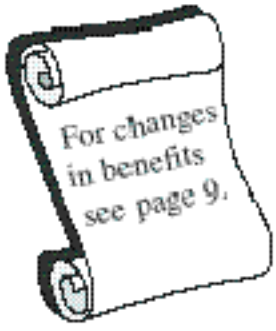
FALLON COMMUNITY HEALTH PLAN

http://www.fchp.org

2001

A Health Maintenance Organization



Serving: Central and Eastern Massachusetts

Enrollment in this Plan is limited; see page 5 for requirements.

This Plan has Excellent accreditation from the NCQA. See the 2001 guide for more information on NCQA.

Enrollment codes for this Plan:

JV1 Self Only
JV2 Self and Family

Authorized for distribution by the:

Authorized for distribution by the

United States
Office of Personnel Management

RI 73-090

Table of Contents

Introduction 4

Plain Language 4

Section 1. Facts about this HMO plan 5

How we pay providers 5

Who provides my health care? 5

Patients' Bill of Rights 5

Service Area 7

Section 2. How we change for 2001 9

Program-wide changes 9

Changes to this Plan 9

Section 3. How you get care 10

Identification cards 10

Where you get covered care 10

- Plan providers 10
- Plan facilities 10

What you must do to get covered care 10

- Primary care 10
- Specialty care 10
- Hospital care 11

Circumstances beyond our control 12

Services requiring our prior approval 12

Section 4. Your costs for covered services 13

- Copayments 13
- Deductible 13
- Coinsurance 13

Your out-of-pocket maximum 13

Section 5. Benefits 14

Overview 14

(a) Medical services and supplies provided by physicians and other health care professionals 15

(b) Surgical and anesthesia services provided by physicians and other health care professionals 23

(c) Services provided by a hospital or other facility, and ambulance services 28

(d) Emergency services/accidents 30

(e) Mental health and substance abuse benefits 32

(f) Prescription drug benefits 34

(g) Special features 37

(h) Dental benefits 39

(i) Non-FEHB benefits available to Plan members 41

Section 6. General exclusions – things we don't cover 42
Section 7. Filing a claim for covered services 43
Section 8. The disputed claims process 44
Section 9. Coordinating benefits with other coverage 46
When you have…
- Other health coverage 46
- Original Medicare 46
- Medicare managed care 48

TRICARE/Workers' Compensation/Medicaid 49
Other Government agencies 49
When others are responsible for injuries 49
Section 10. Definitions of terms we use in this brochure 50
Section 11. FEHB facts 51
Coverage information 51
- No pre-existing condition limitation 51
- Where you get information about enrolling in the FEHB Program 51
- Types of coverage available for you and your family 51
- When benefits and premiums start 52
- Your medical and claims records are confidential 52
- When you retire 52

When you lose benefits 52
- When FEHB coverage ends 52
- Spouse equity coverage 52
- Temporary Continuation of Coverage (TCC) 52
- Converting to individual coverage 53
- Getting a Certificate of Group Health Plan Coverage 53

Inspector General advisory 53
Index 54
Summary of benefits 56
Rates ..... Back cover

Introduction

Fallon Community Health Plan
10 Chestnut Street
Worcester, Massachusetts 01608

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. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Fallon Community Health Plan.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

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.

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 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 copayments.

Fallon pays its providers using various payment methods, including capitation, per diem, incentive, and discounted fee-for-service arrangements. Capitation means paying a fixed dollar amount per month for each member assigned to the provider. Per diem means paying a fixed dollar amount per day for all services rendered. Incentive means a payment that is based on appropriate medical management by the provider. Discounted fee-for-service means paying the provider's usual, customary and regular fee discounted by an agreed-to percentage.

You are entitled to ask if we have special financial arrangements with our physicians that can affect the use of referrals and other services that you might need. To get this information, call our Customer Service Department at 1-800-868-5200 and request information about our physician payment arrangements.

Who provides my health care?

This Plan is a mixed model prepayment plan that offers two provider options from which to choose, Fallon Plus and Fallon Affiliates. You are asked to select a provider option for each member of your family at the time of enrollment. However, you may switch from the Fallon Plus to Fallon Affiliates option and vice versa at any time during the year. The change will become effective on the first of the month following the Plan's receipt of notification.

Each member of a family may choose a different doctor from separate provider options. A member's personal doctor provides routine and emergency care and arranges for specialty care as needed.

The Plan provides coverage for urgent and emergency care around the world. Within the Plan's service area, you must call your doctor for directions before seeking care. Of course, if the emergency is life threatening, go to the nearest emergency room. Outside of the service area, you are covered for emergency services obtained at any medical facility, but should call for authorization before seeking follow-up care.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. 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.

- We are licensed by the Commonwealth of Massachusetts as an HMO. Fallon is also a federally qualified HMO.
- We have been operating since 1977.
- We are 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 Street, Worcester, Massachusetts 01608. You may also contact us by fax at 508-831-0912, or visit our Web site at www.wfchp.org.

