under professional supervision are generally covered under the medical benefit.</p> | <p>At a Plan pharmacy, for up to a 30-day supply:</p> <p>Tier 1: \$10 copayment after you meet your calendar year deductible Tier 2: \$25 copayment after you meet your calendar year deductible Tier 3: \$50 copayment after you meet your calendar year deductible</p> <p>Through our mail-order program, for up to a 90-day supply:</p> <p>Tier 1: \$20 copayment after you meet your calendar year deductible Tier 2: \$50 copayment after you meet your calendar year deductible Tier 3: \$150 copayment after you meet your calendar year deductible</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copayment.</p> |

Covered medications and supplies – continued on next page.

| Covered medications and supplies <i>(continued)</i> | You pay |
|--|---|
| <p>The Plan covers the special medical formulas and food products limited to those listed below. Preauthorization is required.</p> <ul style="list-style-type: none"> • 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. • Enteral formulas for home use for which a physician has issued a written order and which are necessary for the treatment of malabsorption caused by Crohn’s disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids. • Food products modified to be low in protein for individuals that have been diagnosed with phenylketonuria and other inherited diseases of amino acids and organic acids. Coverage is provided for up to \$2,500 per calendar year. You may be required to purchase these products over-the-counter and submit claims to the Plan for reimbursement. | <p>Nothing after you meet your calendar year deductible</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs for appetite suppression</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines, over-the-counter preparations, devices and medical supplies such as antiseptics</i> • <i>Drugs that are investigational or that have not been approved for general sale and distribution by the U.S. Food and Drug Administration</i> • <i>Nicotine patches and gum or other smoking cessation products, unless supplied to you as part of an approved smoking cessation program</i> | <p><i>All charges.</i></p> |

Section 5(g) Special features

| Feature | Description |
|--|---|
| <p>Flexible benefits option</p> | <p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. |
| <p>Out-of-area student coverage</p> | <p>Students attending school outside the Plan service area may not have easy access to a Plan provider. They are covered for a limited number of services while out-of-area, if authorized in advance by the Plan.</p> <p>With the exception of emergency care, all out-of-area student services must be preauthorized by the plan. This includes post-stabilization care or follow-up care needed as a result of an emergency.</p> <p>Services that are covered for students while out of the Plan service area include:</p> <ul style="list-style-type: none"> • Non-routine medical office visits • Diagnostic lab and X-ray connected with a non-routine office visit • 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 • Outpatient services to diagnose and/or treat mental conditions • Short-term rehabilitation services, including physical, occupational and speech therapy. Coverage for physical and occupational therapy is provided for up to 60 consecutive days or 20 nonconsecutive visits (whichever is greater) per illness or injury in each calendar year (combined with any in-area visits). Coverage for speech therapy is determined by medical necessity. <p><i>Aside from emergency care, the services listed above are the only services that are covered for students on an out-of-network basis. To be covered, all other services must be obtained when they return to the Plan service area.</i></p> <p>Services that are not covered for students while out of the Plan service area include:</p> <ul style="list-style-type: none"> • Routine physical, gynecological exams, vision screening and hearing screening • Routine preventive care • Non-emergency prescription medication. You may use the prescription medication mail-order program to fill medication refills. (See pages 91-93.) • Second opinion • Preventive dental care or minor restorative care (e.g., fillings) • Chiropractic care services • Home health care • Outpatient surgical procedures that could be delayed until return to the Plan service area • Maternity care or delivery • Durable medical equipment (e.g., wheelchairs), including maintenance or replacement |

