HEALTH NEW ENGLAND

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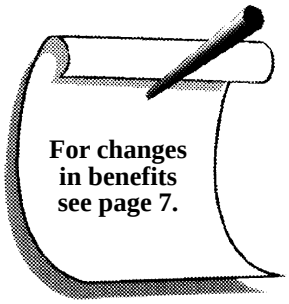
Health New England

2001

A Health Maintenance Organization



Serving: Western Massachusetts and Northern Connecticut

Enrollment in this Plan is limited; see page 6 for requirements.

JULY 3, 2000 - JULY 3, 2003

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

Enrollment code:

DJ1 Self Only

DJ2 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

Federal Employees Health Benefits Program

RI 73-437

Table of Contents

Table of Contents

Introduction

Health New England, Inc.
One Monarch Place, Suite 1500
Springfield, Massachusetts 01144-1500

This brochure describes the benefits of Health New England under our contract (CS2329) 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 7. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communications 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" or "us" means Health New England.

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 practices 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.

Who provides my health care

Health New England has contracts with Baystate Medical Center, Cooley Dickinson Hospital, Holyoke Hospital, Noble Hospital, Berkshire Medical Center, Fairview Hospital, North Adams Regional Hospital, Franklin Medical Center and Mary Lane Hospital, as well as over 300 established primary care doctors and 1,000 specialists. In addition, we have contracts with various hospitals in Worcester and Boston including University of Massachusetts Medical Center, Beth Israel Hospital, and New England Medical Center, which provide, with prior approval from the Plan, specialty services that are not performed locally.

You will need to let us know which primary care physician you select for each member of the family. If you need help in choosing a physician, please call us at 413-787-4004or 800-310-2835. You may change your choice by calling us. Changes will be effective on the first day of the month following the date your request is received.

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. We pay health care providers a number of ways. For example, we may set a fee to be paid for each service, each day (of a hospital stay) or each case. We also may pay an amount each month for each member signed up with a provider or group of providers (this payment is called a capitation payment). In many cases, providers are assigned to a group or pool of providers. A part of each payment to a member of the pool is set aside until the end of the year. At the end of the year, the results for the pool and its providers are compared to set goals or targets. Depending on the results, providers are paid some, or all, of the amount put aside. We do not deny care in order to save money, nor are any of our employees reimbursed for making decisions to deny care. A denial is made exclusively on the basis of medical necessity and appropriateness.

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.

If you want more information about us, call 413-787-4004 or 800-310-2835, or write to Health New England, One Monarch Place, Suite 1500, Springfield, MA 01144-1500. You may also contact us by fax at 413-731-7498 or 413-736-1850 or visit our website at www.healthnewengland.com.

Service Area

To enroll with us, you must live in our service area. This is where our providers practice. Our service area is: the Massachusetts counties of Berkshire, Franklin, Hampden, and Hampshire. The Worcester County towns of Athol, Barre, Brookfield, East Brookfield, Gardner, Hardwick, New Braintree, North Brookfield, Oakham, Petersham, Royalston, Spencer, Sturbridge, Warren, and West Brookfield. The northern Connecticut towns of East Granby, East Windsor, Enfield, Granby, Somers, South Windsor, Suffield, Warehouse Point, West Suffield, Windsor and Windsor Locks.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait for the Open Season to change plans. Contact your employing or retirement office.

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 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 attentions 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 our Member Services Department at 413-787-4004 or 800-310-2835. Health New England has a number of mechanisms in place to monitor patient safety issues and to improve the quality of care that our members receive. Among our patient safety initiatives are: a rigorous examination of all providers credentials at the time of initial contracting and at regular intervals thereafter, concurrent reviews of the care provided to our members in our provider institutions, and a thorough investigation into situations that may result in harm to a member. We are implementing additional patient safety initiatives as well and these include: working with our new Pharmacy Benefit Manager to establish processes to identify potential adverse drug interactions, offering and encouraging providers to attend a special program we have scheduled entitled "Risk Management in Primary Care-the Failure to Diagnose Mental Health and Substance Abuse Issues", establishment of a pysician advisory group by the Medical Director's office and creation of a new department to provide more intensive focus on member advocacy issues and educational efforts. We will be utilizing our website further by implementing self-learning modules members may use to develop a better understanding of self care and by developing an interactive consultation service for providers with senior psychiatric staff on behalf of members. Our disease management programs are well underway, including: the Diabetes Management Program, Brighter Infant Beginnings Program, and Asthma Management Program. You can find out more about patient safety onthe OPM website, 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 medications 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 decrease/increase by 26.3% for Self Only or 79.6% for Self and Family.