Service Area

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

Abington
Acton
Andover
Arlington
Ashburnham
Ashby
Ashland
Assonet
Athol
Attleboro
Auburn
Avon
Ayer
Barre
Bedford
Bellingham
Belmont
Berkley
Berlin
Beverly
Billerica
Blackstone
Bolton
Boston
Boxborough
Boxford
Boylston
Braintree
Bridgewater
Brimfield
Brockton
Brookfield
Brookline
Burlington
Cambridge
Canton
Carlisle
Charlton
Chelmsford
Chelsea
Clinton
Cohasset
Concord
Danvers
Dedham
Dighton
Douglas
Dover
Dracut
Dudley
Dunstable
Duxbury
East Bridgewater
East Brookfield
East Walpole
Easton
Essex
Everett
Fall River
Fitchburg
Foxborough
Framingham
Franklin
Freetown
Gardner
Georgetown
Gloucester
Grafton
Groton
Halifax
Hamilton
Hanover
Hanscom AFB
Hanson
Hardwick
Harvard
Hathorne
Haverhill
Hingham
Holbrook
Holden
Holland
Holliston
Hopedale
Hopkinton
Hubbardston
Hudson
Hull
Ipswich
Kingston
Lakeville
Lancaster
Lawrence
Leicester
Leominster
Lexington
Lincoln
Littleton
Lowell
Lunenburg
Lynn
Lynnfield
Malden
Manchester
Mansfield
Marblehead
Marlborough
Marshfield
Mattapan
Maynard
Medfield
Medford
Medway
Melrose
Mendon
Methuen
Middleborough
Middleton
Milford
Millbury
Millis
Millville
Milton
Monson
Nahant
Natick
Needham
New Braintree
Newton
Norfolk
North Andover
North Attleborough
North Billerica
North Brookfield
North Chelmsford
North Reading
Northborough
Northbridge
Norton
Norwell
Norwood
Oakham
Orange
Oxford
Palmer
Paxton
Peabody
Pembroke
Pepperell
Petersham
Phillipston
Pinehurst
Plainville
Plympton
Princeton
Quincy
Randolph
Raynham
Reading
Rehoboth
Revere
Rockland
Rockport
Rowley
Royalston
Rutland
Salem
Saugus
Scituate
Seekonk
Sharon
Sherborn
Shirley
Shrewsbury
Somerset
Somerville
South Hamilton
South Walpole
Southborough
Southbridge
Spencer
Sterling
Stoneham
Stoughton
Stow
Sturbridge
Sudbury
Sutton
Swampscott
Swansea
Taunton
Templeton
Tewksbury
Topsfield
Townsend
Tyngsborough
Upton
Uxbridge
Village of Nagog Woods
Wales
Walpole
Waltham
Ware
Warren
Watertown
Waverly
Wayland

Webster
Wellesley
Wenham
West Boylston
West Bridgewater
West Brookfield
Westborough
Westford
Westminster
Weston
Westwood
Weymouth
Whitman
Wilmington
Winchendon
Winchester
Winthrop
Woburn
Worcester
Wrentham

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling 1-800-868-5200, **or** checking our Web site, www.fchp.org. You can find out more about patient safety on the OPM Web site, www.opm.gov/insure. To improve your healthcare, take these five steps:

  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-postal premium will increase by 20.4% for Self Only or 33.3% for Self and Family.
- This Plan has expanded coverage for diabetic services and supplies to include blood glucose monitors and monitoring strips for home use, voice synthesizers for blood glucose monitors and visual magnifying aids for the legally blind, urine glucose strips, ketone strips, lancets, insulin pumps and supplies, insulin pens, therapeutic/molded shoes and shoe inserts for members with severe diabetic foot disease, and outpatient training and education, including medical nutrition therapy.

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 (TTD/TTY: 1-877-608-7677).

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 at www.fchp.org.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website at www.fchp.org.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. The Fallon provider directory contains names of, and information about, Plan physicians who are available as primary care physicians. Call Customer Service at 1-800-868-5200 (TTD/TTY 1-877-608-7677) for more information about Plan providers or for assistance in choosing a primary care physician.

- **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may obtain annual eye examinations, mental health services and substance abuse services without a referral from your primary care physician. A woman may also see her Plan gynecologist for her annual routine examination without a referral from her primary care doctor.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex or serious medical condition, your primary care physician will develop

a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

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

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

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

If you are in the hospital when your enrollment in our Plan begins, call our Health Management Services department immediately at 1-800-879-0852. If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or

- The day your benefits from your former plan run out; or

- The 92nd day after you become a member of this Plan, whichever happens first.

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

Circumstances beyond our control

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

Services requiring our prior approval

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

Your physician must obtain prior approval for the following services:

- Organ/tissue transplants
- All non-emergency hospital admissions
- Outpatient surgery
- Certain rehabilitation services, clinics, and diagnostic tests
- Prosthetics and Orthotics
- Nutritionist services

Mental health and substance abuse services do not require a referral from your personal physician, but these services do require authorization (call 1-888-421-8861 to access mental health or substance abuse services).

Services requiring authorization, which have not been authorized by the Plan, may not be covered.

