Questions? Just ask.

If you have questions about this policy, call:

FHLAC Customer Service
1-800-868-5200 (TRS 711)

For answers to general questions or inquiries

Also see **Inquires and grievances**.

With questions about your FHLAC identification card

- If you do not get a card
- If you lose or damage your card

To notify us of changes

- To report any changes in your name, address, phone number, or any other pertinent information

To order materials

- Additional copies of this book, *Outline of Coverage* and any applicable amendments

You can find information and answers to many questions at our website.

Our website
www.fallonhealth.org

For information on Fallon's products and services, visit us at www.fallonhealth.org. Our website is where you can learn more about your plan and its benefits and features. It's also is a convenient and secure way to communicate with us. You can use the site to:

- **Register and log into *my*Fallon** – a secure area to view your specific benefit information, view your claims, print a temporary ID card and more
- Use our online health encyclopedia and reference guide for answers to your health questions
- Contact Customer Service

Can't find what you need online? Use our site search feature or contact the webmaster with your suggestions.

Understanding your health care coverage

Your FHLAC identification card

When you became a member, we sent you an identification card. Please have the card with you at all times. You should show both your Medicare card and your FHLAC card when you seek medical care.

You should get your FHLAC card within 30 days of the date that we confirm your enrollment request. Call our Customer Service Department if:

- You do not get a card
- The information on your card is wrong
- You lose or damage your card

Notify us of changes

Call the Customer Service Department if there are any changes in important information. This would include your:

- Name
- Address
- Phone number

How to access care

With this policy, you do not need to:

- Choose a personal physician
- Get referrals
- Use a special network of providers.

You may see any properly licensed provider for any covered service. For Medicare-covered services, the provider must also be eligible for payment by Medicare.

Know your benefits

This policy gives you coverage secondary to Medicare Parts A and B. It gives you coverage for coinsurance and copayment amounts not paid by Medicare, as described in the *Outline of Coverage*. It also covers some services that Medicare does not. Some plan options cover Medicare deductibles, while some do not (see your *Outline of Coverage*). It is important that you read this book and your *Outline of Coverage* to know and understand your benefits. Some benefits have limits.

Benefit management procedures

For services that Medicare does not cover, this policy has procedures to help you manage that benefit. **The procedures in this section (through page 8) only apply to services that Medicare Part A or Part B do not cover. For services where this policy covers secondary to Medicare, we follow Medicare's coverage decisions.**

These procedures help you get the most appropriate care that is available, while keeping the costs you pay for health care affordable. We may arrange for others to help us manage these procedures. Your contract with us requires that you work with these persons or entities as they carry out these duties. Inpatient admissions, services for organ transplants, mental health services, substance abuse services and speech therapy services all require benefit management procedures.

To reach our Care Services Department, call 1-800-868-5200 (TRS 711).

Prior authorization for inpatient stays

If you know you will need to stay overnight for upcoming medical care, you must let us know in advance. At least one week before, you must call our Care Services Department. We will also make sure the setting and planned treatment is cost-effective for you.

We will then do one of three things:

1. approve your planned admission as medically necessary and appropriate (this is not a guarantee of exact payment or eligibility for benefits),
2. suggest other options to you and your doctor, or
3. let you know that the service is not covered.

We will make our decision within two working days of getting all of the medical information. We will tell your doctor our decision within 24 hours of when we make the decision. If we approve the request, we will send both you and your doctor a notice in writing within two working days of the decision. If we do not approve the request, we will send you and your doctor a letter explaining our decision, and describing your right to file a grievance, within one business day of the decision. (See the **Inquiries and grievances** section to learn more.)

Services related to organ transplants

You must get prior authorization for organ transplant services. At least five days before you have your initial evaluation for an organ transplant, you or someone acting for you must call FHLAC's Transplant Care Manager.

Once you are accepted into the program, you must have your transplant at an affiliated transplant facility. We will work with the facility to coordinate your care. We will work with them during the evaluation and transplant process. When you are ready, we will help to arrange your discharge and follow-up care. If you want a second opinion, we will identify another suitable transplant facility for you. We do not cover opinions beyond a second opinion.

Unplanned admissions not covered by Medicare

There are some cases where unplanned, or emergency, admissions are not covered by Medicare. These can include times when you are already an inpatient and use up your Medicare benefits. If this happens, you must call us. Call Care Services within 48 hours of being admitted (or using up your coverage).

During your stay, we will coordinate your care with the facility's staff, and with you and your family. This is to help make sure that you are discharged at the right time and that any follow-up care is in place. We will tell the facility if you are approved for additional days or services within one working day. We will send written notice to you and the facility within one working day after that. We will tell the facility within 24 hours of any denial, and send written notice to you and the facility within one working day after that.

Inpatient facilities include any medical, surgical, mental health, substance abuse, skilled nursing or maternity facilities.

Case management

We will actively help you manage your care. To do this, we will work with your doctor to find the right setting for your care based on your:

- prognosis,
- general health, and
- family support.

This program will cover the least costly treatment that can reasonably be expected to lead to a satisfactory result. If you do not comply with the care you are given, we will pay only up to the cost of the approved care. For outpatient mental health, substance abuse and speech therapy benefits, the provider of the service must submit a care plan that we will assess for medical necessity. The care plan for these services must be sent to us before the fourth visit. If we do not get a care plan, only the first three visits will be covered. No further visits will be covered.

We will review the care plan and make a decision within one working day of getting all of the medical information. We will tell your doctor what our decision is within 24 hours of the time we make the decision. If we approve a care plan, we will send both you and your doctor a notice in writing within two working days of the decision. If we do not approve a care plan, we will send you and your doctor a letter explaining our decision, and describing your right to file a grievance, within one business day of the decision. (See the **Inquiries and grievances** section to learn more).

Medical management

Utilization review

FHLAC's case management program reviews the care that you get to make sure that care is coordinated, and that the right levels of service are available to members.

Licensed registered nurse case managers, physician reviewers and specialists staff this program. They are in contact with health care providers regularly.

They use national, proof-based criteria that are reviewed every year by a committee of health plan and community-based doctors to make sure that selected services your doctor asks for are medically appropriate for you. These criteria are approved as being consistent with generally accepted standards of medical practice, including prudent layperson standards for emergency room care.

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

Quality management

FHLAC's Quality Management Program tracks your satisfaction with the quality of clinical care and service our members get. A team of doctors, licensed registered nurses, and specialists create and regularly update clinical guidelines to promote selected medical practices and to improve the quality of care. These guidelines are designed to enhance rather than replace your doctor's clinical judgment.

Assessing new technologies

FHLAC maintains a formal way to review new medical technologies and devices through our Technology Assessment Committee. The committee includes physician administrators, practicing primary care or specialty doctors from the relevant field, and staff who do extensive research regarding the suggested technology. We make use of outside research organizations, which review of all the available literature for an individual procedure.

