FALLON COMMUNITY HEALTH PLAN

http://www.fchp.org

2003

A Health Maintenance Organization

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

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

This Plan has Excellent accreditation from the NCQA. See the 2003 Guide for more information on NCQA.

Enrollment codes for this Plan:

JV1 Self Only
JV2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

RI 73-090

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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Federal Employees
Health Benefits Program

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

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

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

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

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

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

- For Government healthcare 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 202-606-0191 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
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 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 will be effective April 14, 2003.

Table of Contents

Introduction

This brochure describes the benefits of Fallon Community Health Plan under our contract (CS 1917) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for Fallon Community Health Plan administrative offices is:

Fallon Community Health Plan
10 Chestnut St.
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, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

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

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 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 (FEHB) 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 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 provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) and explain the situation.
    - If we do not resolve the issue:

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

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

- 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 or with OPM if you are retired.
- 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.

Section 1. Facts about this HMO plan

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

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

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

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

How we pay providers

We contract with individual physicians, medical groups and hospitals to provide care to our members. We negotiate with providers to agree upon a contracted rate. The Plan pays its providers using various payment methods including capitation, per diem, incentive, and discounted fee-for-service arrangements. Capitation means paying a fixed dollar amount per month for each member assigned to the provider. Per diem means paying a fixed dollar amount per day for all services rendered. Incentive means a payment that is based on appropriate medical management by the provider. Discounted fee-for-service means paying the provider's usual, customary and regular fee discounted by a negotiated percentage. When you receive a covered service, the only payment that a provider will collect from you is the copayment amount shown in this brochure.

We cannot guarantee that any one physician, hospital or other provider will be available or remain under contract with us. We reserve the right at any time to end our contract with your primary care physician or with any other plan provider. If this occurs, we will generally no longer pay for services provided to you by that provider.

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 website (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 operation since 1977.
- FCHP is a not-for-profit organization.

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

Service Area

To enroll in this Plan, you must live in or work in our Select Care Service Area. This is where our providers practice. Our service area is in the following Massachusetts counties: all of Essex, Middlesex, Norfolk, Suffolk and Worcester Counties, and parts of Bristol, Franklin, Hampden, Hampshire and Plymouth Counties. This includes the communities listed below.

Abington	Arlington	Assonet	Avon
Acton	Ashburnham	Athol	Ayer
Amesbury	Ashby	Attleboro	Barre
Andover	Ashland	Auburn	Bedford

Bellingham
Belmont
Berkley
Berlin
Beverly
Billerica
Blackstone
Bolton
Boston
Boxborough
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
Erving
Essex
Everett
Fall River
Fitchburg
Foxborough
Framingham
Franklin
Freetown
Gardner
Georgetown
Gloucester
Grafton
Groton
Groveland
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
Mattapan
Maynard
Medfield
Medford
Medway
Melrose
Mendon
Merrimac
Methuen
Middleborough
Middleton
Milford
Millbury
Millis
Millville
Milton
Monson
Nahant
Natick
Needham
New Braintree
New Salem
Newbury
Newburyport
Newton
Norfolk
North Andover
North Attleborough
North Billerica
North Brookfield
North Chelmsford
North Reading
Northborough
Northbridge
Norton
Norwell
Norwood
Oakham
Orange
Oxford
Palmer
Paxton
Peabody
Pembroke
Pepperell
Petersham
Phillipston
Plainville
Plympton
Princeton
Quincy
Randolph
Raynham
Reading
Rehoboth
Revere
Rockland
Rockport
Rowley
Royalston
Rutland
Salem
Salisbury
Saugus
Scituate
Seekonk
Sharon
Sherborn
Shirley
Shrewsbury
Somerset
Somerville
South Hamilton
South Walpole
Southborough
Southbridge
Spencer
Sterling
Stoneham
Stoughton
Stow
Sturbridge
Sudbury
Sutton
Swampscott
Swansea
Taunton
Templeton
Tewksbury
Three Rivers
Topsfield
Townsend
Tyngsborough
Upton
Uxbridge
Village of Nagog Woods
Waban
Wales
Walpole
Waltham
Ware
Warren
Warwick
Watertown
Waverly
Wayland
Webster
Wellesley
Wendell
Wenham
West Boylston
West Bridgewater
West Brookfield
West Newbury
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 benefits. Some benefits are available for out-of-area students (see page 44). We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2003

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

Program-wide changes

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will decrease by 13.5% for self only and increase by 42.7% for self and family.
- We now have a 3-tier prescription drug copayment structure. See page 41.
- Emergency room visit copays are now $50.
- The Plan will provide coverage for autologous tandem transplants for testicular and other germ cell tumors. See page 31.
- You no longer need to pick between Fallon Plus and Fallon Affiliates.

Section 3. How you get care

Identification cards

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

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

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, and you will not have to file claims.

- **Plan providers**

Plan providers are licensed physicians and other health care professionals in our service area that we contract with to provide covered services to our members.

We list Plan providers in the *Provider Directory*, which we update periodically. The *Provider Directory* is also available on our website, www.fchp.org.

- **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 *Provider Directory* is also available on our website.

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.

- **Primary care**

Your primary care physician can be a family practitioner, internist, or pediatrician (or in some cases, a physician assistant or nurse practitioner who works under the supervision of a plan physician). Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians, call Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). You can also change your primary care physician at our web site at www.fchp.org.