| | |
|---|---|
| Services for deaf and hearing impaired | <p>You may access our TDD/TTY equipment at 877-608-7677.</p> |
| Clinical trials | <p>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.</p> |
| Interpreter services | <p>The Plan will, upon request, provide members with interpreter and translation services related to our administrative procedures.</p> |
| Peace of Mind Program™ | <p>Our <i>Peace of Mind Program™</i> provides access to specialty services at specified Boston area medical centers. You may access <i>Peace of Mind Program™</i> providers at your request if you meet the following conditions:</p> <ul style="list-style-type: none"> • Care is for covered services as described in this brochure. The same copayments, calendar year deductibles and benefit limits apply. • You have seen a Plan specialist for this condition within the past three months. • A referral to a specific <i>Peace of Mind Program™</i> physician is made by your primary care provider and notification is given to the Plan that you are accessing that specialist through the <i>Peace of Mind Program™</i>. • The specialist to whom you are referred is on staff at one of the five medical centers listed below: <ul style="list-style-type: none"> – Massachusetts General Hospital – Brigham and Women’s Hospital – Children’s Hospital (Boston) – Dana-Farber Cancer Institute – 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. If you see a provider through the <i>Peace of Mind Program™</i> and that provider recommends or arranges services to be performed at a hospital that is not listed above, these services will not be covered unless the provider has obtained preauthorization from the Plan. You must have a copy of the authorization from the Plan; do not rely on assurances by the <i>Peace of Mind Program™</i> provider regarding your coverage. <p>Once the Plan has been notified of the <i>Peace of Mind Program™</i> referral, you may arrange an appointment to see this specialist for a consultation. You may continue treatment with this specialist or you may return to a Plan provider for care at any time, so long as you obtain appropriate preauthorization. If you wish to see any other <i>Peace of Mind Program™</i> provider, you must get a new referral from your primary care physician, the Plan must be notified of your request, and the request must meet the conditions listed above.</p> <p>You may use the <i>Peace of Mind Program™</i> for all specialty care except mental health, substance abuse, chiropractic services, obstetrics or dental care. You may not use the <i>Peace of Mind Program™</i> for any primary care services, including internal medicine, family practice or pediatrics. If you have not met the conditions listed above, the services will not be covered by the Plan, and the <i>Peace of Mind Program™</i> provider may hold you financially responsible.</p> |

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- The calendar year deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family calendar year deductible can be satisfied by one or more family members. The calendar year deductible applies to all benefits in this Section.
- After you have satisfied your calendar year deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for copayments for eligible medical expenses and prescriptions.
- 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.
- When you enroll in this Plan we establish either an HSA or an HRA for you based on your eligibility. See Section 6(a) *Health Savings Accounts* and Section 6(b) *Health Reimbursement Accounts* for important information about these accounts.

| Accidental injury benefit | You pay |
|--|---|
| <p>The Plan covers emergency medical care, such as to relieve pain and stop bleeding as a result of an accidental injury to sound natural teeth or tissues, when provided as soon as medically possible in the office of a physician or dentist. You do not need a referral or preauthorization for emergency care needed as a result of dental trauma. Go to the closest provider.</p> <p>Note: This accidental injury benefit does not include restorative or other dental services.</p> | <p>\$20 copayment per office visit after you meet your calendar year deductible</p> |
| Out-of-area dental care | |
| <p>While you are out of the Plan service area, we will cover some limited</p> | <p>\$10 per office visit after you meet your calendar</p> |

Dental benefits

The Plan covers 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 800-868-5200 and we will help you find a Plan dentist.

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

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

Dental benefits - continued on next page.

