

Benefit Comparison Chart (Effective 4/1/09)
FCHP Direct Care and FCHP Select Care

Benefit	Premier Value	Premium Saver I/II	Premium Saver Value I/II	Premium Saver Basic I/II	Premium Saver 500	Premium Saver 1000	Premium Saver 1500	Premium Saver 2000	Premium Saver 2000 with \$500 inpatient copay I/II	Premium Saver 65/35	Care Choice 1250/2000
Office visits—routine exams	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Office visits—other primary care	\$15	\$15	\$20	\$25	\$20	\$20	\$25	\$25	\$25	\$25	\$20 per visit after deductible
Office visits—specialty care	\$25	\$15	\$35	\$40	\$20	\$20	\$25	\$25	\$40	\$40	\$20 per visit after deductible
Prescriptions (up to a 30-day supply)	\$10/\$25/\$45	I: \$10/\$25/\$50 II: \$25/\$100/\$100*	I: \$15/\$30/\$50 II: \$15/\$50/\$100	I: \$15/\$30/\$50 II: \$15/\$50/\$100	\$15/\$35/\$60	\$15/\$35/\$60	\$15/\$35/\$60	\$15/\$35/\$60	I: \$15/\$50/\$100 II: \$25/\$100/\$100*	\$15/\$30/\$50	\$10/\$25/\$50 after deductible
Emergency room (waived if admitted)	\$75	\$50	\$75	\$100	\$100	\$150	\$200	\$200	\$200	\$150	\$100 per visit after deductible
Inpatient hospital/ same-day surgery	\$100	\$250/\$150	\$500/\$300	\$1,000/\$600	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	\$500 after deductible/ \$250 after deductible	35% coinsurance	Covered in full after deductible
Basic dental (routine exams)	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10
Chiropractic care (20 visits)	\$15	\$15	\$20	\$25	\$20	\$20	\$25	\$25	\$25	\$25	\$20 after deductible
Diagnostic services (Lab, X-ray, EKG, etc.)**	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	35% coinsurance	Covered in full after deductible
Imaging (CAT, PET, MRI scans)	\$50	\$50	\$50	\$100	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	35% coinsurance	Covered in full after deductible
Preventive services**	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Deductible (ind/fam)	None	None	None	None	\$500/\$1,000	\$1,000/\$2,000	\$1,500/\$3,000	\$2,000/\$4,000	\$2,000/\$4,000	None	\$1,250/\$2,500 \$2,000/\$4,000
Out-of-pocket maximum*** (ind/fam)	\$1,000/\$2,000	\$1,000/\$2,000	\$2,000/\$4,000	\$2,500/\$5,000	\$2,000/\$4,000	\$2,500/\$5,000	\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000	\$2,500/\$5,000 \$4,000/\$8,000

* Moved to closed formulary.

** Diagnostic services are those tests and services that are intended to diagnose, check the status of or treat a disease or condition. Preventive services are services, tests and immunizations that are intended to screen for diseases or conditions and to improve early detection of disease when there is no diagnosis or symptoms. This excludes routine physical exams. For a guide to preventive and diagnostic services, please visit our Web site at fchp.org.

*** Items that count toward the out-of-pocket maximum vary by plan design.

These health plans meet minimum creditable coverage guidelines.

This fact sheet highlights some of the benefits of FCHP Direct Care and FCHP Select Care. For full benefits, please go to fchp.org. The subscriber certificate and all riders define the terms, limitations and conditions of the plan. Should any questions arise, the subscriber certificate and riders will govern.



Benefit Comparison Chart (Effective 4/1/09) Fallon Preferred Care (PPO)

Benefit	Premier Value	Premium Saver	Premium Saver Value I/II	Premium Saver Basic I/II	Premium Saver 500	Premium Saver 1000	Premium Saver 1500	Premium Saver 2000	Premium Saver 1000 80/60	Premium Saver 500 90/70	Premium Saver 2000 with \$500	Care Choice 1250/2000
Office visits—routine exams	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Office visits—other primary care	\$15 per visit	\$15 per visit	\$20 per visit	\$25 per visit	\$20 per visit	\$20 per visit	\$25 per visit	\$25 per visit	\$20 per visit	\$20 per visit	\$25 per visit	\$20 per visit after deductible
Office visits—specialty care	\$25 per visit	\$15 per visit	\$35 per visit	\$40 per visit	\$20 per visit	\$20 per visit	\$25 per visit	\$25 per visit	\$20 per visit	\$20 per visit	\$40 per visit	\$20 per visit after deductible
Prescriptions (up to a 30-day supply)	\$10/\$25/\$45	\$10/\$25/\$50	I: \$15/\$30/\$50 II: \$15/\$50/\$100	I: \$15/\$30/\$50 II: \$15/\$50/\$100	\$15/\$35/\$60	\$15/\$35/\$60	\$15/\$35/\$60	\$15/\$35/\$60	\$10/\$25/\$50	\$10/\$25/\$50	\$15/\$50/\$100	\$10/\$25/\$50 after deductible
Emergency room (waived if admitted)	\$75 per visit	\$50 per visit	\$75 per visit	\$100 per visit	\$100 per visit	\$150 per visit	\$200 per visit	\$200 per visit	\$100 per visit	\$100 per visit	\$200 per visit	\$100 per visit after deductible
Inpatient hospital/ same-day surgery	\$100/\$100	\$250/\$150	\$500/\$300	\$1,000/\$600	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	20% coinsurance after deductible	10% coinsurance after deductible	\$500 after deductible/ \$250 after deductible	Covered in full after deductible
Chiropractic care (20 visits)	\$15 per visit	\$15 per visit	\$20 per visit	\$25 per visit	\$20 per visit	\$20 per visit	\$25 per visit	\$25 per visit	\$20 per visit	\$20 per visit	\$25 per visit	\$20 per visit after deductible
Diagnostic services*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	20% coinsurance after deductible	10% coinsurance after deductible	Covered in full after deductible	Covered in full after deductible
Imaging (CAT, PET, MRI scans)	\$50 per visit	\$50 per visit	\$50 per visit	\$100 per visit	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	20% coinsurance after deductible	10% coinsurance after deductible	Covered in full after deductible	Covered in full after deductible
Preventive services*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Deductible (ind/fam)	\$300/\$600 (out-of-network services only)	\$300/\$600 (out-of-network services only)	\$400/\$800 (out-of-network services only)	\$500/\$1,000 (out-of-network services only)	\$500/\$1,000 (in- and out-of-network services)	\$1,000/\$2,000 (in- and out-of-network services)	\$1,500/\$3,000 (in- and out-of-network services)	\$2,000/\$4,000 (in- and out-of-network services)	\$1,000/\$2,000 (in- and out-of-network services)	\$500/\$1,000 (in- and out-of-network services)	\$2,000/\$4,000 (in- and out-of-network services)	\$1,250/\$2,500 (in- and out-of-network services) \$2,000/\$4,000 (in- and out-of-network services)
Coinsurance for out-of-network services	20%	20%	20%	20%	20%	20%	20%	20%	40%	30%	20%	20%
Out-of-pocket maximum**	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000	\$4,000/\$8,000	\$4,000/\$8,000	\$5,000/\$10,000	\$5,000/\$10,000	\$4,000/\$8,000	\$4,000/\$8,000	\$5,000/\$10,000	\$5,000/\$10,000

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