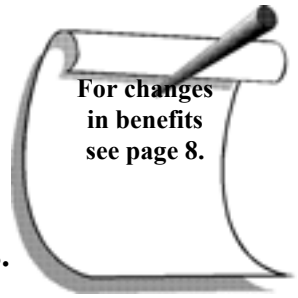
FALLON COMMUNITY HEALTH PLAN

http://www.fchp.org

2002

A Health Maintenance Organization

Serving: Central and Eastern Massachusetts, including the Worcester metropolitan area



Enrollment in this Plan is limited. You must live in or work in our Geographic service area to enroll. See page 6 for requirements.

This Plan has Excellent accreditation from the NCQA. See the 2002 Guide for more information on NCQA.

Enrollment codes for this Plan:

JV1 Self Only
JV2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

RI 73-090

Table of Contents

Introduction

Fallon Community Health Plan
10 Chestnut St.
Worcester, MA 01608

This brochure describes the benefits of Fallon Community Health Plan under our contract number (CS 1917) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 8**.** Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; "we" means Fallon Community Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

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 **1-800-868-5200 (TDD/TTY: 1-877-608-7677)** and explain the situation.
- If we do not resolve the issue, call or write

The Health Care Fraud Hotline
202/418-3300
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.

Section 1. Facts about this HMO plan

This plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals and other providers that contract with us. These plan providers coordinate your health care services.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These plan providers accept a negotiated payment from us, and you will only be responsible for your copayments.

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

You are entitled to ask if we have special financial arrangements with our physicians that can affect the use of referrals and other services that you might need. To get this information, call our Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) and request information about our physician payment arrangements.

Who provides my health care?

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

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

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

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- We are licensed by the Commonwealth of Massachusetts as an HMO. Fallon Community Health Plan is also a federally qualified HMO.
- We have been operating since 1977.
- We are a not-for-profit organization.

If you want more information about us, call 1-800-868-5200 (TDD/TTY: 1-877-608-7677), or write to Fallon Community Health Plan, 10 Chestnut St., Worcester, MA 01608. You may also contact us by fax at 508-831-0912 or visit our website at www.fchp.org.

Service Area

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

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 benefits. Some additional benefits are also available for out-of-area students (see page 38). Otherwise, we will not pay for any other health care services out of our service area unless the services have prior plan approval.

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, 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 until Open Season to change plans. Contact your employing or retirement office.

Abington
Acton
Andover
Arlington
Ashburnham
Ashby
Ashland
Assonet
Athol
Attleboro
Auburn
Avon
Ayer
Barre
Bedford
Bellingham
Belmont
Berkley
Berlin
Beverly
Billerica
Blackstone
Bolton
Boston
Boxborough
Boxford
Boylston
Braintree
Bridgewater
Brimfield
Brockton
Brookfield
Brookline
Burlington
Cambridge
Canton
Carlisle
Charlton
Chelmsford
Chelsea
Clinton
Cohasset
Concord
Danvers
Dedham
Dighton
Douglas
Dover
Dracut
Dudley
Dunstable
Duxbury
East Bridgewater
East Brookfield
East Walpole
Easton
Essex
Everett
Fall River
Fitchburg
Foxborough
Framingham
Franklin
Freetown
Gardner
Georgetown
Gloucester
Grafton
Groton
Halifax
Hamilton
Hanover
Hanscom AFB
Hanson
Hardwick
Harvard
Hathorne
Haverhill
Hingham
Holbrook
Holden
Holland
Holliston
Hopedale
Hopkinton
Hubbardston
Hudson
Hull
Ipswich
Kingston
Lakeville
Lancaster
Lawrence
Leicester
Leominster
Lexington
Lincoln
Littleton
Lowell
Lunenburg
Lynn
Lynnfield
Malden
Manchester
Mansfield
Marblehead
Marlborough
Marshfield
Mattapan
Maynard
Medfield
Medford

Medway
Melrose
Mendon
Methuen
Middleborough
Middleton
Milford
Millbury
Millis
Millville
Milton
Monson
Nahant
Natick
Needham
New Braintree
Newton
Norfolk
North Andover
North Attleboro
North Billerica
North Brookfield
North Chelmsford
North Reading
Northborough
Northbridge
Norton
Norwell
Norwood
Oakham
Orange
Oxford
Palmer
Paxton
Peabody
Pembroke
Pepperell
Petersham
Phillipston
Pinehurst
Plainville
Plympton
Princeton
Quincy
Randolph
Raynham
Reading
Rehoboth
Revere
Rockland
Rockport
Rowley
Royalston
Rutland
Salem
Saugus
Scituate
Seekonk
Sharon
Sherborn
Shirley
Shrewsbury
Somerset
Somerville
South Hamilton
South Walpole
Southborough
Southbridge
Spencer
Sterling
Stoneham
Stoughton
Stow
Sturbridge
Sudbury
Sutton
Swampscott
Swansea
Taunton
Templeton
Tewksbury
Topsfield
Townsend
Tyngsborough
Upton
Uxbridge
Village of Nagog Woods
Wales
Walpole
Waltham
Ware
Warren
Watertown
Waverly
Wayland
Webster
Wellesley
Wenham
West Boylston
West Bridgewater
West Brookfield
Westborough
Westford
Westminster
Weston
Westwood
Weymouth
Whitman
Wilmington
Winchendon
Winchester
Winthrop
Woburn
Worcester
Wrentham

Section 2. How we change for 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- Your share of the non-postal premium will increase by 55.2% for Self Only or 6.0% for Self and Family.
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a plan provider, or fill a prescription at a plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

Where you get covered care

You get care from plan providers and plan facilities. You will only pay copayments, and you will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members.