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 when you receive services. Example: When you see your primary care physician you pay a copayment of $10.
•**Deductible**	We do not have a deductible.
•**Coinsurance**	We do not have coinsurance.
Your out-of-pocket maximum	We do not have an out-of-pocket maximum.

Section 5. Benefits -- OVERVIEW

(See page 9 for how our benefits changed this year and page 56 for a benefits summary.)

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

(a) Medical services and supplies provided by physicians and other health care professionals 14-23

• Diagnostic and treatment services	• Hearing services (testing, treatment, and supplies)
• Lab, X-ray, and other diagnostic tests	• Vision services (testing, treatment, and supplies)
• Preventive care, adult	• Foot care
• Preventive care, children	• Orthopedic and prosthetic devices
• Maternity care	• Durable medical equipment (DME)
• Family planning	• Home health services
• Infertility services	• Alternative treatments
• Allergy care	• Educational classes and programs
• Treatment therapies	
• Rehabilitative therapies	

(b) Surgical and anesthesia services provided by physicians and other health care professionals 23-27

• Surgical procedures	• Oral and maxillofacial surgery
• Reconstructive surgery	• Organ/tissue transplants
	• Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services 28-29

• Inpatient hospital	• Extended care benefits/skilled nursing care facility benefits
• Outpatient hospital or ambulatory surgical center	• Hospice care
	• Ambulance

(d) Emergency services/accidents 30-31
- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits 32-33

(f) Prescription drug benefits 34-36

(g) Special features 37-38
- Services for deaf and hearing impaired members
- Interpreter Services
- Reciprocity benefits
- Peace of Mind program
- Out-of-area emergency and urgent care
- Out-of-area student coverage

(h) Dental benefits 39-40

(i) Non-FEHB benefits available to Plan members 41

Summary of benefits 56

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In a physician's office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion • Outpatient self-management diabetic training and education, including medical nutrition therapy • At home	$10 per office visit (for services in a physician's office); nothing, in any other setting (such as during a hospital stay)
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Preventive care, adult	
Routine screenings, such as: • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including ••Fecal occult blood test ••Sigmoidoscopy, screening – every five years starting at age 50	Nothing
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	Nothing
Routine Pap test Note: The office visit is covered if Pap test is received on the same day; see *Diagnostic and Treatment services*, above.	Nothing
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 and up, one every calendar year	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing
Preventive care, children	**You pay**
• Childhood immunizations in accordance with Massachusetts law	Nothing
• Well-child care charges for routine examinations, immunizations and care (through age 22) • Screening for lead poisoning, for children under 6 years of age, in accordance with Massachusetts law	Nothing

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. This includes nursery charges, circumcision, routine examination, hearing screening, and medically necessary treatments of congenital defects, birth abnormalities or premature birth. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 for the first office visit only for prenatal care, then for all subsequent visits you pay nothing. $10 for each postnatal care office visit.
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling.	*All charges.*

Infertility services	You pay

Fallon covers the diagnosis and treatment of infertility, as defined under Massachusetts law.
 	
To be eligible, you must be an individual who:
(1) should expect fertility as a natural state; and
(2) is a pre-menopausal female or a female who is experiencing menopause at a premature age.
Approval for Assisted Reproductive Technology (ART) is contingent upon review by the Medical Director of your medical history, including but not limited to, diagnosis, fertility treatment history, menopause status, identifiable causes of infertility, risk factors, fertility work-up results (such as menstrual and sexual history, infection, sexually transmitted diseases, previous fertility, and production of sperm), laboratory values and any other relevant clinical information.
 	
Coverage is provided for the services below when determined to be medically necessary by a Plan medical director. Original approval is for 4 ART cycles; if you wish to continue beyond 4 cycles, further medical review by the medical director is required.
 	
Fallon's coverage guidelines for all ART services are available by contacting the Customer Service Department at 1-800-868-5200 and is covered as follows:
 	
• Office visits with a Plan physician or specialty care physician for the evaluation and diagnosis of fertility and diagnostic laboratory and X-ray services
 	
• Artificial insemination:
  • intravaginal insemination (IVI)
  • intracervical insemination (ICI)
  • intrauterine insemination (IUI)
• Other assisted reproductive technologies (ART) including:
  • gamete intrafallopian transfer
  • intracytoplasmic sperm injection
  • zygote intrafallopian transfer
  • in vitro fertilization
• Sperm, egg, and/or inseminated egg procurement, processing, and banking
• Fertility drugs (Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.)
	$10 per office visit; nothing, for services in any other setting.

