Fallon Preferred Care Premium Saver 2000/500

Benefit Summary—*Benefits effective January 1, 2012 and beyond*

The FCHP difference

With Fallon Preferred Care Premium Saver 2000/500, you get everything you need to live a healthy life. This plan features comprehensive medical benefits for lower monthly premiums and slightly higher out-of-pocket expenses compared to our other plans. Your monthly premiums are reduced further through the use of an annual deductible for certain services and a copayment for hospital admissions. Plus, you get:

- **A fitness reimbursement of up to $400** for families ($200 for individual contracts) that can be used for gym memberships at the gym of your choice with no limitations, school and town sports fees, exercise classes, ski lift tickets, and more!
- **$0 copayments for routine physical exams** and other preventive services, including mammograms, cholesterol screenings and immunizations
- **$0 copayments for routine annual eye exams**
- **Nurse Connect:** A free 24/7 nurse call line
- **Member discounts** on products and services to keep you healthy and features you won't find anywhere else.

How to receive care:

With Fallon Preferred Care Premium Saver 2000/500, you have an extensive regional and national network of providers from which to choose. The Fallon Preferred Care network is comprised of over 600,000 network providers—giving you the flexibility to receive care close to where you live and work.

In-network and out-of-network coverage

Fallon Preferred Care is a preferred provider organization (PPO) plan, and as such, we contract with a network of participating providers who have agreed to provide health care services to our members—your use of participating providers is strictly voluntary.

When you obtain covered services from participating providers, you will receive the in-network level of benefits. We pay participating providers directly; you will not have to file claims when you use participating providers. When you obtain covered services from nonparticipating providers, you get the out-of-network level of benefits. You may need to submit a claim for covered services you receive from nonparticipating providers. For information on claims submission, refer to your Fallon Preferred Care *Member Handbook/Evidence of Coverage*.

Emergency medical care

Emergency services do not require referral or authorization. When you have an emergency medical condition, you should go to the nearest emergency department or call your local emergency communications system (police, fire department or 911). For more information on emergency benefits and plan procedures for emergency services, consult your Fallon Preferred Care *Member Handbook/Evidence of Coverage.*

Plan specifics	In-network	Out-of-network
Benefit period The benefit period, sometimes referred to as a "benefit year" is the 12-month span of plan coverage, and the time during which the deductible, out-of-pocket maximum and specific benefit maximums accumulate.	Varies by employer	
Deductible A deductible is the amount of allowed charges you pay per benefit period before payment is made by the plan for certain covered services. The amount that is put toward your deductible is calculated based on the allowed charge or the provider's actual charge— whichever is less.	$2,000 individual $4,000 family	
Embedded deductible Please note that once any one member in a family accumulates $2,000 of services that are subject to the family deductible, that individual member's deductible is considered met, and that family member will receive benefits for covered services less any applicable copayments.	$2,000	
Deductible carryover Any deductible amount that is incurred by the member for services rendered during the last three months of the benefit period will be applied toward the deductible for the next benefit period. Deductible amounts are incurred as of the date of the service.	Included	
Out-of-pocket maximum The out-of-pocket maximum is the total amount of deductible, coinsurance and copayments you are responsible for in a benefit period. Copayments for prescription drugs do not count toward the out-of-pocket maximum. The out-of-pocket maximum also does not include your premium charge or any amounts you pay for services that are not covered by the plan.	$5,000 individual $10,000 family	
Coinsurance Coinsurance is the percentage of medical expense you are required to pay after the deductible amount is satisfied.	n/a	20%
Penalty for failure to follow medical management procedures*	$200 per occurrence	$500 per occurrence

Benefits	Your cost in-network	Your cost out-of-network (after your deductible)
Office		
Routine physical exams	$0	20% coinsurance
Office visits (primary care provider)	$25 per visit	20% coinsurance
Office visits (specialist)	$40 per visit	20% coinsurance
Office visits (limited service clinics, e.g., Minute Clinic)	$25 per visit	20% coinsurance
Routine eye exams (one every 12 months)	$0 per visit	20% coinsurance
Short-term rehabilitative services (60 visits per benefit period)	$25 per visit after deductible	20% coinsurance
Prenatal care	$25 first visit only	20% coinsurance
Postnatal care	$25 per visit	20% coinsurance

** Some services require plan notification or prior authorization. A penalty will be applied for failure to follow the plan's medical management procedures. The penalty does not apply toward the deductible or out-of-pocket maximum.*