The Technology Assessment Committee also looks at all policies from state and federal regulatory agencies that apply to any mandate for coverage of specific procedures. The committee also performs its own literature searches as needed to make sure that we have all of the available information connected to the topic being looked at. The committee makes recommendations about coverage for those new procedures that can offer improved results to our members without greatly increasing the risks of care.

Member rights and responsibilities

Rights

As a Fallon Health & Life Assurance Company (FHLAC) member, you have the right to …

- Be informed about FHLAC and covered services.
- Receive information about FHLAC, its services and members' rights and responsibilities.
- Be informed about how medical care decisions are made by FHLAC, including payment structure.
- Your choice of providers and hospitals.
- Know the names and qualifications of doctors and health care professionals involved in your medical care.
- Receive information about an illness, the course of care and chances for recovery in terms that you can understand.
- Actively participate in decisions regarding your own health and care options, including the right to refuse care.
- Candidly discuss appropriate or medically necessary care options for your condition, regardless of cost or benefit coverage, presented by your doctor in a manner proper to your condition and understanding.
- Be treated with dignity and respect, and to have your privacy observed.
- Keep your personal health information private as protected under federal and state laws—including spoken, written and electronic information across the organization. Unauthorized people do not see or change your records. You have the right to review and get a copy of certain personal health information (there may be a fee for copies).
- Make complaints and appeals without discrimination about FHLAC or the care given, and expect problems to be fairly looked at and appropriately answered.
- Exercise these rights without regard to your race; physical or mental ability; ethnicity; gender; sexual orientation; creed; age; religion; national origin; cultural or educational background; economic or health status; English proficiency; reading skills; or source of payment for your care. Expect these rights to be upheld by FHLAC.
- Make recommendations regarding FHLAC's rights and responsibilities policies.

Responsibilities

As a Fallon Health & Life Assurance Company member, you have the responsibility to …

- Provide, to the extent possible, information that FHLAC, your doctor or other care providers need in order to care for you.
- Do your part to improve your own health condition by following instructions and care plans that you have agreed on with your doctor(s).
- Understand your health problems, and participate in developing new and existing care goals that have been agreed to by you and your doctor(s), as much as you can.

.

If you have any questions about your rights or responsibilities as a Fallon Health & Life Assurance Company member, please contact:

Fallon Health & Life Assurance Company, Inc.
10 Chestnut St.
Worcester, MA 01608
1-800-868-5200 (TRS 711)

For care given to you by a doctor, please contact:

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01881
1-781-876-8200

Confidentiality of member information

In support of our commitment to protect our members' privacy, FHLAC has in place a comprehensive, corporate-wide privacy and security program. The ultimate goal of FHLAC's privacy and security program is to safeguard our members' protected health information (PHI) from inappropriate access, use, and disclosure while permitting appropriate access in order to provide the highest quality health care coverage for our members.

Our numerous privacy and security policies and procedures address the protection of PHI in all forms—oral, written, and electronic—across the organization. We define the appropriate uses and disclosures of information, such as members have the right to authorize the disclosure of PHI for certain non-routine uses and disclosures, and employers right to access PHI for enrollment and disenrollment purposes and under other limited circumstances. Our policies and procedures also address the rights members have with respect to their PHI.

You can be confident that all of us at Fallon Health & Life Assurance Company are committed to safeguarding the privacy and security of our members' PHI. For details on how we use and share your information, please read FHLAC's Notice of Privacy Practices. The Notice of Privacy Practices also provides information regarding the rights members have with respect to their PHI and how members can invoke those rights. For example, members have the right to access most PHI FHLAC has about them, grant others access to their PHI, and request restrictions on who can access their PHI.

This notice is provided to all new subscribers upon enrollment and is available on the Fallon website, fallonhealth.org (keyword: "privacy policies"), or, for a printed copy, call our Customer Service Department at 1-800-868-5200 (TRS 711).

Details of confidentiality and your plan

Your use of the Fallon Health & Life Assurance Company identification card means that you agree that Fallon Health & Life Assurance Company, its providers and affiliated provider organizations may, to the extent permissible under applicable law, (1) obtain medical and medical service-related information from past, present or future providers; and (2) use and disclose this information to necessary persons and entities for the following purposes:

> Managing care through quality improvement and utilization management programs; administering benefits, including claims payment; verification of enrollment and eligibility; coordination of benefits; subrogation; audits; reinsurance and member satisfaction processes; other legitimate business purposes such as investigation of potential fraud; to meet accreditation standards; participation in bona fide research; and when required by law.

In other situations, medical information gathered by us will be kept confidential and will not be shared without your consent.

Inquiries, appeals and grievances

Whenever you have a question or need help using providers and services, FHLAC encourages you to contact our Customer Service Department. If you have a question or concern about an adverse determination, or if you would like to file an appeal or grievance, contact the Member Appeals & Grievances Department.

An adverse determination means a determination by FHLAC or our designated medical management agents, based upon a review of information that denies, reduces, modifies or terminates coverage for health care services. This includes, but is not limited to, cases where the treatment does not meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness. A rescission of coverage may also be appealed.

When you make an inquiry

If you have a question or need help with an issue that is not about an adverse determination, contact Customer Service. You can reach our Customer Service Representative in the following ways:

Call:	1-800-868-5200 (TRS 711) Monday, Tuesday, Thursday, and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.
E-mail:	cs@fallonhealth.org
Writing:	Fallon Health & Life Assurance Company, Inc. Customer Service Department 10 Chestnut St. Worcester, MA 01608

In most cases, our Customer Service Representatives will be able to answer your question or handle your request the first time you call. In some cases, however, FHLAC may need to do more research before FHLAC completes your request. In these cases, FHLAC will make every effort to provide you with a response within three business days. If FHLAC has not been able to provide a satisfactory response to your inquiry within this time period, FHLAC will send you a letter explaining your right to continue with the inquiry process or to have your request handled as a grievance. If you tell FHLAC that you want to have your issue handled as a grievance, FHLAC will proceed to the grievance procedure. (See **Filing a grievance**).

Filing an appeal: internal appeal review

If you disagree with an adverse determination about coverage related to your care, you may file an appeal. An appeal is a request to change a previous decision made by FHLAC.

Please note that the procedures presented below only apply to benefits paid or denied by FHLAC. With regard to benefits paid or denied by Medicare, you must appeal to Medicare. See your Medicare Summary Notice for more information about how to file an appeal with Medicare.

You may file the appeal yourself, or with the completion of the appropriate authorization form, you may have someone else (e.g., a family member, friend, physician/practitioner) do this for you. You must file your appeal within 180 calendar days from when you received the written denial.

