

Fallon Community Health Plan, Inc.

**Fallon Senior Plan Premier HMO  
Schedule of Benefits**

This *Schedule of Benefits* is part of your *2012 Fallon Senior Plan Premier HMO Evidence of Coverage*. It describes your costs for health care.

You are a member of Fallon Senior Plan™ through an employer group. Under this group plan, you have copayments that are different from those shown in your *2012 Fallon Senior Plan Premier HMO Evidence of Coverage*. The information in this document replaces any information in your *Evidence of Coverage* that conflicts with it. If you have any questions about your benefits, please call Customer Service at 1-800-325-5669 (TTY users, please call TRS Relay 711). Calls to these numbers are free. Monday through Friday, 8 a.m. to 8 p.m. (From October 15 – February 14, we’re available seven days a week)

- You have a \$10 copayment for office visits.
- You have a \$10 copayment for urgent care visits.
- You do not have additional dental services coverage.
- You have a \$10 copayment for Tier-1 prescription drugs, a \$20 copayment for Tier-2 prescription drugs, and a \$40 copayment for Tier-3 prescription drugs, for up to a 30-day supply.
- You have a \$20 copayment for Tier-1 prescription drugs, a \$40 copayment for Tier-2 prescription drugs, and a \$80 copayment for Tier-3 prescription drugs, for up to a 90-day supply through a mail-order pharmacy.
- You have no comprehensive preventive dental coverage.

The following changes apply to the Benefits Chart of your *2012 Fallon Senior Plan Premier HMO Evidence of Coverage*:

Benefits chart – your covered services	What you must pay when you get these covered services
<i>Inpatient Care</i>	
<p><b>Hospice care</b></p> <p>You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Drugs for symptom control and pain relief</li> <li>• Short-term respite care</li> <li>• Home care</li> </ul>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not Fallon Senior Plan Premier HMO.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment for hospice consultation services.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p><b>Hospice care, continued</b></p> <p>You are still a member of our plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options:</p> <ul style="list-style-type: none"> <li>You can obtain your non-hospice care from plan providers. In this case, you only pay plan allowed cost sharing</li> <li>--or-- You can get your care covered by Original Medicare. In this case, you must pay the cost-sharing amounts under Original Medicare, except for emergency or urgently needed care. However, after payment, you can ask us to pay you back for the difference between the cost sharing in our plan and the cost sharing under Original Medicare.</li> </ul> <p><b>Note:</b> If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	
<b>Outpatient Services</b>	
<p><b>Physician services, including doctor's office visits</b></p> <p><i>For some office visits (other than office visits to your PCP) and outpatient services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan. For more information, see Chapter 3.</i></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>Medically-necessary medical or surgical services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location</li> <li>Consultation, diagnosis, and treatment by a specialist</li> <li><i>For diagnostic hearing exams to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.</i></li> <li>Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment</li> <li>Telehealth office visits including consultation, diagnosis and treatment by a specialist</li> </ul>	<p>You pay a \$10 copayment for each primary care doctor or specialist office visit for Medicare-covered benefits.</p> <p>You pay a \$10 copayment for each in-area, network urgent care Medicare-covered visit.</p> <p>You pay a \$10 copayment for each Medicare-covered diagnostic hearing exam.</p> <p>You pay a \$10 copayment for Medicare-covered dental benefits.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p><b>Physician services, including doctor’s office visits, continued</b></p> <ul style="list-style-type: none"> <li>• Second opinion by another network provider prior to surgery</li> <li>• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)</li> <li>• Reconstructive surgery (<i>For reconstructive surgery to be covered, your PCP or other plan provider must get prior authorization (approval in advance) from the plan.</i>)                         <ul style="list-style-type: none"> <li>– Surgery for post-mastectomy patients for reconstruction of the breast on which the mastectomy was performed.</li> <li>– Surgery and reconstruction of the other breast to produce a symmetrical appearance.</li> <li>– Treatment for any physical complications resulting from the mastectomy including lymphedema.</li> </ul> </li> </ul>	
<p><b>Chiropractic services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• We cover only manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</li> </ul>	<p>You pay a \$10 copayment for each Medicare-covered office visit for chiropractic services.</p>
<p><b>Podiatry services</b></p> <p><i>For podiatry services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.</i></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</li> <li>• Routine foot care for members with certain medical conditions affecting the lower limbs.</li> </ul>	<p>You pay a \$10 copayment for each Medicare-covered office visit for podiatry services.</p> <p>Medicare-covered podiatry benefits are for medically necessary foot care.</p>