We list plan providers in the P*rovider Directory*, which we update periodically. If you don't have a *Provider Directory*, call Customer Service for a copy free of charge. The list is also on our website at www.fchp.org.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically.

- **How to get covered care**

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

What you must do to get covered care

- **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician (or, in some cases, a physician assistant or nurse practitioner who works under the supervision of a physician). 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.

If our contract with your primary care physician is ending, we will notify you in writing at least 30 days prior to the date of the end of his or her contract, except where the contract has been ended for reasons involving fraud, patient safety or quality of care. If our contract with your primary care physician ends, you will be required to select a new primary care physician. We will also notify you if you are receiving regular care from a specialist, and that specialist will no longer be under contract with us.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral.

However, you may obtain the following Plan services without a referral:

- Obstetrical and gynecology services, except for infertility treatment. This includes an annual examination, Pap smear, routine mammogram, and maternity care. If you are admitted to a hospital as an inpatient (for childbirth, for example), you must notify the plan of your admission.
- Routine dental care (See Section 5(h) for a description of covered dental services)
- Visits to an oral surgeon for extraction of impacted teeth. (Note: visits to an oral surgeon for any other procedure require a referral and authorization)
- Routine eye examinations with an ophthalmologist or optometrist.
- Outpatient mental health and substance abuse services. Call 1-888-421-8861 (TDD/TTY: 1-781-994-7660) to locate a plan provider.

Authorization may be required for follow-up visits with these providers if they are beyond the scope of what is described above. Authorization may also be required if a provider to whom you have self-referred wishes to refer you elsewhere.

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. However, see "Coverage of Non-Plan Providers" on page 12 for an outline of certain situations in which, in accordance with Massachusetts State law, we will temporarily cover services from a non-plan provider.

- 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.

- If you are terminally ill and our contract ends with a provider from whom you are receiving treatment related to that illness, you may continue to receive treatment from that provider.

- We will make pediatric specialty care available, including mental health care, provided by persons with recognized expertise in specialty pediatrics.

• Hospital care

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

If you are in the hospital when your enrollment in our plan begins, call our customer service department immediately at 1-800-868-5200. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

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

In most cases, if your primary care physician refers you to a plan provider within your provider option (Fallon Plus or Fallon Affiliates), no authorization is required. Once your primary care physician tells you that you have been referred, you can make an appointment with the specialist for the services. You do not need to do anything further and you will not get a letter from the plan.

If the specialist you need is not available from a plan provider in your health care option, your primary care physician needs to request approval from the plan for coverage of these services. Certain specified covered services also require plan authorization, even if your primary care physician refers you within your plan option. In these cases, your primary care physician will send a Request for Authorization to the plan. We will make an authorization decision within 2 working days of receipt of medical information. Your primary care physician will be notified of our decision within 24 hours of the time the decision is made.

If we approve the referral, we will send both you and your primary care physician a written notice within two working days of the appeal notification. When you have received your authorization letter (showing the authorization number), you can call the specialist to make your appointment. If you do not receive the authorization letter, you will be financially responsible for services that are provided.

The authorization letter will describe the services for which the plan has approved coverage. If the specialist believes you need additional services or procedures beyond those authorized, the specialist will request authorization for those services directly from the plan. If we approve the request for additional services, we will send both you and your primary care physician a written notice.

If we do not approve a primary care physician's or specialist's request for authorization, we will send you a letter explaining our decision and describing your right to dispute our decision. (See Section 8 for more information.)

Examples of services that *do not require* plan authorization:

- Most specialty medical or surgical consultations with plan providers. In some cases, the specialist may need to obtain an additional referral from your primary care physician and/or authorization from the plan to continue covered treatment.
- Initial evaluations for chiropractic services, physical therapy, speech therapy, or occupational therapy. Plan authorization is required for additional visits.
- Allergy injections, for up to 12 months
- Chemotherapy, for up to 12 months
- Outpatient radiation therapy, for up to 12 months
- Many outpatient diagnostic tests

Examples of services that *do require* plan authorization:

- Many outpatient surgical procedures
- Inpatient hospital admissions (including inpatient surgical admissions)
- Referral to provider a outside your plan option, or to a non-plan provider
- Podiatry consultations
- Transplant evaluation
- Cardiac or pulmonary rehabilitation
- Neuropsychological testing
- Pain clinic
- Certain outpatient diagnostic tests, including CT Scan, EMG/NCV, genetic testing, MRI/MRA scans, Nuclear Medicine Testing, PET/SPECT and Sleep Study
- Durable medical equipment

These are just some examples, not a complete list. To verify whether a service can be authorized by your primary care provider or if it requires plan authorization, check with your primary care physician or call Customer Service.