If you file an appeal, be sure to give us all of the following information:

- The member’s name
- Member identification number
- The facts of the request
- The outcome that you are seeking
- The name of any representative with whom you have spoken

You can file an appeal in any of the following ways:

Write:	Fallon Health & Life Assurance Company, Inc. Member Appeals and Grievances Department 10 Chestnut St. Worcester, MA 01608
Call:	1-800-333-2535, ext. 69950 (TRS 711) Monday through Friday, 8:00 a.m. to 5:00 p.m.
E-mail:	grievance@fallonhealth.org
Fax:	1-508-755-7393
In person:	Fallon Health & Life Assurance Company, Inc. Member Appeals and Grievances Department 10 Chestnut St. Worcester, MA 01608

If you send us a written or electronic appeal, we will acknowledge your request in writing within 15 business days from the date we receive the request, unless you and the plan both agree in writing to waive or extend this time period. We will put an oral appeal made by you or your authorized representative in writing and send the written statement to you or your authorized representative within 48 hours of the time that we talked to you, unless you and the plan both agree in writing to waive or extend this time period.

We will complete our review and send you a written response within 30 calendar days from the date that we receive your request. If the appeal followed from an unresolved inquiry, the 30-day period will start three business days from the date FHLAC received the inquiry or on the day you advise us that you are not satisfied with the results of your inquiry, whichever comes first. These time limits may be waived or extended if you and the plan both agree in writing to the change. This agreement must note the length of the extension, which can be up to 30 days from the date of the agreement.

You have the right to provide any additional information, including evidence and allegations of fact or law, in support or your appeal. This may be done in person or in writing. Any new information received by FHLAC during the course of the appeal may be sent to you for review. At any point before or during the appeal process, you may examine your case file, which may include medical records or any other documentation and records considered during the appeals process.

In some cases, FHLAC will need medical records to complete our review of your appeal. If we do, we may ask you to sign a form to authorize your provider to release the records to us. If you do not send this form within 30 calendar days from receipt of your appeal, FHLAC will complete the review based on the information that we do have, without the medical records.

Your appeal will be reviewed by individuals who are knowledgeable about the matters at issue in the appeal. If your appeal is about an adverse determination, the reviewer will be an individual who did not participate in any of the plan's prior decisions on the issue. The reviewer will consult with a health care professional who is actively practicing in the same or similar specialty that is the subject of your appeal.

If the subject matter of the internal review involves the termination of ongoing services, the disputed coverage or treatment shall remain in effect at our expense through completion of the internal appeal process regardless of the final appeal decision. The appeal must be filed on a timely basis, based on the course of treatment. This includes only that medical care that, at the time it was initiated, was authorized by FHLAC. It does not include medical care that was terminated due to a specific exclusion in your benefits.

Our response will describe the specific information we considered as well as an explanation for the decision. If the appeal is about an adverse determination, the written response will include the clinical justification for the decision, consistent with generally accepted principles of professional medical practice; the information on which the decision was based; pertinent information on your condition; alternative treatment options as appropriate; clinical guidelines or criteria used to make the decision; and your right to request external review and the process for doing so.

Opportunity for reconsideration

If relevant information was received too late, or is expected to become available within a reasonable time period, for internal review, you may ask for a reconsideration of a final adverse determination. In this case, FHLAC would agree in writing to a new time period for review. This would not be longer than 30 days from the date FHLAC agrees to the reconsideration.

Expedited review

You can request an expedited (fast) review either orally or in writing concerning coverage for immediate and urgently needed services.

1. Inpatient admission: During your inpatient admission and prior to discharge, a written decision will be provided to you. If the expedited review results in a denial of coverage regarding the continuation of inpatient care, you will have the opportunity to request an expedited external review and the opportunity to request continuation of services through the external review process available through the Office of Patient Protection (OPP).

2. Immediate and urgent services: You will receive a written determination within 48 hours, if your treating physician certifies that the treatment or proposed treatment is:
   a. Medically necessary;
   b. A denial of coverage for the services would create a substantial risk of serious harm to you; and
   c. Such risk of serious harm is so immediate that the services should not await the outcome of the standard appeal process.

If the expedited review process results in an adverse determination, you will be informed of the opportunity to request an expedited external review through the Office of Patient Protection. If your review involves the termination of ongoing services, you will be notified about the opportunity to request continuation of services.

3. Durable medical equipment: You will receive a written determination within less than 48 hours, if your physician:
   a. Certifies that this equipment is medically necessary;
   b. Certifies that that the denial of the equipment would create a substantial risk of serious harm;
   c. Certifies that such risk of serious harm is so immediate that the services should not await the outcome of the standard appeal process;
   d. Describes the specific immediate and severe harm if no action is taken within the 48 hour time period; and
   e. Specifies a reasonable time period in which FHLAC must respond.

If the expedited review process results in an adverse determination, you will be informed of the opportunity to request an expedited external review through the Office of Patient Protection. If your review involves the termination of ongoing services, you will be notified about the opportunity to request continuation of services.

In the specific instances noted above, you will receive a response within 48 hours. In all other expedited reviews, you will receive a response within 72 hours of receipt of your request.

Expedited review for terminally ill members

If you are terminally ill, you can request an expedited review of your appeal. A determination will be provided to you within five business days from receipt of your appeal request, and will include the specific medical and scientific reasons for denying coverage or treatment, along with information on any covered alternative treatments, services or supplies.

If your request for coverage or treatment is denied, you may request and attend a conference at FHLAC, for further review. The conference will be scheduled within 10 days of receiving your request unless your treating physician determines, after discussion with the FHLAC Medical Director or designee, that an immediate conference is necessary. In that case, the conference will be held within five business days. You may participate at the conference in person or via telephone; however, your attendance is not required. If the conference results in a final adverse determination, you may request an expedited external review through the Office of Patient Protection. If your appeal involves the termination of ongoing coverage or treatment, this coverage or treatment will continue at the plan's expense until we complete our review, regardless of the final decision.

Filing an appeal: external appeal review

An external appeal is a request for an independent review of the final decision made by FHLAC through its internal appeal process. If your appeal involved an adverse determination, and you are not satisfied with our final decision, you have the right to file the case with an external review agency. You must request this in writing within four months from receiving the written notice of the final adverse determination.

If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage or treatment. You must file this request by the end of the second business day after receiving the final adverse determination. If the external review agency finds that termination of services would cause you substantial harm, they may order continuation of coverage at our expense, regardless of the final external review determination.

In any case where we fail to meet our internal timelines, you have the right to file an external review, even if you have not yet exhausted our internal appeals process.

Expedited external review

You may request an expedited (fast) external review. In this case you must submit a written certification from your physician stating that a delay in providing or continuing the health care services that are the subject of a final adverse determination would pose a serious and immediate threat to your health.

You must file your request for external review or expedited external review with:

Health Policy Commission
Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109

For more information about this process, or to file an external review, please contact OPP at 1-800-436-7757 (www.mass.gov/hpc/opp) Fax: 1-617-624-5046.

Your request should:

- Be on the form determined by the Office of Patient Protection
- Include your signature or your authorized representative's signature
- Include a copy of the written final adverse determination made by FHLAC
- Include the $25 fee required. The fee may be waived by the Office of Patient Protection if it
- determines that the payment of the fee would result in an extreme financial hardship to the member.

You may file an expedited external review even if you have not received a decision through our internal appeals process.

Filing a grievance

A grievance is the type of complaint you make if you have any other type of problem with FHLAC or a provider. You would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office.

