Fallon Health & Life Assurance Company, Inc.

MAJOR MEDICAL AMENDMENTS

- Amendment 15 (eff. 01/01/11)
- Amendment 14 (eff. 01/01/11)
- Amendment 13 (eff. 01/01/11)
- Amendment 12 (eff. 04/01/10)
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- Amendment 3 (eff. 07/01/08)
- Amendment 2 (eff. 12/04/07)
- Amendment 1 (eff. 2007)
Fallon Health & Life Assurance Company, Inc.

AMENDMENT 15
This is part of your Fallon Health & Life Assurance Company Member Handbook
Form # 07-670-366
Effective January 1, 2011

This amendment changes certain sections of your Fallon Health & Life Assurance Company Member Handbook. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook, Schedule of Benefits or prior amendments that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TTY users, please call TRS Relay 711). Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Your Member Handbook has been amended to include information on the following:

1) Autism services
2) Infertility/assisted reproductive technology services

The following changes apply to your Member Handbook:

Autism: Effective on plan years beginning on or after January 1, 2011, benefits shall be provided for the diagnosis and treatment of autism spectrum disorder in individuals. Benefits are only available to members who are residents of Massachusetts or whose principal place of employment is in Massachusetts.

07-670-366_A15_0611
In the benefits section, add the following section autism services after ambulance section:

**Autism services**
The plan covers benefits for the diagnosis and treatment of autism spectrum disorder. 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 precertification.

2. Therapeutic care, services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers. Therapeutic care requires precertification.

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 is it 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.
Infertility/assisted reproductive technology services

Under **infertility /assisted reproductive technology services** in the **benefits** section, change the definition of infertility in the first paragraph to read as follows:

Infertility means the condition of an individual who is unable to conceive or produce conception during a period of one year if the female is age 35 or younger or during a period of six months if the female is over the age of 35. If a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one year or six month period, as applicable.
This amendment changes certain sections of your Fallon Health & Life Assurance Company Member Handbook. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook, Schedule of Benefits or prior amendments that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Your Member Handbook has been amended to include information on the following:
1) Prosthetic/orthotic devices and durable medical equipment

The following changes apply to your Member Handbook/Evidence of Coverage:

**Changes in Durable medical equipment and prosthetic/orthotic devices**—Effective on plan years beginning on or after September 23, 2010, there will no longer be a calendar year maximum on durable medical equipment and prosthetic/orthotic devices (this change is specific to the anniversary/renewal date of your plan).
Changes in Prosthetics/orthotic devices and durable medical equipment: Effective on plan years beginning on or after January 1, 2011, durable medical equipment and prosthetic/orthotic devices will be subject to coinsurance (this change is specific to the anniversary/renewal date of your plan).

- Under prosthetics/orthotic devices and durable medical equipment in the benefits section, replace the first paragraph with:
  
  You are covered for prosthetic/orthotic devices and durable medical equipment. Durable medical equipment and prosthetic limbs will be subject to coinsurance of 30% or match the coinsurance of all other benefits subject to coinsurance under the plan. These items must be medically necessary and ordered by a licensed physician.

  This plan covers prosthetic limbs which replace, in whole or in part, an arm or leg. These devices will be subject to 20% coinsurance or will match the coinsurance of all other benefits subject to coinsurance under the plan.

- Replace covered services with the following:
  
  1. The purchase or rental of prosthetic/orthotic devices and durable medical equipment (including the fitting, preparing, repairing and modifying of the appliance).

  2. Scalp hair prosthesis (wigs) for individuals who have suffered hair loss as a result of the treatment of any form of cancer or leukemia. Coverage is provided for up to $350 per member per calendar year when the prosthesis is determined to be medically necessary by a plan physician and the plan.
3. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy
4. Oxygen and related equipment
5. Prosthetic limbs which replace, in whole or in part, an arm or leg.
6. Insulin pumps and insulin pump supplies.

- Under Related exclusions, remove number 1.
AMENDMENT 13
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Form # 07-670-366
Effective January 1, 2011

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Your Member Handbook has been amended to include information on the following:
1) Speech Therapy
2) Disenrollment rates for the year 2009
3) Home health care services
4) Prescription medication
5) General Exclusions and limitations
6) Patient Protection and Affordable Care Act
   a) Dependent Coverage
   b) Preventive Care

The following changes apply to your Member Handbook:

07-670-366_A13_0510
Speech Therapy Services

Under **Case management** in the **Understanding your health care coverage** section, change second paragraph to read:

For outpatient mental health and substance abuse services and speech therapy benefits, we require that the provider of service submit a treatment plan that we will evaluate for medical necessity. The treatment plan for these services requires benefit management procedures.