<b>Benefits chart – your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Outpatient mental health care</b></p> <p><i>For Outpatient mental health care beyond the eighth visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plans.</i></p> <p>Covered services include:</p> <p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>You pay a \$10 copayment for each Medicare-covered individual or group therapy visit for mental health care with or without a psychiatrist.</p>
<p><b>Outpatient substance abuse services</b></p> <p><i>For Outpatient substance abuse services beyond the eighth visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plans.</i></p>	<p>You pay a \$10 copayment for each Medicare-covered individual or group therapy visits.</p>
<p><b>Urgently needed care</b></p> <p>Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.</p> <p>Coverage is within the United States.</p>	<p>You pay a \$10 copayment for each Medicare-covered urgent care visit.</p>
<p><b>Outpatient rehabilitation services</b></p> <p><i>For physical, occupational and speech and language therapy visits beyond the sixth visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.</i></p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>You pay a \$10 copayment for each Medicare-covered physical, occupational or speech and language therapy visit.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p><b>Diabetes self-monitoring, training and supplies</b></p> <p>For all people who have diabetes (insulin and non-insulin users).</p> <p><i>For diabetes self-monitoring supplies to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.</i></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.</li> <li>• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.</li> <li>• Diabetes self-management training is covered under certain conditions.</li> <li>• As needed, for persons at risk of diabetes: Fasting plasma glucose tests.</li> </ul> <p><b>Note:</b> Syringes and insulin (unless used with an insulin pump) are covered under the outpatient prescription drug benefit.</p>	<p>There is no copayment for diabetes self-monitoring training, diabetic services and supplies.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment if the doctor provides services in addition to the diabetes self-management training, diabetic services and supplies.</p>
<p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p><i>For CT scans, PET scans, MRIs and nuclear studies to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.</i></p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation (radium and isotope) therapy including technician materials and supplies</li> <li>• Surgical supplies, such as dressings</li> <li>• Splints, casts and other devices used to reduce fractures and dislocations</li> </ul>	<p>There is no copayment for Medicare covered:</p> <ul style="list-style-type: none"> <li>- lab services</li> <li>- diagnostic procedures and tests</li> <li>- X-rays</li> <li>- therapeutic radiology services</li> </ul> <p>You pay a \$10 primary care doctor or specialist office visit copayment if the doctor provides services in addition to the outpatient diagnostic tests and therapeutic services and supplies.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p><b>Outpatient diagnostic tests and therapeutic services and supplies, continued</b></p> <ul style="list-style-type: none"> <li>• Laboratory tests</li> <li>• Blood. Coverage of storage and administration begins with the first pint of blood that you need.</li> <li>• Other outpatient diagnostic tests</li> <li>• <i>For genetic testing, anesthesia for gastrointestinal endoscopy procedures and sleep studies (polysomnography) to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.</i></li> </ul>	
<p><b>Vision care</b></p> <p><i>For treatment of diseases or injuries of the eye to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.</i></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.</li> <li>• For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year.</li> <li>• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.</li> <li>• One supplemental routine eye exam every year.</li> <li>• One pair of routine eyeglasses (prescription lenses and frames) or contact lenses every calendar year.</li> </ul> <p>The \$150 plan coverage limit includes new eyeglasses, contact lenses, lens replacement, fitting, adjustment or repair. Members pay all charges over \$150 per calendar year. The following exclusions apply:</p> <ul style="list-style-type: none"> <li>- Store promotions or coupons</li> <li>- The one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery</li> </ul>	<p>There is no copayment for Medicare-covered glaucoma tests.</p> <p>You pay a \$10 specialist copayment to diagnose and treat diseases and conditions of the eye.</p> <p>You pay a \$10 specialist copayment for one routine eye exam every year.</p> <p>There is no copayment for:</p> <ul style="list-style-type: none"> <li>- one pair of eyeglasses or contact lenses after cataract surgery</li> <li>- up to 1 pair of eyeglasses or contacts every year</li> </ul> <p>There is a \$150 plan coverage limit for eyewear every year.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p><b>Vision care, continued</b></p> <ul style="list-style-type: none"> <li>- Two pairs of glasses in lieu of bifocals</li> <li>- Non-prescription lenses and/or contact lenses</li> <li>- Non-prescription sunglasses</li> </ul> <p>See Chapter 7, Section 1.1 “If you pay our plan’s share of the cost of your covered services, or if you receive a bill, you can ask us for payment” for more information about reimbursement for the \$150 plan coverage limit for eyewear every year.</p>	
<b>Preventive Care and Screening Tests</b>	
<p><b>Abdominal Aortic Aneurysm Screening</b></p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” physical exam.</p>	<p>There is no copayment for abdominal aortic aneurysm screening.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment if the doctor provides services in addition to the abdominal aortic aneurysm screening.</p>
<p><b>Bone mass measurement</b></p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.</p>	<p>There is no copayment for Medicare-covered bone mass measurement.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment if the doctor provides services in addition to the bone mass measurement.</p>
<p><b>Colorectal cancer screening</b></p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months</li> <li>• Fecal occult blood test, every 12 months</li> </ul> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> <li>• Screening colonoscopy (or screening barium enema as an alternative) every 24 months</li> </ul> <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> <li>• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy</li> </ul>	<p>There is no copayment for colorectal cancer screening procedures.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment if the doctor provides services in addition to the colorectal cancer screening.</p>