If you have a grievance, our Member Appeals and Grievances coordinators are available to assist you in accordance with your rights and in confidence.

You can file a grievance in any of the following ways:

Write: Fallon Health & Life Assurance Company, Inc.
Member Appeals and Grievances Department
10 Chestnut St.
Worcester, MA 01608

Call: 1-800-868-5200 (TRS 711)
Monday through Friday, 8:00 a.m. to 5:00 p.m.

E-mail: grievance@fallonhealth.org

Fax: 1-508-755-7393

Walk-in: Fallon Health & Life Assurance Company, Inc.
Member Appeals and Grievances Department
10 Chestnut St.
Worcester, MA 01608

You may file the grievance yourself, or with the completion of the appropriate authorization form, you may have someone else (e.g., a family member, friend, physician/practitioner) do this for you. You must file your grievance within 180 calendar days.

If you file a grievance, be sure to provide all of the following information:

- Member name
- Member identification number
- Facts of the request
- Outcome that you are seeking
- Name of any representative with whom you have spoken

A Member Appeals and Grievances Representative will acknowledge your oral grievance within 24 to 48 hours of receipt. Written grievances will be acknowledged within 15 calendar days of receipt. We will contact you within 30 calendar days of receiving your grievance to discuss a possible resolution of your concern.

Failure to meet time limits

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.

Massachusetts Office of Patient Protection

The Office of Patient Protection (OPP) is located within the Health Policy Commission as required under Chapter 224 of the Acts of 2012. The OPP will make information on health plans available to consumers, assist consumers with questions and concerns related to managed care, track quality information for managed care practices and regulate the external review process. The information they have for you includes:

- A list of sources of separately published information measuring member satisfaction and the quality of health care services offered by FHLAC
- The amount of premium revenue that went towards health care compared to the amount that went towards administrative expenses
- The number of grievances filed in the last year by FHLAC members, and the result of those grievances

The Office of Patient Protection can be reached by phone at 1-800-436-7757; by fax at 1-617-624-5046; or on their website www.state.mass.gob/hpc/opp.

The claims process

Claims, reimbursements and refunds

Your doctor should first submit a claim to Medicare, even if he or she believes that the service will not be covered by Medicare. Once a Medicare Summary Notice/EOB has been received showing Medicare coverage and payment (or denial) of the claim, either you or your doctor may submit a claim to FHLAC. You or your doctor should submit both a copy of the Medicare notice and an itemized claim form (such as a “1500” or “UB04”). You should send in a claim as soon as you can after you get your Medicare Summary Notice/EOB.

If you receive a claim from a provider or pharmacy and you don’t think you should have; please make sure the provider or pharmacy has the correct insurance information. You may also contact Customer Service for assistance.

For services covered by Medicare, we will also accept a notice from a Medicare carrier on a dually assigned claim. Notices should be sent to the claims address listed below. For all services covered by Medicare, we will make a payment decision based on the information included in the Medicare notice. We will not cover claims that we get more than one year after you had the service.

Most providers will submit a claim on your behalf but if you file a claim directly with us and you did not get a claim form from your provider, call Claims Customer Service at 1-800-868-5200 for a FHLAC Request for Payment of Medical Services form. We will send the form to you within 15 days. All claims should include an itemized list of the services, the dates of services, the charge for each service and receipt of payment.

Send claims to:

Fallon Health & Life Assurance Company, Inc.
P.O. Box 211308
Eagan, MN 55121-2908

For services covered by Medicare Part A and B, FHLAC will only pay the Medicare-approved coinsurance or copayment amount, as described in the *Outline of Coverage*.

Some plan options cover Medicare deductibles, while some do not (see your *Outline of Coverage*). In some cases, providers who do not accept Medicare “assignment” may be able to bill you for amounts that are more than the Medicare-approved deductible or coinsurance amount. In these cases, this amount is your responsibility. It will not be covered by either Medicare or FHLAC.

We will respond to any claim submission in one of three ways: 1) paying the claim; 2) denying the claim and telling you and the provider in writing the reason for the denial; or 3) sending you or the provider notification in writing requesting additional information we need to process the claim. In any case where we fail to take any of the above actions within 45 days of when we get the claim, interest will accrue on the claim as required by Massachusetts state law. Claims that are being investigated due to suspected fraud do not earn interest.

Recovering money owed

If we pay for services that should not have been covered or for services you got when your coverage was not in effect, we have the right to get that money back from you. We may do so by charging the amount you owe us against any reimbursement payments we may owe you. This will satisfy our contract to pay for services you get. We also pursue the provider who may in turn bill you.

Claims questions/refunds

If you have a question about a claim, you should contact Claims Customer Service. If you feel you should get a correction or refund due to differences in the effective date of your coverage or your contract type, send a letter to:

Fallon Health & Life Assurance Company, Inc.
Customer Service Department
10 Chestnut St.
Worcester, MA 01608

Corrections or refunds will be made according to our underwriting guidelines. We will not approve a correction or refund if it is for something that took place more than one year before we get your letter. We also will not approve a correction for an amount less than $5.

Coordination of benefits

Coordination of benefits (COB) is when more than one health insurance company covers a service. This includes companies that provide benefits for hospital, medical, dental or other health care expenses. We will coordinate payment of covered services with other plans under which you are covered. Other plans include personal injury protection insurance, automobile insurance, homeowner's insurance, school insurance and other plans that pay medical expenses. To the extent permitted by law, benefits available under an auto, homeowners or commercial policy shall be primary to this Plan. Medical Payments Coverage under a motor vehicle insurance policy shall always be secondary to and in excess of any Health Benefit Plan or Personal Injury Protection.

Under COB, one plan pays full benefits as the primary carrier. The other (the secondary carrier) pays the rest of covered charges. The primary and secondary carriers are selected by the standard rules that are used by all insurance companies.

This policy provides coverage secondary to Medicare Parts A and B. For any service covered by Medicare or any other government program, Medicare or the government program is the primary carrier and FHLAC is the secondary carrier. Unless required by law, FHLAC will not cover any service or supply for which payment is available through Medicare or any other government program.

We have the right to exchange benefit information with any other group plan, insurer, organization or person to determine benefits payable using COB. We have the right to get reimbursement from you or another party for services given to you. You must provide information and help with this, and sign the necessary documents to help us get payment. You must not do anything to stop this repayment. If payments have been made under any other plan that should have been made under this policy, we have the right to reimburse that plan as long as it satisfies the intent of COB. If we pay benefits in good faith to a plan, we will not have to pay for those benefits again. We also have the right to get back any overpayment made because of coverage under another plan.

We will not duplicate payment for any service. We will not make payment for more than the full benefit available under this contract. If we provide services when another carrier is primary, we have the right to get back any overpayment from the primary carrier or other appropriate party. If we do not get the documentation we need from you, we may deny your claim. In order to get all the benefits available, you must file claims under each plan or ensure your provider will on your behalf.

.

