

## FCHP Direct Care and FCHP Select Care Premium Saver Deductible Plan Options

*Benefits effective April 1, 2011, and beyond.*

Benefit	Premium Saver 500	Premium Saver 1000	Premium Saver 1500	Premium Saver 1500 Classic	Premium Saver 2000/500 I/II*	Premium Saver 2000 Classic	Premium Saver 3000 with Rx †	Premium Saver 3000 No Rx † (Non MCC)
Office visits—routine exams	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Office visits—other primary care	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25
Office visits—specialty care	\$40	\$40	\$40	\$40	\$40	\$40	\$40	\$40
Annual vision exams	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Prescriptions—Retail (up to a 30-day supply)	\$15/40/75	\$15/40/75	\$15/40/75	\$15/40/75	I: \$15/50/100 II: \$25/100/100	\$15/50/100	\$25/50/100	n/a
Prescriptions—Mail-order	\$30/80/225	\$30/80/225	\$30/80/225	\$30/80/225	I: \$30/100/300 II: \$50/200/300	\$30/100/300	\$50/100/300	n/a
Emergency room (waived if admitted)	\$100 copayment after deductible	\$150 copayment after deductible	\$200 copayment after deductible	\$200 copayment after deductible	\$200 copayment after deductible	\$200 copayment after deductible	\$200 copayment after deductible	\$200 copayment after deductible
Inpatient hospital	\$250 copayment after deductible	\$500 after deductible	\$500 after deductible	Covered in full after deductible	\$500 after deductible	Covered in full after deductible	\$500 after deductible	\$500 after deductible
Same-day surgery	\$250 copayment after deductible	\$250 after deductible	\$250 after deductible	Covered in full after deductible	\$250 after deductible	Covered in full after deductible	\$250 after deductible	\$250 after deductible
Chiropractic care (12 visits)	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25
Diagnostic services (Lab, X-ray, EKG, etc.)**	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	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible
Imaging (CAT, PET, MRI scans, Nuclear Cardiology)	\$100 copayment after deductible	\$150 copayment after deductible	\$150 copayment after deductible	Covered in full after deductible	\$150 copayment after deductible	Covered in full after deductible	\$150 copayment after deductible	\$150 copayment 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
Deductible (ind/fam)	\$500/1,000	\$1,000/2,000	\$1,500/3,000	\$1,500/3,000	\$2,000/4,000	\$2,000/4,000	\$3,000/6,000	\$3,000/6,000
Out-of-pocket maximum*** (ind/fam)	\$2,500/5,000	\$3,000/6,000	\$5,000/10,000	\$5,000/10,000	\$5,000/10,000	\$5,000/10,000	\$5,000/10,000	\$5,000/10,000

FCHP Direct Care provides access to a network that is smaller than the FCHP Select Care network. In this plan, members have access to network benefits only from the providers in FCHP Direct Care. Please consult the FCHP Direct Care provider directory – a paper copy can be requested by calling our Customer Service Department at 1-800-868-5200 – or visit the provider search tool at [fchp.org](http://fchp.org) to determine which providers are included in FCHP Direct Care.

\* Premium Saver 2000/500 II uses a closed formulary. The formulary list is limited and drugs not on the list will not be covered by your prescription drug benefit under any circumstances. **Employers cannot offer a closed formulary plan alongside an open formulary plan.**

\*\* 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](http://fchp.org).

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

† **Employer must fund \$1,000 of the deductible through an HRA in order to purchase a Premium Saver 3000 plan.**

This fact sheet highlights some of the benefits of FCHP Direct Care and FCHP Select Care. For full benefits, please go to [fchp.org](http://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.