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

- **Specialty care**

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

In some instances you can self-refer to a plan 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 physician but you must see a Plan provider. You can self-refer for:

- Services with a Fallon Clinic specialist (physician, physician assistant, nurse midwife, or nurse practitioner only) if you have a Fallon Clinic primary care physician.
- Obstetrical and gynecology services. This includes an annual exam, Pap smear, routine mammogram, and maternity care. It does not include infertility treatment or inpatient admissions. If you are admitted to a hospital as an inpatient (for childbirth, for example), you must notify the Plan of your admission.
- Routine dental care by a Plan dentist. See section 5(h) for a description of covered dental services.
- Visits to an oral surgeon for extraction of impacted teeth. Visits to an oral surgeon for any other procedure require a referral and Plan authorization.
- Routine eye examinations with a Plan ophthalmologist or optometrist.
- Outpatient mental health and substance abuse services with Plan providers. Call 1-888-421-8861 (TDD/TTY: 1-781-994-7660) to locate a Plan provider.

Authorization may be required for follow-up visits with these providers if they are beyond the scope of what is described above. Authorization may also be required if a provider to whom you have self-referred wishes to refer you elsewhere.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will issue a "standing referral" to a Plan specialist that allows you to see your specialist for a certain number of visits without additional referrals. For standing referrals, your primary care physician and specialist will work together to develop a treatment plan and the specialist must keep your primary care physician up-to-date on your treatment.

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

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

- We will make pediatric specialty care available, including mental health care, provided by persons with recognized expertise in specialty pediatrics.

- If you have a chronic or 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 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.

We will continue to pay for services of a specialist after our contract with the specialist ends in the following circumstances:

- 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.
- If you are terminally ill and our contract with a provider from who you are receiving treatment related to that illness ends, you may continue to receive treatment from that provider.

- **Hospital care**

Your Plan primary care physician 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 1-800-868-5200 (TDD/TTY: 1-877-608-7677). If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

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

In most cases, your primary care physician can refer you to a specialist without prior authorization from the Plan. Your primary care physician will provide you with a copy of the referral form and then you can make an appointment with the specialist.

Examples of services that *do not require* Plan authorization:

- Most specialty medical or surgical consultations with plan providers. In some cases, the specialist may need to obtain an additional referral from your primary care physician and or authorization from the Plan to continue treatment.
- Initial evaluations for chiropractic services, physical therapy, speech therapy, or occupational therapy. Plan authorization is required for additional visits.
- Allergy injections for up to 12 months.
- Chemotherapy for up to 12 months.
- Outpatient radiation therapy for up to 12 months.
- Many outpatient diagnostic tests.

In some instances your primary care physician will need to get prior authorization for a specialty referral. An authorization is an assurance by the Plan that we have approved a referral to a specialist. When your primary care physician needs prior authorization, he or she will send a "Request for Authorization" to the Plan. We will review the request and make an authorization decision within two working days of receipt of medical information. We will inform your primary care physician of our decision within 24 hours of the time that we make our decision.

If we authorize the service, we will send you and your primary care physician an authorization letter within two working days of the decision. When you get your letter with the authorization number, you can call the specialist to make your appointment. The authorization letter will state the services that the Plan has approved for coverage. If the specialist feels you need services beyond those authorized, the specialist will ask for authorization from the Plan. If we approve the request for additional services, we will send both you and your primary care physician an authorization letter.

If we do not authorize the specialty service, we will send you and your primary care physician a denial letter within one working day of the decision. The letter will explain our reasons for the decision and will describe your right to file a grievance.

Examples of services that *do require* prior authorization from the Plan:

- Inpatient admissions to a hospital or other facility
- Services with non-Plan provider
- Transplant evaluation services
- Podiatry consultations
- Neuropsychological testing
- Pain clinic
- Durable medical equipment

Plan physicians are freely able to recommend treatment options without restraint from the Plan. As such, a referral or treatment recommendation does not guarantee that the service is a covered benefit. It does not guarantee that the specialist is a Plan provider. Therefore, if your primary care physician refers you to a specialist who is not a Plan provider, you will be financially responsible unless a Plan authorization is issued.

Coverage of non-Plan providers

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

- If your prior primary care physician is not a participating provider in any health insurance plan that FEHB offers to you, 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 FEHB offers to you, 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 FEHB offers, we will pay for services from that provider through your post-partum period.
- If you are terminally ill, and you are receiving ongoing treatment from a provider who is not a participating provided in any health insurance plan that FEHB offers to you, we will pay for your services from that provider until your death.

In all cases, the provider must agree to accept reimbursement for services at our rates and adhere to our quality assurance standards, and other policies and procedures such as obtaining appropriate referrals and prior authorizations.

Section 4. Your costs for covered services

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

• **Copayments**	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. Example: When you see your primary care physician you pay a copayment of $10 per office visit.
• **Deductible**	We do not have a deductible.
• **Coinsurance**	We do not have coinsurance.

Your catastrophic protection out-of-pocket maximum

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

Section 5. Benefits -- OVERVIEW

(See page 9 for how our benefits changed this year and page 64 for a benefits summary.)