Subrogation

Subrogation (a process of substituting one creditor for another) applies if you have a legal right to payment from an individual or organization because another party was responsible for your illness or injury. Immediately upon payment by us of any covered services, we shall be subrogated and succeed to all rights of recovery for the reasonable value of the services and benefits we provided to you or on your behalf related to an injury, illness or condition. Our subrogation and reimbursement rights apply to benefits provided to all injured parties covered by the Plan, and our rights are fully enforceable against any party who possesses funds owed to us, including an injured party's guardian, representative or estate.

In addition to our subrogation rights, we have the right to be reimbursed from you or any entity or person that caused your injury or illness and any insurance carrier, including your insurance carrier to the extent permitted by law. If you receive any payment from any party or insurance coverage as a result of an injury, illness or condition, we have the right to recover from you or your representative 100% of the reasonable value of the services and benefits we provided or expenses incurred by us. Our right to repayment comes first, even if you are not paid for all your claims against the other party, or if the payment you receive is described as partial compensation or payment for other than health care expenses. We are entitled to be fully reimbursed for 100% of the value of services provided or paid and we shall not be responsible for the payment of fees or costs, including attorney's fees, incurred in connection with your recovery. We shall be entitled to enforce our subrogation and reimbursement rights, with or without your consent, to recover the reasonable value of injury or accident-related services or benefits we have provided on our behalf. Any recovery by us from your personal injury protection coverage under a Massachusetts automobile policy shall be in accordance with the law.

You agree to cooperate with us in enforcement of our subrogation and reimbursement rights. Your cooperation includes providing us with all necessary documentation and information and the assignment to us of reimbursements received and the right to information and the assignment to us of reimbursements received and the right to reimbursements up to the full value of the services and benefits that we have provided. If we do not receive the necessary documentation from you, we may deny your claim.

Workers' compensation

This policy does not cover any services or supplies that are covered by workers' compensation insurance or a similar program. If you are eligible for workers' compensation or any other employer's liability coverage, we may ask for information from you before processing claims. If we do not get the information that we need from you, we may deny your claim.

How your coverage works

Eligibility
You may become a member as long as:

- You qualify for Medicare Part A and Part B under conditions that make it your primary health insurance coverage, and have paid any necessary premium to maintain your Medicare Part A and Part B coverage.
- If you are under age 65, you do not have Medicare coverage solely due to end-stage renal disease.
- You will not be a member of another Medicare Supplement plan while this policy is in effect.
- You live in Massachusetts.

There is no dependent coverage under this policy. Your spouse may be able to enroll under his or her own policy if he or she is eligible.

Premium charges
The amount of money that is paid to us for your benefits under this policy is called your premium charge. The premium charge must be paid on or before the first day of the billing period to which it applies. Your coverage may be cancelled if you fail to pay your premium.

Premium changes
We may change the premium charge for your coverage. If we do, the change will apply to all contracts of this type, not just your contract. Each time we change the premium charge, we will mail you a notice at least 60 days before the change takes place.

Changes to benefits and premiums may only be made with the approval of the Massachusetts Division of Insurance.

Failure to pay premiums
If we or our agent do not get the premium payment by the time it is due, your coverage will be stopped and your contract cancelled as described in **Leaving Fallon Health & Life Assurance Company.**

Additional contract provisions

Changes in your coverage

We may change part of your contract. If we do, the change will apply to all contracts of this type, not just your contract. Changes to benefits and premiums may only be made with the approval of the Massachusetts Division of Insurance. We will send you notice of any material changes to your coverage within 60 days of the change. The contract will be changed whether or not you get the notice. The notice will tell you the effective date of the change.

When we send you a notice, we will mail it to the most current address we have on file. This includes your bill for premium charges and any notices telling you about changes in the premium charge or changes in the contract. If your name and mailing address change, let us know so that our files can be updated. Be sure to give us your old name and address as well as the new information.

Responsibility for the acts of providers

We are not liable for any injuries or damages as a result of deeds or failures by a provider, facility or person giving services to you. We will not come between the regular relationship between providers and their patients. Responsibility for medical decisions about care options is between the provider and you. However, we can deny payment for services that we decide are not covered under this policy. Such a denial does not release the provider of their professional responsibility to give you proper medical care.

If you are an inpatient, or if you are an outpatient, you will be required to follow all of that facility's rules, including rules on admission, discharge and the availability of services.

Providers can recommend care options, but this does not guarantee that the recommended care is a covered benefit. It does not require FHLAC to pay for the service. Only the services or supplies that are listed as covered in this handbook are covered benefits.

Conditions beyond our control

Under conditions that are beyond our control, we may have to delay your services, or we may not be able to provide services at all. We will not be responsible for failing to provide, or for a delay in providing, services in the cases described below. We will, however, make a good faith effort to provide or arrange for services in these situations, limited by available facilities and personnel:

- In the case of major natural disasters, epidemics or pandemics
- In the case of a war, riot, civil insurrection or acts of terrorism

Leaving Fallon Health & Life Assurance Company

Ineligibility

Your coverage with this policy will end if:

- You are no longer eligible for Medicare Part A and Part B, or Medicare is no longer your primary health insurance coverage.
- You are no longer a resident of Massachusetts.

Cancellation by FHLAC

You do not have to worry that we will cancel your coverage because you are using services or because you will need more services in the future. We will cancel coverage only for the following reasons:

- You made a false statement or worked with someone else to give false information to FHLAC. An example is a wrong or incomplete statement on your application that told us that you could be covered when you could not. In such a case, your coverage will be canceled as of a date we decide. We will refund the premium charge you have paid if appropriate. Any payments made for claims under this contract will be taken away from the refund. If we have paid more for claims under this contract than you have paid in premium charges, we have the right to collect the outstanding amount from you. In any case of false representation FHLAC may not allow you to enroll in the future.

- Your premium charge is not paid within the grace period. (See **How your coverage works** to learn more about grace periods and nonpayment of premium.) FHLAC will send you a notice telling you the effective date of the cancellation. That notice will be sent to the address that we have on file for you.

We can only cancel your policy for the reasons listed here. FHLAC may not cancel or refuse to renew your policy for any other reason. Changes to benefits and premiums may only be made with the approval of the Massachusetts Division of Insurance.

Disenrollment by the subscriber

You may cancel your contract at any time. If you cancel your contract, we will not provide benefits for any services or supplies that you may get after the date your contract is cancelled. We will give back to you any premium already paid for coverage for months past your date of cancellation. In the event of your death, we will give back any premium already paid for coverage for months past the date of your death.

There is one exception to the rule that FHLAC will not provide benefits for services you got after your cancellation date. If you are admitted to a hospital when your policy is cancelled, we will cover that admission until you are released, or until all available benefits under this policy have been used up.

Eligibility for Medicaid

If you are eligible for Medicaid, you may ask to suspend your benefits and premium under this policy for up to 24 months. To do this, you must tell us within 90 days of the date you become eligible for Medicaid.