Under **Rehabilitation services** in the **Benefits** section, change **Covered** service number 3 to read:

3. Medically necessary services for the diagnosis and treatment of speech, hearing and language disorders when services are provided by a speech-language pathologist or audiologist in a hospital, clinic or office setting. For speech therapy, a treatment plan must be submitted to our Care Services Department for authorization of these services.

2009 Disenrollment rates

Under **Involuntary cancellation rate** in **Leaving Fallon Health & Life Assurance Company**, replace the entire paragraph with the following:

For the calendar year 2009, FHLAC’s involuntary cancellation or disenrollment rate was 0.0%. The involuntary disenrollment rate includes any insured disenrolled by FHLAC due to misrepresentation or fraud on the part of the insured or commission of acts of verbal or physical abuse. For the calendar year 2009, FHLAC’s voluntary disenrollment rate was 0.98%.
Changes in Home health care services

- Under **Home health care services** in the **Benefits** section, replace entire section with the following:

The plan covers medically necessary part-time or intermittent skilled nursing care and physical therapy provided in your home by a home health agency. Additional services such as occupational therapy, speech therapy, medical social work, nutritional consultation, the services of a home health aide, and the use of durable medical equipment and supplies are covered to the extent that they are determined to be a medically necessary component of skilled nursing care and physical therapy. To be eligible for home health care, you must be confined to your home due to illness or injury and your doctor must establish a treatment plan that requires services including, but not limited to, nursing care and physical therapy.

Home health care services must be ordered by a licensed physician and provided by a Medicare-certified home health agency. Members receiving skilled services must meet the homebound criteria.

**Covered**

1. Part-time or intermittent skilled nursing care and physical therapy provided in your home by a home health agency

2. Additional services, such as occupational and speech therapy, medical social work, nutrition consultation, home health aide services, medical and surgical supplies and the use of durable medical equipment, are covered to the extent that they are determined to be a medically necessary component of skilled nursing care and physical therapy.
Exclusions
1. Personal comfort items such as a telephone, radio or television
2. Meals, housekeeping services or custodial care

Changes to our Prescription medication section
Under Prescription medication in the Benefits section, add the following Related exclusions:

- The following non sedating antihistamines: Allegra, Allegra ODT, Cetirizine HCl, Clarinex, Claritin, Claritin RediTabs, Fexofenadine HCl, Xyzal and Zyrtec.
- Vimovo

In General exclusions and limitations section:
Delete exclusion number 19.
Add the following exclusion:

112. Interspinous process decompression (or the X-Stop® interspinous process decompression device)

Patient Protection and Affordable Care Act of 2010
The following changes are made as part of the Patient Protection and Affordable Care Act of 2010.

Dependent Coverage: Changes are effective on plan years beginning on or after September 23, 2010.

Under Types of coverage in the How your coverage works section, replace the third bullet with the following:
• Dependent children under age 26.

Under **Age limits for dependent children** in the **How your coverage works** section, replace first paragraph with the following:

• A dependent child is eligible for coverage until his or her 26th birthday. Coverage under the family or adult/child(ren) contract ends on midnight of the day before his or her 26th birthday.

In the **How your coverage works** section, eliminate **Certify dependent status** sub-section.

Under **Ineligibility for you or a dependent** in the **Leaving Fallon Health & Life Assurance Company** section, replace the fourth bulleted item with the following:

• Attainment of age 26.

**Preventive Care:** This change is effective for all plans on September 23, 2010.

Under **Preventive care** in the **Benefits** section, replace the first sentence with the following:

• The plan covers preventive care services under the United States Preventive Services Task Force (USPSTF), Health Resources and Services Administration (HRSA) and the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention (ACIP) as required by the Patient Protection and Affordable Care Act of 2010.
These are the only preventive care guidelines that will be used by FHLAC as of September 23, 2010. In addition to services listed in this section, you may visit our Web site at www.fchp.org for more information on these guidelines.