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

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services,* or valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians and other health care professionals • In physician's office • Office medical consultation • Second surgical opinion • In an urgent care center	$10 per office visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing
Professional services of physicians • At home	$10 per visit

Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing (If you receive these services during an office visit, the $10 copay applies to the office visit only)
Preventive care, adult	
Routine screenings, such as: • Total Blood Cholesterol – once every three years • Fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides)–once every five years for adults age 20 and over	Nothing (If you receive these services during an office visit, the $10 copay applies to the office visit only)
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing (If you receive these services during an office visit, the $10 copay applies to the office visit only)
Colorectal Cancer Screening, including • Fecal occult blood test • Sigmoidoscopy – once every five years starting at age 50; or • Colonoscopy–once every 10 years starting at age 50; or • Double contrast barium enema–once every 5 to 10 years starting at age 50.	Nothing (If you receive these services during an office visit, the $10 copay applies to the office visit only)
Routine Pap test	Nothing (If you receive these services during an office visit, the $10 copay applies to the office visit only)

Preventive Care - Adult -- continued on next page

Preventive care, adult *(continued)*	**You pay**
Routine mammogram–covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 and up, one every calendar year	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually, age 65 and over • Pneumococcal vaccine, age 65 and over	Nothing (If you receive these services during an office visit, the $10 copay applies to the office visit only)
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing (If you receive these services during an office visit, the $10 copay applies to the office visit only)
• Well-child care, routine examinations and immunizations from birth to age 22 • Screening of all children under six years of age for the presence of lead poisoning • Eye and ear examinations for children through age 17, to determine the need for vision and hearing correction • Physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening six times during the child's first year after birth, three times during the next year, annually until age six • Tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the physician	$10 per office visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay, such as nursery charges, circumcision, routine examination, heredity and metabolic screening, newborn hearing screening and medically necessary treatments of congenital defects, birth abnormalities or premature birth. • 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 Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 for the first office visit for prenatal care; all other prenatal visits covered-in-full $10 for each office visit for post natal care
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges.*
Family planning	
A broad range of voluntary family planning services, limited to: • Consultations, examinations, procedures and medical services related to the use of all contraceptive methods • Oral contraceptives • Voluntary sterilization (See Surgical procedures Section 5 (b) • Injectable contraceptive drugs (such as Depo Provera) • Diaphragms • Intrauterine devices (IUDs) • Surgically implanted contraceptives (such as Norplant) NOTE: Contraceptive drugs and devices dispensed at a Plan pharmacy are subject to the to the appropriate prescription medication copayment. Contraceptive drugs and devices supplied by a Plan provider during an office visit are covered under the Plan medical benefit.	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling, over-the-counter birth control preparations or devices	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Office visits for the evaluation and diagnosis of infertility • Diagnostic laboratory and x-ray services • Fertility drugs • Artificial insemination • In vitro fertilization (IVF) • Gamete Intrafallopian transfer (GIFT) • Zygote intrafallopian transfer (ZIFT) • Intracytoplasmic sperm injection • Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs To be eligible, you must be an individual who: (1) is unable to conceive or produce conception during a period of one year; and (2) should expect fertility as a natural state; or (3) is a pre-menopausal female or a female who is experiencing menopause at a premature age. Approval for Assisted Reproductive Technology (ART) is contingent upon review of your medical history by the Plan Medical Director. Initial approval covers 4 ART cycles, if you wish to continue beyond 4 cycles, further medical review by the Plan Medical Director is required. A benefits pamphlet is available by contacting our Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). Note: We cover injectable fertility drugs under the medical benefit and oral fertility drugs under the prescription drug benefit.	$10 per office visit
Not covered: • *Treatments, services and supplies which have not been determined to be medically necessary* • *Donor egg transfer for women who are menopausal, except as stated above* • *Chromosome studies of a donor (sperm or egg)* • *Charges for the storage of donor sperm, eggs, or embryo that remain in storage after the completion of an approved treatment cycle* • *Compensation to a donor (this does not include charges related to the procurement and processing of sperm, egg, and inseminated egg, to the extent that the donor's insurance does not cover these costs)* • *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, of for which there is no diagnosis of infertility* • *Surrogacy or gestational carrier services* • *Transportation costs to or from the medical facility*	*All charges.*

Allergy care	
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	**You pay**
• Chemotherapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 31. • Radiation therapy • Respiratory and inhalation therapy Note: Drug therapies for the treatments of respiratory diseases are covered under the prescription drug benefit. • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – We will only provide coverage for the use of growth hormone therapy when it has been pre-approved by the Plan. Your Plan physician will ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	Nothing except where noted. (Treatment therapies are covered in full when ordered, supplied and administered by a Plan physician.)

Physical and occupational therapies	
• Up to 60 consecutive days or 20 nonconsecutive visits (whichever is greater) per condition per calendar year for: – Physical therapy – Occupational therapy 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. • Cardiac rehabilitation for persons with documented cardiovascular disease.	$10 per office visit Nothing per visit during covered inpatient admission
• Early intervention services provided by certified early intervention specialists as defined in the early intervention operational standards developed by the Department of Public Health for children through age 3. Benefits are limited to a maximum of $3,200 per year per child and an aggregate of $9,600 over the term of the child's Plan membership.	Nothing
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *massage therapy*	*All charges.*
Speech therapy	
Services for the diagnosis and treatment of speech, hearing and language disorders by licensed, plan-affiliated speech-language pathologists or audiologists. Note: Coverage shall not extend to the diagnosis or treatment of speech, hearing and language disorders in a school-based setting.	$10 per office visit Nothing per visit during covered inpatient admission

