



FALLON COMMUNITY HEALTH PLAN

1998

A Health Maintenance Organization



This plan has full accreditation from the NCQA effective October 19, 1994 through October 19, 1997. See the *FEHB Guide* for more information on NCQA.



Serving: Central and Eastern Massachusetts

You must either live or work in the service area to enroll in this plan.

Enrollment Code:

JV1 Self Only

JV2 Self and Family

Service area: Services from Plan providers are available only in the following area:

All of Worcester, Middlesex and Suffolk Counties as well as parts of Essex, Norfolk, Franklin, Hampshire and Hampden Counties. See page 24 for a complete list of towns included in the covered service area.

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1998 Rate Information for Fallon Community Health Plan

FEHB Benefits of this Plan are described in brochure 73-090.

The 1998 rates for this Plan follow. **Non-Postal rates** apply to most non-Postal enrollees. If you are in a special enrollment category, refer to an FEHB Guide or contact the agency that maintains your health benefits enrollment. **Postal rates** apply to all USPS career employees and do not apply to non-career Postal employees, Postal retirees or associate members of any Postal employee organization.

Type of Enrollment	Code	<u>Non-Postal Premium</u>				<u>Postal Premium</u>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	JV1	57.12	19.04	123.76	41.25	67.59	8.57
Self and Family	JV2	142.27	54.75	308.25	118.63	168.36	28.66

Fallon Community Health Plan

The Fallon Community Health Plan, 10 Chestnut Street, Worcester, MA 01608, has entered into a contract (CS 1917) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Fallon Community Health Plan, or FCHP or the Plan.

This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. A person enrolled in the Plan is entitled to the benefits stated in this brochure. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1998, and are shown on page 23 of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation—sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Plan at 1-800-868-5200 and explain the situation.
- If the matter is not resolved after speaking to your Plan (and you still suspect fraud has been committed), call or write:

**THE HEALTH CARE FRAUD HOTLINE
202/418-3300**

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan.

If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 15. If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See “If you are hospitalized” on page 5.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined

person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- *The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.*
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- *You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.*
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

General Information *continued*

- Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.
- You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800-638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available. *Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.*

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

Notification and election requirements:

Separating employees — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

General Information *continued*

Children — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Facts about this Plan

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll in an HMO, you are joining an organized system of health care that arranges in advance with specific doctors, hospitals and other providers to give care to members and pays them directly for their services. Benefits are available only from Plan providers except during a medical emergency. Members are required to select a personal doctor from among participating Plan primary care doctors. Services of a specialty care doctor can only be received by referral from the selected primary care doctor. There are no claim forms when Plan doctors are used.

Your decision to join an HMO should be based on your preference for the Plan's benefits and delivery system, not because a particular provider is in the Plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan places great emphasis on preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Who provides care to Plan members?

The Fallon Community Health Plan is a mixed model HMO that began operations in 1977 as the first HMO in Central Massachusetts.

The Plan provides a comprehensive program for routine preventive care as well as protection against major illness. Benefits include office visits, complete physical examinations, hospitalization, pediatric care and laboratory, X-ray and pharmacy services.

Facts about this Plan *continued*

The Fallon Community Health Plan offers members three provider options from which to choose. The Fallon Plus option offers a choice of over 401 physicians practicing in multi-specialty medical centers throughout Central Massachusetts as well as doctors from the Lowell area. The UMass Group Practice option offers a choice of nearly 319 physicians based primarily at the UMass Medical Center, a state-of-the-art teaching hospital. The Fallon Affiliates option offers a network of over 1,041 independent practitioners practicing in offices throughout Central and Eastern Massachusetts. Members are asked to select a provider option at the time of enrollment, *and may change a provider option or personal physician at any time throughout the year. The change will become effective on the first day of the month following a 30-day notification received by us.*

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

The Plan provides coverage for urgent and emergency care around the world. Within the Plan's service area, members must call their 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, members are covered for emergency services obtained at any medical facility, but should call for authorization before seeking follow-up care.