- You no longer need a referral to see an ophthalmologist.

- You no longer need a referral to obtain most Durable Medical Equipment (DME) items.

Clarifications to this Plan

- Your diabetic supplies, such as syringes, needles and blood glucose monitoring strips, are covered whether you are an insulin-dependant diabetic or not.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card. 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 413-787-4004 or 800-310-2835.

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 have contracts with over 300 established primary care physicians and 1000 specialists.

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

• 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. We have contracts with Baystate Medical Center, Cooley Dickinson Hospital, Holyoke Hospital, Noble Hospital, Berkshire Medical Center, Fairview Hospital, North Adams Regional Hospital, Franklin Medical Center and Mary Lane Hospital. In addition, we have contracts with various hospitals in Worcester and Boston, however, services provided by these facilities need to be pre-approved by us.

What you must do

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. If you need help in choosing a physician, please call us at 413-787-4004 or 800-310-2835. You may change your choice by calling us.

• 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 see your Plan obstetrician or gynecologist, obtain one eye exam each year, or obtain medically necessary ophthalmologist services without a referral.

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. All inpatient hospital care, including skilled care and inpatient rehabilitation must be pre-approved by us.

If you are in the hospital when your enrollment in our Plan begins, call our Member Services Department immediately at 413-787-4004 or 800-310-2835 . 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 arrange 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 attending physician must complete our HNE Authorization Request Form and provide it to us at least 7 days before any scheduled surgery.

Services or procedures which require our preauthorization include:

- Assisted reproductive technology (ART)
  (See Infertility services, page 17.)
- Growth hormone therapy (GHT)
  (See Treatment therapies, page 18.)
- Pulmonary rehabilitation
  (See Rehabilitative therapies, page 19.)
- Insulin pumps
  (See Durable medical equipment, page 22.)
- Other Durable medical equipment such as, air mattress, alternating pressure pads, bone stimulator, continuous passive motion (CPM) device, electric hospital bed, manual hospital bed, portable parrafin bath unit, patient lift, penile implant, roll-about-chair, traction equipment, ultra violet cabinet.
  (See Durable medical equipment, page 22.)
- Educational programs
  (See Educational programs, page 23.)
- Morbid obesity
  (See Surgical procedures, page 24.)
- Correction of congenital anomalies
  (See Reconstructive surgery, page 25.)
- Extended care benefits/Skilled nursing facility
  (See Extended care/Skilled nursing facility benefit, page 31.)
- Hospice care
  (See Hospice care, page 31.)
- Mental health and substance abuse services
  (See Mental health and substance abuse, page 34.)
- Formulas
  (See Special features, page 39.)

Note: The above list is subject to change from time to time without prior notice.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

A copayment is a fixed amount of money you pay to the provider when you receive services.

Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay nothing.

Your out-of-pocket maximum

After your copayments total $2,375.00 per person or $5,250.00 per family enrollment in any calendar year, you will be reimbursed by us for any further copayments for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 59 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. To obtain more information about our benefits, contact us at 413-787-4004 or 800-310-2835 or at our website at www.healthnewengland.com.

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.
- 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 physician's office	$10 per office visit; nothing for hospital visits
Professional services of physicians • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment •• Services received as an inpatient •• Services received in physician's office • Office medical consultations • Second surgical opinion in physician's office	$10 per office visit; nothing for hospital visits Nothing Nothing $10 per office visit $10 per office visit $10 per office visit
Professional services of physicians • At home	$10 per home visit

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Pap tests • Pathology • X-rays • Mammograms (See *Preventive care, adult*) • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit Nothing in outpatient lab or hospital
Not covered: Pre-marital bloodwork	*All charges*

Preventive care, adult	You pay
Routine screenings, such as: • Total Blood Cholesterol - once every three years • Colorectal Cancer Screening, including: •• Fecal occult blood test •• Sigmoidoscopy, one screening every five years starting at age 50	$10 per office visit
Prostate Specific Antigen (PSA test) - one annually for men age 40 and older, limited to when the following symptoms are revealed: •• The presence of a prostatic nodule upon a rectal examination, or •• An incomplete assessment of the prostate upon rectal examination with suspicion of carcinoma	$10 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *diagnosis and treatment* above.	$10 per office visit