Hearing services (testing, treatment, and supplies)	You pay
• Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
• Diagnosis and treatment of diseases of the eye	$10 per office visit
• Routine eye exam to determine the need for vision correction, once per 12-month period (including written prescriptions for eyeglasses) Note: See Preventive care, children for eye exams for children	$10 per office visit
Not covered: • *Eyeglasses or contact lenses* • *Eye examinations for contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *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* • *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)*	*All charges.*
Orthopedic and prosthetic devices	
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 Note: All orthopedic and prosthetic devices must be ordered by a Plan physician and authorized by the Plan	Nothing up to the benefit limit of $1500 per calendar year. You pay all charges beyond the benefit limit. Orthopedic and prosthetic devices and durable medical equipment are subject to a combined benefit limit.
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.
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: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device. Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	Nothing

Orthopedic and prosthetic devices- Continued on next page

Orthopedic and prosthetic devices *(Continued)*	**You pay**
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges.*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician and authorized by the Plan, such as • crutches • wheelchairs • walkers • hospital beds • blood glucose monitors • insulin pumps • therapeutic/molded shoes and shoe inserts for the treatment of severe diabetic foot disease • visual magnifying aids and voice synthesizers for blood glucose monitors for use by the legally blind	Nothing up to the benefit limit of $1500 per calendar year. You pay all costs over and above the benefit limit. Orthopedic and prosthetic devices and durable medical equipment are subject to a combined benefit limit.
• oxygen and oxygen equipment	Nothing
Not covered: • *Items that are not covered include, but are not limited to air conditioners, air purifiers, arch supports, ear plugs (to prevent fluid from entering the ear canal during water activities), foot orthotics, orthopedic shoes (except when part of a brace) or other supportive devices for the feet, articles of special clothing, 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.* • *Oxygen and related equipment when received from a non-plan provider. This includes oxygen and related equipment that you are supplied with while you are out of our service area.*	*All charges.*

Home health services	You pay
Home health care ordered by a Plan physician and authorized by the Plan. Services include: • skilled nursing care • physical, occupational and speech therapy • oxygen and intravenous therapy • medical social services • home health aide services • medical and surgical supplies and durable medical equipment • nutritional consultation • medication visits to monitor, evaluate or adjust the prescription medication dosage that is being prescribed for a medical or psychological condition Note: Durable medical equipment provided as part of your home health care services is not counted toward the annual limit	Nothing
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges.*
Chiropractic	
Chiropractic services for acute musculoskeletal conditions. The condition must be new or an exacerbation of a previous condition. Treatment must be provided by a Plan chiropractor and requires a referral from your primary care physician. Coverage is provided for up to 20 visits in each calendar year.	$10 per office visit (visits 1-10) $25 per office visit (visits 11-20)

Alternative treatments	You pay
Not covered: • *naturopathic services* • *aquatic therapy* • *hypnotherapy* • *biofeedback*	*All charges.*
Educational classes and programs	
• Diabetes self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider	$10 per office visit
• Smoking Cessation Program Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.	Nothing
• Health education and nutrition services, such as library services, nutrition classes and programs, behavioral medicine and women's wellness. The Fallon Foundation offers many health education programs and classes at the Lifetime Center for Family Health, 630A Plantation St., Worcester, for those who want to take a more active role in their healthcare. (Similar classes and programs may be available in other locations through Plan-affiliated hospitals.) In addition, the Lifetime Center offers a variety of free brochures and booklets that provide information about wellness, prevention and coping with various illnesses.	Copayments vary, call Customer Service (1-800-868-5200) or the Lifetime Center for Family Health (1-800-891-233) for details

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- 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 PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR SOME SURGICAL PROCEDURES. Please refer to the prior authorization information shown in Section 3 to be sure which services require authorization and identify which surgeries require prior authorization.

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit Nothing for services in a hospital outpatient or ambulatory surgical center Nothing for inpatient hospital visits
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*

Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	$10 per office visit Nothing for services in a hospital outpatient or ambulatory surgical center Nothing for hospital visits
• All stages of breast reconstruction surgery following a mastectomy, such as: – • surgery to produce a symmetrical appearance on the other breast; – • treatment of any physical complications, such as lymphedemas; Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per office visit Nothing for services in a hospital outpatient or ambulatory surgical center Nothing for hospital visits
• Breast prostheses and surgical bras and replacements (see Prosthetic devices, Section 5(a))	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges.*

Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Evaluation and treatment of temporomandibular joint disorder when a medical condition is diagnosed; • Removal or exposure of impacted teeth; • 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.	$10 per office visit
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone)*	*All charges.*

Organ/tissue transplants	You pay
Services must be provided at a Plan-affiliated facility, subject to your acceptance into the facility's program. The transplant facility makes the final determination on eligibility for transplant coverage. The plan may require that members receive their transplant at a specified facility. If a covered bone marrow transplant is not available from Plan provider, benefits will be paid at the same benefit level for services rendered by a non-Plan provider. Limited to: • Cornea • Heart • Heart/lung transplant for patients under age 60 with end-stage primary or secondary pulmonary hypertension • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Kidney • Liver • Lung transplant for patients under age 60 with end-stage obstructive or restrictive pulmonary disease • Allogeneic (donor) bone marrow transplants for leukemia, aplastic anemia, severe combined immunodeficiency disease, Wiskott-Aldrich syndrome, or for patients with high-risk lymphoblastic lymphoma in remission, or patients under 60 with myelodysplasia. • Autologous bone marrow transplants (autologous stem cell and peripheral cell cell support) for acute lymphocytic or non-lymphocytic leukemia, resistant non-Hodgkins disease or advanced Hodgkin's disease, recurrent or refractory neuroblastoma, or for persons diagnosed with breast cancer that has progressed to metastatic disease, or for persons under age 65 with chemo-responsive multiple myeloma. • Autologous tandem transplants for testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Human Leukocyte (HLA) or histocompatibility locus antigen testing for A, B, or DR antigens, or any combination thereof, necessary to establish bone marrow transplant donor suitability • Autologous tandem transplants for testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors Limited Benefits - Treatment for epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Implants of artificial organs* • *Transplants not listed as covered* • *Donor screening tests and donor search expenses, except those performed for the actual donor*	*All charges.*