## Fallon Preferred Care Premium Saver Deductible Plan Options

*Benefits effective April 1, 2011, and beyond.*

Benefit	Premium Saver 500	Premium Saver 1000	Premium Saver 1500	Premium Saver 1500 Classic	Premium Saver 2000/500	Premium Saver 2000 Classic	Premium Saver 3000 with Rx †	Premium Saver 3000 No Rx † (Non MCC)
Office visits—routine exams	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Office visits—other primary care	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25
Office visits—specialty care	\$40	\$40	\$40	\$40	\$40	\$40	\$40	\$40
Annual vision exams	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Prescriptions—Retail (up to a 30-day supply)	\$15/40/75	\$15/40/75	\$15/40/75	\$15/40/75	\$15/50/100	\$15/50/100	\$25/50/100	n/a
Prescriptions—Mail-order	\$30/80/225	\$30/80/225	\$30/80/225	\$30/80/225	\$30/100/300	\$30/100/300	\$50/100/300	n/a
Emergency room (waived if admitted)	\$100 copayment after deductible	\$150 copayment after deductible	\$200 copayment after deductible	\$200 copayment after deductible	\$200 copayment after deductible	\$200 copayment after deductible	\$200 copayment after deductible	\$200 copayment after deductible
Inpatient hospital	\$250 copayment after deductible	\$500 after deductible	\$500 after deductible	Covered in full after deductible	\$500 after deductible	Covered in full after deductible	\$500 after deductible	\$500 after deductible
Same-day surgery	\$250 copayment after deductible	\$250 after deductible	\$250 after deductible	Covered in full after deductible	\$250 after deductible	Covered in full after deductible	\$250 after deductible	\$250 after deductible
Chiropractic care	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25
Diagnostic services (Lab, X-ray, EKG, etc.)*	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	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible
Imaging (CAT, PET, MRI scans, Nuclear Cardiology)	\$100 copayment after deductible	\$150 copayment after deductible	\$150 copayment after deductible	Covered in full after deductible	\$150 copayment after deductible	Covered in full after deductible	\$150 copayment after deductible	\$150 copayment 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
Deductible (ind/fam)—for both in- and out-of-network services	\$500/1,000	\$1,000/2,000	\$1,500/3,000	\$1,500/3,000	\$2,000/4,000	\$2,000/4,000	\$3,000/6,000	\$3,000/6,000
Co-Insurance for out-of-network services	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Out-of-pocket maximum** (ind/fam)	\$4,000/8,000	\$4,000/8,000	\$5,000/10,000	\$5,000/10,000	\$5,000/10,000	\$5,000/10,000	\$5,000/10,000	\$5,000/10,000

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*Fallon Health & Life Assurance Company, Inc., is a wholly owned subsidiary of Fallon Community Health Plan.*



## FCHP Direct Care and FCHP Select Care Qualified High Deductible and Coinsurance Plan Options

*Benefits effective April 1, 2011, and beyond.*

Benefit	Premium Saver 65/35	Care Choice 1250	Care Choice 2000
Office visits—routine exams	\$0	\$0	\$0
Office visits—other primary care	\$25	\$25 per visit after deductible	\$25 per visit after deductible
Office visits—specialty care	\$40	\$40 per visit after deductible	\$40 per visit after deductible
Annual vision exams	\$0	\$0	\$0
Prescriptions—Retail (up to a 30-day supply)	\$15/30/50	\$15/30/50 after deductible	\$15/30/50 after deductible
Prescriptions—Mail order	\$30/60/150	\$30/60/150 after deductible	\$30/60/150 after deductible
Emergency room (waived if admitted)	35% coinsurance	\$100 per visit after deductible	\$100 per visit after deductible
Inpatient hospital	35% coinsurance	Covered in full after deductible	Covered in full after deductible
Same-day surgery	35% coinsurance	Covered in full after deductible	Covered in full after deductible
Chiropractic care (12 visits)	\$25	\$25 per visit after deductible	\$25 per visit after deductible
Diagnostic services (Lab, X-ray, EKG, etc.)*	35% coinsurance	Covered in full after deductible	Covered in full after deductible
Imaging (CAT, PET, MRI scans, Nuclear Cardiology)	35% coinsurance	Covered in full after deductible	Covered in full after deductible
Preventive services*	Covered in full	Covered in full	Covered in full
Deductible (ind/fam)	None	\$1,250/2,500	\$2,000/4,000
Out-of-pocket maximum** (ind/fam)	\$5,000/10,000	\$4,000/8,000	\$5,000/10,000

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## Fallon Preferred Care Qualified High Deductible Plan Options