<b>Benefits chart – your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>HIV screening</b></p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> <li>• One screening exam every 12 months</li> </ul> <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> <li>• Up to three screening exams during a pregnancy</li> </ul>	<p>There is no copayment for each Medicare-covered HIV screening.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment if the doctor provides services in addition to the HIV screening.</p>
<p><b>Immunizations</b></p> <p><i>For immunizations (other than the pneumonia vaccine, flu shots and Hepatitis B vaccines) to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.</i></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Pneumonia vaccine</li> <li>• Flu shots, once a year in the fall or winter</li> <li>• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B</li> <li>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules</li> <li>• Some vaccines are covered under our Part D prescription drug benefit.</li> </ul>	<p>There is no copayment for Flu, Pneumonia vaccines, or for Hepatitis B vaccine.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment if the doctor provides services in addition to the immunizations.</p>
<p><b>Breast cancer screening (mammograms)</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• One baseline mammogram between the ages of 35 and 39</li> <li>• One screening mammogram every 12 months for women age 40 and older</li> <li>• Clinical breast exams once every 24 months</li> </ul>	<p>There is no copayment for Medicare-covered breast cancer screening.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment if the doctor provides services in addition to the breast cancer screening.</p>
<p><b>Cervical and vaginal cancer screening</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• For all women: Pap tests and pelvic exams are covered once every 24 months</li> <li>• If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months.</li> </ul>	<p>There is no copayment for Medicare-covered cervical and vaginal cancer screening.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment if the doctor provides services in addition to the cervical and vaginal cancer screening.</p>