Not covered continued • *Services for the organ donor that are covered by another insurance plan* • *Services for the organ donor if the recipient is not a member of this Plan* • *Transportation, housing or home cleaning services incurred by either the donor or the recipient*	

Anesthesia	You pay
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Nothing
Professional services provided in: • Physician's Office	$10 per office visit

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

IMPORTANT

Here are some important things to remember 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 and you must be hospitalized in a Plan facility.
- 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 covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require PRIOR AUTHORIZATION.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • 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.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: • *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*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay
• 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 • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Extended care benefits/skilled nursing care facility benefits	
The Plan covers inpatient services in a skilled nursing facility for up to 100 days in each calendar year. You may be admitted to a skilled nursing facility if, based on your medical condition, you need daily skilled nursing care, skilled rehabilitation services or other medical services that may require access to 24-hour medical care but does not require the specialized care of an acute care hospital. Services provided are: • Room and board in a semiprivate room (or private room if medically necessary) • The services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, nursing services, physical, speech and occupational therapy, medical supplies and equipment. • Drugs, biologicals, equipment and supplies ordinarily provided or arranged by the skilled nursing facility, when prescribed by a Plan physician.	Nothing
Not covered: custodial care, or personal comfort items such as telephone, radio or television	*All charges.*

Hospice care	You pay
The Plan provides coverage for hospice care services. 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. Services are provided, as necessary, to maintain the terminally ill individual at home such as: • Physicians services, nursing care and medical social services • Medical appliances and supplies including drugs and biologicals (prescription copayments may apply) • Inpatient respite care in a Plan affiliated facility (hospice or skilled nursing) for up to five consecutive days	Nothing
Not covered: Independent nursing, homemaker services	*All charges.*
Ambulance	
• Ambulance transportation when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

Emergency Care

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

Emergency services do not require referral or authorization, but you or someone on your behalf must notify the Plan of any emergency services that you receive within 48 hours or as soon as is medically possible. You should also notify your primary care physician. Your primary care physician will work with the Plan to assure that any follow-up or continuing care that is medically necessary will be arranged for you.

If you need to be hospitalized the Plan must be notified as soon as reasonably possible. If you are hospitalized in a non-Plan facility and Plan doctors believe care can be better provided in a Plan hospital, you would be transferred when medically appropriate.

Urgent Care within our service area:

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

Urgent Care outside our service area:

If you have a minor medical emergency and you are outside our service area, go to the nearest medical facility for care. You or someone on your behalf must notify the Plan within 48 hours or as soon as is medically possible. You should also notify your primary care physician if you need follow-up care.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 copay (waived if admitted or held in an observation room)
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	S10 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 copay (waived if admitted or held in an observation room)
Not covered: • *Elective 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*	*All charges.*
Ambulance	
Professional ambulance service when medically appropriate (See Section 5(c) for non-emergency ambulance services).	Nothing
Not covered: • *Air ambulance when not appropriate to medical or geographic condition* • *Transfers between hospitals when the patients' medical condition does not warrant that he/she be transported to another facility*	*All charges.*

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

IMPORTANT

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR AUTHORIZATION FOR SOME OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
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. Note: Plan benefits are payable only when we determine the care is medically necessary to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit

Mental health and substance abuse benefits - continued on next page

Mental health and substance abuse benefits *(continued)*	**You pay**
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *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.*	*All charges.*

Prior authorization

To be eligible to receive these benefits you must follow the following authorization processes*:*

You may self-refer for outpatient mental health or substance abuse services with a Plan provider. Read Section 3, *Specialty care*, for information about self-referral. For assistance in finding a contracted provider, call 1-888-421-8861 (TDD/TTY: 781-994-7660).

Inpatient services require prior authorization. To access inpatient mental health or substance abuse services, call 1-888-421-8861 (TDD/TTY: 781-994-7660).

Limitation

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

Section 5 (f). Prescription drug benefits

IMPORTANT

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.
- 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.

IMPORTANT

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 must fill the prescription at a Plan pharmacy, or through a Plan-affiliated mail order pharmacy supplier. See your *Provider Directory* for a list of plan pharmacies.
- **We use a formulary.** Our formulary is a list of medications that shows the copayment tier and prior authorization requirements for each medication. We have selected the tiers and determined the criteria for prior authorization based on efficacy and cost effectiveness. Coverage of certain drugs is based on medical necessity. They are shown on the formulary as "MN". Your physician must get prior authorization from the Plan before writing a prescription for these drugs.

  The formulary has a three-tiered copayment structure. There is a different copayment for each tier. Tier 1 drugs have the lowest copayment. Tier 2 drugs have the next lowest copayment, and Tier 3 drugs have the highest copayment. All drugs on the formulary have been approved for sale and distribution by the U. S. Food and Drug Administration (FDA).