Role of a primary care doctor

The first and most important decision each member must make is the selection of a personal doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your personal doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other Plan providers are covered only when there has been a referral by the member's personal doctor ***with the following exceptions: annual eye examinations, mental health and substance abuse services, or a woman may see her Plan obstetrician/gynecologist for her annual routine examination without a referral from their personal physician.*** To access mental health and substance abuse providers, call the provider directly. Mental health and substance abuse providers' telephone numbers and locations are listed in the Plan's Physician directory.

Choosing your doctor

The Plan's provider directory lists (family practitioners, pediatricians, and internist) with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Plan's Customer Service Office at toll free at 1-800-868-5200; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

Should you decide to enroll, you will be asked to select personal doctors for you and for each member of your family. Members may change their doctor selection at any time,

If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.

Referrals for specialty care

Except in a medical emergency, or when a personal doctor has designated another doctor to see patients when he or she is unavailable, you must contact your personal doctor for a referral before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion *and must be approved by the Plan.* If specialists or consultants are required beyond those participating in the Plan, the primary care doctor will make arrangements for appropriate referrals *in accordance with Plan guidelines.*

On referrals, the *Plan* will give specific written instructions to the consultant as to what services are authorized. If additional services or visits are suggested by the consultant, you must first check with your personal doctor. Do not go to the specialist unless your personal doctor has arranged for and the Plan has issued an authorization for the referral in advance.

Authorizations

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Your Plan doctor will determine medical necessity but must obtain authorization from the Plan before you may be hospitalized, referred for specialty care or obtain follow-up care from a specialist.

Facts about this Plan *continued*

For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan personal doctor for the care to be covered by the Plan. If the doctor who originally referred you prior to your joining this Plan is now your Plan personal doctor, you need only call to explain that you now belong to this Plan and ask *for a referral to that specialist. Your physician and the Plan will review your request and arrange for appropriate care.*

If you are selecting a new personal doctor, you must schedule an appointment so the personal doctor can decide whether to treat the condition directly or refer you back to the specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket maximum

Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments which are required for a few benefits.

Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures which may be recommended by Plan providers.

The Plan's service area

The service area for this Plan, where Plan providers and facilities are located, is described on the front cover of this brochure and on page 24. You must live or work in the service area to enroll in this Plan. Benefits for care outside the service area are limited to emergency services, as described on page 15.

If you or a covered family member move outside the *service area, or farther away from the service area*, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

Reciprocity

Due to reciprocal agreements, many health maintenance organizations (HMOs) provide arrangements for emergency and urgent care to Fallon members who are outside the Fallon service area. The members may call 1-800-868-5200 for the name and location of the closest HMO in the area.

General Limitations

Important Notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan. This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

General Limitations *continued*

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Arbitration of claims

Any claim for damages for personal injury, mental disturbance or wrongful death arising out of the rendition of or failure to render services under this contract must be submitted to binding arbitration.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, benefits will be coordinated with Medicare according to Medicare's determination of which coverage is primary. Generally, you do not need to take any action after informing the Plan of your or your family member's eligibility for Medicare. Your Plan will provide you with further instructions if a Medicare claim needs to be filed.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is "primary" (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayment from other coverage.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers' Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

General Limitations *continued*

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State or Federal Government agency.

Liability insurance and third party action

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the plan will provide you with its subrogation procedure.

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition *as discussed under Authorizations on page 9*. The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency benefits)
- Expenses incurred while not covered by this Plan
- Services furnished or billed by a provider or facility barred from the FEHB Program
- Services not required according to accepted standards of medical, dental, or psychiatric practice
- Procedures, treatments, drugs or devices that are experimental or investigational
- Procedures, services, drugs and supplies related to sex transformations; and
- Abortions, except when the life of the mother would be endangered if the fetus were carried to term

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; you pay a \$5 office visit copay, but no additional copay for laboratory tests and X-rays. Within the service area, house calls will be provided if in the judgment of the Plan doctor, such care is necessary and appropriate. You pay nothing for a doctor's house call and for home visits by nurses and health aides.