Coverage of non-plan providers

Once you become a plan member, we will generally only pay for services that you receive from plan providers. However, there are some circumstances in which we will temporarily pay for services that you receive from a non-plan provider, if you had been receiving care from that provider prior to becoming a member:

- If your prior primary care physician is not a participating provider in any health insurance plan that FEHB offers to you, we will pay for services from that provider for 30 days from your effective date.
- If you are receiving an ongoing course of treatment from a provider who is not a participating provider in any health insurance plan that FEHB offers to you, we will pay for services from that provider for 30 days from your effective date.
- If you are terminally ill, and you are receiving ongoing treatment from a provider who is not a participating provider in any health insurance plan that FEHB offers to you, we will pay for your services from that provider until your death.

In all cases, the provider must agree to accept reimbursement for services at our rates, and to adhere to our quality assurance standards, and other policies and procedures such as obtaining appropriate referrals and prior authorizations. You will be eligible for benefits as if the provider was under contract with us.

Utilization Review

Our case management program reviews and evaluates the health care our members receive to make sure that our members' care is coordinated, and that appropriate levels of service are available to all members.

The program is staffed by licensed registered nurse case managers, physician reviewers and specialists who are in routine contact with our health care providers. They use national, evidence-based criteria that are reviewed annually by a committee of health plan and community-based physicians to determine the medical appropriateness of selected services requested by your physician. These criteria are approved as being consistent with generally accepted standards of medical practice, including prudent layperson standards for emergency room care.

We also develop in-house criteria, making use of local specialist input and current medical literature, as well as guidelines from Medicare and the Commonwealth of Massachusetts.

To obtain information about the status or outcome of a utilization review decision, call 1-800-868-5200, extension 69915 (TDD/TTY: 1-877-608-7677).

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 a provider, facility, pharmacy, etc., when you receive services. Example: When you see your primary care physician you pay a copayment of $10 per office visit.
•**Deductible**	We do not have a deductible.
•**Coinsurance**	We do not have coinsurance.
Your catastrophic protection out-of-pocket maximum	We do not have an out-of-pocket maximum.

Section 5. Benefits -- Overview

(See page 8 for how our benefits changed this year and page 57 for a benefits summary

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

Section 5 (a). Medical services and supplies p and other health care profess

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 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 other coverage, including with Medicare.

Benefit Description
Diagnostic and treatment services
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion • Outpatient self-management diabetic training and education, including medical nutrition therapy
• At home
Professional services of physicians • During a hospital stay • In a skilled nursing facility
Lab, X-ray and other diagnostic tests
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG

Preventive care, adult

Routine screenings, such as:

- Total Blood Cholesterol – once every three years
- Colorectal Cancer Screening, including
  - Fecal occult blood test
- Sigmoidoscopy, screening – every five years starting at age 50

Prostate Specific Antigen (PSA test) – one annually for men age 40 and older

Routine Pap test

Note: The office visit is covered if Pap test is received on the same day; see *Diagnosis and Treatment*, above.

Routine mammogram–covered for women age 35 and older, as follows:

- From age 35 through 39, one during this five-year period
- From age 40 and up, one every calendar year

Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.

Routine immunizations, limited to:

- Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immu
- Influenza/Pneumococcal vaccines, annually, age 65 and over

- Childhood immunizations recommended by the American Academy of Pediatrics

- Well-child care charges for routine examinations, immunizations and care (up to age 22)
  - Physcial examination, history, measurements, sensory screening, neuro-psyciatric evaluation, and development scree children under six years of age
  - Screening for lead poisoning, for children under six years of age
  - Hereditary and metabolic screening at birth, newborn hearing screening test performed before the new born infant is hospital or birthing center, tuberculin tests, hematocrit, hemoglobin, and other appropriate blood test and urinalysis

Maternity care

Complete maternity (obstetrical) care, such as:

- Prenatal care
- Delivery
- Postnatal care

Note: Here are some things to keep in mind:

- You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. This incl circumcision, routine

Maternity care *(Continued)*

- examination, hearing screening, and medically necessary treatments of congenital defects, birth abnormalities or prema other care for an infant who requires non-routine treatment only if we cover the infant under a "Self and Family" enroll inpatient stay if medically necessary.
- We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We wil infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment.

- We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Sectior (Section 5b).

We cover the following services when provided during an inpatient maternity admission: childbirth, nursery charges, circu examination, hearing screening and medically necessary treatments of cogenital defects, birth abnormalities or premature l

Not covered: Routine sonograms to determine fetal age, size or sex

Family planning

Voluntary family planning services, limited to:

- Voluntary sterilization
- Injectable contraceptive drugs (such as Depo Provera)
- Diaphragms

NOTE: We cover oral contraceptives under the prescription drug benefit.

Intrauterine devices (IUDs)

Norplant (a surgically implanted contraceptive)

Not covered: reversal of voluntary surgical sterilization, genetic counseling,

Infertility services

Fallon covers the diagnosis and treatment of infertility, as defined under Massachusetts law.

