



FALLON COMMUNITY HEALTH PLAN

<http://www.fchp.org>

2004

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 2004 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](http://www.opm.gov/insure)



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 2004 Federal Employees Health Benefits (FEHB) Program plan brochure. The brochure describes the benefits this plan offers you for 2004. Because benefits vary from year to year, you should review your plan's brochure every Open Season – especially Section 2, which explains how the plan changed.

It takes a lot of information to help a consumer make wise healthcare decisions. The information in this brochure, our FEHB Guide, and our web-based resources, make it easier than ever to get information about plans, to compare benefits and to read customer service satisfaction ratings for the national and local plans that may be of interest. Just click on www.opm.gov/insure!

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any healthcare program in the country.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of employer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at www.opm.gov. OPM's *HealthierFeds* campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain healthcare costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become an educated consumer to meet your healthcare needs. Use this brochure, the FEHB Guide, and the web resources to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to www.usajobs.opm.gov.

Sincerely,

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

Kay Coles James
Director



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

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

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

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

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

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

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

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

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

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

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure 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 are effective April 14, 2003.

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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, 2004, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2004, and changes are summarized on page 11. Rates are shown at the end of this brochure.

Plain Language

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

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Insurance Services Program, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (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 a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) and explain the situation.
 - If we do not resolve the issue:

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

OR WRITE TO:

**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.

Preventing Medical Mistakes

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

1. **Ask questions if you have doubts or concerns.**
 - Ask questions and make sure you understand the answers.
 - Choose a doctor with whom you feel comfortable talking.
 - Take a relative or friend with you to help you ask questions and understand answers.
2. **Keep and bring a list of all the medicines you take.**
 - Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
 - Tell them about any drug allergies you have.
 - Ask about side effects and what to avoid while taking the medicine.
 - Read the label when you get your medicine, including all warnings.
 - Make sure your medicine is what the doctor ordered and know how to use it.
 - Ask the pharmacist about your medicine if it looks different than you expected.
3. **Get the results of any test or procedure.**
 - Ask when and how you will get the results of test or procedures.
 - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
 - Call your doctor and ask for your results.
 - Ask what the results mean for your care.

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

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

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

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

Want more information on patient safety?

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

Section 1. Facts about this HMO plan

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

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You 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 the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayment when you receive a covered service.

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 existence since 1977.
- Fallon Community Health Plan is a not-for-profit organization.

If you want more information about us, call 1-800-868-5200 (TDD/TTY: 1-877-608-7677), or write to Fallon Community Health Plan, 10 Chestnut 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 includes providers throughout Essex, Middlesex, Norfolk, Suffolk and Worcester Counties, and in parts of Bristol, Franklin, Hampden, Hampshire and Plymouth Counties. The following is a list of the cities and towns in the Select Care service area:

Abington	Auburn	Billerica	Brookfield
Acton	Auburndale	Blackstone	Brookline
Allston	Avon	Bolton	Burlington
Amesbury	Ayer	Boston	Cambridge
Andover	Baldwinville	Boxborough	Canton
Arlington	Barre	Boxford	Carlisle
Ashburnham	Bedford	Boylston	Charlestown
Ashby	Bellingham	Braintree	Charlton
Ashland	Belmont	Bridgewater	Chelmsford
Assonet	Berkley	Brighton	Chelsea
Athol	Berlin	Brimfield	Cherry Valley
Attleboro	Beverly	Brockton	Chestnut Hill

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

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

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

Section 2. How we change for 2004

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

- We added information regarding two new Federal Programs that complement FEHB benefits, the Federal Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program. See page 60.
- We added information regarding Preventing medical mistakes. See page 6.
- We added information regarding enrolling in Medicare. See page 51
- We revised the Medicare Primary Payer Chart. See page 53.

Changes to this Plan

- Your share of the non-Postal premium will increase by 62.1% for Self Only or 38.4% for Self and Family.
- We have eliminated the two-tier chiropractic benefit. Your copayment for each covered visit with a chiropractor is \$10.
- You have a \$100 copayment for each inpatient admission to a hospital or other facility.
- Your copayments for covered prescriptions obtained at a Plan pharmacy have increased. You will pay \$20 for up to a 30-day supply of a Tier-2 medication, and \$40 for up to a 30-day supply of a Tier-3 medication
- When you refill your prescription through our mail-order program you will pay \$10 for up to a 90-day supply of a Tier-1 medication, \$40 for up to a 90-day supply of a Tier-2 medication, and \$120 for up to a 90-day supply of a Tier-3 medication.
- Your copayments for minor restorative dental care (such as metal or composite fillings) have increased. Copayments vary from \$16 to \$49. See Section 5 (h) Dental benefits.
- The Plan covers injectable contraceptive drugs, such as Depo Provera, under the prescription drug benefit. We also cover certain other contraceptives, such as the contraceptive patch, under the prescription drug benefit.
- If you decide that you may be discharged sooner than 48 hours following a vaginal delivery or 96 hours following a Caesarean section delivery, you are entitled to one home visit by a registered nurse, physician or certified nurse midwife.
- Students attending school outside the service area have coverage for as many visits as are medically necessary to treat the abuse of or addiction to alcohol or drugs. See Section 5(g) Special features.
- Students attending school outside the service area have coverage for up to 60 consecutive days or 20 nonconsecutive visits for short-term physical or occupational therapy (whichever is greater) per illness or injury in each calendar year (combined with any in-area visits). See Section 5(g) Special features.

