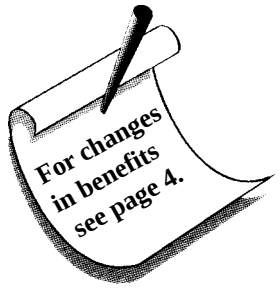
FALLON COMMUNITY HEALTH PLAN 2000

A Health Maintenance Organization



Serving: Central and Eastern Massachusetts

Enrollment in this Plan is limited; see page 21 for requirements.

Enrollment Code:

JV1 Self only
JV2 Self and family

This plan has been rated "excellent" by the NCQA. See the *2000 Guide* for more information on NCQA.

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's website at http://www.fchp.org

Authorized for distribution by the:

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Introduction

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

This brochure describes the benefits you can receive from Fallon Community Health Plan under its contract (CS 1917) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 4. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Fallon Community Health Plan as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Health Maintenance Organizations (HMO). This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.
2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.
3. How to get benefits. Make sure you read this section; it tells you how to get services and how we operate.
4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. General exclusions — Things we don't cover. Look here to see benefits that we will not provide.
7. Limitations — Rules that affect your benefits. This section describes limits that can affect your benefits.
8. FEHB facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services, 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. (See Section 3, How to get benefits, for more information).

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

Your share of the premium will increase by 9.2% for Self Only or 9.1% for Self and Family.

The copayment for prescription drugs has changed from $5 per prescription unit or refill for generic and name brand drugs to $5 for generic and $10 for name brand for up to a 30-day supply. For the Mail Order Program the copay has changed from $3 for generic and name brand to $3 for generic and $8 for name brand for up to a 30-day supply.

Scalp hair prosthesis (wigs) are covered for individuals who have suffered hair loss as the result of any treatment for cancer or leukemia. Coverage is provided for up to $350 per member per calendar year when determined to be medically necessary by a Plan doctor and the Plan.

Hospice care is covered in full for the first five days in a hospice facility and you must pay all charges thereafter. Hospice home visits are covered with a $5 copay per visit.

The office visit copay has increased from $5 to $10 per visit.

Section 3. How to get benefits

What is this Plan's service area?

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is the following Massachusetts counties: all of Worcester, Middlesex, Norfolk and Suffolk, as well as parts of Bristol, Essex, Franklin, Hampshire, Hampden and Plymouth. This includes the following towns in Massachusetts:

Abington
Acton
Andover
Arlington
Ashburnham
Ashby
Ashland
Athol
Attleboro
Auburn
Avon
Ayer
Barre
Bedford
Bellingham
Belmont
Berkley
Berlin
Beverly
Billerica
Blackstone
Bolton
Boston
Boxboro
Boxford
Boylston
Braintree
Bridgewater
Brimfield
Brockton
Brookfield
Brookline
Burlington
Cambridge
Canton
Carlisle
Charlton
Chelmsford
Chelsea
Clinton
Cohasset
Concord
Danvers
Dedham
Dighton
Douglas
Dover
Dracut
Dudley
Dunstable
Duxbury
East Bridgewater
East Brookfield
East Walpole
Easton
Essex
Everett
Fall River
Fitchburg
Foxborough
Framingham
Franklin
Freetown
Gardner
Georgetown
Gloucester
Grafton
Groton
Halifax
Hamilton
Hanover
Hanscom AFB
Hanson
Hardwick
Harvard
Hathorne
Haverhill
Hingham
Holbrook
Holden
Holland
Holliston
Hopedale
Hopkinton
Hubbardston
Hudson
Hull
Ipswich
Kingston
Lakeville
Lancaster
Lawrence
Leicester
Leominster
Lexington
Lincoln
Littleton
Lowell
Lunenburg
Lynn
Lynnfield
Malden
Manchester
Mansfield
Marblehead
Marlborough
Marshfield
Maynard
Medfield
Medford
Medway
Melrose
Mendon
Methuen
Middleboro
Middleton
Milford
Millbury
Millis
Millville
Milton
Monson
Nahant
Natick
Needham
New Braintree
Newton
Norfolk
North Andover
North Attleboro
North Billerica
North Brookfield
North Chelmsford
North Reading
Northborough
Northbridge
Norton
Norwell
Norwood
Oakham
Oxford
Palmer
Paxton
Peabody
Pembroke
Pepperell
Petersham
Phillipston
Pinehurst
Plainville
Plympton
Princeton
Quincy
Randolph
Raynham
Reading
Rehoboth
Revere
Rockland
Rockport
Rowley
Royalston
Rutland
Salem
Saugus
Scituate
Seekonk
Sharon
Sherborn
Shirley
Shrewsbury
Stoughton
Somerset
Somerville
South Hamilton
South Walpole
Southborough
Southbridge
Spencer
Sterling
Stoneham
Stow
Sturbridge
Sudbury
Sutton
Swampscott
Swansea
Taunton
Templeton
Tewksbury
Topsfield
Townsend
Tyngsboro
Upton
Uxbridge
Village of Nagog Woods
Wales
Wakefield
Walpole
Waltham
Ware
Warren
Watertown
Waverly
Wayland
Webster
Wellesley
Wenham
West Boylston
West Boxford
West Bridgewater
West Brookfield
Westborough
Westford
Westminster
Weston
Westwood
Weymouth
Whitman
Wilmington
Winchendon
Winchester
Winthrop
Woburn
Worcester
Wrentham