  Any drug not shown on the formulary will be considered a Tier 3 drug. Your physician must get prior approval from the Plan before writing a prescription for these drugs.
- **These are the dispensing limitations.** Prescription drugs are generally dispensed for up to a 30-day supply. Occasionally, for safety reasons or as directed by your physician, the length of therapy will be less than 30 days. For maintenance medications, your prescription may be for a 90-day supply. We follow FDA dispensing guidelines. You generally cannot obtain a refill until most or all of the previous supply has been used.

  A generic drug is a drug product that meets the approval of the FDA and is equivalent to a brand name product in terms of quality and performance. You will generally receive a generic drug from plan pharmacies anytime one is available, unless your doctor has directed the pharmacist to only dispense a specific brand name drug. However, some drugs do not have a generic equivalent. In both of these cases you will receive the brand name drug and you will be responsible for the copayment for that drug.

- **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 brand name drugs must meet the same standards for safety, purity, strength and effectiveness. A generic prescription costs you—and—us less than a brand name prescription.

- **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 (less the appropriate copayment) for up to a 14-day supply of medication. Claims can be submitted to Fallon Community Health Plan, Claims Department, P. O. Box 15121., Worcester, MA 01615-0121.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. • Diabetic supplies and medications, including insulin, insulin syringes, blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, insulin pumps, insulin pump supplies and insulin pens. • Disposable needles and syringes for the administration of covered medications • Fertility drugs • Drugs for sexual dysfunction (requires prior authorization from the Plan) • Contraceptive drugs • Emergency prescriptions (up to a 14-day supply) provided out of the service area as part of an approved emergency treatment • Off-label use of covered drugs in the treatment of HIV, AIDS or cancer Note: Injectables administered in a doctor's office or under professional supervision are generally covered under the medical benefit.	At a Plan pharmacy: Tier 1: $5 copay for up to a 30-day supply Tier 2: $15 copay for up to a 30-day supply Tier 3: $35 copay for up to a 30-day supply Mail Order: Tier 1: $3 copay for up to a 30-day supply Tier 2: $13 copay for up to a 30-day supply Tier 3: $33 copay for up to a 30-day supply

Covered medications and supplies -- continued on next page

Covered medications and supplies *(continued)*	**You pay**
The Plan covers the special medical formulas and food products limited to those listed below. Prior authorization is required. • Special medical formulas for the treatment of phenylketonuria, tyrosinemia, homcystinuria, maple syrup disease, propionic acidemia, or methylmalonic acidemis 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
• 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.	Nothing up to a maximum of $2500 per calendar year
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines, over-the-counter preparations and devices, and medical supplies such as dressings and antiseptics* • *Drugs that are investigational or that have not been approved for general sale and distribution by the U.S. Food and Drug Administration* • *Nicotine patches, and gum or other smoking cessation products unless supplied to you as part of an approved smoking cessation program.*	*All charges.*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to 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.
Out-of-area student coverage	Students attending school outside the plan service area may not have easy access to the Plan provider network. They are covered for a limited number of services while out-of-area, if authorized in advance by the Plan. These services include: • Nonroutine medical office visits • Diagnostic lab and X-ray connected with a nonroutine office visits • 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, up to 20 office visits in each calendar year 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 20 office visits in each calendar year per illness or injury (combined with any in-area visits). Coverage for speech therapy is determined by medical necessity *Aside from emergency care, the services listed above are the only services that are covered for students on an out-of-network basis. To be covered, all other services must be obtained when they return to the Plan service area.* Services that are **not** covered for students while out of the Plan service area include: • Routine physical, gynecological exams, vision screening and hearing screening • Routine preventive care • Nonemergency prescription medication. You may use the prescription medication mail order program to fill medication refills. (See pages 41-42.) • 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

Section 5 (g). Special features

Interpreter Services	We will, upon request, provide members with interpreters and translation services related to our administrative procedures.
Services for the hearing impaired	You may access our TDD/TTY equipment at 1-877-608-7677
Peace of Mind Program™	Our Peace of Mind Program™ provides access to specialty services at specified Boston area medical centers. You may access Peace of Mind Program™ providers if you meet the following conditions; • Care is for covered services as described in this brochure. The same copayments and benefit limits apply • You have seen a Plan specialist for this condition within the past three months • A referral to a specific Peace of Mind Program™ physician is made by your primary care physician and notification is given to the plan that you are accessing that specialist through the Peace of Mind Program ™ • The physician to whom you are referred is on staff at one of the six medical centers listed below: – Massachusetts General Hospital – Brigham and Women's Hospital – Children's Hospital (Boston) – Dana-Farber Cancer Institute – New England Medical Center – Boston IVF (for infertility services only) Once the plan has been notified of the Peace of Mind Program™ referral to a specific physician, 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 authorization. If you wish to see any other Peace of Mind Program™ provider, you must request a separate referral from your primary care physician and the plan must be notified of your request, and the request must meet the conditions listed above. You should advise your Peace of Mind Program™ provider that all laboratory, x-ray services and tests must be authorized in advance by the Plan. To ensure coverage, the Peace of Mind Program™ provider should work with the Plan's Peace of Mind Program™ Coordinator to make arrangements for these services. Whenever practical, arrangements will be made for these services to be performed by Plan providers. Unauthorized services will not be covered. You should not rely on an assurance from the Peace of Mind Program™ provider that a service will be covered by the Plan. Services must be authorized by the Plan to be covered. 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, or if you or your physician has not obtained Plan authorization for a Peace of Mind Program™ service, the service 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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; 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.