Section 3. How you get care

Identification cards

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

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

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

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

• Plan facilities

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

What you must do to get covered care

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

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

- If your prior primary care provider is not a participating provider in any health plan offered by the FEHB Program we will pay for services from that provider for 30 days from your effective date.
- If you are receiving an ongoing course of treatment from a provider who is not a participating provider in any health insurance plan that the FEHB Program offers, we will pay for services from that provider for 30 days from your effective date.
- If you are in the second or third trimester of pregnancy and you are receiving services related to your pregnancy from a provider who is not a participating provider in any health insurance plan that the FEHB Program offers we will pay for services from that provider through your postpartum period.
- If you are terminally ill and you are receiving ongoing treatment from a provider who is not a participating provider in any other health insurance plan that the FEHB Program offers we will pay for services from that provider until your death.

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

• **Primary care**

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

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

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

• **Specialty care**

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

Services you can self refer for:

- Office visits with a Fallon Clinic specialist (physician, physician assistant, nurse midwife or nurse practitioner only) if you have a Fallon Clinic primary care provider.
- Services with an obstetrician or gynecologist. This includes an annual gynecological examination, Pap smear, and routine mammogram; services for acute or emergent gynecological conditions; and maternity care. It does not include inpatient admissions or infertility treatment (unless provided by a Fallon Clinic specialist and you have a Fallon Clinic primary care provider); see page 22 for more information on “Infertility/assisted reproductive technology services”).
- Office visits to an oral surgeon for extraction of impacted teeth. Visits to an oral surgeon for any other procedure require a referral and authorization. See page 29 for more information on covered oral surgery services.
- Routine eye examinations with an ophthalmologist or optometrist.
- Routine dental care
- Outpatient mental health and substance abuse services. For help in finding a network provider, call 1-888-421-8861 (TDD/TTY: 781-994-7660).

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

Services that need a referral from your primary care provider:

- Office visits with a specialist (if you have a Fallon Clinic primary care provider you may self refer to a Fallon Clinic specialist); your primary care provider or specialist must obtain authorization from the Plan for most specialty services.
- Initial visit to a chiropractor or podiatrist; the chiropractor or podiatrist must obtain authorization from the Plan for all subsequent visits.
- Physical, occupational and speech therapy; your primary care provider completes a prescription to a therapist. Coverage is provided for up to six visits, the therapist must obtain authorization from the Plan for any additional visits.

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

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

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you are terminally ill and our contract with a provider from whom you are receiving treatment related to that illness ends, you may continue to receive treatment from that provider.
- 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.
- If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

• **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 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. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

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

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

- All elective admissions to a hospital or other inpatient facility
- Services with a non-Plan provider
- Peace of Mind Program™
- Organ transplant evaluation and services
- Reconstructive surgery
- Infertility/assisted reproductive technology services
- Oral surgery (with the exception of the extraction of impacted teeth)

- Genetic testing
- Neuropsychological testing
- Prosthetics/orthotics and durable medical equipment
- Home health care (including hospice care)
- Non-emergency ambulance
- PET scans

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

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

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

Section 4. Your costs for covered services

You must share the 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 provider you pay a copayment of \$10 per office visit

•**Deductible**

We do not have a deductible.

•**Coinsurance**

We do not have coinsurance.

Catastrophic protection out-of-pocket maximum

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

Section 5. Benefits -- OVERVIEW

(See page 11 for how our benefits changed this year and page 65 for a benefits summary.)

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

(a) Medical services and supplies provided by physicians and other health care professionals	19-27
•Diagnostic and treatment services	•Speech therapy
•Lab, X-ray, and other diagnostic tests	•Hearing services
•Preventive care, adult	•Vision services
•Preventive care, children	•Foot care
•Maternity care	•Orthopedic and prosthetic devices
•Family planning	•Durable medical equipment (DME)
•Infertility services	•Home health services
•Allergy care	•Chiropractic
•Treatment therapies	•Alternative treatments
•Physical and occupational therapies	•Educational classes and programs
(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	27-30
•Surgical procedures	•Oral and maxillofacial surgery
•Reconstructive surgery	•Organ/tissue transplants
(c) Services provided by a hospital or other facility, and ambulance services.....	31-33
•Inpatient hospital	•Skilled nursing care facility benefits
•Outpatient hospital or ambulatory surgical center	•Hospice care
	•Ambulance
(d) Emergency services/accidents	34-35
•Medical emergency	•Ambulance
(e) Mental health and substance abuse benefits.....	36-37
(f) Prescription drug benefits	38-41
(g) Special features	42-43
• Flexible benefits option	
• Out-of-area student benefits	
• Services for the hearing impaired	
• Interpreter services	
• Peace of Mind Program™	
(h) Dental benefits	44-45
(i) Non-FEHB benefits available to Plan members	46
Summary of benefits.....	65