Preventive care, adult— Continued on next page

Preventive care, adult *(Continued)*	**You pay**
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 through 64, one every calendar year	$10 per office visit
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 or when medically necessary due to a medical condition.	$10 per office visit
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel. Services that a third party or a court order require.	*All charges*
Preventive care, children	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit
• Examinations, such as: •• Eye exams through age 17 to determine the need for vision correction. •• Ear exams through age 17 to determine the need for hearing correction •• Examinations done on the day of immunizations (through age 22)	$10 per office visit
• Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per office visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as:	$10 for initial office visit to determine pregnancy; after that nothing
• Prenatal care	Nothing
• Delivery	Nothing
• Postnatal care	
•• First postpartum visit	Nothing
•• All visits after the first postpartum visit	$10 per office visit
Note: Here are some things to keep in mind:	
• Your physician must preregister your pregnancy.	
• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.	Nothing
• 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.	Nothing
• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See *Hospital benefits* (Section 5c) and *Surgery benefits* (Section 5b).	
Not covered: Home deliveries, delivery outside the service area after you have been told that you are at risk for early delivery or after the 37th week of pregnancy.	*All charges*

Family planning	You pay
• Voluntary sterilization	Nothing
•• In hospital	Nothing
•• In physician's office	$10 per office visit
• Surgically implanted contraceptives	$10 per office visit
• Injectable contraceptive drugs injected at physician's office	$10 per office visit
• Intrauterine devices (IUDs) inserted at physician's office	$10 per office visit
Note: See *Prescription drug benefits* (Section 5f) regarding coverage for birth control and devices.	
• Genetic counseling	$10 per office visit
Not covered: Reversal of voluntary sterilization.	*All charges*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: •• *intravaginal insemination (IVI)* •• *intracervical insemination (ICI)* •• *intrauterine insemination (IUI)*	$10 per office visit
• Assisted reproductive technology (ART) procedures require our pre-approval to be covered, such as: •• in vitro fertilization •• embryo transfer and GIFT Note: Assisted reproductive technology (ART) requires our preauthorization and will be provided in accordance with our infertility protocol.	$10 per office visit
• Services and supplies related to ART procedures • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	$10 per office visit
Not covered: • *Reversal of voluntary sterilization* • *Infertility treatment for Members who are not medically infertile* • *Any cost associated with any form of surrogacy, including gestational carriers* • *Cryopreservation of eggs* • *Procedures associated with gender selection, convenience or genetic engineering* • *Any experimental infertility procedure*	*All charges*

Allergy care	You pay
Testing and treatment	$10 per office visit
Allergy injection	$10 per office visit
Allergy serum obtained in physician's office	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 27.	Nothing
• Respiratory and inhalation therapy	Nothing
• Dialysis–hemodialysis and peritoneal dialysis	Nothing
• Intravenous (IV)/Infusion Therapy–home IV and antibiotic therapy	Nothing
• Growth hormone therapy (GHT) Note:We will only cover GHT when we preauthorize the treatment. Call your physician to initiate preauthorization from our Health Services Department. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3 on page 10. GHT is not covered under your prescription drug benefit.	Nothing
Not covered: Alternative/Complementary treatment therapies.	*All charges*

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy: • 25 visits or up to 2 months, per condition, per calendar year, for the services of each of the following: •• 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.	$10 per office visit
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, at a Plan facility.	$10 per office visit
• Pulmonary rehabilitation Note:We will only cover pulmonary rehabilitation when we preauthorize the treatment. Call your physician to initiate preauthorization from our Health Services Department. We will ask you to submit information that establishes that the pulmonary rehabilitation is medically necessary. Ask us to authorize pulmonary rehabilitation before you begin treatment; otherwise, we will only cover pulmonary rehabilitation services from the date you submit the information. If you do not ask or if we determine pulmonary rehabilitation is not medically necessary, we will not cover the pulmonary rehabilitation or related services and supplies. See *Services requiring our prior approval* in Section 3 on page 10.	$10 per office visit
Not covered: • *Early intervention services* • *Long-term rehabilitative therapy* • *Exercise programs* • *Maintenance therapy* • *Massage therapy including myotherapy* • *Vocational rehabilitation*	*All charges*
Hearing services (testing and treatment)	**You pay**
• Hearing testing for children through age 17 (see *Preventive care, children*) • Medically necessary hearing tests for adults	$10 per office visit $10 per office visit
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges*