To be eligible, you must be an individual who:
(1) Is unable to conceive or produce conception during a period of one year;
(2) should expect fertility as a natural state; and
(3) is a pre-menopausal female or a female who is experiencing menopause at a premature age.

Approval for Assisted Reproductive Technology (ART) is contingent upon review of your medical history by a Plan Medic coverage guidelines for all ART services are available by contacting the Customer Service Department at 1-800-868-5200 (T

Coverage is provided for the services below when determined to be medically necessary by a Plan Medical Director. Origi cycles; if you wish to continue beyond 4 cycles, further medical review by the Medical Director is required.

- Office visits with a Plan physician or specialty care physician for the evaluation and diagnosis of fertility, and diagnos services
- Artificial insemination:
  — intravaginal insemination (IVI)
  — intracervical insemination (ICI)
  — intrauterine insemination (IUI)
- Other assisted reproductive technologies (ART) including:
  — gamete intrafallopian transfer
  — intracytoplasmic sperm injection
  — zygote intrafallopian transfer
- In vitro fertilization
- Sperm, egg, and/or inseminated egg procurement, processing, and banking
- Fertility drugs

(Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benef

Infertility services *(Continued)*

Not covered:

- *Treatments, services and supplies which have not been determined to be medically necessary*
- *Donor egg transfer for women who are menopausal, except as stated above*
- *Chromosome studies of a donor (sperm or egg)*
- *Charges for the storage of donor sperm, eggs, or embryo that remain in storage after the completion of an approved treatment cycle*
- *Compensation to a donor (this does not include charges related to the procurement and processing of sperm, egg, and inseminated e donor's insurance does not cover these costs)*
- *Supplies that may be purchased without a physician's written order, such as ovulation test kits*
- *Services which are necessary due to a voluntary sterilization, of for which there is no diagnosis of infertility*
- *Surrogacy or gestational carrier services*
- *Transportation costs to or from the medical facility*

Allergy care

Testing and treatment

Allergy injection

Allergy serum

Not covered: provocative food testing and sublingual allergy desensitization

Treatment therapies

- Chemotherapy and radiation therapy

Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants list
Transplants on page 27.

- Respiratory and inhalation therapy
- Dialysis – Hemodialysis and peritoneal dialysis
- Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy
- Growth hormone therapy (GHT)

Note: Growth hormone is covered under the prescription drug benefit.

Note: We will only cover GHT when we preauthorize the treatment. See your plan physician for preauthorization; he or s
that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we v
from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will nc
services and supplies. See *Services requiring our prior approval* in Section 3.

Physical and occupational therapies

Up to 60 consecutive days or 20 nonconsecutive visits (whichever is greater) per condition per calendar year for the service
— qualified physical therapists and
— occupational therapists.

Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due tc

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction

Early intervention services for children through age three for services such as physical, occupational and speech therapy, n
psychological counseling. Benefits are limited to a maximum of $3,200 per calendar year per child and $9,600 over the term

Not covered:

- *long-term rehabilitative therapy*
- *exercise programs*
- *massage therapy*

Speech therapy

- Up to 60 consecutive days or 20 nonconsecutive visits (whichever is greater) per condition per calendar year.
- Medically necessary services for the diagnosis and treatment of speech, language and hearing disorders provided by a speech-language pathologist or audiologist.

Hearing services (testing, treatment, and supplies)

- Hearing testing for children through age 17

Not covered:
- *all other hearing testing*
- *hearing aids, testing and examinations for them*

Vision services (testing, treatment, and supplies)

- Diagnosis and treatment of diseases of the eye

- Eye exam to determine the need for vision correction
- Annual eye refractions, including written lens prescriptions for eyeglasses

Not covered:

- *Eyeglasses or contact lenses*
- *Eye exercises and orthoptics*
- *Radial keratotomy and other refractive surgery*
- *Eye examination for contact lenses*

Foot care

Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes (pre

See orthopedic and prosthetic devices for information on podiatric shoe inserts.

Not covered:

- *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot,*
- *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the surgery)*

Orthopedic and prosthetic devices

- Prosthetic devices, such as artificial limbs and eyes

- Scalp hair prosthesis (wigs) for members who have suffered hair loss as a result of any treatment for cancer or leukemia

- Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy
- Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast imp
  Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for cov
  the device.
- Occlusal splint for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Orthopedic and prosthetic devices *(Continued)*

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*

Durable medical equipment (DME)

Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your plan dialysis equipment. Under this benefit, we also cover:

- hospital beds
- wheelchairs
- crutches
- walkers
- blood glucose monitors for home use; therapeutic/molded shoes and shoe inserts for the treatment of severe diabetic fo magnifying aids and voice synthesizers for blood glucose monitors, for use by the legally blind.

Not covered:

Items that are not covered include, but are not limited to: air conditioners, air purifiers, arch supports, ear plugs (i.e., to prevent fluid f during water activities), foot orthotics, orthopedic shoes (except when part of a brace) or other supportive devices for the feet, articles of stockings, bedpans, raised toilet seats, dehumidifiers, dentures, elevators, safety grab bars, car seats, seizure helmets, hearing aids, heati exercise equipment or similar devices.