The following services are included:

- Preventive care, including well-baby care and periodic checkups
- Baseline mammogram for women age 35-40; annual mammogram for women age 40 and older
- Routine immunizations and boosters; no copay required
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. You pay \$5 office visit copayment for the first office visit, all remaining prenatal office visits are covered in full. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confine

Medical and Surgical Benefits *continued*

ment for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.

- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum); allergy injections do not require a copay
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, kidney and liver transplants; heart-lung transplants for patients under age 60 with end-stage primary or secondary pulmonary hypertension; lung (single or double) transplants for patients under age 60 with end-stage obstructive or restrictive pulmonary disease; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma; advanced neuroblastoma; testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; breast cancer; multiple myeloma; and epithelial ovarian cancer. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan. All transplants require approval by the Plan's Transplant Committee and must be performed in a Plan-affiliated facility.

Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.

- Chemotherapy
- Radiation therapy, and inhalation therapy; no copay required
- Surgical treatment of morbid obesity
- Home health services of nurses and health aides, including intravenous fluids and medications when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers.
- Outpatient dialysis at a Plan designated center or Continuous Ambulatory Peritoneal Dialysis (CAPD); no copay required
- Cardiac rehabilitation
- *Diagnosis and treatment of infertility is covered. Artificial insemination is covered, including intravaginal insemination (IVI); intracervical insemination (ICI); and intrauterine insemination (IUI). Other assisted reproductive technologies (ART) procedures including gamete intrafallopian transfer, intracytoplasmic sperm injection, zygote intrafallopian transfer, and in vitro fertilization, are covered. Donor sperm for male factor infertility is covered. Fertility drugs are covered under Prescription Drug Benefits. To qualify for coverage the member must be diagnosed as being infertile by a Plan Fertility Specialist.*
- Food products which have been modified to be low in protein for individuals diagnosed with phenylketonuria. Coverage provided up to \$2,500 in each calendar year.

Limited benefits

Orthopedic and prosthetic devices and durable medical equipment, such as braces, artificial limbs, implanted lenses following cataract removal, wheelchairs and hospital beds, are provided up to a maximum benefit of \$1,500 per member per calendar year.

Oral and maxillofacial surgery is provided for non-dental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, removal of impacted teeth, biopsy of oral lesions, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Medical and Surgical Benefits *continued*

Reconstructive surgery will be provided for removal of breast implants due to complications of non-cosmetic surgery or autoimmune disease; and to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient basis for up to two months per condition if significant improvement can be expected within two months. Outpatient short-term rehabilitative therapy (physical, speech and occupational) is provided for up to 20 visits (nonconsecutive) per condition in a calendar year. You pay a \$5 copay per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Chiropractic services are provided for the treatment of acute musculoskeletal conditions. The condition treated must be new or an exacerbation of a previous condition. Treatment must be provided by a contracted chiropractor and requires a referral by a primary care doctor. Coverage is provided for up to 20 office visits. You pay a \$5 copay for visits 1-10 and a \$25 copay for visits 11-20.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Plastic surgery primarily for cosmetic purposes
- Hearing aids
- Orthopedic shoes or other support devices for the feet including foot orthotics
- Homemaker services
- Long-term rehabilitative therapy
- Transplants not listed as covered

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. You pay nothing. All necessary services are covered; including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units
- Blood and blood derivatives

Extended care

The Plan provides a comprehensive range of benefits for 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. You pay nothing. All necessary services are covered, including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certified that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Hospital/Extended Care Benefits *continued*

Ambulance service Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 17 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television;
- Custodial care, rest cures, domiciliary or convalescent care

Emergency Benefits

What is a medical emergency?

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

Emergencies within the service area

If you are in an emergency situation, please call your personal doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the police department or fire department) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 24 hours ***unless it was not reasonably possible to do so***. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

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

Plan pays...

All charges for emergency services rendered in an emergency room or in an urgent care center to the extent the services would have been covered if received from Plan providers.

You pay...

\$25 copayment per hospital emergency room visit; (waived if admitted).