Dental benefits *(continued)*

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

| Dental benefits | You pay |
|---|---------------------|
| Diagnostic (exams) | |
| 121 Periodic oral examination | \$10 |
| 141 Limited oral evaluation (problem focused) | \$10 |
| 151 Comprehensive oral evaluation | \$10 |
| 170 Reevaluation limited (problem focused) | \$10 |
| 221 Intraoral: (periapical, first film) | \$10 |
| 231 Intraoral: (periapical, each additional film) | \$10 |
| 241 Intraoral: (occlusal film) | \$10 |
| 270 Bitewing (single film) | \$10 |
| 273 Bitewings (two films) | \$10 |
| 274 Bitewings (four films) | \$10 |
| 461 Pulp vitality tests | \$10 |
| 470 Diagnostic casts | \$10 |
| Preventive (cleanings) | |
| 1111 Prophylaxis (adult, every six months) | \$10 |
| 1121 Prophylaxis (child, every six months) | \$10 |
| 1202 Topical application fluoride (includes prophylaxis–under age 14) | \$10 |
| 1203 Topical application fluoride (excludes prophylaxis–under age 14) | \$10 |
| 1206 Topical application fluoride (includes prophylaxis–age 14 and over) | \$10 |
| Minor restorative (fillings) | |
| 2111 Amalgam (one surface, primary) | \$16 |
| 2121 Amalgam (two surfaces, primary) | \$22 |
| 2132 Amalgam (three surfaces, primary) | \$26 |
| 2133 Amalgam (four or more surfaces, primary) | \$34 |
| 2141 Amalgam (one surface, permanent) | \$18 |
| 2151 Amalgam (two surfaces, permanent) | \$24 |
| 2160 Amalgam (three surfaces, permanent) | \$26 |
| 2161 Amalgam (four or more surfaces, permanent) | \$34 |
| 2330 Resin (one surface, anterior) | \$23 |
| 2331 Resin (two surfaces, anterior) | \$26 |
| 2332 Resin (three surfaces, anterior) | \$34 |
| 2335 Resin (four or more surfaces, or involving incisal angle – anterior) | \$40 |
| 2383 Resin (one surface, posterior primary) | \$22 |
| 2384 Resin (two surfaces, posterior primary) | \$31 |
| 2385 Resin (three or more surfaces, posterior primary) | \$38 |
| 2385 Resin (one surface, posterior permanent) | \$23 |
| 2386 Resin (two surfaces, posterior permanent) | \$30 |
| 2387 Resin (three surfaces, posterior permanent) | \$42 |
| 2388 Resin (four or more surfaces, posterior permanent) | \$49 |
| <i>Not covered: Procedures not shown are not covered.</i> | <i>All charges.</i> |

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

| Special features | Description |
|------------------------------------|--|
| Health education resources | <p>Visit our Web site at www.fchp.org for:</p> <ul style="list-style-type: none"> • <u>Healthwise® Knowledgebase</u>: 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. • <u>Preventive Healthcare Guidelines</u>: access preventive health care guidelines and perinatal recommendations from the Massachusetts Health Quality Partners and the Massachusetts Department of Public Health’s guidelines for adult diabetes care. • <u>Leapfrog Group</u>: 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. • <u>Healthy Communities</u>: 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. |
| Account management tools | <p>If you have an HSA,</p> <ul style="list-style-type: none"> • You will receive a monthly statement from Sovereign Bank, outlining your account balance and activity for the month. This statement will be either paper or electronic – it’s your choice. • You may access your account toll-free at 1-877-HSA, Monday through Friday from 8 a.m. to 8 p.m. Eastern, or online at www.sovereignhsa/fchp. <p>If you have an HRA,</p> <ul style="list-style-type: none"> • Your HRA balance will be available toll-free at 1-877-924-3967, Monday through Friday from 8 a.m. to 8 p.m. Eastern, or online at www.wageworks.com. • Your deductible balance will also be shown on your Explanation of Benefits (EOB) form. |
| Consumer choice information | <p>As a member of this HDHP, you may choose any provider in our network. A directory is available online by going to www.fchp.org.</p> <p>Pricing information for typical medical care is available at www.fchp.org.</p> <p>Educational materials on the topics of HSAs, HRAs and HDHPs are available at http://www.opm.gov/hsa and www.fchp.org.</p> |
| Care support | <p>Patient safety</p> <p><i>Leapfrog Group</i></p> <p>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.</p> <p>We also report the following progress with our outpatient safety programs:</p> <p><i>Web-based Health Education Program</i></p> <p>FCHP is currently working with a pharmaceutical vendor to implement a Web-based education program of disease management modules, as well as modules in wellness, women's health, and health screening.</p> |

Health education resources and account management tools – continued on next page.

| Special features | Description |
|------------------|---|
| | <p><i>Public Report Card on Quality</i></p> <p>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.</p> <p><i>Advancing Better Care (ABC) Project</i></p> <p>Because FCHP understands that being healthy improves quality of life, we participate in a collaborative project with the Alliance of Community Health Plans (ACHP) that focuses on engaging and activating patients to become more involved in their care. This project proposes to develop a member education and awareness campaign about the quality measures that Massachusetts Health Quality Partners released in 2004.</p> <p>Care Management</p> <p>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.</p> <p>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, and Diabetes.</p> <p>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 the you. Care Managers may also refer you to local support groups, classes and rehabilitation programs.</p> <p>For 2005 and 2006, FCHP be expanding our Care Services Program and adding a new High-Risk Pregnancy program and Depression Care Services program.</p> |

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.