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

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan providers must provide your care.
- Be sure to read Section 3, *How you get care*, for important information on what you must do to get covered care.
- You are responsible for copayments when you receive certain services. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • In physician's office • In an urgent care center • Second surgical opinion • Office medical consultation 	\$10 per office visit
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • At home 	\$10 per home visit
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing (If you receive these services during an office visit a \$10 copay applies to the office visit only)

Preventive care, adult	You pay
Routine screenings, such as: <ul style="list-style-type: none"> • 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 older • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – 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. • Osteoporosis screening – for women age 65 and older and beginning at age 60 for women at increased risk 	Nothing (If you receive these services during an office visit a \$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 a \$10 copay applies to the office visit only)
Routine Pap test	Nothing (If you receive these services during an office visit a \$10 copay applies to the office visit only)
Routine mammogram –covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 and older, one every calendar year 	Nothing
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and over 	Nothing (If you receive these services during an office visit a \$10 copay applies to the office visit only)

Preventive care, children	You pay
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Hereditary and metabolic screening at birth, tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the provider • Screening of all children under six years of age for the presence of lead poisoning 	<p>Nothing</p> <p>(If you receive these services during an office visit a \$10 copay applies to the office visit only)</p>
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (through age 22) • Physical examination, history, measurements, sensory screening, neuropsychiatric evaluation, development screening and assessment six times during the child's first year after birth, three times during the next year, and annually until age six • Examinations, such as: <ul style="list-style-type: none"> – Eye exams through age 17 to determine the need for vision correction – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations (through age 22) 	<p>\$10 per office visit</p>
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need pre-authorization for your normal delivery; see page 15 for other circumstances. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a Caesarean delivery. We will extend your inpatient stay if medically necessary. If you are discharged sooner (the mother must decide to accept an early discharge), you are covered for one home visit by a registered nurse, physician or certified nurse midwife. • We cover routine nursery care, routine examination, newborn hearing screening and circumcision of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	<p>\$10 for the first office visit for prenatal care, all other prenatal visits covered in full;</p> <p>\$10 per office visit for postnatal care</p> <p>\$100 copay applies to inpatient care.</p>

Maternity care -- continued on next page

<i>Not covered: Routine sonograms to determine fetal age, size or sex</i>	<i>All charges.</i>
Family planning	You pay
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Consultations, examinations, procedures and medical services related to the use of all contraceptive methods • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Contraceptives that are furnished by a provider during an office visit, such as: <ul style="list-style-type: none"> – Surgically implanted contraceptives (such as Norplant) – Intrauterine devices (IUDs) – Diaphragms – Cervical caps <p>NOTE: We cover oral contraceptives and certain other contraceptives, such as Depo Provera and the contraceptive patch under the prescription drug benefit.</p>	\$10 per office visit
<i>Not covered: reversal of voluntary surgical sterilization, genetic counseling, over-the-counter contraceptive drugs or devices</i>	<i>All charges.</i>
Infertility services	
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Office visits for the evaluation and diagnosis of infertility • Artificial insemination (AI) • In vitro fertilization and embryo placement (IVF-EP) • Gamete Intra fallopian transfer (GIFT) • Zygote Intra fallopian transfer (ZIFT) • Intracytoplasmic sperm injection (ICSI) • Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs <p>To be eligible, you must be an individual who:</p> <ol style="list-style-type: none"> (1) is unable to conceive or produce conception during a period of one year; and (2) should expect fertility as a natural state; or (3) is a premenopausal female or a female who is experiencing menopause at a premature age. <p>Approval for Assisted Reproductive Technology (ART) is contingent upon review of your medical history by the Plan medical director. Initial approval covers four ART cycles, if you wish to continue beyond four cycles, further medical review by the Plan medical director is required.</p> <p>A benefits pamphlet is available by contacting Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).</p> <p>Note: We cover oral and injectable fertility drugs that are self-administered under the prescription drug benefit.</p>	\$10 per office visit

<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Treatments, services and supplies which have not been determined to be medically necessary</i> • <i>Donor egg transfer for women who are menopausal, except as stated above</i> • <i>Chromosome studies of a donor (sperm or egg)</i> • <i>Charges for the storage of donor sperm, eggs or embryo that remain in storage after the completion of an approved treatment cycle</i> • <i>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.)</i> • <i>Supplies that may be purchased without a physician's written order, such as ovulation test kits</i> • <i>Services which are necessary due to a voluntary sterilization, or for which there is no diagnosis of infertility</i> • <i>Surrogacy or gestational carrier services</i> • <i>Transportation costs to or from the medical facility</i> 	<p><i>All charges.</i></p>
<p>Allergy care</p>	<p>You pay</p>
<p>Testing and treatment Allergy injections</p>	<p>\$10 per office visit</p>
<p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered: provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges.</i></p>
<p>Treatment therapies</p>	
<ul style="list-style-type: none"> • Chemotherapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/tissue transplants on page 30.</p> <ul style="list-style-type: none"> • Radiation therapy <p>Note: drug therapies for the treatment of respiratory diseases are covered under the prescription drug benefit</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and continuous ambulatory peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit. We will only provide coverage for GHT when we preauthorize the treatment. Your Plan provider will submit a request for authorization before you begin treatment. If your Plan provider does not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>Nothing</p> <p>(If you receive these services during an office visit a \$10 copay applies to the office visit only)</p>