Infertility benefits—continued on next page

Not covered: • *Treatments, services and supplies which have not been determined to be medically necessary* • *Donor egg transfer for women who are menopausal, except as stated above* • *Chromosome studies of a donor (sperm or egg)* • *Charges for the storage of donor sperm, eggs, or embryo that remain in storage after the completion of an approved treatment cycle* • *Compensation to a donor (this does not include charges related to the procurement and processing of sperm, egg, and inseminated egg, to the extent that the donor's insurance does not cover these costs)* • *Supplies that may be purchased without a physician's written order, such as ovulation test kits* • *Services which are necessary due to a voluntary sterilization, or for which there is no diagnosis of infertility* • *Surrogacy or gestational carrier services* • *Transportation costs to or from the medical facility*	*All charges.*
Allergy care	
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	**You pay**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 25. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT)—Note: – We will only cover GHT when we preauthorize the treatment. See your Plan physician to obtain preauthorization; he or she can submit information that establishes that the GHT is medically necessary. Coverage is under the prescription benefit.	$10 per office visit

Rehabilitative therapies	You pay

Physical therapy, occupational therapy and speech therapy –
• Up to 60 consecutive days or 20 nonconsecutive visits (whichever is greater) per condition per calendar year for the services of each of the following:
  ◦◦qualified physical therapists;
  ◦◦speech therapists; and
  ◦◦occupational therapists.
  Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury.
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction.
• Early intervention services for children through age three for services such as physical, occupational, and speech therapy, nursing care and psychological counseling. Benefits are limited to a maximum of $3,200 per year per child and a total of $9,600 over the term of the child's membership.
	$10 per outpatient session

Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*
Hearing services (testing, treatment and supplies)	
• Hearing testing for children through age 17	$10 per visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	**You pay**
• Diagnosis and treatment of diseases of the eye.	$10 per office visit
• Eye exam to determine the need for vision correction • Annual eye refractions, including written lens prescriptions for eyeglasses	$10 per office visit

Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Eye examination for contact lenses*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for metabolic or peripheral vascular disease, such as diabetes (preauthorization is required). See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*
Orthopedic and prosthetic devices	**You pay**
• Prosthetic devices, such as artificial limbs and eyes. Durable medical equipment and prosthetic devices are covered up to a combined maximum of $1500 per calendar year.	Nothing up to $1500 per calendar year for orthopedic devices, prosthetic devices and durable medical equipment combined; you pay all charges beyond $1500.
• Scalp hair prostheses (wigs) for members who have suffered hair loss as a result of any treatment for cancer or leukemia.	Nothing up to $350 per calendar year; you pay all charges beyond $350.
• Breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Occlusal splint for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome (preauthorization is required).	Nothing

Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges.*
Durable medical equipment (DME)	**You pay**
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Durable medical equipment and prosthetic devices are covered up to a combined maximum of $1500 per calendar year. Under this benefit, we also cover: • hospital beds; • wheelchairs; • crutches; • walkers; • blood glucose monitors for home use; therapeutic/molded shoes and shoe inserts for the treatment of severe diabetic foot disease; and visual magnifying aids and voice synthesizers for blood glucose monitors, for use by the legally blind.	Nothing up to $1500 per calendar year for orthopedic devices, prosthetic devices and durable medical equipment combined; you pay all charges beyond $1500. (Oxygen is not subject to the $1500 limit. You pay nothing for oxygen.)
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Services include: • skilled nursing care • physical therapy, occupational therapy, oxygen therapy, intravenous therapy, and medications • medical social services, nutritional services and home health aide services • medication visits to monitor, evaluate or adjust the prescription medication dosage that is being prescribed for a medical or psychological condition.	Nothing
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication*	*All charges.*

Alternative treatments	
• Chiropractic services, for the treatment of acute musculoskeletal conditions. The condition must be new or an exacerbation of a previous condition. Treatment must be provided by a participating chiropractor and requires a referral by a primary care doctor. Coverage is provided for up to 20 office visits in each calendar year.	$10 per visit (visits 1-10) $25 per visit (visits 11-20)
Not covered: • *naturopathic services* • *hypnotherapy* • *acupuncture* • *biofeedback*	*All charges.*
Educational classes and programs	
Health education and nutritional services, such as: • Health Education • Library Services • Nutrition classes and programs • Behavioral Medicine • Women's Wellness • Outpatient self-management diabetic training and education, including medical nutrition therapy (may require preauthorization)	copayment varies; see your *Fallon Member Magazine* for more information.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- 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.)
- YOU MUST GET PREAUTHORIZATION OF SOME SURGICAL PROCEDURES. Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
Such as: • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • 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 18 or over. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. • Voluntary sterilization • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit; nothing, for hospital visits.
• Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Family Planning services are covered under 5(a)	$200 per implantation procedure except for Norplant, for which you pay a $400 copayment per implantation procedure. There will be no refund of any portion of these copays if the implanted time-release medication is removed before the end of its expected life.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*

Reconstructive surgery	

• Surgery to correct a functional defect
• Surgery to correct a condition caused by injury or illness if:
  ◦◦ the condition produced a major effect on the member's appearance and
  ◦◦ the condition can reasonably be expected to be corrected by such surgery
• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.
• All stages of breast reconstruction surgery following a mastectomy, such as:
  ◦◦ surgery to produce a symmetrical appearance on the other breast;
  ◦◦ treatment of any physical complications, such as lymphedemas;
  ◦◦ breast prostheses and surgical bras and replacements (see Prosthetic devices)
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.
	Nothing

Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office visit.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Kidney • Liver for adults with primary sclerosing cholangitis, primary biliary cirrhosis, hepatitis B surface antigen negative, postnecrotic cirrhosis, alcoholic cirrhosis, alpha-1 antitrypsin deficiency disease, Wilson's disease, or primary hemochromatosis; or for children with biliary atresia or end-stage liver disease. • Heart/lung for patients under age 60 with end-stage primary or secondary pulmonary hypertension • Lung (single or double) for patients under age 60 with end-stage obstructive or restrictive pulmonary disease • 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; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; epithelial ovarian cancer; testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; or for patients under age 65 with chemo-responsive multiple myeloma • Allogeneic bone marrow transplant for leukemia, aplastic anemia, severe combined immunodeficiency disease, Wiskott-Aldrich syndrome for patients with high risk lymphoblastic lymphoma in remission, or for patients under age 60 with myelodysplasia Services must be provided at a Plan-affiliated transplant facility, subject to your acceptance into the facility's program. The transplant facility makes the final determination on eligibility for transplant coverage. Note: We cover related medical and hospital expenses of the donor when we cover the recipient, unless the donor's expenses are covered by other insurance.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Transplants not listed as covered, including (but not limited to) bone marrow transplants for treatment of solid tumors* • *Services for the organ donor that are covered by another insurance plan* • *Services for the organ donor if the recipient is not a member of this plan* • *Transportation, housing or home cleaning services incurred by either the donor or recipient*	*All charges*

Anesthesia	You pay
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We do not have a calendar year deductible.
- 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 Section 5(a) or (b).
- **YOU MUST GET PREAUTHORIZATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, 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	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds*	*All charges.*

Outpatient hospital or ambulatory surgical center	
• 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 • Presurgical testing • Dressings, casts and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Extended care benefits/skilled nursing care facility benefits	**You pay**
This Plan provides a comprehensive range of benefits for 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by this Plan. All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, equipment and supplies ordinarily provided or arranged by the skilled nursing facility, when prescribed by a Plan doctor.	Nothing
Not covered: custodial care, or long-term inpatient care	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include outpatient care, family counseling, and short-term inpatient care for up to 5 days of continuous inpatient care. These services are provided under the direction of a Plan doctor who certified that the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

If you are in an emergency situation, please call your primary care physician. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., 911, the police department or fire department) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so you can notify this Plan. You or a family member must notify this Plan as soon as reasonably possible to do so. It is your responsibility to ensure that we have been notified in a timely manner.

Emergencies within our service area:

If you need to be hospitalized, this Plan must be notified as soon as reasonably possible. If you are hospitalized in a non-Plan facility and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers only if a delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition. Any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Emergencies outside our service area:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified as soon as reasonably possible. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Any follow-up care recommended by Plan providers must be approved by this Plan or provided by Plan providers.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per visit at a doctor's office or a Fallon urgent care center
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per visit at a hospital emergency room (waived if admitted or held in observation room)
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per visit at a doctor's office or urgent care center
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per visit at a hospital emergency room (waived if admitted or held in observation room)
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges.*
Ambulance	
Professional ambulance service when medically appropriate.	Nothing
Not covered: • *air ambulance, when not appropriate to medical and geographic conditions* • *transfers between hospitals when the patient's medical condition does not warrant that he/she be transported to another facility*	*All charges.*

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

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

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:

- All benefits are subject to the definitions, limitations and exclusions in this brochure.
- 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 PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists or clinical social workers • Medication management	$10 per visit
• Diagnostic tests	Nothing
• 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	Nothing

Not covered: Services we have not approved *Note : OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization

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

To access mental health and substance abuse services, call 1-888-421-8861 (TDD/TTY 781-994-7660). Identify yourself as a member, and you will be assisted in choosing an appropriate mental health or substance abuse clinician.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause

If this condition applies to you, we will allow you reasonable time to transfer your care to a network mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Limitation

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

.

How to submit claims

You should only need to file a claim if you receive services out of area as part of an approved emergency medical treatment. The address to submit mental health and substance abuse claims is:

Beacon Health Strategies
500 Unicorn Park Drive
Woburn, Massachusetts 01801

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A plan physician, a referral doctor on an authorized visit or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, or through a Plan-affiliated mail order pharmacy supplier. Services are provided through the pharmacy network designated by your health care option (Fallon Plus or Fallon Affiliates).
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with this Plan's drug formulary. A drug formulary is a list of medications selected to be offered by our drug program, based on safety, efficacy, and cost-effectiveness. Fallon's formulary is developed and maintained by the Fallon Drug Evaluation Committee under the direction of the Pharmacy and Therapeutics Committee.

  Drugs not listed on the Fallon Formulary may be available through the non-formulary request program. This process provides the prescribing physician with the ability to request non-formulary drugs that he or she feels is necessary to treat your medical condition. Non-formulary drugs will be covered only when prescribed by a Plan doctor and approved by the Plan. It is the prescribing doctor's responsibility to obtain authorization for non-formulary drugs before they are dispensed.
- **Dispensing limitations.** Prescription drugs will generally be dispensed for up to a 30-day supply. We follow FDA dispensing guidelines; in no case will a supply greater than 90 days be dispensed. You generally cannot obtain a refill until most or all of the previous supply has been used.