Discounted dental services

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

Eyewear discounts

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

It Fits!

With *It Fits!*, Plan members can get reimbursed up to \$400 per family (\$200 per individual) for membership at their local fitness center, in Weight Watchers[®], or both, and aerobics, Pilates and yoga (when taught by a certified instructor). 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 800-868-5200 (TDD/TTY: 877-608-7677).

Medicare prepaid Plan enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on pages 105-106, 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 through *Every Day Health*

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

We do not cover the following:

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

Section 7 Filing a claim for covered services

When you see Plan 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 HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call Customer Service at 800-868-5200 (TDD/TTY: 877-608-7677).

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

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

Submit your claims to: Fallon Community Health Plan
Claims Department
P. O. Box 15121
Worcester, MA 01615-0121

Deadline for filing your claim

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

When we need more information

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

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval. Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

| Step | Description |
|----------|---|
| 1 | <p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Fallon Community Health Plan, Consumer Affairs Department, 10 Chestnut St., Worcester, MA 01608, or fax it to us at: 508-755-7393; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
| 2 | <p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3. |
| 3 | <p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p> |
| 4 | <p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> |

The disputed claims process (*continued*)

Send OPM the following information:

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

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

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

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

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

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

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

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

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

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

Section 9 Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the 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 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

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

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

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

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

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

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

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

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

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

- **Medicare Advantage (Part C)**

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

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

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

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

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

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

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

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10 Definitions of terms we use in this brochure

| | |
|---|---|
| Calendar year | January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year. |
| Copayment | A copayment is a fixed amount of money you pay when you receive covered services. See page 18. |
| 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. |
| Calendar year deductible | A calendar year 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 services | 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. |
| 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. |
| Us/we | Us and we refer to Fallon Community Health Plan (FCHP). |
| You | You refers to the enrollee and each covered family member. |

High Deductible Health Plan (HDHP) Definitions

Health Reimbursement Arrangement (HRA)

An account consisting of funds set aside by your employer to reimburse you for employer-selected qualified medical expenses.

Health Savings Account (HSA)

An investment account or retirement account from which you can withdraw money tax-free for qualified medical expenses. Otherwise the money accumulates with tax-free interest until retirement, when you can withdraw for any purpose and pay normal income taxes. These accounts are owned by the employee and are portable.

Preventive care

Services, tests and immunizations that are intended to screen for diseases or conditions and to improve early detection of disease when there is no diagnosis or symptoms.

Routine physical exam/ health maintenance visit

FCHP follows the Massachusetts Health Quality Partners (MHQP) recommended guidelines for pediatric and adult health maintenance visits. You can see them on our Web site (www.fchp.org) by clicking on "Members," then "Resources" and then "Preventive Health Care Guidelines."

For adults, this refers to annual physical exams with your primary care physician (internist, family practitioner or pediatrician) and gynecologist.

For children, the following chart represents MHQP's recommended guidelines. As always though, please be sure to consult with your child's primary care physician if you have questions about his or her health care.

| Age | Frequency |
|----------------------|--|
| Newborn to 12 months | Age 1 to 2 weeks, and 1, 2, 4, 6, 9 and 12 months. Breastfeeding check between the ages of 3 days and 2 weeks. |
| Age 1 to 4 years | Ages 15, 18, 24 months, and 3 and 4 years |
| Age 5 to 18 years | Annually |

Section 11 FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

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

Information on the FEHB Program and plans available to you

- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems
- Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:
 - When you may change your enrollment;
 - How you can cover your family members;
 - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
 - When your enrollment ends; and
 - When the next open season for enrollment begins.

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

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

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

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

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

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

- **Children’s Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2006 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan’s 2005 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

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

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

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

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

Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);

You decided not to receive coverage under TCC or the spouse equity law; or

You are not eligible for coverage under TCC or the spouse equity law.

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

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

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

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

Section 12 Two Federal Programs complement FEHB benefits

Important information

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.

Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.

The maximum annual amount that can be allotted for the HCFSA is \$5,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.

Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return and who is mentally or physically incapable of self care.

The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year.