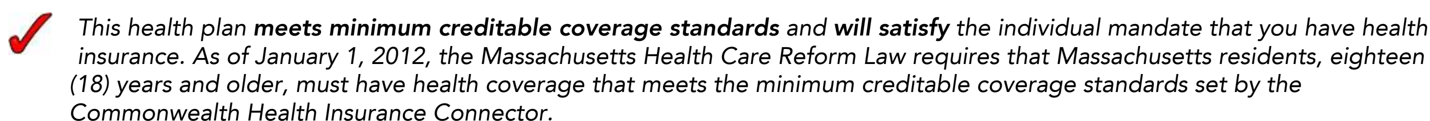
Benefits	Your cost in-network	Your cost out-of-network (after your deductible)
Preventive services Tests, immunizations and services geared to help screen for diseases and improve early detection when symptoms or diagnosis are not present	Covered in full	20% coinsurance
Diagnostic services Tests, immunizations and services that are intended to diagnose, check the status of, or treat a disease or condition	Covered in full after deductible	20% coinsurance
Imaging (CAT, PET, MRI, Nuclear Cardiology)	$150 copayment after deductible	20% coinsurance
Manual manipulation of the spine ($500 benefit per benefit period)	$25 per visit	20% coinsurance
Prescriptions	**Tier 1/Tier 2/Tier 3**	
Prescription drugs, including oral contraceptives, insulin and insulin syringes	$15/$50/$100 (30-day supply)	20% coinsurance
Prescription medication refills obtained through the mail order program	$30/$100/$300 (90-day supply)	20% coinsurance
Prilosec OTC, Prevacid 24HR, omeprazole OTC (prescription required)	$5	20% coinsurance
Inpatient hospital services		
Room and board in a semiprivate room (private when medically necessary)	$500 copayment after deductible	20% coinsurance
Physicians' and surgeons' services	Covered in full after deductible	20% coinsurance
Physical and respiratory therapy	Covered in full after deductible	20% coinsurance
Intensive care services	Covered in full after deductible	20% coinsurance
Maternity care	Covered in full after deductible	20% coinsurance
Same-day surgery		
Same-day surgery in a hospital outpatient or ambulatory care setting	$250 copayment after deductible	20% coinsurance
Emergencies		
Emergency room visit	$200 per visit after deductible (waived if admitted)	
Skilled nursing		
Skilled care in a semiprivate room	$500 copayment after deductible	20% coinsurance
Substance abuse		
Office visits	$25 per visit	20% coinsurance
Detoxification in an inpatient setting	$500 copayment after deductible	20% coinsurance
Rehabilitation in an inpatient setting	$500 copayment after deductible	20% coinsurance

Benefits	Your cost in-network	Your cost out-of-network (after your deductible)
Mental health		
Office visits	$25 per visit	20% coinsurance
Services in a general or psychiatric hospital	$500 copayment after deductible	20% coinsurance
Other health services		
Skilled home health care services	Covered in full after deductible	20% coinsurance
Durable medical equipment	30% coinsurance after deductible	30% coinsurance
Medically necessary ambulance services	Covered in full after deductible	20% coinsurance
Value-added benefits and features		
It Fits!, an annual fitness reimbursement (including school and town sports programs, gym memberships, Weight Watchers®, aerobics, Pilates and yoga classes)		$200 individual $400 family
Oh Baby!, a program that provides prenatal vitamins, a convertible car seat and other "little extras" for expectant parents—all at no additional cost.		Included
Free 24/7 nurse call line		Included
Free chronic care management		Included
Free stop-smoking program		Included
Member discount program		Included
Free online access to health and wellness encyclopedia		Included
CVS Caremark ExtraCare Health Card – provides 20% discount on CVS/pharmacy Brand health related items.		Included
Exclusions		
Dental benefits and discounts, other than those listed in the *Evidence of Coverage*		
Hearing aids and the evaluation for a hearing aid		
Long-term rehabilitative services		
Nonprescription drugs and vitamins		
Cosmetic surgery		
Experimental procedures or services that are not generally accepted medical practice		
Routine foot care		
Custodial confinement		

A complete list of benefits and exclusions is in the Fallon Preferred Care *Member Handbook/Evidence of Coverage*, available by request. This is only a summary of benefits and exclusions.

Questions?

If you have any questions, please contact Fallon Community Health Plan Customer Service at 1-888-468-1541 (TDD/TTY: 1-877-608-7677), or visit our Web site at fchp.org.



This health plan ***meets minimum creditable coverage standards*** *and* ***will satisfy*** *the individual mandate that you have health insurance. As of January 1, 2012, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years and older, must have health coverage that meets the minimum creditable coverage standards set by the Commonwealth Health Insurance Connector.*

Benefits may vary by employer group.
Weight Watchers® is a registered trademark of Weight Watchers International, Inc.
Fallon Health & Life Assurance Company, Inc., is a wholly owned subsidiary of Fallon Community Health Plan.