- Change item number one under **Covered** to read as follows:

  1. Periodic physical exams for the prevention and detection of disease.
AMENDMENT 12

This is part of your Fallon Health & Life Assurance Company Member Handbook Form # 07-670-366 Effective April 1, 2010

This amendment changes certain sections of your Fallon Health & Life Assurance Company Member Handbook. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Your Member Handbook has been amended to include information on the following:

1) Change to our General exclusions and limitations

In General exclusions and limitations, add the following exclusion:

111. Services provided by a lactation consultant are excluded.
AMENDMENT 11
This is part of your Fallon Health & Life Assurance Company Member Handbook
Form # 07-670-366
Effective date – See individual sections.

This amendment changes certain sections of your Fallon Health & Life Assurance Company Member Handbook. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:
1) Dependent eligibility
2) Change to our prescription medication section

The following changes apply to your Member Handbook/Evidence of Coverage:

Change in dependent eligibility (This change is effective on the plan year beginning on or after October 9, 2009.)

Under Types of coverage in How your coverage works, add the following bullet:

● A dependent child who would otherwise cease to be eligible due to a loss of full-time student status remains eligible for coverage where

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required by Michelle’s Law, P.L. 110-381 (Michelle’s Law will only be applied in circumstances when the Massachusetts Dependent Mandate is not applicable).

Change to our prescription medication section

(This change is effective 1-1-2010.)

Under Related exclusions in the Prescription medication section under Benefits, add the following related exclusions:

- Bio-identical hormone replacement therapy.
- The following Proton Pump Inhibitors: Prevacid, lansoprazole, Protonix, pantoprazole, Zegerid, omeprazole, Prilosec
Fallon Health & Life Assurance Company, Inc.

AMENDMENT 10
This is part of your Fallon Health & Life Assurance Company Member Handbook
Form # 07-670-366
Effective July 1, 2009

This amendment changes certain sections of your Fallon Health & Life Assurance Company Member Handbook. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:
1) Mental health and Substance abuse services
2) Rehabilitation services

The following changes apply to your Member Handbook/Evidence of Coverage:

* Please note Substance abuse services benefit is now part of the Mental health benefit in the Benefits section. Replace the entire Mental health section with the following:

Mental health and substance abuse services
The plan covers the diagnosis and treatment of mental conditions on an outpatient, intermediate and inpatient basis. 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 determined as such by a plan provider and the plan. The level of care needed is authorized by a plan provider. Treatment 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 other provider as authorized by the plan.

An insured who loses member who loses eligibility as a dependent upon reaching age 19 and is receiving ongoing mental health treatment at the time may be eligible to continue coverage for the treatment. Call FHLAC Customer Service for more information. (Members who lose eligible as a dependent may also continue full coverage under COBRA; see conversion options.)

For mental health and substance abuse emergencies, follow the same procedures as for any other medical emergency, as outlined in emergency and urgent care.

**Inpatient services**
The plan covers mental health services in an inpatient or alternative (intermediate) setting, when authorized by the plan. Unlimited coverage is provided for inpatient care when medically necessary in a licensed general hospital, a psychiatric hospital or a substance abuse facility (or its equivalent in an alternative program). Mental health care provided in an alternative setting may include day or evening treatment or partial hospitalization; short-term residential treatment; and hospital-based programs.

Inpatient services must be precertified by our Care Services Department (see understand your health care coverage) and arranged by a licensed provider. Any
FHLAC review of mental health services will be performed by licensed mental health professionals.

**Services**

1. Inpatient hospital care for as many days as your conditions requires, including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, individual, family and group therapy, pharmacological therapy, and diagnostic laboratory services.

2. Professional services provided by physicians or other health care professionals for the treatment of mental conditions while you are an inpatient.

**Outpatient services**

The plan covers services provided in person in an ambulatory care setting. Outpatient services may be provided 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. A treatment plan for outpatient services must be submitted to our Care Services Department before your fourth visit occurs (see **understanding your health care coverage**). If you fail to submit your provider’s treatment plan, only the first three visits will be covered; no further visits will be covered. Any FHLAC review of mental health services will be performed by licensed mental health professionals. The plan covers medically necessary mental health and substance abuse services in an outpatient setting, as follows:
Services
1. Outpatient office visits, including individual, group or family therapy. The actual number of visits authorized beyond the initial eight is based on medical necessity as determined by the plan, and may include individual, group, or family therapy.
2. Psychopharmacological services, such as visits with a physician to review, monitor and adjust the levels of prescription medication to treat a mental condition
3. Neuropsychological assessment services when medically necessary

Related exclusions (please see general exclusions and limitations for additional limitations)
1. Mediation (dispute resolution) or intervention services
2. Vocational evaluation, vocational counseling, vocational rehabilitation, and or vocational training
3. Faith-based counseling (e.g., Christian counseling) or vocational counseling
4. Services that do not include face-to-face participation by the member, such as “phone therapy”
5. Residential halfway house services
6. Acupuncture, biofeedback and biofeedback devices for home use, or any other alternative treatment for the treatment of a mental health or substance abuse condition.
7. Services or programs that are not medically necessary for the treatment 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 an educational, vocational or recreational setting.