<b>Benefits chart – your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Prostate cancer screening exams</b></p> <p>For men age 50 and older, the following are covered once every 12 months:</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Digital rectal exam</li> <li>• Prostate Specific Antigen (PSA) test</li> </ul>	<p>There is no copayment for Medicare-covered prostate cancer screening.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment if the doctor provides services in addition to the prostate cancer screening exams.</p>
<p><b>Cardiovascular disease testing</b></p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is no copayment for Medicare-covered cardiovascular screening blood tests.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment if the doctor provides services in addition to the cardiovascular disease testing.</p>
<p><b>Diabetes screening</b></p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>There is no copayment for the Medicare-covered diabetes screening.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment if the doctor provides services in addition to the diabetes screening.</p>
<p><b>Medical nutrition therapy</b></p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when referred by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into another calendar year.</p>	<p>There is no copayment for the Medicare-covered medical nutrition therapy.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment if the doctor provides services in addition to the medical nutrition therapy.</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<b>Other Services</b>	
<p><b>Services to treat kidney disease and conditions</b> Covered services include:</p> <ul style="list-style-type: none"> <li>• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.</li> <li>• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)</li> <li>• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)</li> <li>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)</li> <li>• Home dialysis equipment and supplies</li> <li>• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)</li> </ul> <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, "Medicare Part B prescription drugs."</p>	<p>There is no copayment for services to treat kidney disease and conditions.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment if the doctor provides services in addition to the services to treat kidney disease and conditions.</p>
<p><b>Medicare Part B prescription drugs</b></p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> <li>• Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services</li> <li>• Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan</li> <li>• Clotting factors you give yourself by injection if you have hemophilia</li> <li>• Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li> </ul>	<p>There is no copayment for drugs that are administered by a health care professional.</p> <p>You pay a \$10 primary care doctor or specialist office visit copayment.</p> <p><b>For prescription drugs that are covered under Original Medicare you pay:</b></p> <p><i>Retail pharmacy:</i> Tier 1: \$10 copayment for up to a 30-day supply; \$20 copayment for up to a 60-day supply; \$30 copayment for up to a 90-day supply</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<p><b>Medicare Part B prescription drugs, continued</b></p> <ul style="list-style-type: none"> <li>• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug</li> <li>• Antigens</li> <li>• Certain oral anti-cancer drugs and anti-nausea drugs</li> <li>• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen<sup>®</sup>, Procrit<sup>®</sup>, epoetin alfa, Aranesp<sup>®</sup>, or darbepoetin alfa)</li> <li>• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases</li> </ul> <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed in Chapter 6.</p> <p>All of the drugs on our formulary are available with an extended day supply except certain narcotics which are prohibited under Massachusetts State Law from being dispensed in quantities greater than a 30-day supply.</p>	<p>Tier 2: \$20 copayment for up to a 30-day supply; \$40 copayment for up to a 60-day supply; \$60 copayment for up to a 90-day supply</p> <p>Tier 3: \$40 copayment for up to a 30-day supply; \$80 copayment for up to a 60-day supply; \$120 copayment for up to a 90-day supply</p> <p><i>Mail-order pharmacy:</i>                      Tier 1: \$10 copayment for up to a 30-day supply; \$20 copayment for up to a 60-day supply; \$20 copayment for up to a 90-day supply</p> <p>Tier 2: \$20 copayment for up to a 30-day supply; \$40 copayment for up to a 60-day supply; \$40 copayment for up to a 90-day supply</p> <p>Tier 3: \$40 copayment for up to a 30-day supply; \$80 copayment for up to a 60-day supply; \$80 copayment for up to a 90-day supply</p> <p>There is no benefit limit on drugs covered under Original Medicare</p>

Benefits chart – your covered services	What you must pay when you get these covered services
<b>Additional Benefits</b>	
<p><b>Dental services</b></p>	<p>You do not have additional dental services coverage. Please see “Physician services, including doctor’s office visits” on page 2 for your dental coverage.</p>
<p><b>Hearing services</b></p> <p><i>For diagnostic hearing exams to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.</i></p> <ul style="list-style-type: none"> <li>• Diagnostic hearing exams.</li> <li>• Hearing aid allowance of up to \$500 in each 36-month period.</li> </ul> <p>Note: Routine hearing exams and hearing aids are not covered.</p>	<p>You pay a \$10 specialist copayment for each Medicare-covered diagnostic hearing exam.</p> <p>There is a \$500 plan coverage limit for hearing aids every 36 months. You pay any amount over the \$500 plan coverage limit.</p>
<p><b>Health and wellness education programs</b></p> <p><b>Health Club Membership/Fitness Classes</b></p> <ul style="list-style-type: none"> <li>• SilverSneakers® Fitness Program—a basic fitness membership to participating locations with access to amenities and fitness classes including the signature SilverSneakers classes designed to improve muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination.</li> <li>• SilverSneakers® Steps—available as an alternative to the SilverSneakers® Fitness Program for members residing outside the participating fitness location network (usually 15 miles from nearest participating location). SilverSneakers Steps is a self-directed physical activity program that allows members to measure, track and increase physical activity doing activities of their choice. SilverSneakers Steps provides the equipment, tools and motivation necessary for members to achieve a healthier lifestyle through increased physical activity.</li> </ul>	<p>You pay \$0 for:</p> <ul style="list-style-type: none"> <li>- SilverSneakers® Fitness Program or SilverSneakers® Steps</li> <li>- Nurse Connect</li> <li>- Newsletter</li> <li>- Weight Watchers®</li> <li>- Case Management and Disease Case Management programs</li> <li>- Infusion Drug program</li> </ul> <p>Depending on the type of class and its location you pay \$0 to \$10 for:</p> <ul style="list-style-type: none"> <li>- health/wellness education classes</li> <li>- nutritional training</li> </ul>