Physical and occupational therapies	You pay
<ul style="list-style-type: none"> • Up to 60 consecutive visits or 20 nonconsecutive visits (whichever is greater) per illness or injury per calendar year for: <ul style="list-style-type: none"> — physical therapy — occupational therapy <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p>	<p>\$10 per office visit</p> <p>Nothing per visit during covered inpatient admission</p>
<ul style="list-style-type: none"> • Cardiac rehabilitation for persons with documented cardiovascular disease, initiated within 26 weeks after the diagnosis of cardiovascular disease. • Early intervention services delivered by certified early intervention specialists according to operational standards developed by the Department of Public Health, for children from birth to their 3rd birthday. Benefits are limited to a maximum of \$3,200 per year per child and an aggregate of \$9,600 over the term of the child's Plan membership. 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs • Acupuncture, aquatic therapy or massage therapy 	<p><i>All charges.</i></p>
Speech therapy	
<p>Medically necessary services for the diagnosis and treatment of speech, hearing and language disorders when services are provided by a Plan provider who is a speech-language pathologist or audiologist; at a Plan facility or provider's office.</p>	<p>\$10 per office visit</p> <p>Nothing per visit during covered inpatient admission</p>
Hearing services	
<p>Hearing testing for children through age 17 (see <i>Preventive care, children</i>)</p>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing and examinations for them 	<p><i>All charges.</i></p>
Vision services	
<ul style="list-style-type: none"> • Diagnosis and treatment of diseases of the eye • Annual eye refractions 	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Eyeglasses or contact lenses • Eye examinations for contact lenses • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery 	<p><i>All charges.</i></p>

Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts</p>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All charges.</i></p>
Orthopedic and prosthetic devices	
<p>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</p> <p>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</p> <p>Corrective orthopedic appliances for nondental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</p> <p>Note: All orthopedic and prosthetic devices must be ordered by a Plan provider and authorized by the Plan.</p>	<p>Nothing up to the benefit limit of \$1,500 per calendar year. You pay all charges beyond the benefit limit.</p> <p>Orthopedic and prosthetic devices and durable medical equipment are subject to a combined benefit limit.</p>
<p>Scalp hair prosthesis (wigs) for individuals who have suffered hair loss as a result of the treatment of any form of cancer or leukemia</p>	<p>Nothing up to the benefit limit of \$350 per calendar year. You pay all charges beyond the benefit limit.</p>
<p>Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy</p> <p>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.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> 	<p><i>All charges.</i></p>

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

Home health services	You pay
<p>Home health care ordered by a Plan physician and authorized by the Plan. Services include:</p> <ul style="list-style-type: none"> • 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 <p>Note: Durable medical equipment and physical and occupational therapy provided as a medically necessary component of home health care are not subject to the benefit limits.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> 	<i>All charges.</i>
Chiropractic	
<p>Chiropractic services for acute musculoskeletal conditions. The condition must be new or an exacerbation of a previous condition. 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.</p>	\$10 per office visit
Alternative treatments	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Biofeedback</i> 	<i>All charges.</i>
Educational classes and programs	
<p>Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs</p>	Nothing
<p>Diabetes self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider</p>	\$10 per office visit

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

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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 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 PRE-AUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the pre-authorization information shown in Section 3 to be sure which services require pre-authorization.

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Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • 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 <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for pacemaker and surgery benefits for insertion of the pacemaker.</p>	<p>\$10 per office visit</p> <p>\$100 per admission for inpatient surgical procedures</p> <p>Nothing for surgical procedures in a hospital outpatient, day surgery or ambulatory surgical center</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> 	<p><i>All charges.</i></p>

Reconstructive surgery	You pay
<p>The Plan covers reconstructive surgery to repair a condition resulting from:</p> <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – the condition produced a major effect on the member’s appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – reconstruction of the breast on which the mastectomy was performed; – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$10 per office visit</p> <p>\$100 per admission for inpatient surgical procedures</p> <p>Nothing for surgical procedures in a hospital outpatient, day surgery or ambulatory surgical center</p>
<p>Breast prostheses and surgical bras and replacements (see Prosthetic devices)</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges.</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges.</i></p>
Organ/tissue transplants	You pay

<p>Transplant services must be provided at a Plan-affiliated facility, subject to your acceptance into the facility's transplant 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 transplant is not available from a Plan provider, benefits will be paid at the same benefit level for services rendered by a non-Plan provider.</p> <p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung for patients under age 60 with end-stage primary or secondary pulmonary hypertension • Kidney • Liver • Lung transplant for patients under age 60 with end-stage obstructive or restrictive pulmonary disease • Allogenic (donor) bone marrow transplants for leukemia, aplastic anemia, severe combined immunodeficiency disease, or Wiskott-Aldrich Syndrome; for patients with high-risk lymphoblastic lymphoma in remission; or for patients under age 60 with myelodysplasia • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; resistant or advanced non-Hodgkin's lymphoma; recurrent or refractory neuroblastoma; for patients diagnosed with breast cancer that has progressed to metastatic disease; for patients under age 65 with chemo-responsive multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Human Leukocyte Antigen (HLA) or histocompatibility locus antigen testing for A, B, or DR antigens, or any combination thereof, to establish bone marrow transplant donor suitability <p>Limited Benefits - Treatment for breast cancer, multiple myeloma, and 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.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient</p>	<p>\$10 per office visit</p> <p>\$100 per admission for inpatient surgical procedures</p> <p>Nothing for surgical procedures in a hospital outpatient, day surgery or ambulatory surgical center</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Transplants not listed as covered</i> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Services for the organ donor that are covered by another insurance plan</i> 	<p><i>All charges.</i></p>