IMPORTANT

Accidental injury benefit	You pay
We cover 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 after the injury. You do not need authorization for emergency care needed as a result of dental trauma. Go to the closest dentist and notify us within 48 hours of receiving care. Note: This accidental injury benefit does not include restorative or other dental services.	$10 per office visit
Out-of-Area care	
While you are out of the plan service area, we will cover some limited urgent dental care services for minor ailments such as a toothache or loose filling. Go to the closest provider and notify the plan within 48 hours of receiving urgent dental care.	$10 per office visit Coverage is provided for up to $50 per incident

Dental benefits

The Plan covers preventative 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 the *Dental Directory* for a list of Plan dentists, or call Customer Services at 1-800-868-5200 and we will help in find a Plan dentist.

Preventative 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 $13 to $35.

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

Dental Benefits

	Service	You pay
110	Initial oral examination	$10
120	Periodic oral examination	$10
130	Emergency oral examination	$10
140	Limited 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
241	Bitewing (single film)	$10
272	Bitewings (two films)	$10
273	Bitewings (three films)	$10
274	Bitewings (four films)	$10
460	Pulp vitality tests	$10
461	Diagnostic casts	$10
1110	Prophylaxis (adult, every six months)	$10
1120	Prophylaxis (child, every six months)	$10
1201	Top application fluoride (includes prophylaxis–child under age 16)	$10
1203	Top application fluoride (excludes prophylaxis–child under age 16)	$10
1205	Top application fluoride (includes prophylaxis–adult age 16 and over)	$10
1130	Oral hygiene instruction	$10
2110	Amalgam (one surface, primary)	$13
2120	Amalgam (two surfaces, primary)	$18
2130	Amalgam (three surfaces, primary)	$22
2131	Amalgam (four or more surfaces, primary)	$28
2140	Amalgam (one surface, permanent)	$15
2150	Amalgam (two surfaces, permanent)	$20
2160	Amalgam (three surfaces, permanent)	$22
2161	Amalgam (four or more surfaces, permanent)	$28
2330	Resin (one surface, anterior)	$19
2331	Resin (two surfaces, anterior)	$22
2332	Resin (three surfaces, anterior)	$28
2335	Resin (three surfaces, or involving incisal angle – anterior)	$33
2385	Resin (one surface, posterior permanent)	$19
2386	Resin (two surfaces, posterior permanent)	$25
2333	Resin (three or more surfaces, posterior permanent)	$35

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

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**.

Discounts on chiropractic visits
For conditions that are not usually covered under the Plan's chiropractic benefit–and for visits 21 and beyond–you may see a Plan chiropractor at a discounted rate. For more information on discounted chiropractic services, or to locate a participating Plan chiropractor, call Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

Discounted dental services
We have arranged for discounts on non-covered dental services at participating plan dentists. For a complete listing of discounted dental services call the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

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

Hearing aid discounts
The Plan has arranged for discounts off the regular price of hearing aids. Contact the Customer Services Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) for a 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 more information call the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

Naturally Well
Through our Naturally Well program we offer discounts on alternative health care. Currently we offer discounts on acupuncture, massage therapy and nutrition counseling. For information on the Naturally Well program, call the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

Weight Watchers®
Plan members are entitled to a 12-week membership to Weight Watchers® in each calendar year. The membership includes the registration fee and weekly fee for a 12-consecutive week series of Weight Watchers®. Additional memberships and food products are not covered. To request coupons call the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

Medicare prepaid plan enrollment
This plan offers Medicare recipients the opportunity to enroll in the plan through Medicare. As indicated on page xx, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan if one is available in their area. They may then later re-enroll in the FEHB program. Most federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid program but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact our Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) for information on benefits available under the Medicare HMO.

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, and we agree,** as discussed under*, Services requiring our prior approval on page 12*.

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are 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; or
- Services, drugs, or supplies you receive without charge while in active military service.

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.

You will only need to file a claim when you receive emergency services from non-plan providers. Send all claims for urgent or emergency care to us within six months of the date of service. You may submit the claim yourself, or the provider may submit them directly. With your authorization, we will pay benefits directly to the provider. Otherwise, we will send payment to you. All bills should include a description of the services, the dates of service and the charge for each service. We will pay for the reasonable cost of services in full, less the appropriate copayment.

Claims for services in a foreign country may be submitted if the services are not provided free of charge by that country. The bills must be itemized and in English (or translated into English). Payment will be made to you, and you must pay the provider.

Services, drugs or supplies

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

When you must file a claim -- such as for services you receive outside of 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:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send 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; or make your request by telephone at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) Monday through Friday, 8:30 a.m. to 5:00 p.m.; or make your request in person at our Consumer Affairs Department; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. Also include your name, FCHP identification number, and the name of any FCHP representative with whom you have spoken. If you send us a written or electronic grievance, we will acknowledge your request in writing within 15 business days from the date that we receive the request. If you call us or come in to our offices, we will put your grievance in writing and send a written statement to you or your authorized representative within 48 hours of the time that we talked to you.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. Your grievance will be reviewed by FCHP administrators and/or physicians who are knowledgeable about matters at issue in the grievance. As part of certain types of review, we may ask you to participate in a conference. 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. We will write to you with our decision. Our response will describe the specific information considered as well as an explanation for the decision. You may ask for a reconsideration of a final adverse determination if any relevant information was received too late to review within the time limits described above, or is expected to become available within a reasonable time period after you receive our written response. If we agree to reconsider, we will indicate a new time period for review in writing. This would not be longer than 30 days from the date we agree to the reconsideration. If we do not complete a review in the time limits specified above, the decision will automatically be in favor of the member. Time limits include any extensions made by mutual written agreement between you or your authorized representative and the plan.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information.