Vision services (testing and treatment)	You pay
• Eye exam to determine the need for vision correction for children through age 17 (see *Preventive care, children*)	$10 per office visit
• Annual eye exam	$10 per office visit
Note: More frequent eye examinations will be covered with a referral from your physician if determined to be medically necessary.	
• Opthalmologist visit	$10 per office visit
Not covered:	*All charges*
• *Eyeglasses or contact lenses*	
• *Eye exercises and orthoptics*	
• *Radial keratotomy and other refractive surgery*	

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$10 per office visit
• Podiatry visit for evaluation and surgical treatment of bone spurs or bunions	$10 per office visit
Not covered:	*All charges*
• *Podiatric foot inserts*	
• *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above*	
• *Treatment of weak, strained or flat feet; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	

Orthopedic and prosthetic devices	You pay
Coverage for Durable medical equipment, orthopedic and prosthetic devices, combined, is limited to $2,000 per calendar year. We cover:	
• Artificial limbs and eyes; stump hose	Nothing
• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy	Nothing- *not subject to $2,000 DME limit* *(See page 22 on DME)*
• Internal prosthetic devices such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy Note: See 5(b) for coverage for the surgery to insert the device	Nothing- *not subject to $2,000 DME limit* *(See page 22 on DME)*
• Corrective orthopedic appliances for non-dental treatment of Temporomandibular Joint (TMJ) pain dysfunction syndrome Note:We will only cover non-dental treatment of TMJ when we preauthorize the treatment. Call your physician to initiate preauthorization from our Health Services Department. We will ask you to submit information that establishes that the non-dental treatment of TMJ is medically necessary. Ask us to authorize non-dental treatment of TMJ before you begin treatment; otherwise, we will only cover non-dental treatment of TMJ services from the date you submit the information. If you do not ask or if we determine non-dental treatment of TMJ is not medically necessary, we will not cover the non-dental treatment of TMJ or related services and supplies. See *Services requiring our prior approval* in Section 3 on page 10. Note: The above DME items require a written order from your physician and repairs or replacements (not provided for under a manufacturer's warranty or purchase agreement) are covered when noted on the written order.	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* Note: The above list of not covered items is not an exclusive list.	*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. Coverage for durable medical equipment, orthopedic and prosthetic devices, combined, is limited to $2,000 per calendar year. Under this benefit, we also cover: • Hospital beds • Non- motor driven wheelchairs • Crutches • Ostomy supplies • Walkers • Blood glucose monitors	Nothing
• Insulin pumps Note: Insulin pumps are covered when we determine medical necessity and must be preauthorized by us. There are certain other items which require authorization of our Health Services Department, such as, air mattress, alternating pressure pads, bone stimulator, continuous passive motion (CPM) device, electric hospital bed, manual hospital bed, portable parrafin bath unit, patient lift, penile implant, roll-about-chair, traction equipment, ultra violet cabinet.	Nothing- *not subject to $2,000 DME limit*
Not covered: • *Motorized wheel chairs or beds* • *Hearing aids* • *Dentures* • *Comfort items such as telephone arms, air conditioners and overbed tables* • *Disposable supplies such as lancets, dressings and bandages* • *Exercycles and exercise equipment* • *Bidets; toilet and bathtub seats; sauna and whirlpool baths* • *Elevators* • *Humidifiers and air cleaners/purifiers* • *Any devices or special equipment needed for sports or occupational purposes* • *Repair or replacement of equipment or devices as a result of loss, negligence, willful damage, or theft* Note: The above list of not covered items is not an exclusive list.	*All charges*

Home health services	You pay
• 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.	Nothing
• Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • *Care requested by, or for the convenience of, the patient or the patient's family* • *Custodial care, unskilled home health care*	*All charges*

Educational programs	You pay
Coverage is limited to: • Diabetes self-management • Gestational diabetes counseling • Nutritional counseling Note: We will only cover educational programs when we preauthorize the treatment. Call your physician to initiate preauthorization from our Health Services Department. We will ask you to submit information that establishes that the educational program is medically necessary. Ask us to authorize an educational program before you begin treatment; otherwise, we will only cover an educational program from the date you submit the information. If you do not ask or if we determine that the educational program is not medically necessary, we will not cover the educational program. See *Services requiring our prior approval* in Section 3 on page 10.	$10 per office visit

Section 5 (b). Surgical and anesthesia 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.
- 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 and identify which surgeries require preauthorization.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• 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*, page 25) • Surgical treatment of morbid obesity Note: We will only cover surgical treatment of morbid obesity when we preauthorize the treatment. Call your physician to initiate preauthorization from our Health Services Department. We will ask you to submit information that establishes that surgical treatment of morbid obesity is medically necessary. Ask us to authorize the surgical treatment of morbid obesity before you begin treatment; otherwise, we will only cover surgical treatment of morbid obesity from the date you submit the information. If you do not ask or if we determine that the surgical treatment of morbid obesity is not medically necessary, we will not cover the surgical treatment of morbid obesity. See *Services requiring our prior approval* in Section 3 on page 10. • Insertion of internal prosthetic devices. See 5(a)–*Orthopedic and prosthetic devices* for coverage information.	$10 per office visit; *Nothing for hospital visits*

Surgical procedures–Continued on next page.