Organ/tissue transplants –continued on next page

<p><i>Not covered continued:</i></p> <ul style="list-style-type: none"> • <i>Services of the organ donor if the recipient is not a Plan member</i> • <i>Transportation, housing or home cleaning services incurred by either the donor or the recipient</i> 	
<p>Anesthesia</p>	<p>You pay</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Skilled nursing facility • Hospital outpatient department or day surgery • Ambulatory surgical center 	<p>Nothing</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Office 	<p>\$10 per office visit</p>

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

Here are some important things to remember about these benefits:

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- 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 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 PRE-AUTHORIZATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require pre-authorization.

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Benefit Description	You pay
Inpatient hospital	
<p>Room and board, such as</p> <ul style="list-style-type: none"> • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. <p>NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • 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 	<p>\$100 per admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	<p><i>All charges.</i></p>

Outpatient hospital or ambulatory surgical center	You pay
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	Nothing
Skilled nursing care facility benefits	
<p>Skilled nursing facility (SNF): The Plan covers inpatient services in a SNF for up to 100 days in each calendar year. You may be admitted to a SNF if, based on your medical condition, you need daily skilled nursing care, skilled rehabilitation services or other medical services that may require access to 24-hour medical care but does not require the specialized care of an acute care hospital.</p> <p>Services provided are:</p> <ul style="list-style-type: none"> • Room and board in a semiprivate room (or private room if medically necessary) • The services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, nursing services, physical, speech and occupational therapy, medical supplies and equipment. • Drugs, biologicals, equipment and supplies ordinarily provided or arranged by the skilled nursing facility, when prescribed by a Plan physician. 	\$100 per admission
<p><i>Not covered: custodial care or personal comfort items such as telephone, radio or television</i></p>	All charges.
Hospice care	
<p>Hospice care is a method of caring for the terminally ill that helps those individuals continue their lives with as little disruption as possible. This type of care emphasizes supportive services, such as home care and pain control, rather than the cure-oriented services that are provided in hospitals. To be eligible for hospice care you must be terminally ill with a life expectancy of less than six months.</p> <p>Hospice services are provided, as necessary, to maintain the terminally ill individual at home such as:</p> <ul style="list-style-type: none"> • Physicians services, nursing care and medical social services • Medical appliances and supplies including drugs and biologicals (prescription copayments may apply) • Inpatient respite care in a Plan-affiliated facility (hospice or skilled nursing) for up to five consecutive days 	<p>Nothing for hospice care provided in your home</p> <p>Note: \$100 copay applies to inpatient respite care provided in a skilled nursing or hospice facility</p>

Ambulance	
Ambulance transportation when medically appropriate	Nothing

Section 5 (d). Emergency services

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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.

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What is a medical emergency?

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

What to do in case of emergency:

Emergency care

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

Emergency services do not require referral or 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 medically possible. You should also notify your primary care provider. Your primary care provider 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 medically possible. If you are hospitalized in a non-Plan facility and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically 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. Doctors' 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 the Plan 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 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	
<ul style="list-style-type: none"> Care for a minor emergency in a doctor's office or urgent care center 	\$10 per visit
<ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$50 per visit (waived if admitted)
Emergency outside our service area	
<ul style="list-style-type: none"> Care for a minor emergency in a doctor's office or urgent care center 	\$10 per visit
<ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$50 per visit (waived if admitted)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges.</i>
Ambulance	
<p>Emergency ambulance service when medically appropriate. See 5(c) for non-emergency service.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Air ambulance when not appropriate to medical condition or geographic location</i> <i>Transfers between hospitals when the patient's medical condition does not warrant that he or she be transported to another facility</i> <i>Commercial airline transportation</i> 	<i>All charges.</i>

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

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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 PRE-AUTHORIZATION INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE CARE.** See the instructions after the benefits description below.

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost sharing responsibilities are no greater than for other illness or conditions.
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	\$10 per office visit
<ul style="list-style-type: none"> • Diagnostic tests 	<p>Nothing</p> <p>(If you receive these services during an office visit a \$10 copay applies to the office visit only)</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>\$100 per admission</p> <p>Nothing for services in alternative care settings</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges.</i>

Mental health and substance abuse benefits – continued on next page

Pre-authorization

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

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

Inpatient mental health and substance abuse services require pre-authorization, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660).

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

Limitation

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

Section 5 (f). Prescription drug benefits

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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.

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

- **Who can write your prescription.** A licensed Plan provider or a provider who you have seen on an authorized referral can write your prescription.
- **Where you can obtain them.** You may fill your prescription at a Plan pharmacy or through our mail order program. In emergencies, when you are out of the Plan service area and cannot fill your prescription at a Plan pharmacy, we will provide coverage for up to a 14-day supply. You may fill the prescription at any location and submit the receipt for reimbursement. You will be reimbursed the cost of a 14-day supply, less the applicable copayment. See “When you have to file a claim” below for information on submitting proof of payment for reimbursement.