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. For information on this Plan's coverage for students who are outside the Fallon service area, please see page 16. Due to reciprocal arrangements, many health maintenance organizations (HMOs) provide arrangements for emergency and urgent care to Fallon members who are outside the Fallon service area. You may call 1-800-223-0654 for the name and location of the closest HMO in the area. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services, except for laboratory and X-ray services.

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care?

The Fallon Community Health Plan is a mixed model prepayment plan that offers three provider options from which to choose. The Fallon Plus option offers a choice of over 252 physicians practicing in multi-specialty medical centers throughout Central Massachusetts. The UMass Group Practice option offers a choice of nearly 350 physicians based primarily at the UMass Medical Center, a state-of-the-art teaching hospital. The Fallon Affiliates option offers a network of over 2,502 independent practitioners practicing in offices throughout Central and Eastern Massachusetts.

You are asked to select a provider option for each member of your family at the time of enrollment. However, you may switch from the Fallon Plus to Fallon Affiliates option and vice versa at any time of the year; the change will become effective on the first of the month following the Plan's receipt of notification. Changes in or out of the UMass Group Practice option can only be made on your anniversary date.

Each member of a family may choose a different doctor from separate provider options. A member's personal doctor provides routine and emergency care and arranges for specialty care as needed.

The Plan provides coverage for urgent and emergency care around the world. Within the Plan's service area, you must call your doctor for directions before seeking care. Of course, if the emergency is life threatening, go to the nearest emergency room. Outside of the service area, you are covered for emergency services obtained at any medical facility, but should call for authorization before seeking follow-up care.

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at 800/868-5200. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist with the following exceptions: annual eye examinations, mental health and substance abuse services, or a woman may see her Plan gynecologist for her annual routine examination without a referral from her primary care doctor.

If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan and will obtain Plan authorization for the additional referrals.

What do I do if I am seeing a specialist when I enroll?

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

What do I do if my specialist leaves the Plan?

Call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

How do you decide if a service is experimental or investigational?

The Plan's Benefits & Technology Assessment Committee determines what procedures, devices and services are experimental/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 over currently accepted procedures, devices or services.

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us at 800/868-5200 and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefit Contract Division IV at (202) 606-0737 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

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

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

What address should I send my disputed claim to?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contract Division IV, P.O. Box 436, Washington, D.C. 20044.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; you pay a $10 office visit copay, but no additional copay for laboratory tests and X-rays. Within the service area, house calls will be provided if in the judgment of the Plan doctor, such care is necessary and appropriate. You pay nothing for a doctor's house call and for home visits by nurses and health aides.

The following services are included:

- Preventive care, including well-baby care and periodic checkups
- Baseline mammogram for women age 35-40; annual mammogram for women age 40 and older
- Routine immunizations and boosters; no copay required
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor or certified nurse midwife. You pay a $10 office visit copayment for the first office visit, all remaining prenatal office visits are covered in full.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum); allergy injections do not require a copay
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, kidney and liver transplants; heart-lung transplants for patients under age 60 with end-stage primary or secondary pulmonary hypertension; lung (single or double) transplants for patients under age 60 with end-stage obstructive or restrictive pulmonary disease; allogeneic (donor) bone marrow transplants; 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, advanced non-Hodgkin's lymphoma; advanced neuroblastoma; testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; breast cancer; multiple myeloma; and epithelial ovarian cancer. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan. Services must be provided at a Plan-affiliated transplant facility, subject to the member's acceptance into the facility's program. The transplant facility makes the final determination on eligibility for transplant coverage.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Chemotherapy
- Radiation therapy, and inhalation therapy; no copay required
- Surgical treatment of morbid obesity
- Home health services of nurses and health aides, including intravenous fluids and medications