\$5 copayment per Urgent Care Department or doctor's office visit.

Emergencies outside the service area

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

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

Emergency Benefits *continued*

Plan pays... All charges for emergency care services rendered in an emergency room or in an urgent care center to the extent the services would have been covered if received from Plan providers.

You pay... \$25 copayment per hospital emergency room visit; (waived if admitted).
\$5 copayment per urgent care center or doctor's office visit.

What is covered

- Emergency care at a doctor's office or an urgent care center;
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan

What is 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

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 22.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, this Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care Up to 20 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; you pay a \$2 per visit copay for each covered visit—all charges thereafter.

Inpatient care This Plan provides an unlimited number of days in a general hospital and up to 60 days in a psychiatric hospital in each calendar year; you pay nothing for first 60 days in a psychiatric hospital—all charges thereafter.

What is not covered

- Care for psychiatric conditions which in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Mental Conditions/Substance Abuse Benefits *continued*

Substance abuse

- What is covered** This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition.
- Outpatient care** All necessary outpatient visits to Plan providers for treatment provided; you pay a \$2 copay for each visit.
- Inpatient care** All necessary inpatient substance abuse rehabilitation programs in an alcohol detoxification or rehabilitation center approved by the Plan are covered; you pay nothing.
- What is not covered**
- Treatment not authorized by a Plan doctor

Prescription Drug Benefits

What is covered Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply; you pay a \$5 copay per prescription unit or refill. If the price of the prescription is less than \$5, the copay is the lower amount. Certain prescription drugs can be obtained through the Plan's Mail Order Program by calling 1-800-868-5200 (For additional information, see Prescription Medication Mailing Service under Non-FEHB Benefits on page 21 of this brochure).

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Non-formulary drugs will be covered when prescribed by a Plan doctor and approved by the Plan.

Covered medications and accessories include:

- Drugs for which a prescription is required by *Federal* law
 - Insulin with a copay charge applied to each vial
 - Disposable needles and syringes needed for injecting covered prescribed medication, including insulin
 - Intravenous fluids and medications for home use
 - Allergy serum
 - Oral contraceptive drugs
 - Blood glucose test strips, for insulin dependent diabetics
 - Emergency prescription medication (up to a 14-day supply) provided out of the service area as part of an approved emergency medical treatment.
 - Implanted time-release medication, such as Norplant. For Norplant, you pay a one-time copay of \$400 per implantation procedure. For other internally implanted time-release medication, you pay \$200 for implantation. There will be no refund of any portion of these copays if the implanted time-release medication is removed before the end of its expected life.
 - Fertility drugs
- What is not covered**
- Drugs available without a prescription or for which there is a nonprescription equivalent available
 - Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies
 - Vitamins and nutritional substances that can be purchased with or without a prescription
 - Medical supplies such as dressings and antiseptics
 - Contraceptive devices
 - Injectable contraceptive drugs

Limited benefit

Prescription Drug Benefits *continued*

- Diabetic supplies except for needles and syringes; and blood glucose test strips (for non-insulin dependent diabetics)
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Nicotine patches, *gum or other smoking cessation products*

Other Benefits

Dental Care

What is covered

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	Copayment
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 6 months)	10
1120	Prophylaxis child (every 6 months)	10
1201	Top application fluoride includes prophylaxis- child <age 16	10
1203	Top application fluoride excludes prophylaxis- child <age 16	10
1205	Top application fluoride includes prophylaxis- adult - age 16 and over	10
1998	Bundled diagnostic & preventive services - Dependent child	10
1999	Bundled diagnostic & preventive services - Adult	10
Minor Restorative (Fillings)		
2110	Amalgam-one surface primary	12
2120	Amalgam-two surfaces primary	16

Other Benefits *continued*

2130	Amalgam-three surfaces primary	\$20
2131	Amalgam-4 or more surfaces, primary	25
2140	Amalgam-one surface permanent	14
2150	Amalgam-two surfaces permanent	18
2160	Amalgam-three surfaces permanent	20
2161	Amalgam-four or more surfaces permanent	25
2330	Resin-one surface anterior	17
2331	Resin-two surfaces anterior	20
2332	Resin-three surfaces anterior	25
2335	Resin > 3 surfaces or involving incisal angle - anterior	30

What is not covered • Dental services not shown as covered

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, this Plan provides annual eye refractions, including written lens prescriptions for eye-glasses, from Plan providers. You pay a \$5 copay per visit.