*Benefits effective April 1, 2011, and beyond.*

Benefit	Care Choice 1250	Care Choice 2000
Office visits—routine exams	\$0	\$0
Office visits—other primary care	<b>\$25 per visit after deductible</b>	<b>\$25 per visit after deductible</b>
Office visits—specialty care	\$40 per visit after deductible	\$40 per visit after deductible
Annual vision exams	\$0	\$0
Prescriptions—Retail (up to a 30-day supply)	<b>\$15/30/50 after deductible</b>	<b>\$15/30/50 after deductible</b>
Prescriptions—Mail order	<b>\$30/60/150 after deductible</b>	<b>\$30/60/150 after deductible</b>
Emergency room (waived if admitted)	\$100 per visit after deductible	\$100 per visit after deductible
Inpatient hospital	Covered in full after deductible	Covered in full after deductible
Same-day surgery	Covered in full after deductible	Covered in full after deductible
Chiropractic care	<b>\$25 per visit after deductible</b>	<b>\$25 per visit after deductible</b>
Diagnostic services (Lab, X-ray, EKG, etc.)*	Covered in full after deductible	Covered in full after deductible
Imaging (CAT, PET, MRI scans, Nuclear Cardiology)	Covered in full after deductible	Covered in full after deductible
Preventive services*	Covered in full	Covered in full
Deductible (ind/fam) —for both in- and out-of-network services	\$1,250/2,500	\$2,000/4,000
Co-Insurance for out-of-network services	20% after deductible	20% after deductible
Out-of-pocket maximum** (ind/fam)	\$5,000/10,000	\$5,000/10,000

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## FCHP Direct Care and FCHP Select Care Premium Saver Inpatient Copayment Plan Options

*Benefits effective April 1, 2011, and beyond*

Benefit	Premium Saver I	Premium Saver II (Closed Formulary)	Premium Saver Value I	Premium Saver Basic I	Premium Saver Basic II
Office visits—routine exams	\$0	\$0	\$0	\$0	\$0
Office visits—other primary care	\$15	\$15	\$20	\$25	\$25
Office visits—specialty care	\$30	\$30	\$35	\$40	\$40
Annual vision exams	\$0	\$0	\$0	\$0	\$0
Prescriptions—Retail (up to a 30-day supply)	\$15/30/50	\$25/100/100*	\$15/30/50	\$15/30/50	\$15/50/100
Prescriptions—Mail-order	\$30/60/150	\$50/200/300	\$30/60/150	\$30/60/150	\$30/100/300
Emergency room (waived if admitted)	\$100	\$100	\$150	\$150	\$150
Inpatient hospital	\$350	\$350	\$600	\$1,200	\$1,200
Same-day surgery	\$350	\$350	\$600	\$800	\$800
Chiropractic care (12 visits)	\$15	\$15	\$20	\$25	\$25
Diagnostic services (Lab, X-ray, EKG, etc.)	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Imaging (CAT, PET, MRI scans, Nuclear Cardiology)	\$50	\$50	\$75	\$150	\$150
Preventive services	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Out-of-pocket maximum** (ind/fam)	\$2,000/4,000	\$2,000/4,000	\$2,000/4,000	\$3,000/6,000	\$3,000/6,000

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## Fallon Preferred Care Premium Saver Inpatient Copayment Plan Options

*Benefits effective April 1, 2011, and beyond*

Benefit	Premium Saver I	Premium Saver Value I	Premium Saver Basic I	Premium Saver Basic II
Office visits—routine exams	\$0	\$0	\$0	\$0
Office visits—other primary care	\$15	\$20	\$25	\$25
Office visits—specialty care	\$30	\$35	\$40	\$40
Annual vision exams	\$0	\$0	\$0	\$0
Prescriptions—Retail (up to a 30-day supply)	\$15/30/50	\$15/30/50	\$15/30/50	\$15/50/100
Prescriptions—Mail-order	\$30/60/150	\$30/60/150	\$30/60/150	\$30/100/300
Emergency room (waived if admitted)	\$100	\$150	\$150	\$150
Inpatient hospital	\$350	\$600	\$1,200	\$1,200
Same-day surgery	\$350	\$600	\$800	\$800
Chiropractic care	\$15	\$20	\$25	\$25
Diagnostic services (Lab, X-ray, EKG, etc.)	Covered in full	Covered in full	Covered in full	Covered in full
Imaging (CAT, PET, MRI scans, Nuclear Cardiology)	\$50	\$75	\$150	\$150
Preventive services	Covered in full	Covered in full	Covered in full	Covered in full
Out-of-network deductible (for services received out-of-network only)	\$300/600	\$400/800	\$500/1000	\$500/1000
Co-insurance for out-of-network services	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Out-of-pocket maximum** (ind/fam)	\$2,500/5,000	\$2,500/5,000	\$3,000/6,000	\$3,000/6,000

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