Benefits chart – your covered services	What you must pay when you get these covered services
<p><b>Health and wellness education programs, continued</b></p> <p><b>Nursing Hotline</b></p> <ul style="list-style-type: none"> <li>• Nurse Connect – phone and online access to registered nurses and other health care professionals who serve as health coaches which is available 24 hours a day, seven days a week.</li> </ul> <p><b>Newsletter</b></p> <ul style="list-style-type: none"> <li>• A communication that is filled with information to help keep you well.</li> </ul> <p><b>Other Health/Wellness Programs</b></p> <ul style="list-style-type: none"> <li>• Weight Watchers®—members are eligible for one 13-consecutive-week membership, including registration fee, per calendar year.</li> <li>• Nutritional training and health/wellness education classes—members must receive services from network providers and may pay a copayment depending on the type of class and its location.</li> <li>• Case Management and Disease Case Management programs are available for members with chronic conditions such as diabetes, coronary artery disease and asthma.</li> <li>• An Infusion Drug program is available for members with infusion drug therapies to help ensure that infusion drugs are administered in the most appropriate and convenient setting for the member.</li> </ul> <p>For more information on any of these health and wellness education programs, call Customer Service at the number on the cover of this booklet.</p>	

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**SECTION 3      What types of benefits are not covered by the plan?**

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**Section 3.1      Benefits we do not cover (exclusions)**

This section tells you what kinds of benefits are “excluded.” Excluded means that the plan doesn’t cover these benefits.

The list below describes some services and items that aren’t covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Evidence of Coverage*, **the following items and services aren't covered under Original Medicare or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study. (See Chapter 3, Section 5 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

- Routine dental care, such as cleanings, fillings or dentures. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Routine hearing exams, hearing aids, or exams to fit hearing aids.
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Services for the diagnosis and treatment of infertility.
- The FCHP Peace of Mind program, a second opinion program with certain providers, is not covered.
- Transportation that does not meet Medicare criteria.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

The following changes apply to the following sections of your *2012 Fallon Senior Plan Premier HMO Evidence of Coverage*:

Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed in Chapter 6.

**Your share of the cost when you get a *one-month* supply (or less) of a covered Part D prescription drug from:**

	<b>Network pharmacy</b> (up to a 30-day supply)	<b>The plan's mail-order service</b> (up to a 30-day supply)	<b>Network long-term care pharmacy</b> (up to a 30-day supply)	<b>Out-of-network pharmacy</b> (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
<b>Cost-Sharing Tier 1</b> (Preferred generic drugs)	\$10 copay	\$10 copay	\$10 copay	\$10 copay
<b>Cost-Sharing Tier 2</b> (Preferred brand drugs)	\$20 copay	\$20 copay	\$20 copay	\$20 copay
<b>Cost-Sharing Tier 3</b> (Non-preferred brand drugs)	\$40 copay	\$40 copay	\$40 copay	\$40 copay

**Your share of the cost when you get a *long-term* (90-day) supply of a covered Part D prescription drug from:**

	<b>Network pharmacy</b> (up to a 90-day supply)	<b>The plan's mail-order service</b> (up to a 90-day supply)
<b>Cost-Sharing Tier 1</b> (Preferred generic drugs)	\$30 copay	\$20 copay
<b>Cost-Sharing Tier 2</b> (Preferred brand drugs)	\$60 copay	\$40 copay
<b>Cost-Sharing Tier 3</b> (Non-preferred brand drugs)	\$120 copay	\$80 copay