What is not covered

- Eye exercises
- Corrective glasses and frames or contact lenses
- Eye examinations for contact lenses (including the fitting of the lenses)

Out-of-Area Student Coverage

What is covered

Students attending school outside the Plan service area are covered for additional benefits for services received out-of-area if authorized in advance by the Plan.

- Outpatient services to treat the abuse of/or addiction to alcohol or drugs, covered up to 20 office visits in each calendar year. You pay \$2 per visit.
- Nonelective inpatient services if the Plan is notified within 48 hours of admission. You pay nothing.
- Non-routine office visits. You pay \$5 per visit.
- Diagnostic lab and x-ray services connected with non-routine office visits. You pay nothing.
- Outpatient services to diagnose and/or treat mental conditions, covered up to 20 office visits in each calendar year (combined with any in-area visits). You pay \$10 per visit.
- Short-term rehabilitation services, including physical, occupational, and speech therapy, covered up to 20 outpatient office visits in each calendar year (combined with any in-area visits). You pay \$5 per visit.

What is not covered

- Routine physicals, gynecological exams, vision screening and hearing screening
- Maternity care or delivery
- Outpatient surgical procedures that could have been delayed until return to the Plan service area
- Durable medical equipment (e.g., wheelchairs), including maintenance or replacement
- Preventive dental care
- Second opinion
- Home health care
- Non-emergency prescription drugs
- Routine preventive care

Other Benefits *continued*

Weight Watchers® Program

- What is covered**
- One twelve consecutive week membership in each calendar year. You pay nothing.
- What is not covered**
- More than one membership per member in each calendar year
 - *Food products*

Weight Watchers is a registered trademark of Weight Watchers International, Inc.

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract, with the FEHB Program, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; *and* any charges for these services do not count toward any FEHB deductibles, *or* out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedures.

Discounted Dental Services - The Plan has arranged for discounts for non-covered services. If you would like a list of the services and the fee schedule, contact the Plan at 1-800-868-5200.

PEACE OF MIND PROGRAM™ - If you are a Fallon Plus or Fallon Affiliates member and you want to receive care from a Boston-based physician rather than a Plan physician, you may do so under the Peace of Mind Program. The physician that you choose must be on staff at either Massachusetts General Hospital, Brigham and Women's Hospital, Children's Hospital (Boston), or Dana-Farber Cancer Institute.

Whenever you need specialty care, you must first obtain a referral from your personal physician to see a Plan specialist. If after seeing the Plan specialist you decide you want to see a physician at one of the above hospitals, you may elect to use the Peace of Mind Program. The referral must be arranged by either your Plan specialist or personal physician. You may see the Boston physician for a consultation and may continue on for treatment with that specialist, or you may return to your Fallon specialist for care.

You may elect to use Peace of Mind for all specialty care except psychiatry, substance abuse, or chiropractic services. You may not use the Peace of Mind Program for any primary care including internal medicine, family practice, pediatrics or routine obstetrics.

All care authorized under the Peace of Mind Program must be for covered services as described in this brochure.

Prescription Medication Mailing Service - You may have your prescription mailed directly to you at home or at any other location if you are traveling within the country, (most medications can be mailed; however, there are some that may not. The pharmacist will make the determination). Depending upon your health care option services are provided through the Fallon Clinic Pharmacy or through the Express Scripts Mail Order Program. Additional information providing instructions for accessing this service is enclosed with this brochure.

Personal Emergency Response System - The Fallon Plan offers a 10% discount on the Personal Emergency Response System (PERS) offered by Valtron, Inc. located in Auburn, Massachusetts. The PERS is a device that can be used to call for help from a friend, a relative, or an emergency service such as the police, the fire department or an ambulance. To obtain additional information about the PERS device please contact Valtron, Inc. at 1-800-310-7100.