9. Services or programs that provide primarily custodial care.

Under Rehabilitation services in the Benefits section, change Covered item number 5 to read:

5. Medically necessary early intervention services delivered by a certified early intervention specialist, according to operational standards developed by the Department of Public Health, for children from birth to their third birthday.
AMENDMENT 9
This is part of your Fallon Health & Life Assurance Company Member Handbook
Form # 07-670-366
Effective # 07-670-366
Effective January 1, 2009

This amendment changes certain sections of your Fallon Health & Life Assurance Company Member Handbook. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:
1) Disenrollment rates for the year 2008
2) Nurse practitioners
3) Office visits and outpatient services
4) Prosthetic/Orthotic Devices

The following changes apply to your Member Handbook/Evidence of Coverage:

2008 disenrollment rates
Under Involuntary cancellation rate in Leaving Fallon Health & Life Assurance Company, replace the entire paragraph with the following:

For the calendar year 2008, FHLAC’s involuntary cancellation or disenrollment rate was 0.0%. The involuntary disenrollment rate includes any insured
Fallon Health & Life Assurance Company
Amendment 9

disenrolled by FHLAC due to misrepresentation or fraud on the part of the insured or commission of acts of verbal or physical abuse. For the calendar year 2008, FHLAC’s voluntary disenrollment rate was 0.77%.

Under the Glossary section, add the following definition:
• Nurse practitioner: A registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under M.G.L. c.112, § 80B.

Under Office visits and outpatient services in the Benefits section, replace first paragraph with:
You are covered for the services listed below when arranged by a licensed provider. Coverage is provided on a nondiscriminatory basis for services delivered or arranged by a nurse practitioner. Pediatric specialty care, including mental health care, is covered when provided to a member requiring such services by a provider with recognized expertise in specialty pediatrics.

Under Office visits and outpatient services in the Benefits section, add number 4 to the list of exclusions:
4. Laboratory tests to evaluate cardiovascular disease risk, such as Lipoprotein, The PLAC Test, NMR Lipoprophile®.

Under Prosthetic/orthotic devices and durable medical equipment in the Benefits section, add the following exclusion under number 3:
• Adjustable shoe-styling positioning devices, such as the Bebax™ Shoe.
AMENDMENT 8
This is part of your Fallon Health & Life Assurance Company Member Handbook
Form # 07-670-366
Effective April 1, 2009

This amendment changes certain sections of your Fallon Health & Life Assurance Company Member Handbook. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:
1) Special Enrollment Rights

The following changes apply to your Member Handbook/Evidence of Coverage:

In the “How Your Coverage Works” section after the “Changing your coverage” subsection, add a new subsection entitled:

Special enrollment rights in case of Medicaid and Children’s Health Insurance Program
If you qualify under Public Law 111-3-Feb. 4, 2009, your plan sponsor shall permit you if you are eligible, but not enrolled, or your dependent if your dependent is eligible, but not enrolled, to enroll under the group health plan in the following circumstances:

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• You or your dependent loses coverage under a Medicaid or CHIP program (in Massachusetts, MassHealth) due to a loss of eligibility. You have 60 days from the date of termination of coverage to request coverage under the group health plan for you or your dependent.

• You or your dependent becomes newly eligible for a premium assistance subsidy program under Medicaid or CHIP. You have 60 days after the date you or your dependent is determined to be eligible for the premium assistance subsidy to request coverage under the group health plan.
Fallon Health & Life Assurance Company, Inc.

AMENDMENT 7
This is part of your Fallon Health & Life Assurance Company Member Handbook
Form # 07-670-366
Effective April 1, 2009

This amendment changes certain sections of your Fallon Health & Life Assurance Company Member Handbook. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:
1) Rehabilitation services
2) Changes to our General exclusions and limitations

The following changes apply to your Member Handbook/Evidence of Coverage:

Under Rehabilitation services in the Benefits section, delete the first paragraph and replace with the following:
The plan covers outpatient rehabilitation services. Services must be medically necessary, ordered by a licensed physician, and provided by a licensed provider. Short-term rehabilitation services, such as physical and occupational therapy, are covered for up to 60 visits combined per calendar year. Coverage for speech therapy is based on medical necessity.