The Disputed Claims process *(Continued)*

Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Health Benefits Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent 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 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 1-800-868-5200 (TDD/TTY 1-877-608-7677) and we will expedite our review. If you have a terminal illness, and if our review of your expedited review results in denial of coverage, you may request a conference. We will schedule the conference within 10 business days from the date on which we receive your request; or within five business days if your physician determines, after consultation with a plan medical director, that based on standard medical practice, the effectiveness of the proposed treatment, services or supplies or any alternative treatment, services or supplies would be materially reduced if not provided at the earliest possible date. You may attend the conference, but your attendance is not required; 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 Benefits Contracts Division 3 at 202/606-0737 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. We follow the National Association of Insurance Commissioners' guidelines in determining secondary coverage.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

•The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

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 about filing your claims, call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

We do not waive any costs when you have Medicare.

(Primary payer chart begins on next page.)

The following chart illustrates whether the Original Medicare Plan 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 either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB (Ask your employing office which of these applies to you)		✓
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) 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,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

•Medicare managed care plan

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

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

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

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care plan's service area.

•If you do not enroll in Medicare Part A or Part B

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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 a 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. You must use our providers.

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 a 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 14.

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 medication. Custodial care that lasts 90 days or more is sometimes known as Long term care. Custodial care is not covered by the Plan.

Experimental or investigational services

The Plan's Benefits & Technology Assessment Committee determines what procedures, devices and services are experimental or investigational use 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 medical or hospital service which is rendered for treatment or diagnosis of an injury or illness, not furnished primarily for the convenience of the member, physician or provider, and is in accordance with professionally recognized medical standards and plan medical criteria.

Provider

A person, agency or facility that may furnish health care to you under the terms of this contract. This includes doctors of medicine, osteopathy and podiatry; registered nurse anesthetists; and nurse practitioners.

Us/We

Us and we refer to Fallon Community Health Plan

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that 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. 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 will 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 health 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 Federal Employees Health Benefits (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 option of the Blue Cross and Blue Shield Service Benefit Plan that provides the lower level of coverage;
- 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 make any changes after retirement. Contact you employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective on 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. 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.

- **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 supply 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 website 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 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 (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 have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Still Available!

Open Season

The Federal Long Term Care Insurance Program's open season for enrollment ends on December 31, 2002. If you're a Federal employee, this is the chance for you and your spouse to apply by answering only a few questions about your health.

You Can Also Apply Later

You and your qualified relatives can still apply for coverage after open season ends. The difference for employees and their spouses is that they won't have the advantage of open season's abbreviated underwriting, so they'll have to answer more health-related questions. For annuitants and other qualified relatives, there's no difference in the underwriting requirements during and after the open season.

FEHB Doesn't Cover It

It's important to keep in mind that neither your FEHB plan nor Medicare covers the cost of long term care. Also called "custodial care," it's care you receive when you need help performing activities of daily living -- such as bathing or dressing yourself. This need can strike any one at any age and the cost of care can be substantial.

It's Not Too Late!

It's not too late to protect yourself against the high cost of long term care by applying for the Federal Long Term Care Insurance Program. Don't delay -- if you apply during open season, your premiums will be based on your age as of July 1, 2002. After open season, your premiums are based on your age at the time your application for enrollment is received by LTC Partners.

Find Out More

Call 1-800-LTC-FEDS (1-800-582-3337) or visit www.ltcfeds.com to get more information and to request an application.

Index

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

Summary of benefits for the Fallon Community Health Plan 2003

- **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.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	Office visit copay: $10 primary care; $10 specialist	16
Services provided by a hospital: • Inpatient..... • Outpatient	Nothing Nothing	34 35
Emergency benefits: • In-area..... • Out-of-area	$50 per visit $50 per visit	38 38
Mental health and substance abuse treatment	Regular cost sharing.	39
Prescription drugs	Tier 1: $5 copay for up to a 30-day supply Tier 2: $15 copay for up to a 30-day supply Tier 3: $35 copay for up to a 30-day supply	41
Dental Care	$10 copay for preventative limited services $13-$35 copay for minor restorative services Discounts available for other dental procedures	46
Vision Care	$10 per visit	23
Special Features…….	Flexible benefits option Services for the hearing impaired Peace of Mind Program™ Out-of-Area Student Coverage Interpreter Services	44
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum).....	We do not have a catastrophic protection out-of-pocket maximum	14

2003 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 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.

		Non-Postal Premium				***Postal Premium***	
		Biweekly		**Monthly**		**Biweekly**	
Type of Enrollment	**Code**	**Gov't Share**	**Your Share**	**Gov't Share**	**Your Share**	**USPS Share**	**Your Share**

Location Information: Central and Eastern Massachusetts, Including the Worcester metropolitan area

High Option Self Only	**JV1**	**$105.98**	**$35.32**	**$229.61**	**$76.54**	**$125.40**	**$15.90**
High Option Self & Family	**JV2**	**$249.62**	**$113.53**	**$540.84**	**$245.99**	**$294.70**	**$68.45**