Surgical procedures (Continued)	**You pay**
• Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a)-*Family planning*, page 16. 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*
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot* See *5(a)-Foot care,* page 20.	*All charges*
Reconstructive surgery	**You pay**
• Surgery to correct a functional defect if medically necessary	$10 per office visit; *Nothing for hospital visits*
• 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: cleft lip; cleft palate; webbed fingers; and webbed toes. Note: We will only cover surgery to correct congenital anomalies when we preauthorize the treatment. Call your physician to initiate preauthorization from our Health Services Department. We will ask you to submit information that establishes that the surgery is medically necessary. Ask us to authorize the surgery before you begin treatment; otherwise, we will only cover surgical services from the date you submit the information. If you do not ask or if we determine surgery is not medically necessary, we will not cover the surgery or related services and supplies. See *Services requiring our prior approval* in Section 3 on page 10.	
• All stages of breast reconstruction surgery following a mastectomy, such as: •• Reconstruction of the breast on which the mastectomy was performed; •• Surgery and reconstruction of the other breast to produce a symmetrical appearance; •• Treatment of any physical complications, such as lymphedemas; •• Breast prostheses and surgical bras and replacements (See 5(a) *Orthopedic and prosthetic devices*, page 21.) 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.	$10 per office visit; *Nothing for hospital visits*
Not covered: • *Cosmetic surgery–any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	You pay
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 when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	$10 per office visit - *Nothing for hospital visits*
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental care involved in the treatment of Temporomandibular Joint (TMJ) pain dysfunction syndrome*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea Note: We cover contact lenses following a cornea transplant for up to one year if medically necessary. • Heart • Heart/lung • Kidney • Liver • Lung: Single-Double • Autologous bone marrow transplants for metastasized breast cancer and for the following diagnoses: •• Acute leukemia in remission •• Resistent non-Hodgkins lymphomas •• Advanced Hodgkins disease •• Recurrent or refractory neuroblastoma • Allogeneic or autologous bone marrow transplants for multiple myeloma, aplastic anemia, leukemia, severe combined immunodeficiency disease, Wiskott-Aldrich Syndrome, and cases of metastatic breast cancer Note: We cover related medical and hospital expenses of the donor when we cover the recipient if the expenses are not covered by the donor's insurance.	$10 per office visit; *Nothing for hospital visits*
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Transplants not listed as covered* • *Experimental medical procedures, treatment, or course of treatment*	*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 Nothing Nothing $10 per office visit

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.
- 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).
- YOUR PHYSICIAN 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 • 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 • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services	Nothing

Inpatient hospital services — Continued on next page

Inpatient hospital *(Continued)*	**You pay**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Charges incurred after the date on which your membership ends* • *Blood or blood products, including the cost of donating and storing blood for use during surgery or other medical procedure* Note: The above list of not covered items is not an exclusive list.	*All charges*
Outpatient hospital or ambulatory surgical center	**You pay**
• 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 • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	Nothing
Not covered: Blood or blood products, including the cost of donating and storing blood for use during surgery or other medical procedure.	*All charges*

Extended care benefits/skilled nursing care facility benefits	You pay
Extended care benefit/Skilled nursing facility (SNF): We provide a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing or rehabilitative care is medically necessary and confinement in a facility, or part of one, licensed to provide skilled nursing or rehabilitative care, is medically appropriate as determined by your Plan doctor and preapproved by us. Services include: • Bed, board and general nursing care • Drugs, supplies and equipment	Nothing
Not covered: Custodial care, long-term care, or unskilled nursing home care.	*All charges*
Hospice care	**You pay**
Hospice care: We provide coverage for licensed hospice services to terminally ill patients with a life expectancy of 6 months or less. (See Section 3 for *Services requiring our prior approval*, page 10.)	Nothing
Not covered: Independent nursing and homemaker services.	*All charges*
Ambulance	**You pay**
• Ambulance service when medically appropriate	$25 per ambulance trip

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.
- 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:

Emergencies within our service area:

If you are in an emergency situation, please call your primary care doctor. If you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they know where to submit your claims. You or a family member must notify us within 48 hours, unless it is not reasonably possible to do so. It is your responsibility to ensure that we have been notified in a timely manner.