We use a formulary. Our formulary is a list of medications that shows the copayment tier and prior authorization requirements for each medication. We have chosen the tiers and determined the criteria for prior authorization based on cost and efficacy. Coverage of certain drugs is based on medical necessity. They are designated on the formulary as “MN”. Your provider must get authorization from the Plan before giving you a prescription for one of these medications.

- **These are the dispensing limitations.** When you fill a covered prescription at a Plan pharmacy you pay one copayment for each 30-day supply. Occasionally, for safety reasons or as directed by your provider, the length of therapy may be less than 30 days. We follow FDA dispensing guidelines. You generally cannot refill a prescription until most of the previous supply has been used.

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

- **Mail order program.** When you fill or refill your prescription through our mail order program you may order up to a 90-day supply of most medications. You have a fixed copayment for each tier of medication through our mail order program. The copayment for up to a 90-day supply of Tier-1 and Tier-2 medications is equal to the cost of two pharmacy (30-day supply) copayments. The Tier-3 mail order copayment is equal to three pharmacy (30-day supply) copayments.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you -- and us -- less than a name brand prescription.
- **If you are called to active duty need medication during a national or other emergency** you can get up to a 90-day supply of a maintenance medication at a participating pharmacy or through our mail-order program. If you need assistance with the process, call Customer Service at 800-868-5200.
- **When you have to file a claim.** If you need an emergency prescription as part of an approved emergency treatment while you are out of the Plan service area, the Plan will reimburse you for the cost of a 14-day supply of medication, less the appropriate copayment. Submit proof of payment to: Fallon Community Health Plan, Claims Department, P.O. Box 15121, Worcester, MA 01615-0121.

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan provider and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase except those listed as <i>not covered</i> • Diabetic supplies and medications limited to insulin, insulin syringes, blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, insulin pumps, insulin pump supplies and insulin pens • Oral medications that influence blood sugar levels • Self-administered injectable agents • Hormone replacement therapy • Disposable needles and syringes for the administration of covered medications • Fertility drugs • Drugs for sexual dysfunction • Contraceptive drugs and devices • Off-label use of covered drugs in the treatment of HIV, AIDS or cancer <p>Note: injectables furnished and administered in a provider’s office or under professional supervision are generally covered under the medical benefit.</p>	<p>At a Plan pharmacy: Tier 1: \$5 copay for up to a 30-day supply Tier 2: \$20 copay for up to a 30-day supply Tier 3: \$40 copay for up to a 30-day supply</p> <p>Mail order: Tier 1: \$10 copay for up to a 90-day supply Tier 2: \$40 copay for up to a 90-day supply Tier 3: \$120 copay for up to a 90-day supply</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<p>The Plan covers the special medical formulas and food products limited to those listed below. Prior authorization is required.</p> <ul style="list-style-type: none"> • Special medical formulas for the treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria • Enteral formulas for home use for which a physician has issued a written order and which are necessary for the treatment of malabsorption caused by Crohn’s disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids 	<p>Nothing</p>
<ul style="list-style-type: none"> • Food products modified to be low in protein for individuals that have been diagnosed with phenylketonuria and other inherited diseases of amino acids and organic acids. Coverage is provided for up to \$2,500 per calendar year. You may be required to purchase these products over-the-counter and submit claims to the Plan for reimbursement 	<p>Nothing up to a maximum of \$2,500 per calendar year</p>

Covered medications and supplies – continued on next page

<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines, over-the-counter preparations and devices and medical supplies such as dressings and antiseptics</i> • <i>Drugs that are investigational or that have not been approved for general sale and distribution by the U.S. Food and Drug Administration</i> • <i>Nicotine patches and gum or other smoking cessation products unless supplied to you as part of an approved smoking cessation program</i> 	<p><i>All charges</i></p>
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Section 5 (g). Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Out-of-area student coverage	<p>Students attending school outside the Plan service area may not have easy access to a Plan provider. They are covered for a limited number of services while out-of-area, if authorized in advance by the Plan. These services include:</p> <ul style="list-style-type: none"> • Non-routine medical office visits • Diagnostic lab and X-ray connected with a non-routine 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, while out of the Plan service area • Outpatient services to diagnose and/or treat mental conditions • Short-term rehabilitation services, including physical, occupational and speech therapy. Coverage for physical and occupational therapy is provided for up to 60 consecutive days or 20 nonconsecutive visits (whichever is greater) per illness or injury in each calendar year (combined with any in-area visits). Coverage for speech therapy is determined by medically necessary <p><i>Aside from emergency care, the services listed above are the only services that are covered for students on an out-of-network basis. To be covered, all other services must be obtained when they return to the Plan service area.</i></p> <p>Services that are not covered for students while out of the Plan service area include:</p> <ul style="list-style-type: none"> • Routine physical, gynecological exams, vision screening and hearing screening • Routine preventive care • Non-emergency prescription medication. You may use the prescription medication mail order program to fill medication refills. (See pages 38-41.) • 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