when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need

- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers.
- Outpatient dialysis at a Plan designated center or Continuous Ambulatory Peritoneal Dialysis (CAPD); no copay required
- Cardiac rehabilitation
- Diagnosis and treatment of infertility is covered. Artificial insemination is covered, including intravaginal insemination (IVI); intracervical insemination (ICI); and intrauterine insemination (IUI). Other assisted reproductive technologies (ART) including gamete intrafallopian transfer, intracytoplasmic sperm injection, zygote intrafallopian transfer, and in vitro fertilization are covered. Donor sperm for male factor infertility is covered. Fertility drugs are covered under Prescription Drug Benefits. To qualify for coverage the member must be diagnosed as being infertile by a Plan Fertility Specialist and coverage will be provided as defined under Massachusetts law.
- Food products which have been modified to be low in protein for individuals diagnosed with phenylketonuria. Coverage provided up to $2,500 in each calendar year.
- Medication visits to monitor, evaluate or adjust the prescription medication dosage that is being prescribed for a medical or psychological condition.

Limited benefits

Oral and maxillofacial surgery is provided for non-dental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, removal of impacted teeth, biopsy of oral lesions, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery and for removal of breast implants due to complications of non-cosmetic surgery or autoimmune disease. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient basis for up to two months per condition if significant improvement can be expected within two months. Outpatient short-term rehabilitative therapy (physical, speech and occupational) is provided for up to 20 nonconsecutive visits (or 60 consecutive days, whichever is greater), per condition in a calendar year. You pay a $10 copay per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Orthopedic and prosthetic devices and durable medical equipment, such as braces, artificial limbs, breast prostheses and surgical bras, implanted lenses following cataract removal, wheelchairs and hospital beds, are provided up to a maximum benefit of $1,500 per member per calendar year.

Scalp hair prosthesis (wigs) are covered for members who have suffered hair loss as a result of any treatment for cancer or leukemia for up to a maximum Plan payment of $350 per member, per calendar year.

Chiropractic services are provided for the treatment of acute musculoskeletal conditions. The condition treated must be new or an exacerbation of a previous condition. Treatment must be provided by a participating chiropractor and requires a referral by a primary care doctor. Coverage is provided for up to 20 office visits. You pay a $10 copay for visits 1-10 and a $25 copay for visits 11-20.

Early intervention services for children up to age 3 years and 3 months for medically necessary physical, speech, and occupational therapy; nursing care; and psychological counseling is covered in full for up to a $3,200 maximum Plan payment per calendar year and a $9,600 maximum Plan payment per lifetime.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Hearing aids
- Orthopedic shoes or other support devices for the feet including foot orthotics
- Homemaker services
- Long-term rehabilitative therapy
- Transplants not listed as covered

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. You pay nothing. All necessary services are covered; including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Maternity and newborn care services. Covered services include but are not limited to: childbirth, nursery charges, routine examination, hearing screening and medically necessary treatments of congenital defects, birth abnormalities or premature birth. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a Cesarean delivery. Inpatient stays will be extended if medically necessary. However, we may pay for a shorter stay if your attending provider, after consulting with you, discharges you or your newborn earlier. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Specialized care units, such as intensive care or cardiac care units
- Blood and blood derivatives

Extended care

The Plan provides a comprehensive range of benefits for 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. You pay nothing. All necessary services are covered, including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certified that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. Short-term inpatient care is provided for up to 5 days of continuous inpatient care.

You pay nothing for the first 5 days in a hospice facility — all charges thereafter.

You pay a $10 copay per home visit.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 13 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television;
- Custodial care, rest cures, domiciliary or convalescent care

Emergency Benefits

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 the Plan may determine are medical emergencies-what they all have in common is the need for quick action.

Emergencies within the service area

If you are in an emergency situation, please call your personal doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the police department or fire department) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 24 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified in a timely manner.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in a non-Plan facility and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

Any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays...

All charges for emergency services rendered in an emergency room or in a doctor's office to the extent the services would have been covered if received from Plan providers.

You pay...