If you need to be hospitalized, we must be notified within 48 hours or on the first working day following your admission, unless it is not reasonably possible to notify us within that time. 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 in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

Any follow-up care recommended by a non-Plan provider must be approved by us or provided by a Plan provider.

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, we must be notified within 48 hours or on the first working day following your admission, unless it is not reasonably possible to notify us within that time. 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 a non-Plan provider must be approved by us or provided by a Plan provider.

We will pay for emergency services to the extent the services would have been covered if received from Plan providers.

Benefit Description	You pay
Emergency care within our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at a hospital, including doctors' services	$50 per visit
• Emergency care resulting in a direct admission to the hospital	Nothing
Not covered: Elective care or non-emergency care.	*All charges*
Emergency care outside our service area	**You pay**
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at a hospital, including doctors' services	$50 per visit
• Emergency care resulting in a direct admission to the hospital	Nothing
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	**You pay**
Professional ambulance service when medically appropriate	$25 per ambulance trip
Limited benefit: • Air ambulance covered when medically appropriate	$25 per ambulance trip

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	
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
• All diagnostic tests	$10 per visit
• Services provided by a hospital or other facility • Services in approved alternative care center such as partial hospitalization, acute 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*

Mental health and substance abuse benefits — Continued on next page

Preauthorization

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

- All services must be approved in advance by us. Please call our Mental Health Department at 413-787-4000, ext. 5020, before getting care.

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 Plan 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, 2001, and this transitional benefit does not apply.

Limitation

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

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. We follow FDA dispensing guidelines.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed Plan physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, or by mail through our mail order pharmacy service for a maintenance medication.
- **We use a formulary.** The Health New England (HNE) Formulary is developed and maintained by a joint Pharmacy and Therapeutics Committee. The Committee consists of physicians and pharmacists who review all therapeutic drug classes annually. The review includes evaluation of new medications and review of new data on existing medications. Both formulary and nonformulary medications are covered by us, the difference being the amount of copayment paid by the member.

  Drugs are prescribed by Plan doctors and dispensed in accordance with our drug formulary. Nonformulary drugs will be covered when prescribed by a Plan doctor.
- **These are the dispensing limitations.** Generic drugs will be dispensed unless otherwise specified by the Plan doctor. In most cases, there is more than one brand name drug available to treat a condition when there is no generic drug available. The formulary is a list of brand name drugs that do not have an available generic equivalent. Brand name drugs are offered to members for a somewhat higher copayment than the generic drugs. Non-formulary drugs are brand name drugs not on the formulary that are available at the highest of the three copayment levels. If there is no generic equivalent available for a brand name medication, you will still have to pay the brand name copayment.

  A mail order pharmacy service is available for most maintenance medications. Maintenance medications include medications taken for a chronic illness. Mail order is a convenient and less costly method to order and refill up to a 90-day supply of maintenance drugs. You may contact our Member Services Department for more information at 413-787-4004 or 1-800-310-2835.

  If you send in a refill order too soon after the last prescription was filled, our mail order pharmacy service will enter your refill order into the mail order processing system and place an electronic “hold” on the refill order with the date it becomes eligible for refill attached to it. The refill order is then filled on the date that it becomes eligible for refill.

Prescription drug benefits–Continued on 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 for which a prescription is required by federal law • FDA-approved drugs, prescriptions and devices for birth control • Insulin • Insulin syringes and needles • Blood glucose monitoring strips for diabetics • Disposable needles and syringes needed to inject covered prescribed medication • Prenatal vitamins • Vitamins with fluoride for infants up to one year of age • Non-injectable fertility drugs (injectable fertility drugs are covered under Medical and Surgical Benefit) Note: Intravenous fluids and intravenous medication for home use are covered under Medical and Surgical Benefits.	At a Plan pharmacy: $ 7 copay per prescription or refill for up to a 30-day supply of generic drugs; $ 15 copay per prescription or refill for up to a 30-day supply of brand name formulary drugs; $ 30 copay per prescription or refill for up to a 30-day supply of brand name non-formulary drugs; *Note: If there is no generic equivalent available, you will still have to pay the brand name copay.* Through Mail Order: $ 14 copay per prescription or refill for a 90-day supply of generic drugs; $ 30 copay per prescription or refill for a 90-day supply of brand name formulary drugs; $ 90 copay per prescription or refill for a 90-day supply of brand name non-formulary drugs;
Limited: • Smoking cessation drugs and medications, including nicotine patches • Sexual dysfunction or erectile dysfunction drugs • Migraine and pain medications • Motion sickness medications • Fungal nail infection medications • Weight loss medications • Diabetic foot ulcer medication • Certain vitamin replacement medication Note: These prescriptions have certain limitation and coverage requirements. Contact us for details at 413-787-4004 and 800-310-2835.	