<p>Services for deaf and hearing impaired</p>	<p>You may access our TDD/TTY equipment at 1-877-608-7677.</p>
<p>Interpreter services</p>	<p>We will, upon request, provide members with interpreters and translation services related to our administrative procedures.</p>
<p>Peace of Mind Program™</p>	<p>Our Peace of Mind Program™ provides access to specialty services at specified Boston area medical centers. You may access Peace of Mind Program™ providers if you meet the following conditions:</p> <ul style="list-style-type: none"> • Care is for covered services as described in this brochure. The same copayments 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 provider 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: <ul style="list-style-type: none"> – Massachusetts General Hospital – Brigham and Women’s Hospital – Children’s Hospital (Boston) – Dana-Farber Cancer Institute – New England Medical Center – Boston IVF (for infertility services only) <p>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.</p> <p>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.</p> <p>You may use the Peace of Mind Program™ for all specialty care except mental health, substance abuse, chiropractic services, obstetrics or dental care. You may not use the Peace of Mind Program™ for any primary care services, including internal medicine, family practice or pediatrics. If you have not met the conditions listed above, or if you or your physician have 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.</p>

Section 5 (h). Dental benefits

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 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. See Section 5 (c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

Dental benefits

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

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

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

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

Dental Benefits

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

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

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

Discounted dental services

Plan members are eligible for discounts on non-covered dental services, such as sealants, crowns, inlays, bridges, root canals, gingivectomies and dentures when performed by participating Plan dentists. Discounts reflect a 25% to 50% discount off the area's usual and customary fees. For a listing of discounted dental services call Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

Eyewear discounts

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

Hearing aid discounts

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

It Fits!

With *It Fits!*, Plan members can get reimbursed up to \$200 per family (\$100 per individual) for membership at their local fitness center, in Weight Watchers^R, or both. With *It Fits!*, it's your choice!

Medicare prepaid Plan enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 51, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid Plan if one is available in their area. They may then later re-enroll in the FEHB program. Most federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid program but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid Plan. Contact our Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) for information on benefits available under the Medicare HMO.

Health education and wellness programs

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

Section 6. General exclusions -- things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan provider determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 15.**

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. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. 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 pre-authorization:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andMail your request to us at: Fallon Community Health Plan, Consumer Affairs Department, 10 Chestnut St., Worcester, MA 01608; or fax it to us at: 1-508-755-7393; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. Be sure to include the member's name, membership ID number and the name of any Plan representatives you may have spoken with.We will acknowledge your written or faxed request in writing within 15 business days from the date that we receive the request. If you call or come in to our offices we will put your request in writing and send the written statement to you or your authorized representative within 48 hours of the time that we talked to you. If your request involves termination of ongoing treatment, this treatment will continue until we complete our review and send you a response.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial -- go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. A Plan administrator and/or Plan physicians who are knowledgeable about the matters at issue will review your request. For certain types of review, we may ask you to participate in a conference.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision. In our written response we will describe the specific information considered.</p> <p>If we deny your request (we call this an adverse determination) you may ask for a reconsideration if any relevant information was received too late to review within the time limits described above. If we agree to reconsider, we will inform you in writing of the new time period for review. This would be no longer than 30 days from the date we agree to reconsideration.</p> <p>If we fail to complete a review within 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 the member, or the member's authorized representative, and the Plan.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or120 days after we asked for additional information.

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

The Disputed Claims process (*Continued*)

Send OPM the following information:

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

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

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

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

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

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

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

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

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

- (a) If we haven't responded yet to your initial request for care or pre-authorization or prior approval, then call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) and we will expedite our review. In certain cases we may automatically reverse our decision if your provider certifies in writing that a denial of coverage would create a substantial risk of serious harm, and that this risk is so substantial that you cannot wait for the outcome of the normal review process. If you are an inpatient at the time you submit your request for review, we will respond before you are discharged from the hospital. In all other expedited reviews we will send you a written response within 72 hours of our receipt of your request. If you have a terminal illness, we will respond to you within five business days from our receipt of your request.
- (b) We denied your initial request for care or pre-authorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

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

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

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

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

Should I enroll in Medicare?

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

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

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

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + 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 + Choice 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 to file your claim, call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

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

(Primary payer chart begins on next page)

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

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

* Unless you have FEHB coverage through your spouse who is an active employee

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

•Medicare + Choice plan

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

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

This Plan and our Medicare + Choice plan: You may enroll in our Medicare + Choice 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 + Choice plan: You may enroll in another plan's Medicare + Choice plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare + Choice 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 + Choice plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare + Choice plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare + Choice plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare + Choice plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare + Choice 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 + Choice 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 65.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care furnished to meet non-medically necessary needs such as assistance in mobility, dressing, bathing, eating, preparation of special diets and taking medications. Custodial care that lasts 90 days or more is sometimes known as long-term care. Custodial care is not covered by the Plan.
Experimental or investigational services	Our 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 (FCHP).
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

Coverage information

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition 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 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 Blue Cross and Blue Shield Service Benefit Plan's Basic Option,
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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

When benefits and premiums start

The benefits in this brochure are effective 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. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2004 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2003 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

•When FEHB coverage ends

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

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

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

• Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to 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 website (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.