  At the pharmacy, you pay a $5 copay for generic items (when available) or a $10 copay for a 30-day supply of name brand items. There is a $2 discount for prescription medication refills obtained through a Fallon mail order program. Most medications can be mailed; however, there are some that cannot be mailed. The pharmacist will make this determination. If the price of a prescription is less than the normal copay amount, your copay is the lower amount. If there is no generic equivalent available, you will still have to pay the brand name copay.
- **When you have to file a claim.** You should only need to file a claim if you obtain prescriptions out of area as part of an approved emergency medical treatment. Claims can be submitted to: Fallon Community Health Plan, Claims Department, 10 Chestnut Street, Worcester, Massachusetts 01608.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. This includes drugs used on an off-label basis for the treatment of cancer and HIV/AIDS. • Diabetic supplies and medications, including insulin, insulin syringes, blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, insulin pumps and insulin pump supplies, and insulin pens. • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (contact us for preauthorization or dose limits) • Fertility drugs • Allergy serum • Oral contraceptives and contraceptive devices • Injectable agents • Emergency prescriptions (up to a 14-day supply) provided out of the service area as part of an approved emergency medical treatment	Pharmacy: $5 copay per 30-day supply (generic) $10 copay per 30-day supply (brand name) Mail order: $3 copay per 30-day supply (generic) $8 copay per 30-day supply (brand name) Note: If there is no generic equivalent available, you will still have to pay the brand name copay
• Injectable contraceptive drugs, such as DepoProvera	$30 copay per 3 month supply when dispensed by a pharmacy; nothing when supplied by your physician
• Food products which have been modified to be low in protein for individuals with phenylketonuria.	Nothing, up to a maximum of $2,500 per person per calendar year
• Enteral formulas for home use in the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic internal pseudo-obstruction, and inherited diseases of amino acids and organic acids.	Nothing

Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Medical supplies such as dressings and antiseptics* • *Diabetic supplies except as noted above* • *Drugs to enhance athletic performance* • *Nicotine patches, and gum or other smoking cessation products.*	*All Charges*

Section 5 (g). Special Features

Feature	Description
Services for deaf and hearing impaired	You may access our TTD/TTY equipment at 1-877-608-7677
Interpreter services	All contracted providers will make reasonable efforts to provide interpreters, including interpreters for sign language for the hearing impaired. Requests for interpreter services must be made at the same time as you schedule your medical appointments. Please ask the appointment secretary to schedule an interpreter in your primary language when you schedule your medical visit(s).
Reciprocity benefit	Many health maintenance organizations provide arrangements for emergency and urgent care to Fallon members who are outside the service area. Call Customer Service at 1-800-868-5200, Monday through Friday, 8:00 a.m. to 6:00 p.m. Eastern time, for the name and location of the HMO closest to where you are traveling.
Peace of Mind Program	If you are a Fallon Plus or Fallon Affiliates member and you want to see a Boston-based specialist (other than your usual physician), you may do so under the Peace of Mind Program if you meet the following conditions: • Care is only for covered services as described in this brochure. The same copayments and benefit limits apply. • You must have already seen a Plan specialist for this condition within the past three months. • A referral to a specific Peace of Mind physician is made by your Plan physician and authorized by the Plan. • The physician is on staff at either Massachusetts General Hospital, Brigham and Women's Hospital, Children's Hospital (Boston), Dana-Farber Cancer Institute, or New England Medical Center. Service for infertility will be provided at Boston IVF instead of one of these four hospitals. You may use the Peace of Mind program for all specialty care except mental health, substance abuse or chiropractic services. You may not use the Peace of Mind program for any primary care services including internal medicine, family practice, pediatrics or routine obstetrics. If you have not met the conditions listed above or you or your physician have not obtained Plan authorization for a Peace of Mind service, the service will not be covered by the Plan and the Peace of Mind Program provider may hold you financially responsible. Please contact the Plan at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) for further information and complete instructions.

Out-of-area emergency and urgent care	Send all claims for urgent or emergency care to us within 6 months of the date of service. You may submit the claims yourself, or the provider may submit them directly. With your authorization, we will pay benefits directly to the provider. Otherwise, we will send any payment to you. All bills should include a description of the services, the dates of service and the charge for each service. We will pay for the reasonable cost of services in full, minus the appropriate copayment. Claims for services in a foreign country may be submitted if the services are not provided free of charge by that country. The bills must be itemized and in English (or translated into English). Payment will be made to you, and you must pay the provider.
Out-of-area student coverage	We cover students attending school outside the Plan service area, for additional benefits for services received out-of-area, if authorized by the Plan in advance. Coverage continues to age 22 or until marriage, whichever occurs first. • Outpatient services to treat the abuse of, or addiction to, alcohol and drugs. You pay a $10 copay per visit. • Non-elective inpatient services if the Plan is notified as soon as reasonably possible. You pay nothing. • Non-routine office visits. You pay a $10 copay per visit. • Diagnostic lab and X-ray services connected with non-routine office visits. You pay nothing. • Outpatient services to diagnose and/or treat mental conditions. You pay a $10 copay per visit. • Short-term rehabilitation services, including physical, occupational, and speech therapy, covered up to 20 outpatient visits per calendar year. *Not covered out-of-area:* • *Routine physicals, gynecological exams, vision screening, hearing screening, or other routine preventive care* • *Maternity care or delivery* • *Outpatient surgical procedures that could have been delayed until return to the Plan service area* • *Durable medical equipment (e.g. wheelchairs), including maintenance and replacement* • *Preventive dental care* • *Second opinion* • *Home health care* • *Non-emergency prescription drugs*