Prescription drug benefits–Continued on next page

Covered medications and supplies *(Continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you require a name brand drug when a federally-approved generic drug is available, then your physician must specify "Dispense as Written" on the prescription. You will be responsible for a higher copayment. • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 413-787-4004 or 800-310-2835.	
Not covered: • *Drugs available without a prescription* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Vitamins (other than those listed above) and nutritional substances that can be purchased without a prescription* • *Medical supplies such as dressings and antiseptics* • *Drugs for cosmetic purposes, including appetite suppressants* • *Drugs to enhance athletic performance*	*All Charges*

Section 5 (g). Special features

	Description
	We cover:
Formulas	• Some kinds of special formulas. These formulas include non-prescription enteral formulas for home use for the following conditions: •• Malabsorption caused by Crohn's disease •• Ulcerative colitis •• Gastroesophageal reflux •• Gastrointestinal motility •• Chronic pseudo-intestinal obstruction •• Inherited diseases of amino acids and organic acids Note: Coverage for formulas requires our preauthorization. Call your physician to initiate preauthorization from our Health Services Department. We will ask you to submit information that establishes that the formula is medically necessary. Ask us to authorize the formula before you begin treatment; otherwise, we will only cover a formula from the date you submit the information. If you do not ask or if we determine the formula is not medically necessary, we will not cover the formula. See *Services requiring our prior approval* in Section 3 on page 10. Please contact Member Services at 413-787-4004 or 800-310-2835 for additional information. No copayment is required.
Low protein foods	• Low protein foods for members with inherited diseases of amino acids and organic acids up to $2,500 per member per calendar year. No copayment is required.
Wigs	• Wigs will be covered by us for hair loss suffered due to the treatment of any form of cancer or leukemia. You will be reimbursed by us up to $350 towards the cost of the wig. Benefit is limited to $350 per calendar year. You must request reimbursement from our Member Services Department. Your request must include proof of payment and a written statement from your doctor that the wig is medically necessary. You must pay all costs over $350.

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.
- 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

Benefit Description	You pay
Accidental injury benefit	
We cover the initial emergency dental care needed due to a traumatic injury to sound, natural teeth. The need for these services must result from an accidental injury. You must receive all services, except for suture removal, within 72 hours of the accidental injury. You must report emergency dental care to us within 48 hours, or as soon as you are medically able.	$10 per office visit; or $50 per emergency room visit
Not covered: • *Follow-up dental care* • *Restorative treatment*	*All charges*
Pediatric dental benefit	
Children under the age of 12 receive the following benefits: • Initial oral examination; periodic exam, up to once every six months • X-rays of entire mouth, up to once every 60 months • Bitewing X-rays, up to once every six months when oral conditions indicate need • Single tooth X-ray, as needed • Routine cleaning, scaling, and polishing of teeth up to once every six months • Fluoride treatments, up to once every six months	$25 deductible per child per calendar year
Not covered: • *All other dental services*	

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 out-of-pocket maximums.

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium.

HealthyDirections Benefit: NEW!

HEALTH NEW ENGLAND OFFERS MEMBERS ACCESS TO A WIDE VARIETY OF COMPLEMENTARY HEALTHCARE PROGRAMS. THIS BENEFIT IS OFFERED TO YOU BY HEALTH NEW ENGLAND AND IS ADMINISTERED BY AMERICAN SPECIALTY HEALTH NETWORKS (ASHN).
For a complete packet of information, including a list of participating complementary healthcare providers, members must call ASHN Member Services toll-free at 877-327-2746, Monday through Friday, from 8 am to 11 pm, or Saturday from 9 am to 6 pm. (ASHN is closed on Sundays).

This benefit includes:

A **25% Discount** on the following services:
- Chiropractic care
- Acupuncture
- Massage Therapy

Access to:
- The International Fitness Club Network

Access to:
- An online directory of complementary healthcare providers, a library of educational information on complementary healthcare and an online catalog of over 1000 health and wellness products.