If you lose your right to Medicaid before the 24 months is up, you may reinstate this policy. To do this, tell us within 90 days of the date you lose Medicaid, and pay any premium due for this policy from the date you lost Medicaid coverage. We will reinstate you as of the date you lost your Medicaid entitlement. Your coverage will be as close as possible to the same coverage you had before. Your premium will be based on a classification as close as possible to what would have applied if you had not left to join Medicaid.

Benefits

The benefits listed are available to members as long as they meet the rules below. Covered services under this policy fall into two areas: services secondary to Medicare and non-Medicare services required by Massachusetts state law.

For Medicare-covered services:

- The services are received from a provider or facility that is eligible to receive payments from Medicare.
- The services are covered by Medicare Part A or Part B.
- The charges for the services do not exceed the Medicare allowed amount.

For other services:

- The services are received from a properly licensed provider or facility.
- The services are described as a covered service in this handbook, and are not limited or excluded elsewhere in this handbook, in the Outline of Coverage, or in an amendment to this handbook.
- The services are medically necessary, or meet any other criteria described in this handbook.

This policy does not cover losses as a result of sickness any differently than it covers losses as a result of accidental injury.

Medicare-covered services

This policy supplies secondary coverage for any service covered by Medicare Part A or B. This includes, but is not limited to the services listed in this section. It covers coinsurance and copayment amounts that are not paid by Medicare, as described in the *Outline of Coverage*. Some plan options cover Medicare deductibles, while some do not (see your *Outline of Coverage*). Unless it is stated somewhere else in the handbook or in your *Outline of Coverage*, the services listed below are covered by this policy only if Medicare Part A or Part B covers them. (See your *Outline of Coverage* for more detailed information.)

When changes are made to Medicare deductible and coinsurance amounts, benefits available under this policy also change to the new amounts.

Note that Medicare coverage of certain services may be limited, or may be only for services which meet certain standards. FHLAC will not provide coverage for any service not covered by Medicare unless stated somewhere else in this handbook or in your *Outline of Coverage*.

Ambulance

This policy covers Medicare coinsurance amounts for Medicare-covered ambulance transportation.

Emergency care

This policy covers Medicare coinsurance amounts for Medicare-covered care in a hospital emergency room or other emergency care location.

When you have an emergency medical condition you should go to the nearest emergency room for care or call your local emergency number (e.g., police or fire department, or 911) to ask for ambulance transportation.

An emergency medical condition, whether physical or mental, shows symptoms (including pain) such that a prudent layperson, with an average knowledge of health and medicine, could expect a lack of fast medical attention to result in:

1. serious risk to the health of the member or another person (or unborn child)
2. serious harm to bodily functions or
3. serious dysfunction of any bodily organ or part.

Examples of emergencies are stroke, unconsciousness, heart attack symptoms or severe bleeding.

Note that Medicare for the most part does not cover services that you get outside the United States.

Home health care services

This policy covers the Medicare coinsurance amounts for Medicare-covered home health care.

Hospice care

This policy covers the Medicare coinsurance amounts for Medicare-covered hospice care.

Hospital inpatient services

This policy covers the Medicare coinsurance amounts for Medicare-covered inpatient hospital services, including copayments for lifetime reserve days.

It also has limited coverage for inpatient hospital days that Medicare does not cover because you have reached your day limit for a particular benefit period, and have used up your lifetime reserve days. Coverage is given for the first 90 days per benefit period, plus 60 lifetime reserve days, then up to 365 lifetime inpatient hospital days (some plan options cover amounts applied to your Medicare Part A deductible, while some do not; see your *Outline of Coverage*). This benefit includes charges for the first three pints of blood.

Mental health and substance abuse services

This policy covers the Medicare coinsurance amounts for Medicare-covered services related to mental health and substance abuse. This includes coinsurance for inpatient lifetime reserve days.

It also has limited coverage for inpatient hospital days that Medicare does not cover because you have reached your Medicare inpatient mental health lifetime maximum. This maximum is 190 days. Coverage is given for up to 60 days per calendar year (some plan options cover amounts applied to your Medicare Part A deductible, while some do not; see your *Outline of Coverage*). It does not include services in the same calendar year covered as a state-mandated benefit.

Office visits and outpatient services

This policy covers the Medicare coinsurance amounts for Medicare-covered office visits and outpatient services. This includes, but is not limited to:

- the services of physicians and other health care professionals
- diagnostic and laboratory tests and procedures, including X-rays,
- surgery,
- therapeutic services,
- kidney dialysis,
- cardiac rehabilitation services,
- physical, occupational and speech therapy,
- clinical trials.

Oral surgery and dental services

This policy covers the Medicare coinsurance amounts for Medicare-covered oral surgery and dental services.

Organ transplants

This policy covers the Medicare coinsurance amounts for Medicare-covered organ transplant services.

Note that, for certain types of transplants, Medicare only covers facilities approved by Medicare for that type of transplant. This policy will not cover a transplant at a facility that is not approved by Medicare to do that type of transplant.

Prosthetic devices and durable medical equipment

This policy covers the Medicare coinsurance amounts for Medicare-covered prosthetic devices and durable medical equipment.

Skilled nursing facility

This policy covers the Medicare coinsurance amounts for Medicare-covered inpatient skilled nursing facility services, as described in the *Outline of Coverage*.

Medicare Supplement 1 benefits

For the Medicare Supplement 1 plan option only, this policy covers:

- The Medicare daily skilled nursing coinsurance for Christian Science Sanatorium nursing services for up to 30 days per benefit period.
- Non-Medicare covered services rendered by a dentist during a Medicare-eligible admission for those services.

Services mandated by Massachusetts law

Services below are covered by this policy under Massachusetts state law. These are covered even if Medicare does not cover them or if they are given to you by providers who do not accept Medicare. However, if Medicare does cover these services, FHLAC's coverage will be secondary to Medicare. All FHLAC coverage will be less any payments made by Medicare, and may not include amounts applied to a Medicare deductible.

If Massachusetts law changes to cover more services, benefits under this policy change to match the new requirements. Premiums may be changed when this happens. The member must agree to the change in benefits and premiums.

Autism services

Benefits shall be provided for the diagnosis and treatment of autism spectrum disorder. Benefits are only available to members who are residents of Massachusetts. Diagnosis includes medically necessary assessments, evaluations including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has one of the autism disorders. Treatment includes care prescribed, provided or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary.

Covered services

1. Habilitative or rehabilitative care, professional counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst. Services require prior authorization.
2. Therapeutic care, services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers. Therapeutic care requires prior authorization.
3. Pharmacy care, medications prescribed by a licensed physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the contract for other medical conditions.
4. Psychiatric care, direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
5. Psychological care, direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Coverage for the diagnosis and treatment of autism spectrum disorders is not subject to any annual or lifetime dollar or unit of service limitation which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions nor subject to a limit on the number of visits an individual may make to an autism services provider.

The following terms shall have the following meaning:

Applied behavior analysis: The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism services provider: A person, entity or group that provides treatment of autism spectrum disorders.

Autism spectrum disorders: Any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

Board certified behavior analyst: A behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.