Enroll during Open Season

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

- Online: visit www.fsafeds.com and click on Enroll.

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

What is SHPS?

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

Who is eligible to enroll?

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

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

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

• How much should I contribute to my FSA?

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

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

• What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as calendar year deductibles you must meet before the Plan provides benefits or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 18 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

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

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

Under the High Deductible Health Plan, typical out-of-pocket expenses include: calendar year deductible, office visit and prescription copayments; hearing aids; eyeglasses; and orthodontia.

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

• Tax savings with an FSA

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would

do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

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

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

- **Tax credits and deductions**

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

- **Health care expenses**

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

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

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

- **Dependent care expenses**

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

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

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

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

- **Contact us**

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

E-mail: FSAFEDS@shps.net

Telephone: 1-877-FSAFEDS (1-877-372-3337)

TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **It's important protection**

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

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

To request an Information Kit and application

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

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

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Summary of benefits for the High Option of Fallon Community Health Plan - 2006

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

| High Option Benefits | You pay | Page |
|--|---|------|
| Medical services provided by physicians: | | |
| • 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 | \$15 copayment per office visit with your primary care physician or obstetrician or gynecologist \$25 copayment per office visit with a specialist | 23 |
| Services provided by a hospital: | | |
| • Inpatient | \$250 copayment per admission until you meet your annual copayment maximum | 41 |
| • Outpatient | \$50 copayment per surgery until you meet your annual copayment maximum | 42 |
| Emergency benefits: | | |
| • Emergency room | \$50 copayment per emergency room visit | 44 |
| • Doctor's office or urgent care facility | \$15 copayment per urgent care visit | 45 |
| Mental health and substance abuse treatment: | | |
| | Regular cost sharing | 46 |
| Prescription drugs: | | |
| Retail pharmacy | Tier 1, 2 and 3: up to a 30-day supply \$5/\$25/\$50 copayment | 49 |
| Mail order | Tier 1, 2, and 3: up to a 90-day supply \$10/\$50/\$150 copayment | 49 |
| Dental care | | |
| | \$10 per office visit for preventive care; copayments vary from \$16 to \$49 for minor restorative care | 54 |
| Vision care: | | |

| | | |
|--|--|------------------|
| <ul style="list-style-type: none"> • Diagnosis and treatment of disease of the eye | \$15 copayment per office visit with your primary care physician \$25 copayment per office visit with a specialist | 31 |
| <ul style="list-style-type: none"> • Annual eye exam | \$15 copayment | 31 |
| Special features: | Flexible benefits option Out-of-area student benefits Clinical trials Services for the hearing impaired Interpreter services Peace of Mind Program™ | 51 52 |
| Protection against catastrophic costs (Your catastrophic protection out-of-pocket maximum) | We do not have a catastrophic out-of-pocket maximum. | 19 |

Summary of benefits for the Standard Option of Fallon Community Health Plan - 2006

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

| Standard 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* | \$20 copayment per office visit to a physician or other health care professional. Services provided to you during the office visit, such as diagnostic tests and medical or surgical procedures, are subject to your calendar year deductible. | 23 |
| Services provided by a hospital: | | |
| • Inpatient* | Nothing after you meet your calendar year deductible | 41 |
| • Outpatient* | Nothing after you meet your calendar year deductible | 42 |
| Emergency benefits: | | |
| • Emergency room | \$75 copayment per emergency room visit | 44 |
| • Doctor's office or urgent care facility* | \$20 copayment per urgent care visit | 45 |
| Mental health and substance abuse treatment: | Regular cost sharing | 46 |
| Prescription drugs: | | |
| Retail pharmacy | Tier 1, 2 and 3: up to a 30-day supply \$10/\$30/\$60 copayment | 49 |
| Mail order | Tier 1, 2, and 3: up to a 90-day supply \$20/\$60/\$180 copayment | 49 |
| Dental care | \$10 per office visit for preventive care; copayments vary from \$16 to \$49 for minor restorative care | 54 |

| | | |
|--|--|----|
| Vision care: | | |
| • Diagnosis and treatment of disease of the eye* | \$20 copayment per office visit with a specialist | 31 |
| • Annual eye exam | \$20 copayment | 31 |
| Special features: | Flexible benefits option | 51 |
| | Out-of-area student benefits | |
| | Clinical trials | 52 |
| | Services for the hearing impaired | |
| | Interpreter services | |
| | Peace of Mind Program™ | |
| Protection against catastrophic costs (Your catastrophic protection out-of-pocket maximum) | We do not have a catastrophic out-of-pocket maximum. | 19 |