Health Education Benefit: NEW!

HEALTH NEW ENGLAND MEMBERS CAN GET A **10% DISCOUNT** OFF THE COST OF HEALTH EDUCATION CLASSES OFFERED AT PARTICIPATING PLAN HOSPITALS.
A partial listing of health education classes and programs can be found at www.healthnewengland.com or in your MemberMatters newsletter.

Vision Benefit:

HEALTH NEW ENGLAND MEMBERS CAN GET A **15% DISCOUNT** OFF THE LOWEST PRICE OF PRESCRIPTION EYEGLASSES AND CONTACT LENSES AT PARTICIPATING EYEWEAR PROVIDERS.
Participating eyewear facilities are listed in our Provider Directory or on our website at www.healthnewengland.com

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
- Procedures, 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
- Procedures, services, drugs, or supplies related to sex transformations
- 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, and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 413-787-4004 or 800-310-2835.

When you must file a claim — such as for out-of-area emergency 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 the facility that provided the service or supply
- Dates you received the service or supply
- 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)
- Receipts, if you paid for your services

Submit your claims to: ***Health New England, Member Services Department, One Monarch Place, Suite 1500, Springfield, Massachusetts, 01144-1500***

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: Health New England, Attn: Complaints & Appeals, One Monarch Place, Suite 1500, Springfield, Massachusetts 01144-1500; 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. 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 • 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 413-787-4004 or 800-310-2835 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 202-606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you 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. Your care must continue to be authorized by your Plan PCP, or preauthorized as required.

When we process a claim as the secondary payer, you will not be responsible for any copayments.

(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, and (a) 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 413-787-4004 or 800-310-2835.

Please note that if your Plan doctor does not participate in Medicare, you will have to file a claim with Medicare.

•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 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 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 your 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 the usual, reasonable and customary charges for any benefits provided to you. 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 to the provider when you receive covered services. See page 11.

Covered services

Care we provide benefits for, as described in this brochure.

Experimental or investigational services

Experimental means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that are considered to be unsafe, experimental or investigational according to, among other sources, formal or informal studies, opinions and references to or by the American Medical Association, the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies, experts in the field and any other association or federal program or agency that has the authority to approve medical testing or treatment.

Medically necessary services/ Medical necessity

Those covered services and supplies that our Medical Director determines are:

- essential for the treatment of your medical condition
- in accordance with generally accepted medical practice
- provided at an appropriate facility and at the appropriate level of care for the treatment of your medical condition

Us/We/Our

Us and we and our refer to Health New England.

You/Your

You and your 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
- When the next open season for enrollment begins

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

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
- 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

If you are divorced from a Federal employee or annuitant, you may not continue coverage 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

•• 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 413-787-4004 or 800-310-2835 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE—202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

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.

Summary of benefits for Health New England - 2001

- **Do not rely on this chart alone.** All benefits are provided in full unless otherwise indicated and ar subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize 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	13
Services provided by a hospital:		
• Inpatient	Nothing	29
• Outpatient	Nothing	30
Emergency benefits:		
• In-area	$50 per visit	33
• Out-of-area	$50 per visit	33
Mental health and substance abuse treatment	Regular cost sharing	34
Prescription drugs	At a Plan pharmacy: $7 per prescription or refill for up to a 30-day supply of generic drugs; $15 per prescription or refill for up to a 30-day supply of brand name formulary drugs; $30 per prescription or refill for up to a 30-day supply of brand name non-formulary drugs.	37
	Through Mail Order: $14 per prescription or refill for up to a 90-day supply of generic drugs; $30 per prescription or refill for up to a 90-day supply of brand name formulary drugs; $90 per prescription or refill for up to a 90-day supply of brand name non-formulary drugs.	37
Dental care	Accidental injury: $10 per office visit; $50 per emergency room visit. Preventive care to age 12: $25 deductible per child per calendar year.	40
Vision care	One annual eye exam: $10 per office visit	20
Special features: Some kinds of special formulas, low protein foods and wigs.		39
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $2,375 per person or $5,250 per family enrollment per calendar year (some costs do not count towards this protection)	11

2001 Rate Information for
Health New England

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
Fill in Location Here							
Self Only	DJ1	$86.59	$35.68	$187.61	$77.31	$102.22	$20.05
Self and Family	DJ2	$195.82	$108.90	$424.28	$235.95	$231.17	$73.55