$25 per hospital emergency room visit, (waived if admitted) or $5 per Fallon urgent care visit.

Emergencies outside the service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays...

All charges for emergency care services rendered in an emergency room or in a doctor's office to the extent the services would have been covered if received from Plan providers.

You pay...

$25 copayment per hospital emergency room visit; (waived if admitted).

What is covered

- Emergency care at a doctor's office;
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan

What is not covered

- Elective care or non-emergency care;
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 7.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, this Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to 25 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; you pay a $10 per visit copay for each covered visit-all charges thereafter.

Inpatient care

This Plan provides an unlimited number of days in a general hospital and up to 60 days in a psychiatric hospital in each calendar year; you pay nothing for first 60 days in a psychiatric hospital-all charges thereafter. Services in a day-treatment setting may be provided in place of one inpatient day when you agree to the substitution. Day-treatment is defined as intensive, structured treatment for a minimum of 3 hours a day, three times a week with no overnight stay.

What is not covered

- Care for psychiatric conditions which in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addition, the same as for any other illness or condition.

Outpatient care

All necessary outpatient visits to Plan providers for treatment provided; you pay a $10 copay for each visit.

Inpatient care

All necessary inpatient substance abuse rehabilitation programs in an alcohol detoxification or rehabilitation center approved by the Plan are covered; you pay nothing. Rehabilitation services in a day-treatment setting may be provided in place of one inpatient day when you agree to the substitution. Day-treatment is defined as intensive, structured treatment for a minimum of 3 hours a day, three times a week.

What is not covered

- Treatment not authorized by a Plan doctor

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor on an authorized visit and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply; you pay a $5 copay for generic or a $10 copay for name brand per prescription unit or refill. If the price of the prescription is less than $5 the normal copay amount, your copay is the lower amount. You are entitled to a discount of $2 for each 30-day supply of covered prescription medication refill(s) obtained through the Fallon Clinic Pharmacy or affiliated pharmacy mail order program. Services are provided through the pharmacy network designated by your health care option. For additional information about this program you may call our Member Services Department at 1 (800) 868-5200.

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. The drug formulary is developed and maintained by the Fallon Drug Evaluation Committee under the direction of the Pharmacy and Therapeutics Committee. Non-formulary drugs will be covered when prescribed by a Plan doctor and approved by the Plan. It is the prescribing doctor's responsibility to obtain authorization for non-formulary drugs before they are dispensed.

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law
- Insulin
- Disposable needles and syringes needed for injecting covered prescribed medication, including insulin
- Allergy serum
- Oral contraceptive drugs
- Injectable contraceptive drugs (Depo Provera), you pay a $30 copay per 3 month supply when dispensed by a pharmacy. No copay applies if supplied by your physician.
- Devices used for contraception (intra-uterine device or diaphragm). This includes the fitting and provision of the device by a Plan physician. You pay nothing for the device and a $10 copay for the office visit.
- Blood glucose test strips, for insulin dependent diabetics
- Fertility drugs
- Emergency prescription medication (up to a 14-day supply) provided out of the service area as part of an approved emergency medical treatment.

Limited benefit

- Implanted time-release medication, such as Norplant. For Norplant, you pay a one-time copay of $400 per implantation procedure. For other internally implanted time-release medication, you pay $200 for implantation. There will be no refund of any portion of these copays if the implanted time-release medication is removed before the end of its expected life.
- Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased with or without a prescription
- Medical supplies such as dressings and antiseptics
- Diabetic supplies except for needles and syringes; and blood glucose test strips (for non-insulin dependent diabetics)
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Nicotine patches, gum or other smoking cessation products

Other Benefits

Dental Care

What is covered

Preventive dental care services are covered; services are available twice per calendar year; you pay a $10 copay for the office visit, and additional copayments for minor restorative care services as follows:

ADA Code	Description	Copayment
110	Initial oral examination	$10
120	Periodic oral examination	10
130	Emergency oral examination	10
140	Ltd oral evaluation — problem focused	10
150	Comprehensive oral evaluation	10
220	Intraoral-periapical-first film	10
230	Intraoral-periapical-each additional film	10
240	Intraoral-occlusal film	10
270	Bitewing-single film	10
272	Bitewings-two films	10
273	Bitewings-three films	10
274	Bitewings-four films	10
460	Pulp vitality tests	10
470	Diagnostic casts	10
Preventive (Cleanings)		
1110	Prophylaxis adult (every 6 months)	10
1120	Prophylaxis child (every 6 months)	10
1201	Top application fluoride includes prophylaxis- child <age 16	10
1203	Top application fluoride excludes prophylaxis- child <age 16	10
1205	Top application fluoride includes prophylaxis- adult - age 16 and over	10
1998	Bundled diagnostic & preventive services - Dependent child	10
1999	Bundled diagnostic & preventive services - Adult	10
Minor Restorative (Fillings)		
2110	Amalgam-one surface primary	12
2120	Amalgam-two surfaces primary	16
2130	Amalgam-three surfaces primary	20
2131	Amalgam-four or more surfaces, primary	25
2140	Amalgam-one surface permanent	14
2150	Amalgam-two surfaces permanent	18
2160	Amalgam-three surfaces permanent	20
2161	Amalgam-four or more surfaces permanent	25
2330	Resin-one surface anterior	17
2331	Resin-two surfaces anterior	20
2332	Resin-three surfaces anterior	25
2335	Resin > three surfaces or involving incisal angle - anterior	30

What is not covered

- Dental services not shown as covered

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, this Plan provides annual eye refractions, including written lens prescriptions for eyeglasses, from Plan providers. You pay a $10 copay per visit.

What is not covered

- Eye exercises
- Corrective glasses and frames or contact lenses
- Eye examinations for contact lenses (including the fitting of the lenses)

Out-of-Area Student Coverage

Students attending school outside the Plan service area are covered for additional benefits for services received out-of-area if authorized in advance by the Plan up to age 22 or marriage, whichever occurs first.

What is covered

- Outpatient services to treat the abuse of or addiction to alcohol or drugs are covered up to 20 office visits in each calendar year. You pay a $10 copay per visit.
- Non-elective inpatient services if the Plan is notified within 48 hours of admission. You pay nothing.
- Non-routine office visits. You pay a $10 copay per visit.
- Diagnostic lab and X-ray services connected with non-routine office visits. You pay nothing.
- Outpatient services to diagnose and/or treat mental conditions, covered up to 25 office visits in each calendar year (combined with any in-area visits). You pay $10 per visit.
- Short-term rehabilitation services, including physical, occupational, and speech therapy, covered up to 20 outpatient office visits in each calendar year (combined with any in-area visits). You pay a $10 copay per visit.

What is not covered

- Routine physicals, gynecological exams, vision screening and hearing screening
- Maternity care or delivery
- Outpatient surgical procedures that could have been delayed until return to the Plan service area
- Durable medical equipment (e.g., wheelchairs), including maintenance or replacement
- Preventive dental care
- Second opinion
- Home health care
- Non-emergency prescription drugs
- Routine preventive care

Weight Watchers® Program

What is covered

- One twelve consecutive week membership in each calendar year. You pay nothing.

What is not covered

- More than one membership per member in each calendar year
- Food products

Weight Watchers is a registered trademark of Weight Watchers International, Inc.

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract, with the FEHB Program, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; and any charges for these services do not count toward any FEHB deductibles, or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedures.

Dental services discounts - The Plan has arranged for discounts for non-covered dental services. If you would like a list of the services and the fee schedule, contact the Plan at 1-800-868-5200.

Peace Of Mind Program™ - If you are a Fallon Plus or Fallon Affiliates member and you want to receive care from a Boston-based physician rather than a Plan physician, you may do so under the Peace of Mind Program. The physician that you choose must be on staff at either Massachusetts General Hospital, Brigham and Women's Hospital, Children's Hospital (Boston), or Dana-Farber Cancer Institute.

Whenever you need specialty care, you must first obtain a referral from your personal physician to see a Plan specialist. If after seeing the Plan specialist you decide you want to see a physician at one of the above hospitals, you may elect to use the Peace of Mind Program. The referral must be arranged by either your Plan specialist or personal physician. You may see the Boston physician for a consultation and may continue on for treatment with that specialist, or you may return to your Fallon specialist for care.

You may elect to use Peace of Mind for all specialty care except psychiatry, substance abuse, optometry or chiropractic services. You may not use the Peace of Mind Program for any primary care including internal medicine, family practice, dental, pediatrics or routine obstetrics.

All care authorized under the Peace of Mind Program must be for covered services as described in this brochure.