Home health services

- Home health care ordered by a plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N nurse (L.V.N.), or home health aide. Services include:
  - — skilled nursing care
  - — physical therapy, occupational therapy, oxygen therapy, intravenous therapy, and medications
  - — medical social services, nutritional services and home health aide services
  - — medical and surgical supplies and durable medical equipment
  - — medication visits to monitor, evaluate or adjust the prescription medication dosage that is being prescribed for a med condition

Not covered:

- *nursing care requested by, or for the convenience of, the patient or the patient's family;*
- *home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabil*

Chiropractic

- Chiropractic services for acute musculoskeletal conditions. The condition must be new or an exacerbation of a previou be provided by a plan chiropractor and requires a referral from a primary care doctor. Coverage is provided for up to

Alternative treatments

Not covered:
- *naturopathic services*
- *hypnotherapy*
- *acupuncture*
- *biofeedback*

Educational classes and programs

Coverage is limited to:

- Smoking Cessation – Up to $100 for one smoking cessation program per member per lifetime, including all related expen

- Diabetes self-management (may require preauthorization)

- Health education and nutritional services, such as health education, library services, nutrition classes and programs, beha women's wellness.

The Fallon Foundation offers many health education programs and classes at the Lifetime Center for Family Health, 630A those who want to take a more active role in their health care. (Similar classes and programs also may be available in other affiliated hospitals.) In addition, the Lifetime Center offers a variety of free brochures and booklets that provide informatio prevention and coping with various illnesses.

Section 5 (b). Surgical and a
and other h

Benefit Description
Surgical procedures
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity—a condition in which an individual weighs 100 pounds or 100% over his or her n current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information.
• Voluntary sterilization • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay pacemaker and Surgery benefits for insertion of the pacemaker.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*

Reconstructive surgery

- Surgery to correct a functional defect
- Surgery to correct a condition caused by injury or illness if:
  - the condition produced a major effect on the member's appearance and
  - the condition can reasonably be expected to be corrected by such surgery
- Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.

- All stages of breast reconstruction surgery following a mastectomy, such as:
  - surgery to produce a symmetrical appearance on the other breast
  - treatment of any physical complications, such as lymphedemas
  - breast prostheses and surgical bras and replacements (see Prosthetic devices)

Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the after the procedure.

Not covered:

- *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance throu except repair of accidental injury*
- *Surgeries related to sex transformation*

Oral and maxillofacial surgery

Oral surgical procedures, limited to:

- Reduction of fractures of the jaws or facial bones;
- Surgical correction of cleft lip, cleft palate or severe functional malocclusion;
- Removal of stones from salivary ducts;
- Excision of leukoplakia or malignancies;
- Excision of cysts and incision of abscesses when done as independent procedures; and
- Other surgical procedures that do not involve the teeth or their supporting structures.

Not covered:

- *Oral implants and transplants*
- *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*

Organ/tissue transplants

Limited to:

- Cornea
- Heart
- Heart/lung, for patients under 60 with end-stage primary or secondary pulmonary hypertension
- Kidney
- Liver
- Lung, for patients under age 60 with end-stage obstructive or restrictive pulmonary disease
- Allogeneic (donor) bone marrow transplants for leukemia, aplastic anemia, severe combined immunodeficiency disease syndrome for patients with high risk lymphoblastic lymphoma in remission, or for patients under age 60 with myelody
- Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditic remission; advanced Hodgkin's disease; resistant non-Hodgkin's disease; recurrent or refractive neuroblastoma; or brea
- Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such pancreas
- Human leukoctye (HLA) or histocompatability locus antigen testing for A,B, or DR antigens, or any combination thereo marrow transplant donor suitability

Services must be provided at a plan-affiliated transplant facility, subject to your acceptance into the facility's program. The the final determination on eligibility for transplant coverage. The plan may require that members receive their transplant a If a covered bone marrow transplant is not available from a plan provider, benefits will be paid at the same benefit level fo non-plan provider.
Note: We cover related medical and hospital expenses of the donor when we cover the recipient.

Not covered:

- *Donor screening tests and donor search expenses, except as listed above, and those performed for the actual donor*
- *Transplants not listed as covered, including but not limited to bone marrow transplants for treatment of solid tumors*
- *Services for the organ donor that are covered by another insurance plan*
- *Services for the organ donor if the recipient is not a member of this plan*
- *Transportation, housing or home cleaning services incurred by either the donor or recipient*

Anesthesia

Professional services provided in –

- Hospital (inpatient)

Professional services provided in –

- Hospital outpatient department
- Skilled nursing facility
- Ambulatory surgical center
- Office

Benefit Description
Inpatient hospital
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivat
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes or schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*

Outpatient hospital or ambulatory surgical center

- Operating, recovery, and other treatment rooms
- Prescribed drugs and medicines
- Diagnostic laboratory tests, X-rays, and pathology services
- Administration of blood, blood plasma, and other biologicals
- Blood and blood plasma, if not donated or replaced
- Presurgical testing
- Dressings, casts, and sterile tray services
- Medical supplies, including oxygen
- Anesthetics and anesthesia service

NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical
cover the dental procedures.