Two new Federal Programs complement FEHB benefits

Important information

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

The Federal Flexible Spending Account Program - *FSAFEDS*

- **What is an FSA?**

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

There are two types of FSAs offered by the FSAFEDS Program:

Health Care Flexible Spending Account (HCFSAs)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. **Note:** The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSAs is \$3,000 annually. The minimum amount is \$250 annually.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.
- The maximum that can be allotted for the DCFSA is \$5,000 annually. The minimum amount is \$250 annually. **Note:** The IRS limits contributions to a Dependent Care FSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any childcare subsidy you may receive.

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the FEHB Open Season. Even if you enrolled during the initial Open Season for 2003, you must make a new election to continue participating in 2004. Enrollment is easy!

- Enroll online anytime during Open Season (November 10 through December 8, 2003) at www.fsafeds.com.
- Call the toll-free number 1-877-FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time and a FSAFEDS Benefit Counselor will help you enroll.

What is SHPS?

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

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you're not enrolled in FEHB–

you can choose to participate in either, or both, of the flexible spending accounts. If you are not eligible for FEHB, you are not eligible to enroll for a Health Care FSA. However, almost all Federal employees are eligible to enroll for the Dependent Care FSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same no matter what agency you work for.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits of an FSA, the IRS places strict guidelines on them. You need to estimate how much you want to allocate to an FSA because current IRS regulations require you forfeit any funds remaining in your account(s) at the end of the FSA plan year. This is referred to as the “use-it-or-lose-it” rule. You will have until April 29, 2004 to submit claims for your eligible expenses incurred during 2003 if you enrolled in FSAFEDS when it was initially offered. You will have until April 30, 2005 to submit claims for your eligible expenses incurred from January 1 through December 31, 2004 if you elect FSAFEDS during this Open Season.

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

- **What can my HCFSA pay for?**

Every FEHB health plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 65 and detailed throughout this brochure. Your HCFSA will reimburse you for such costs when they are for tax-deductible medical care for you and your dependents that are NOT covered by this FEHB Plan or any other coverage that you have.

Under This Plan, typical out-of-pocket expenses include: office visit, prescription and inpatient hospital copays, hearing aids, eyeglasses and orthodontia.

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

- **Tax savings with an FSA**

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

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

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

- **Tax credits and deductions**

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

Health care expenses

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

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

Dependent care expenses

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

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

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

Probably not. While there is an administrative fee of \$4.00 per month for an HCFSA and 1.5% of the annual election for a DCFSA, most agencies have elected to pay these fees out of their share of employment tax savings. To be sure, check the FSAFEDS.com website or call 1-877-FSAFEDS (372-3337). Also, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end

of the plan year and wind up forfeiting your end of year account balance, per the IRS “use-it-or-lose-it” rule.

- **Contact us**

To find out more or to enroll, please visit the **FSAFEDS Website** at www.fsafeds.com, or contact SHPS by email or by phone. SHPS Benefit Counselors are available from 9:00 a.m. until 9:00 p.m. eastern time, Monday through Friday.

- E-mail: fsafeds@shps.net
- Telephone: 1-877-FSAFEDS (372-3337)
- TTY: 1-800-952-0450 (for hearing impaired individuals that would like to utilize a text messaging service)

The Federal Long Term Care Insurance Program

It’s important protection

Here’s why you should consider enrolling in the Federal Long Term Care Insurance Program:

- **FEHB plans do not cover the cost of long-term care.** Also called “custodial care,” long term care is help you receive when you need assistance performing activities of daily living – such as bathing or dressing yourself. This need can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long-term care.** This coverage gives you control over the type of care you receive and where you receive it. It can also help you remain independent, so you won’t have to worry about being a burden to your loved ones.
- **It’s to your advantage to apply sooner rather than later.** Long-term care insurance is something you must apply for, and pass a medical screening (called underwriting) in order to be enrolled. Certain medical conditions will prevent some people from being approved for coverage. By applying while you’re in good health, you could avoid the risk of having a change in health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don’t have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting. Qualified relatives are also eligible to apply with full underwriting.

To find out more and to request an application

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

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

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Summary of benefits for Fallon Community Health Plan 2004

- **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 providers, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office..... 	Office visit copay: \$10	19
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient..... • Outpatient..... 	\$100 per admission copay Nothing	28 33
Emergency benefits: <ul style="list-style-type: none"> • In-area..... • Out-of-area..... 	\$50 per visit \$50 per visit	35 35
Mental health and substance abuse treatment.....	Regular cost sharing	37
Prescription drugs.....	Tier 1: \$5 copay for up to a 30-day supply Tier 2: \$20 copay for up to a 30-day supply Tier 3: \$40 copay for up to a 30-day supply	39
Dental Care.....	\$10 per office visit for preventive care; copayments vary from \$16 to \$49 for minor restorative care	44
Vision Care.....	\$10 per visit	24
Special features:	Flexible benefits option Out-of-area student benefits Services for the hearing impaired Interpreter services Peace of Mind Program™	43
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2004 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.

Type of Enrollment	Code	<i>Non-Postal Premium</i>				<i>Postal Premium</i>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
		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	\$121.40	\$57.26	\$263.03	\$124.07	\$143.32	\$35.34
High Option Self & Family	JV2	\$277.09	\$157.14	\$600.36	\$340.47	\$327.12	\$107.11