Summary of benefits for the HDHP of Fallon Community Health Plan - 2006

- **Do not rely on this chart alone.** All benefits 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.
- In 2006 for each month you are eligible for the HSA, we will deposit \$62.50 per month for Self Only enrollment or \$125.00 per month for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), you must satisfy your calendar year deductible of \$1,500 for Self Only and \$3,000 for Self and Family before using your HSA. Once you satisfy your calendar year deductible, Traditional medical coverage begins.
- For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of \$750 for Self Only and \$1,500 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.
- Below, an asterisk (*) means the item is subject to the calendar year deductible.

| Benefits | You pay | Page |
|--|--|------|
| Medical services provided by physicians: | | |
| Routine physical examinations and related services with your PCP | Nothing | 67 |
| Preventive care for children to age 22 | Nothing | 68 |
| Diagnostic and treatment services provided in the office | \$20 copayment per office visit | 71 |
| Services provided by a hospital: | | |
| Inpatient* | Nothing | 84 |
| Outpatient* | Nothing | 85 |
| Emergency benefits: | | |
| Emergency room* | \$75 copayment per visit | 88 |
| Doctor's office or urgent care facility* | \$20 copayment per visit | 88 |
| Mental health and substance abuse treatment: | | |
| | Regular cost sharing | 89 |
| Prescription drugs: | | |
| Retail pharmacy | Tier 1, 2 and 3: up to a 30-day supply \$10/\$25/\$50 copayment | 92 |
| Mail order | Tier 1, 2 and 3: up to a 90-day supply \$20/\$50/\$150 copayment | 92 |
| Dental care: | | |
| | \$10 per office visit for preventive care; copayments vary from \$16 to \$49 for minor restorative care | 96 |
| Vision care: | | |
| | | 76 |

| | | |
|--|--|--------------|
| Diagnosis and treatment of diseases or injuries to the eye* | Nothing for treatment of diseases or injuries to the eye \$20 copayment per associated office visit | 76 |
| Annual eye exam | \$20 copayment per office visit (No deductible) | 76 |
| Special features: | Flexible benefits option Out-of-area student benefits Clinical trials Services for the hearing impaired Interpreter services Peace of Mind Program™ | 94 95 |
| Protection against catastrophic costs (Your catastrophic protection out-of-pocket maximum) | After your copayments and calendar year deductibles total \$3,000 for Self Only enrollment or \$6,000 for Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. | 19 |

2006 Rate Information for Fallon Community Health Plan

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

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

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

| Type | Enrollment Code | <i>Non-Postal</i> Government | <i>Non-Postal</i> <u>Premium</u> <u>Biweekly</u> Your Share | <i>Non-Postal</i> Government | <i>Non-Postal</i> <u>Premium</u> <u>Monthly</u> Your Share | <i>Postal</i> <u>Premium</u> <u>Biweekly</u> USPS Share | <i>Postal</i> <u>Premium</u> <u>Biweekly</u> Your Share |
|-------------|-----------------|---------------------------------|--|---------------------------------|---|--|--|
| High Option | JV1 | \$139.18 | \$67.17 | \$301.56 | \$145.53 | \$164.31 | \$42.04 |
| High Option | JV2 | \$316.08 | \$185.43 | \$684.84 | \$401.77 | \$373.15 | \$128.36 |
| Standard | JV4 | \$139.18 | \$47.22 | \$301.56 | \$102.31 | \$164.31 | \$22.09 |
| Standard | JV5 | \$316.08 | \$136.95 | \$684.84 | \$296.73 | \$373.15 | \$79.88 |
| HDHP | DV1 | \$139.18 | \$49.29 | \$301.56 | \$106.79 | \$164.31 | \$24.16 |
| HDHP | DV2 | \$316.08 | \$129.05 | \$684.84 | \$279.61 | \$373.15 | \$71.98 |