Extended care benefits/skilled nursing care facility benefits

The plan provides a comprehensive range of benefits for 100 days per calendar year when full-time skilled nursing care is r
in a skilled nursing facility is medically appropriate as determined by a plan doctor and approved by the plan. All necessa
including:

- Bed, board, and general nursing care
- Drugs, biologicals, equipment and supplies ordinarily provided or arranged by the skilled nursing facility, when prescri

Not covered: custodial care or long-term inpatient care

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include outpa
counseling, and short-term inpatient care for up to 5 days of continuous inpatient care. These services are provided under
doctor who certified that the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months o

Not covered: Independent nursing, homemaker services

Ambulance

- Local professional ambulance service when medically appropriate

Section 5 (d). E

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury (mental or physical) that you believe more detailed definition, as required by Massachusetts state law). Some problems are emergencies because, if not treated p potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. The 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 physician. In extreme emergencies, if you are unable to hospital emergency room. Be sure to tell the emergency room personnel that you are a plan member so you can notify the plan has been notified in a timely manner.

If you need to be hospitalized, the plan must be notified as soon as reasonably possible. If you are hospitalized in a non-pla any ambulance charges covered in full.

Benefits are available for care from non-plan providers only if a delay in reaching a plan provider would result in death, di plan or provided by plan providers.

Emergencies outside our service area:

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

If you need to be hospitalized, the plan must be notified as soon as reasonably possible. If a plan doctor believes care can b

Any follow-up care recommended by plan providers must be approved by the plan or provided by plan providers.

Benefit Description
Emergency within our service area
• Emergency care at a doctor's office • Emergency care at an urgent care center
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services
Not covered: Elective care or non-emergency care
Emergency outside our service area
• Emergency care at a doctor's office • Emergency care at an urgent care center
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services
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*
Ambulance
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.
Not covered: • *air ambulance, when not appropriate to medical and geographical conditions* • *transfers between hospitals when the patient's medical condition does not warrant that he/she be transported to another facility*

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

IMPORTANT

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.
- Mental health and Substance Abuse treatment may be provided by a psychiatrist, psychologist, psychotherapist, licensed clinical specialist in psychiatric and mental health nursing, licensed independent clinical social worker, mental health counselor, pediatric specialist, or other provider as authorized by the plan.
- **YOU MUST GET PREAUTHORIZATION FOR SOME OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	**You Pay**
All diagnostic and treatment services recommended by a plan provider and authorized by the plan (when necessary). 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 any necessary authorization.	Your cost sharing responsibilities are no 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 outpatient visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing

Mental health and substance abuse benefits *(Continued)*	**You Pay**
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization

To be eligible to receive these benefits you must obtain plan authorization when nec

Inpatient services require preauthorization. To access services, call 1-888-421-8861 (T 7660).

You may self-refer, without prior plan authorization, for outpatient services with a p assistance in finding a contracted provider, call 1-888-421-8861 (TDD/TTY: 781-994-

Section 5 (f). I

Benefit Description
Covered medications and supplies
We cover the following medications and supplies prescribed by a plan physician and obtained from a plan pharmacy or th program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, exc *covered*. This includes drugs used as off-label basis for treatment of cancer and HIV/AIDS. • Diabetic supplies and medications, including insulin, insulin syringes, blood glucose monitoring strips, urine glucose s insulin pumps, insulin pump supplies, and insulin pens. • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (contact us for preauthorization and dose limits) • Oral contraceptives and contraceptive devices • Fertility drugs • Allergy serum • Injectable agents • Emergency prescriptions (up to a 14-day supply) provided out of the service area as part of an approved emergency tr
• Injectable contraceptive drugs, such as Depo Provera
• Special medical formulas to treat certain metabolic disorders as required by Massachusetts law. Metabolic disorders cc phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, methylmalonic acidem medically necessary to protect unborn fetuses of pregnant women with phenylketonuria
• Food products which have been modified to be low in protein for individuals with inherited diseases of amino acids a

Covered medications and supplies *(Continued)*

- Enteral formulas for home use in the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroes gastrointestinal motility, chronic internal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

Not covered:

- *Drugs and supplies for cosmetic purposes*
- *Drugs to enhance athletic performance*
- *Drugs obtained at a non-plan pharmacy; except for out-of-area emergencies*
- *Vitamins, nutrients and food supplements even if a physician prescribes or administers them*
- *Nonprescription medicines*
- *Medical supplies such as dressings and antiseptics*
- *Nicotine patches, and gum or other smoking cessation products unless supplied to you as part of an approved smoking cessation pr*