Not covered:

1. Equine therapy
2. Aqua therapy

Bone marrow transplants for breast cancer patients
This policy covers bone marrow transplants for persons diagnosed with breast cancer that has developed into metastatic disease. Coverage follows the standards established by the Massachusetts Department of Public Health.

Contraceptive services and hormone replacement therapy
This policy covers services for contraceptives or hormone replacement therapy, according to Massachusetts state law:

- Hormone replacement services in the doctor's office for perimenopausal or postmenopausal women.
- Outpatient contraceptive services, including:
  a. consultations,
  b. examinations,
  c. procedures and
  d. medical services related to the use of all contraceptive methods, including those that are given by a licensed provider during an office visit.

This benefit does not include any items covered under Medicare Part D.

Hearing aids
In accordance with Massachusetts state law, this policy covers hearing aids for individuals age 21 or younger for the cost of 1 hearing aid per hearing impaired ear up to $2,000 for each hearing aid device only, every 36 months.
- Related services and supplies for hearing aids (not subject to the $2,000 limit)

Not covered:
1. Hearing aids for individuals over age 21

HIV associated lipodystrophy treatment
In accordance with Massachusetts state law, this policy covers medical or drug treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome including, but not limited to, reconstructive surgery, such as assisted lipectomy, other restorative procedures and dermal injections of fillers for reversal of facial lipoathrophy.

Hospice care
In accordance with Massachusetts state law, this policy covers hospice care. This care is covered even when these services are not covered by Medicare or are given by a provider who does not accept Medicare.

You are covered for hospice care services listed below. Hospice care is care for the terminally ill to live with as little disruption as possible. This type of care focuses on services such as home care and pain control. It does not focus on cure-oriented services given in a facility.

Hospice care services must be ordered by a licensed doctor, and given by a licensed hospice provider.

Hospice services include, but are not limited to:
- doctor's services;
- nursing care by or under the supervision of a registered professional nurse;
- dietary, occupational, physical, speech and respiratory therapy for reasons of symptom control or to allow the person to keep activities of daily living;
- medical supplies and appliances; drugs that cannot be self-administered;
- medical social services;
- counseling services by professional or volunteer staff under professional supervision;
- volunteer services and
- respite care.

Covered:

1. Nursing care by or under the supervision of a registered professional nurse
2. Medical social services by a social worker
3. Outpatient physicians' services by a doctor of medicine or doctor of osteopathy
4. Counseling services, such as dietary or bereavement, for the terminally ill individual and the family members or other persons caring for the individual at home
5. Short-term inpatient care for the control of pain and management of acute and severe clinical problems that cannot be managed at home.
6. Medical appliances and supplies
7. Physical therapy, occupational therapy and speech-language pathology services for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills
8. Prescription medication related to the terminal illness of the person

Not covered:

1. Long-term rehabilitative care
2. Personal comfort items such as television, radio or telephone
3. Drugs that are investigational or that have not been approved for general sale and distribution by the U.S. Food and Drug Administration
4. Vitamins, whether or not a prescription is required

Mammograms and pap smears

In accordance with Massachusetts state law, this policy covers:

- a baseline mammogram for women age 35 to 40,
- a yearly mammogram for women age 40 and older,
- an annual Pap smear for women age 18 and older.

Mental health and substance abuse services

In accordance with Massachusetts state law, this policy covers mental health services. This coverage is given even if these services are not covered by Medicare or are received from a provider who does not accept Medicare.

You are covered for inpatient, intermediate and outpatient services for the diagnosis and care of mental conditions, as shown below. A mental condition is defined as a condition that is described in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and that is decided as such by a licensed provider and FHLAC. Care may be provided by a:

- psychiatrist,
- psychologist,
- psychotherapist,
- licensed nurse,
- mental health clinical specialist,
- licensed independent clinical social worker,
- mental health counselor,
- pediatric specialist,
- certified alcohol and drug abuse counselor or
- marriage and family therapist
- other provider as authorized by FHLAC.

Inpatient mental health services are subject to your overall lifetime maximum on inpatient mental health services. (See your *Outline of Coverage* for more detailed information.)

For mental health emergencies, follow the same process as for any other medical emergency. (See **Emergency care**.)

Inpatient services
You are covered for mental health services in an inpatient (intermediate) setting. Coverage is given for inpatient care when medically necessary in a licensed general hospital, psychiatric hospital or substance abuse facility (or its equivalent in another program). Inpatient services must be arranged by a licensed doctor. Levels vary from least to most restrictive and include: respite or crisis stabilization; day or evening care or partial hospitalization; short-term residential care; and hospital-based programs.

Covered inpatient services:

1. Inpatient hospital care, including room and board. This includes the services and supplies that would be given to you while you are an inpatient. These also include but are not limited to; person; family and group therapy; pharmacological therapy and diagnostic laboratory services.
2. Professional services provided by doctors or other health care professionals for the care of mental conditions while you are an inpatient.

Outpatient services
You are covered for medically necessary services given in person. Outpatient services may be given in a licensed hospital, a mental health or substance abuse clinic licensed by the Department of Public Health, a public community mental health center, or a professional office.

Covered outpatient services:

1. Outpatient office visits, including group or family therapy.
2. Psychopharmological services, such as visits with a doctor to review, track and adjust the levels of prescription medication to treat a mental condition.
3. Neuropsychological evaluation services when medically necessary.

Not covered:

1. Mediation (dispute resolution) or intervention services
2. Work evaluation, counseling, rehabilitation, and/or training
3. Faith-based counseling (e.g., Christian counseling)
4. Services that do not include face-to-face participation by the member, such as “phone therapy”
5. Residential halfway house services. This exclusion does not apply to services received in a facility that provides mental health services in a 24-hour setting, with clinical staff and appropriately trained professional and paraprofessional staff to insure safety for the individual, while providing active treatment and reassessment.
6. Acupuncture, biofeedback and biofeedback devices for home use, or any other care for a mental health or substance abuse condition
7. Services or programs that are not medically necessary for the care of a mental health or substance abuse condition. Some examples of services or programs that are not covered include (but are not limited to) at-risk youth expeditions, outward bound-type programs, and wilderness programs.
8. Services or programs that are provided in a learning, work or recreation location.
9. Services or programs that provide mostly custodial care.

Special formulas

You are covered for the special medical formulas and food products listed below, when medically necessary and ordered by a licensed doctor. Except for these items, FHLAC does not cover any nutritional formulas, supplements or food products. Nutritional supplements or formulas for adults or children are not covered unless they are listed below as a covered item.

Covered services:

1. Enteral formulas, upon a doctor's written order, for use at home in the care of malabsorption caused by Crohn's disease, ulcerative colitis, gastro-esophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids.
2. Food products that have been changed to be low in protein for persons with inherited diseases of amino acids and organic acids. Coverage is given for up to $5,000 per member in each calendar year.

Speech, hearing and language services

This policy covers medically necessary services for the diagnosis and care of speech, hearing and language disorders, according to Massachusetts state law. The services must be given by a licensed provider who is a speech-language pathologist or audiologist, in a hospital, clinic or office setting.