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You pay
We cover emergency medical care such as to relieve pain and stop bleeding as a result of an accidental injury to sound natural teeth or tissues, when provided as soon as medically possible after the injury. This does not include restorative or other services.	$10 per visit
We also cover some limited urgent dental care services while you are out of the Plan service area. This includes treatments for minor ailments such as a toothache, or loose filling. Coverage is provided for up to $50 per incident.	$10 per visit

Dental Benefits

We cover preventive dental care services which are available twice per calendar year; you pay a $10 copay for the office visit, and additional copayments for minor restorative care services as follows:

ADA Code	Description	You pay
110	Initial oral examination	$10
120	Periodic oral examination	10
130	Emergency oral examination	10
140	Ltd. oral evaluation (problem focused)	10
150	Comprehensive oral evaluation	10
220	Intraoral (periapical, first film)	10
230	Intraoral (periapical, each additional film)	10
240	Intraoral (occlusal film)	10
270	Bitewing (single film)	10
272	Bitewing (two films)	10
273	Bitewing (three films)	10
274	Bitewing (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	(Top application flouride (includes prophylaxix – child< age 16)	10
1203	(Top application flouride (excludes prophylaxix – child< age 16)	10
1201	(Top application flouride (includes prophylaxix – adult age 16 and over)	10
1330	Oral hygiene instructions	10

Minor Restorative (Fillings)		
2110	Amalgam (one surface, primary)	13
2120	Amalgam (two surfaces, primary)	18
2130	Amalgam (three surfaces, primary)	22
2140	Amalgam (four or more surfaces, primary)	28
2150	Amalgam (two surfaces, permanent)	15
2160	Amalgam (three surfaces, permanent)	22
2161	Amalgam (four or more surfaces, permanent)	28
2330	Resin (one surface, anterior)	19
2331	Resin (two surfaces, anterior)	22
2332	Resin (three surfaces, anterior)	28
2335	Resin (three surfaces or involving incisal angle-anterior)	33
2385	Resin (one surface, posterior permanent)	19
2386	Resin (two surfaces, posterior permanent)	25
2387	Resin (three or more surfaces, posterior permanent)	35

Not covered:

Dental services not shown as covered.

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 out-of-pocket maximums.

Dental services discounts – This Plan has arranged for discounts for non-covered dental services. If you would like a list of the services and the fee schedule, contact our Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

Eyewear discounts – Fallon has arranged for a 25% discount on the first pair of eyeglass frames and prescription lenses purchased from participating Fallon optical providers. When you purchase multiple pairs of prescription eyeglasses at the same time, you receive an additional 35% discount on the additional pairs. In addition, you receive a 10% discount on all complete contact lens packages purchased at participating Fallon optical providers. This discount does not apply to individual lenses, the evaluation/fitting of contact lenses, or other items/services which are not specifically listed above.

Hearing aid discounts – This Plan has arranged for discounts of 20% to 30% off the regular price of hearing aids and assistive listening devices. Contact the Fallon Customer Service department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) for a complete list of providers.

Fitness center discounts – Members of this Plan are entitled to discounted memberships at several area health clubs. Discounts vary from club to club. For information on participating health clubs and the associated discounts, call the Fallon Customer Service department at 1-800-868-5200 (TTD/TTY: 1-877-608-7677).

Medicare prepaid plan enrollment – This Plan offers Medicare recipients the opportunity to enroll in this Plan through Medicare. As indicated on page **50**, 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 when 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 Fallon Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) for information on the benefits available under the Medicare HMO.

Weight Watchers program – Plan members are entitled to one twelve-week membership in each calendar year, at no cost. Additional memberships and food products are not covered under this feature.

Benefits on this page are not part of the FEHB contract.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness, disease, injury or condition.**

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; or
- Services, drugs or supplies you receive from a provider or facility barred from the FEHB Program.

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/Hospital/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.

When you must file a claim -- such as for out-of-area care -- 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
10 Chestnut Street
Worcester, Massachusetts 01608

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs or supplies – including a request for preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Fallon Community Health Plan 10 Chestnut Street Worcester, Massachusetts 01608; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it.
	You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information.
	Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436.

	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 different claims, 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 provide 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.
6	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. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.
	You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division III at 202/606-0737 between 8 a.m. and 5 p.m. Eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered 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.

•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.
- Part B (Medical Insurance). Most people pay monthly for Part B.

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

•The Original Medicare Plan

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

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care.

(Primary payer chart begins on next page.)