Section 5 (g). Special features

Feature	Description
Services for deaf and hearing impaired	You may access our TTD/TTY equipment at 1-877-608-7677.
Peace of Mind™ Program	If you are a Fallon Plus or Fallon Affiliates member and you want to see a Boston-base usual physician), you may do so under the Peace of Mind Program if you meet the foll • Care is only for covered services as described in this brochure. The same copayments • You must have already seen a plan specialist for this condition within the past three r • A referral to a specific Peace of Mind physician is made by your plan physician and a • The physician is on staff at Massachusetts General Hospital, Brigham and Women's H (Boston), New England Medical Center or Dana-Farber Cancer Institute. Services for Boston IVF instead of one of these four hospitals. Once the plan has authorized the Peace of Mind referral to a specific physician, you m see this specialist for a consultation. You may continue on with this specialist for treat plan physician at any time for care. If you wish to see any other Peace of Mind provid separate referral from your plan physician and receive authorization from the plan, m above. You should advise your Peace of Mind Program provider that all laboratory, X-ray se authorized in advance by the plan. To ensure coverage, the Peace of Mind Program p plan's Referral Management staff to make arrangements for these services. Whenever be made for these services to be performed by plan providers. You may use the Peace of Mind program for all specialty care except mental health, su chiropractic services. You may not use the Peace of Mind program for any primary ca internal medicine, family practice, pediatrics or routine obstetrics. If you have not me above or you or your physician have not obtained plan authorization for a Peace of M will not be covered by the plan and the Peace of Mind Program provider may hold yo
Out-of-area emergency and urgent care	Send all claims for urgent or emergency care to us within six months of the date of serv claims yourself, or the provider may submit them directly. With your authorization, w to the provider. Otherwise, we will send any payment to you. All bills should include services, the dates of service and the charge for each service. We will pay for the reasor full, minus the appropriate copayment. Claims for services in a foreign country may be submitted if the services are not provic country. The bills must be itemized and in English (or translated into English). Payme you must pay the provider.

Out-of-area student coverage	We cover students attending school outside the plan service area, for additional benefi out-of-area, if authorized by the plan in advance. Coverage continues to age 22 or unti occurs first. • Outpatient services to treat the abuse of, or addiction to, alcohol and drugs. You p • Non-elective inpatient services if the plan is notified as soon as reasonably possibl • Non-routine office visits. You pay a $10 copay per visit. • Diagnostic lab and X-ray services connected with non-routine office visits. You pa • Outpatient services to diagnose and/or treat mental conditions. You pay a $10 cop • Short-term rehabilitation services, including physical, occupational, and speech th outpatient visits per calendar year. *Not covered out-of-area:* • *Routine physicals, gynecological exams, vision screening, hearing screening, or other routi* • *Maternity care or delivery* • *Outpatient surgical procedures that could have been delayed until return to the Plan servi* • *Durable medical equipment (e.g. wheelchairs), including maintenance and replacement* • *Preventive dental care* • *Second opinion* • *Home health care* • *Non-emergency prescription drugs*
Interpreter services	We will, upon request, provide members with interpreters and translation services rel Health Plan administrative procedures.

Section 5 (h). Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental 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.

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

Dental benefits

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

ADA Code	Description	You pay
110	Initial oral examination	$10
120	Periodic oral examination	10
130	Emergency oral examination	10
140	Ltd. oral evaluation (problem focused)	10
150	Comprehensive oral evaluation	10
220	Intraoral (periapical, first film)	10
230	Intraoral (periapical, each additional film)	10
240	Intraoral (occlusal film)	10
270	Bitewing (single film)	10
272	Bitewings (two films)	10
273	Bitewings (three films)	10
274	Bitewings (four films)	10
460	Pulp vitality tests	10
470	Diagnostic casts	10
Preventive (Cleanings)		
1110	Prophylaxis (adult, every six months)	10
1120	Prophylaxis (child, every six months)	10
1201	Top application flouride (includes prophylaxis—child < age 16)	10
1203	Top application flouride (excludes prophylaxis—child < age 16)	10
1205	Top application flouride (includes prophylaxis—adult age 16 and over)	10
1330	Oral hygiene instruction	10
Minor Restorative (Fillings)		
2110	Amalgam (one surface, primary)	13
2120	Amalgam (two surfaces, primary)	18

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

Procedures not shown are not covered by the Plan.

Section 5 (i). Non-FEHB benefits available to plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

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

Eyewear discounts—Fallon has arranged for discounts on eyeglass frames, prescription lenses and complete contact lens at participating Fallon optical providers. For more information, contact the Fallon Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

Hearing aid discounts—The plan has arranged for discounts off the regular price of hearing aids and assistive listening devices. Contact the Fallon Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) for a complete list of providers.

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

Medicare prepaid plan enrollment—This plan offers Medicare recipients the opportunity to enroll in the plan through Medicare. As indicated on page 46, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later re-enroll in the FEHB Program. Most federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid program but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact Fallon Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) for information on the benefits available under the Medicare HMO.

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

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

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or** condition and we agree, as discussed under *Services Requiring Our Prior Approval* on page 11.