Treatment of cleft lip and cleft palate

In accordance with Massachusetts state law, this policy covers the treatment of cleft lip and cleft palate for children under the age of 18. The coverage shall include benefits for medical, dental, oral and facial surgery, surgical management and follow-up care by oral and plastic surgeons, orthodontic treatment and management, preventative and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy, speech therapy, audiology, and nutrition services. Payment for dental or orthodontic treatment not related to the management of the congenital conditions of cleft lip and cleft palate will not be covered.

Not covered:

1. Care of the teeth and supporting structures, including reconstructive, major restorative or cosmetic dental services, such as dental implants (also known as osseointegrated or titanium implants), dentures, crowns, and orthodontics. Care of the teeth and supporting structures is not covered (unless related to the management of the congenital conditions of cleft lip and cleft palate). Similarly, medical or surgical procedures in preparation for a dental procedure are also not covered (for example, a bone graft to prepare for a dental implant).

Treatment of Lyme disease

In accordance with Massachusetts state law, this policy covers long-term antibiotic therapy for a patient with Lyme disease when determined to be medically necessary and ordered by a licensed physician after making a thorough evaluation of the patient's symptoms, diagnostic test results or response to treatment. An experimental drug shall be covered as a long-term antibiotic therapy if it is approved for an indication by the United States Food and Drug Administration.

Other Plan Features

SilverSneakers®

With SilverSneakers, you can visit contracted fitness centers to access treadmills, weights, pools and fitness classes. You can also attend classes for older adults taught by certified instructors.
For details contact 1-888-423-4632.

Nurse Connect

Members get free access to registered nurses and other health care professionals who serve as health coaches, 24 hours a day, 7 days a week, 365 days a year. You can reach a Nurse Connect Health Coach by calling 1-800-609-6175 (TDD/TYY: 1-800-848-0160).

Vision Care

One routine eye exam every year. Up to $150 allowance for one pair of routine eyeglasses (prescription lenses and frames) or contact lenses every calendar year. This $150 benefit includes new eyeglasses, contact lenses, lens replacement, frame replacement, fitting, adjustment or repair. Members pay all charges over $150 per calendar year. There are Plan exclusions, for example, store promotions or coupons and the one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.

Discounts/programs

Naturally Well

Discounts on acupuncture, chiropractic care and massage therapy from Plan providers. Health and wellness products also are available at a reduced rate through The ChooseHealthy®™Program.

Interactive online wellness tool
Healthwise Knowledgebase

The Healthwise Knowledgebase is an online health encyclopedia which features information on diseases, conditions, medications and other health topics.

Non Smoking Program
Smoking Cessation

One-on-one telephone-based coaching offered by certified tobacco treatment counselors from our smoking cessation program, Quit to Win.

General exclusions and limitations

You are not covered for the following services. These are in addition to any exclusions listed or discussed in **Benefits**:

1. Services and supplies that are not covered by Medicare, unless shown as covered in this handbook
2. Drugs and biologicals eligible for coverage under Medicare Part D
3. Charges for amounts paid by Medicare, or (for some plan options; see your *Outline of Coverage*) applied to a Medicare deductible
4. Services or supplies that are not given by or at the direction of a licensed doctor or other appropriate licensed provider
5. Services or supplies that are not medically necessary for the prevention, detection or care of an illness, injury or disease as decided by a FHLAC medical director, unless covered by Medicare or shown as covered in this handbook. Services or supplies that do not meet FHLAC's medical criteria are not considered to be medically necessary
6. Any experimental procedure or service that is not generally accepted medical practice, unless required by law (for example, bone marrow transplants for breast cancer as required by state law). This is decided by a FHLAC medical director
7. Any services supplied by any provider not having a license or approval, under applicable state law, to supply that type of service
8. Care that we decide is custodial. Custodial care is a level of care which: (a) is made to help a person with the activities of daily life; and (b) cannot be expected to greatly improve a medical condition
9. Services given to someone other than the member
10. Services and supplies received for reasons of preference or convenience
11. Exams or care required by a third party unless medically necessary as decided by a doctor and FHLAC. Examples are pre-employment or school physicals, premarital medical tests, court-ordered care or immunizations required for your job or work conditions
12. An illness or injury that we determine came from, or during, your employment
13. Services or supplies given for disabilities received while you were in or as a result of military service, for which you are legally entitled to services and for which facilities are reasonably available, or care for conditions that state and local law require be treated at a public facility
14. Services that are given by a member of your family or household, unless that person is a licensed health care provider employed in a job that involves these services
15. Services to reverse a voluntary sterilization
16. Services related to the termination of pregnancy that are not medically necessary to prevent the death of the mother
17. Dental care, except as indicated in **Oral surgery and dental services**
18. Other therapies such as acupuncture, biofeedback and biofeedback devices for home use, neurofeedback, acquatic (unless given by a doctor or physical therapist with one-to-one patient contact), art, herbal and massage (unless given by a doctor or physical therapist with one-to-one patient contact)
19. Services given free of charge, that you would not pay for except for the fact that you have this contract, or that would be paid for by a governmental program (other than Medicaid or Medicare)

20. Refractive eye surgery
21. Hearing aids
22. Prescription drugs or medications, unless covered by Medicare Part A or Part B
23. Services related to care for infertility
24. Charges for amounts that go beyond the Medicare-approved deductible, copayment or coinsurance amount
25. Bio-identical hormone replacement therapy

Index

Acupuncture 34
Ambulance 26
American Psychiatric Association 30
Appeal 13
Appliances 29
Autism services 28
Bone marrow transplant 29, 34
Cardiac rehabilitation 27
Claims process 19
Counseling 29
Outpatient 31
Court-ordered treatment 34
Custodial care 34
Customer Service 5, 6, 13, 20
Department of Public Health 18, 29, 31
Dialysis, outpatient 27
Durable medical equipment 27
Emergency care 26, 31
Emergency services 2, 26
Employment-related illness or injury 34
Enteral formulas 32
Food products, low protein 32
General exclusions and limitations 34
Home health care 26, 29
Home health care services 26
Hospice 26, 29
Hospice care 29–30
Hospital inpatient services 26, 27
Identification card 6
Infertility 35
Inpatient care 30, 31
Mammogram 30
Medical records
Release of 14
Medical supplies 29
Medicare 4, 6, 9, 13, 19, 20, 22, 24, 25, 26, 27, 28, 29, 30, 34, 35
Mental health 26–27, 27, 30
Nutrition 32
Supplements 32
Occupational therapy 30
Office of Patient Protection 16, 18
Office visits and outpatient services 27
Organ transplants 27
Outpatient services 2, 23, 27, 30, 31, See Office visits and outpatient services
Personal injury protection 21
Prescription drugs 30, 31
Prescription medications 30
Termination of coverage 23–25
Transportation 26, See Ambulance
Treatment plan 10
Urgent care 26
Work-required immunizations 34

.

10 Chestnut St.
Worcester, MA 01608-2810

fallonhealth.org