Eyewear discounts - Fallon has arranged for a 25% discount on the first pair of eyeglass frames and prescription lenses purchased from participating Fallon optical providers. When you purchase multiple pairs of prescription eyeglasses at the same time, you receive a 35% discount on the additional pairs. In addition, you receive a 10% discount on all complete contact lens packages purchased at participating Fallon optical providers. This discount does not apply to individual lenses, the evaluation/fitting of contact lenses, or others items/services which are not specifically listed above.

Hearing aid discounts - The Plan has arranged for discounts of 20% to 30% off the regular price of hearing aids and assistive listening devices. Contact the Plan at 1-800-868-5200 for a complete list of providers.

Fitness center discounts - Members of the Plan are entitled to discounted memberships at several area health clubs. Discounts vary from club to club. For information on participating health clubs and the associated discounts, call the Fallon Customer Service Department at 1-800-868-5200.

Medicare prepaid plan enrollment - This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 18, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan 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 us at 1-800-868-5200 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800-868-5200 for information on the benefits available under the Medicare HMO.

Benefits on this page are not part of the FEHB contract.

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 or condition.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services ;
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and 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;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Limitations - Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 17.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be.

After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 800/868-5200, 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 website at www.fchp.org.

Where do I get information about enrolling in the FEHB Program?

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:

- 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
- The next Open Season for enrollment.

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.

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

What happens when I 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, which is described later in this section.

What types of coverage are available for me and my 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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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

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

Are my medical and claims records confidential?

We will keep your medical and claims information confidential. Only the following will have access to it:

OPM, this Plan, and subcontractors when they administer this contract,

This plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims,

- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions,
- OPM and the General Accounting Office when conducting audits,
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions under my old plan?

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

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get more information about your coverage choices.

What is TCC?

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 TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

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.

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

How can I get a Certificate of Group Health Plan 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. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Fallon Community Health Plan - 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS OR OTHER AUTHORIZED PROVIDERS (E.G., DENTISTS, PHYSICIAN ASSISTANTS OR NURSE PRACTITIONERS).

Benefits		Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services with no dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	11
	Extended care	All necessary services, for up to 100 days in a calendar year. **You pay** nothing	11
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for an unlimited number of days in a general hospital and up to 60 days of inpatient care in a psychiatric hospital per calendar year. **You pay** nothing	13
	Substance abuse	All necessary, Plan-approved substance abuse rehabilitation programs. **You pay** nothing	13
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic checkups and routine immunizations; limited chiropractic services; laboratory tests and X-rays; complete maternity care (first prenatal visit only). **You pay** a $10 copay per office visit; nothing per home visit	9
	Home health care	All necessary visits by nurses and health aides. **You pay** nothing	11
	Mental conditions	Up to 25 outpatient visits per year. **You pay** a $10 copay per visit	13
	Substance abuse	All necessary outpatient visits per year. **You pay** a $10 copay per visit	13
Emergency care		Actual charges for services and supplies required because of a medical emergency. **You pay** $25 copayment when services are received in a hospital emergency room.	12
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $5 copay (generic); $10 copay (name brand) per prescription unit or refill or the cost of the prescription, whichever is less. Emergency prescription medication provided out of area as part of an emergency medical treatment. **You pay** a $5 copay (generic); $10 copay (brand-name) per 14-day supply. Prescription medication obtained through the mail order program of your health care option. You receive a $2 discount off your regular copay per 30-day supply.	14
Dental care		Preventive dental care services (twice per calendar year) **you pay** a $10 copay per visit. Fillings; **you pay** a $12-30 copay per filling. Out-of-area emergency dental care services (loose filling, tooth ache) limited to $50 per incident; **you pay** $10 copay per visit.	15
Vision care		One visit for eye refractions annually. **You pay** a $10 copay per visit	16
Out-of-pocket maximum		Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments that are required for a few benefits.	

2000 Rate Information for Fallon Community Health Plan

Non-Postal rates apply to most non-Postal enrollees. 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 most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee, but not a member of a special postal employment class, refer to the category definitions in, "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2 to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans.

		Non-Postal Premium				**Postal Premium A**		**Postal Premium B**	
		Biweekly		**Monthly**		**Biweekly**		**Biweekly**	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Central / Eastern Massachusetts									
Self Only	JV1	$65.55	$21.85	$142.03	$47.34	$77.57	$9.83	$77.57	$9.83
Self and Family	JV2	$168.92	$56.31	$366.00	$122.00	$199.89	$25.34	$199.89	$25.34