The following chart illustrates whether Original 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 either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB		✓
Ask your employing office which of these applies to you.		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability,		
a) And are an annuitant, or	✓	
b) Are an active employee		✓

Claims process -- You probably will never have to file a claim form when you have both our Plan and Medicare.

- 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 claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800-868-5200.

- **Medicare managed care plan**

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

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments for your FEHB coverage.

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium (OPM does not contribute to your Medicare managed care plan premium). For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan service area.

- **Enrollment in Medicare Part B**

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease 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 a similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

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 13.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care furnished to meet nonmedically necessary needs such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial Care is not covered by the Plan.
Experimental or Investigational services	This Plan's Benefits & Technology Assessment Committee determines what procedures, devices and services are experimental or investigational using 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 over currently accepted procedures, devices or service.
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.
Us/We	Us and we refer to Fallon Community Health Plan.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about:

- 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.

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.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

  You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. 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.

- **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.

  You may not elect TCC if you are fired from your Federal job due to gross misconduct.

  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.

•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

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.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy or hospital 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 800-868-5200 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, D C 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Accidental injury 30
Allergy tests 19
Alternative treatment 23
Ambulance 28,29,31
Anesthesia 23
Autologous bone marrow transplant 26
Biopsies 24
Blood and blood plasma 28
Breast cancer screening 16
Casts 24
Changes for 2001 9
Chemotherapy 19
Childbirth 17
Cholesterol tests 16
Circumcision 17
Claims 43
Coinsurance 13
Colorectal cancer screening 16
Congenital anomalies 17
Contraceptive devices and drugs 17
Coordination of benefits 46
Covered charges 50
Covered providers 10
Crutches 22
Deductible 13
Definitions 50
Dental care 39,41
Diagnostic services 15
Disputed claims review 44
Donor expenses (transplants) 26
Dressings 28
Durable medical equipment (DME) 22
Educational classes and programs 23
Effective date of enrollment 52
Emergency 30
Experimental or investigational 50
Eyeglasses 41
Family planning 17
Fecal occult blood test 16
General Exclusions 42
Hearing services 20, 41
Home health services 22
Hospice care 29
Home nursing care 22
Hospital 11, 28, 43
Immunizations 16
Infertility 18
Inhospital physician care 15
Inpatient Hospital Benefits 28
Insulin 35
Laboratory and pathological services 15
Magnetic Resonance Imagings (MRIs) 15
Mail Order Prescription Drugs 35
Mammograms 16
Maternity Benefits 17
Medicaid 49
Medically necessary 50
Medicare 41, 46
Mental Conditions/Substance Abuse Benefits 32
Newborn care 17
Non-FEHB Benefits 52
Nurse
  Licensed Practical Nurse 22
  Nurse Anesthetist 28
  Registered Nurse 22
Nursery charges 17
Obstetrical care 17
Occupational therapy 20
Office visits 15
Oral and maxillofacial surgery 25
Orthopedic devices 21
Out-of-pocket expenses 13
Outpatient facility care 29
Oxygen 29
Pap test 16
Physical therapy 20
Physician 10
Precertification 33
Preventive care, adult 16
Preventive care, children 16
Prescription drugs 34
Preventive services 16
Prior approval 12
Prostate cancer screening 16
Prosthetic devices 21
Psychologist 32
Psychotherapy 32
Radiation therapy 19
Rehabilitation therapies 20
Renal dialysis 19
Room and board 28
Second surgical opinion 15
Skilled nursing facility care 29
Speech therapy 20
Splints 28
Sterilization procedures 17
Subrogation 49
Substance abuse 32
Surgery 23
- Anesthesia 27
- Oral 25
- Outpatient 29
- Reconstructive 25

Syringes 35
Temporary continuation of coverage 52
Transplants 26
Treatment therapies 15, 19
Vision services 20
Well child care 16
Wheelchairs 22
Workers' compensation 49
X-rays 15

NOTES:

Summary of benefits for Fallon Community Health Plan - 2001

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	Office visit copay: $10 primary care; $10 specialist	15
Services provided by a hospital: • Inpatient ..... • Outpatient	 Nothing Nothing	28 29
Emergency benefits: • In-area..... • Out-of-area.....	emergency room $25 per visit at a hospital emergency room	31 31
Mental health and substance abuse treatment.....	Regular cost sharing	32
Prescription drugs.....	Pharmacy: $ 5 copay per 30-day supply (generic) $ 10 copay per 30-day supply (brand name) Mail order: $ 3 copay per 30-day supply (generic) $ 8 copay per 30-day supply (brand name)	34
Dental Care	$10 copayment for certain preventive services; $13-$35 copayment for certain minor restorative services.	39
Vision Care	No benefit.	

Special features:	• Services for deaf and hearing impaired members • Reciprocity benefit • Peace of Mind Program • Out-of-area Emergency and Urgent Care • Out-of-area Student coverage	37

2001 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 special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and 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. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Central/Eastern Massachusetts							
Self Only	JV1	$78.93	$26.31	$171.02	$57.00	$93.40	$11.84
Self and Family	JV2	$195.82	$75.05	$424.28	$162.61	$231.17	$39.70