Eyewear discounts - The Fallon Plan offers a 25% discount on the first pair of eyeglass frames and prescription lenses purchased from the Fallon Optical Centers. When you purchase multiple pairs of prescription eyeglasses at the same time, you receive a 35% discount on the additional pairs. In addition, you receive a 10% discount on all complete contact lens packages purchased at the Fallon Optical Centers. This discount does not apply to individual lenses, the evaluation/fitting of contact lenses, or others items/services which are not specifically listed above.

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 800/868-5200.

Medicare prepaid plan enrollment - *This Plan offers Medicare recipients the opportunity to enroll in the plan through Medicare. As indicated on page 11, 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 reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan 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 us at 1-800-868-5200 for information on the Medicare prepaid plan and the cost of that enrollment.*

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800-868-5200 for information on the benefits available under the Medicare HMO.

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

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Customer Service Office at 1-800-868-5200 or you may write the Plan at 10 Chestnut Street, Worcester, MA 01608.

Disputed claims review

Plan reconsideration

If a claim for payment or for services is denied by the Plan, you must ask the Plan, in writing, within one year of the denial, to reconsider its denial before you request a review by OPM. OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan should state why you believe the denied claim for payment or service should have been paid or provided. Refer to specific benefit provisions in this brochure.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

The right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative and request an OPM review on your behalf and with your written consent. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review should state why you believe the Plan should have paid the denied claim. Refer to specific benefit provisions in this brochure. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (If the Plan failed to respond, provide instead (a) the date of your request to the Plan, or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical records, Explanation of Benefit forms, etc.); and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 4, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

How to Obtain Benefits *continued*

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement—If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How Fallon Community Health Plan Changes January 1998

Do not rely on this page; it is not an official statement of benefits.

Benefit changes

Program-wide Changes:

This year, the Office of Personnel Management (OPM) instituted minimum benefit levels in all plans for normal deliveries (48 hours of inpatient care), caesarian sections (96 hours of inpatient care) and mastectomies (48 hours of inpatient care). See pages 12 and 13 for this Plan's benefits. The Plan's routine mammography screening schedule is on page 12.

OPM review

OPM also requires each prepaid plan to list the specific artificial insemination procedures that it covers. See page 13 for this Plan's benefits.

Changes to this Plan:

The copayment for office visits is now \$5 instead of \$2 per visit. Previously, the copayment was \$2 per visit.

The copayment for short-term rehabilitative therapy visits are now \$5 instead of \$2 per visit.

Chiropractic services are covered subject to a \$5 copayment per visit. Previously, the copayment was \$2 per visit.

Smoking cessation drugs and medications are no longer covered.

One twelve consecutive week membership per member in a Weight watchers Program is now covered.

The Plan now covers preventative dental care for adults (see page 18).

The Plan has added a non-FEHB dental benefit (see page 21).

The Plan's Service and Enrollment Area has been expanded to include the following cities and towns in Massachusetts: Beverly, Danvers, Essex, Georgetown, Gloucester, Hamilton, Ipswich, Lynn, Manchester, Marblehead, Nahant, Peabody, Rockport, Rowley, Salem, Swampscott, Topsfield, and Wenham.

Service Area

You must live or work in one of the following towns to enroll in this Plan:

Acton	Framingham	Milton	Sterling
Andover	Franklin	Monson	Stoneham
Arlington	Gardner	Nahant	Stow
Arlington Heights	Georgetown	Natick	Sturbridge
Ashburnham	Gloucester	Needham	Sudbury
Ashby	Grafton	New Braintree	Sutton
Ashland	Groton	Newton	Swampscott
Athol	Hamilton	New Town	Templeton
Auburn	Hanscomb AFB	Nonantum	Tewksbury
Ayer	Hardwick	Norfolk	Topsfield
Babson Park	Harvard	North Andover	Townsend
Barre	Hathorne	North Billerica	Tufts University
Bedford	Haverhill	North Brookfield	Tyngsboro
Bellingham	Holden	North Chelmsford	Upton
Belmont	Holland	North Reading	Uxbridge
Berlin	Holliston	Northborough	Village of Nagog Woods
Beverly	Hopedale	Northbridge	Wales
Billerica	Hopkinton	Norwood	Wakefield
Blackstone	Hubbardston	Nutting Lake	Walpole
Bolton	Hudson	Oakham	Waltham
Boston	Ipswich	Oxford	Ware
Boxboro	Lancaster	Palmer	Warren
Boylston	Lawrence	Paxton	Watertown
Boxford	Leicester	Peabody	Waverly
Brimfield	Leominster	Pepperell	Wayland
Brookfield	Lexington	Petersham	Webster
Brookline	Lincoln	Phillipston	Wellesley
Brookline Village	Littleton	Pinehurst	Wenham
Burlington	Lowell	Prides Crossing	West Boylston
Carlisle	Lunenburg	Princeton	West Boylston
Cambridge	Lynn	Randolph	West Brookfield
Canton	Lynnfield	Reading	West Medford
Chelsea	Malden	Revere	West Townsend
Charlton	Manchester	Rockport	Westborough
Chelmsford	Marblehead	Rowley	Westford
Clinton	Marlborough	Royalston	Westminster
Concord	Maynard	Rutland	Weston
Danvers	Medfield	Salem	Westwood
Dedham	Medford	Saugus	Wilmington
Dover	Medway	Sherborn	Winchendon
Dracut	Melrose	Shirley	Winchester
Dudley	Mendon	Shrewsbury	Winthrop
Dunstable	Methuen	Somerville	Woburn
East Brookfield	Middleton	South Hamilton	Worcester
East Walpole	Milford	South Walpole	Wrentham
Essex	Millbury	Southborough	
Everett	Millis	Southbridge	
Fitchburg	Millville	Spencer	

Summary of Benefits for Fallon Community Health Plan — 1998

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS OR OTHER AUTHORIZED PROVIDERS (DENTISTS, PHYSICIAN ASSISTANTS, OR NURSE PRACTITIONERS).**

Benefits		Plan pays/provides	Page
Inpatient care	Hospital	Comprehensive range of medical and surgical services with no dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing	14
	Extended care	All necessary services, for up to 100 days in a calendar year. You pay nothing	14
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for an unlimited number of days in a general hospital and up to 60 days of inpatient care in a psychiatric hospital per calendar year. You pay nothing	16
	Substance abuse	All necessary, Plan-approved substance abuse rehabilitation programs. You pay nothing	17
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic checkups and routine immunizations; limited chiropractic services; laboratory tests and X-rays; complete maternity care (first prenatal visit only). You pay a \$5 copay per office visit; nothing per home visit	12-14
	Home health care	All necessary visits by nurses and health aides. You pay nothing	13
	Mental conditions	Up to 20 outpatient visits per year. You pay a \$2 copay per visit	16
	Substance abuse	All necessary outpatient visits per year. You pay a \$2 copay per visit	17
Emergency care		Actual charges for services and supplies required because of a medical emergency. You pay \$25 copayment when services are received in a hospital emergency room. You pay \$5 copayment when services are received in an urgent care center or doctor's office.	15, 16
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay a \$5 copay per prescription unit or refill or the cost of the prescription, whichever is less. Emergency prescription medication provided out of area as part of an emergency medical treatment. You pay a \$5 copay per 30-day supply. Prescription medication obtained through the mail order program of your health care option. You pay a \$5 copay per 30-day supply.	17, 18
Dental care		Preventive dental care <i>services (twice per calendar year) you pay \$10 copay per visit. Fillings; you pay \$12-30 copy per filling. Out-of-area emergency dental care services (loose filling, tooth ache) limited to \$50 per incident; you pay \$10 copay per visit.</i>	18, 19
Vision care		One visit for eye refractions annually. You pay a \$5 copay per visit	19
Out-of-pocket maximum		Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments that are required for a few benefits.	10