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, including services received for reasons of preference or convenience
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Experimental or investigational procedures, treatments, drugs or devices
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

When you see plan physicians, receive services at plan hospitals and facilities, or obtain your prescription drugs at plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

When you must file a claim—such as for out-of-area care—submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer —such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

Fallon Community Health Plan
Claims Department
10 Chestnut St.
Worcester, MA 01608

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Fallon Community Health Plan, Consumer Affairs Department, 10 Chestnut St., Worcester, MA 01608; or fax it to us at 508-755-7393; or make your request by telephone at 1-800-868-5200 (TDD/TTY: 1-800-607-7677) Monday through Friday, 8:30 a.m. to 5:00 p.m.; or make your request in person at our Consumer Affairs Department; 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. Also include your name, FCHP identification number, and the name of any FCHP representative with whom you have spoken. If you send us a written or electronic grievance, we will acknowledge your request in writing within 15 business days from the date that we receive the request. If you call us or come in to our offices, we will put your grievance in writing and send a written statement to you or your authorized representative within 48 hours of the time that we talked to you.
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 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. Your grievance will be reviewed by FCHP administrators and/or physicians who are knowledgeable about the matters at issue in the grievance. As part of certain types of review, we may ask you to participate in a conference. 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. Our response will describe the specific information considered as well as an explanation for the decision. You may ask for a reconsideration of a final adverse determination if any relevant information was received too late to review within the time limits described above, or is expected to become available within a reasonable time period after you receive our written response. If we agree to reconsider, we will indicate a new time period for review in writing. This would not be longer than 30 days from the date we agree to the reconsideration. If we do not complete a review in the time limits specified above, the decision will automatically be in favor of the member. Time limits include any extensions made by mutual written agreement between you or your authorized representative and the plan
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 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include 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 or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-868-5200 and we will expedite our review. If you have a terminal illness, and if our review of your expedited review results in denial of coverage, you may request a conference. We will schedule the conference within 10 business days from the date on which we receive your request; or within five business days if your physician determines, after consultation with a plan medical director, that based on standard medical practice, the effectiveness of the proposed treatment, services or supplies or any alternative treatment, services or supplies would be materially reduced if not provided at the earliest possible date. You may attend the conference, but your attendance is not required; 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 3 at 202-606-0737 from 8 a.m.to 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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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 (Part A or Part B)

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

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

The following chart illustrates whether **the Original Medicare Plan** 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, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

We do not waive any costs when you have Medicare.

• Medicare managed care plan If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare + Choice plan—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 provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare managed care plan, the following options are available to you:

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

This plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our plan providers), but we will not waive any of our copayments. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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's service area.

•If you do not enroll in If you do not have one or both Parts of Medicare, you can still be covered Medicare Part A or Part B under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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 illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide
- 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 care. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement .

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care furnished to meet nonmedically necessary needs such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial Care is not covered by the plan.
Experimental or investigational services	The plan's Benefits & Technology Assessment Committee determines what procedures, devices, and services are experimental or investigational using FDA guidelines and long-term clinical studies. Clinical studies are used to ensure that the procedure, device, or service has proven to be more effective over currently accepted procedures, devices, or service.
Group health coverage	Health care coverage through a partnership, association, or corporation that has an agreement to pay the plan, or its agent, the plan premium for a group of subscribers. FEHB is an example of a group.
Medical necessity	A medical or hospital service which is rendered for treatment or diagnosis of an injury or illness, not furnished primarily for the convenience of the member, physician or provider, and is in accordance with professionally recognized medical standards and plan medical criteria.
Provider	A person, agency or facility that may furnish health care to you under the terms of this contract. This includes doctors of medicine, osteopathy and podiatry; registered nurse anesthetists; and nurse practitioners.
Us/We	Us and we refer to Fallon Community Health Plan
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

- When you may change your enrollment
- How you can cover your family members
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
- When your enrollment ends
- 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 for which your employing or retirement office authorizes coverage. 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 (adopted children are eligible from the time of placement in the home). 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 joined this plan during Open Season, your coverage begins on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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 coverage

If you are divorced from a Federal employee or annuitant, 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.

In the event of divorce, the subscriber's former spouse may remain covered under the FEHB family coverage. Coverage may continue, with no additional premium due, unless: (1) the divorce decree does not require (or no longer requires) the subscriber to maintain health insurance coverage for the former spouse, or (2) either the subscriber or the former spouse remarry.

If the subscriber remarries and wishes to add his or her new spouse to the family coverage, the former spouse remains eligible for coverage under FEHB. However, the former spouse must move from family coverage to individual coverage and additional premium will be required; the former spouse only remains eligible under the group if the divorce decree provides for such coverage. If the former spouse remarries, the former spouse's eligibility ends.

Notice of cancellation of coverage of a former spouse will be mailed to the former spouse at his or her last known address, along with notice of any applicable right to reinstate coverage retroactively to the date of cancellation. The former spouse may also be eligible for continuation of coverage or conversion to an individual guarantee-issue policy.

•Temporary Continuation of coverage (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, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. 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. It explains what you have to do to enroll.

•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

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is federal law that offers limited federal protections for health coverage availability and continuity to people who lose employer group 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.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB Web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance is coming later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. It can supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planning.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.

- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of benefits for Fallon Community Health Plan - 2002

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

	Benefits
Medical services provided by physicians:	
• Diagnostic and treatment services provided in the office.....	
Services provided by a hospital:	
• Inpatient.....	
• Outpatient.....	
Emergency benefits:	
• In-area.....	
• Out-of-area	
Mental health and substance abuse treatment	
Prescription drugs	
Dental Care	
Vision Care.....	
Special features.....	
Protection against catastrophic costs (your out-of-pocket maximum)	