07-670-366_A7_0309
Replace covered #1 and #2 with the following:
1. Physical and occupational therapy to restore function after medical illness, accident or injury. Physical and occupational therapy services are covered for up to 60 visits combined per calendar year when medically necessary.

Under Mental health in the Benefits section, change related exclusion number 4 to read:
4. Alternative therapies such as acupuncture, biofeedback and biofeedback devices for home use, neurofeedback, aquatic (unless provided by a physician or physical therapist with one-to-one patient contact), art, herbal, massage (unless provided by a physician or physical therapist with one-to-one patient contact).

Under Substance abuse services in the Benefits section, change related exclusion number 6 to read:
6. Alternative therapies such as acupuncture, biofeedback and biofeedback devices for home use, neurofeedback, aquatic (unless provided by a physician or physical therapist with one-to-one patient contact), art, herbal, massage (unless provided by a physician or physical therapist with one-to-one patient contact).

Change to our General exclusions and limitations
In General exclusions and limitations, the following change applies:

Change exclusion number 5 to read:
5. Alternative therapies such as acupuncture, biofeedback and biofeedback devices for home use, neurofeedback, aquatic (unless provided by a physician or physical therapist with one-to-one patient contact), art, herbal, massage (unless provided by a physician or physical therapist with one-to-one patient contact).
patient contact), art, herbal, massage (unless provided by a physician or physical therapist with one-to-one patient contact).
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AMENDMENT 6
This is part of your
Fallon Health & Life Assurance Company Member Handbook
Form # 07-670-366
Effective # 07-670-366
Effective October 28, 2008

This amendment changes certain sections of your Fallon Health & Life Assurance Company Member Handbook. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:
1) Special formulas

The following changes apply to your Member Handbook/Evidence of Coverage:

special formulas
Under special formulas in the benefits section, replace covered item number 3 with the following:

3. Food products that have been modified to be low in protein for individuals with inherited diseases of amino acids and organic acids. Coverage is provided for up to $5,000 per insured in each calendar year.
This amendment changes certain sections of your Fallon Health & Life Assurance Company Member Handbook. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:

1) Coverage for End Stage Renal Disease (ESRD)

The following changes apply to your Member Handbook/Evidence of Coverage:

Under medicare in the "claims process" section, replace the entire section with the following:

**medicare**

If you are entitled to Medicare, it is generally considered to be your primary health insurance, even if you also have health coverage under this policy.

However, there are some circumstances in which this plan might be primary over Medicare. Your age, work status and (if you are eligible for Medicare due to

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disability) the presence of specific disabling medical conditions may affect which coverage is considered to be your primary insurance.

If you are covered under a group health plan and are eligible for Medicare only because of End Stage Renal Disease (ESRD), we will be the primary payer for covered services for a period of 30 months starting with the date you become eligible for ESRD Medicare coverage. After 30 months, Medicare will become the primary payer and we will become the secondary payer. As the secondary payer, our payments will be reduced by the Medicare allowed amount for the same covered services. Payments will be reduced if you are eligible for ESRD Medicare coverage, even if you decline to enroll.

If you are entitled to Medicare, and Medicare is your primary carrier, we have a legal right to obtain reimbursement for services for which FHLAC paid benefits, if the services are covered by Medicare.

• Under office visits and outpatient services in the benefits section, replace covered bullet number 10 with the following:

10. Outpatient renal dialysis, when arranged by a licensed physician. (Please see medicare under the claims process section for more information.)
AMENDMENT 4
This is part of your Fallon Health & Life Assurance Company Member Handbook
Form # 07-670-366
Effective November 1, 2008

This amendment changes certain sections of your Fallon Health & Life Assurance Company Member Handbook. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:

1) Coverage for visits to mini-clinics.

The following changes apply to your Member Handbook/Evidence of Coverage:

Under office visits and outpatient services in the benefits section add the following under covered:

- covered:
  mini-clinics

  15. Visit to a limited service clinic. Services are provided for a variety of common illnesses, including, but not limited to:
  - strep throat

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- ear, eyes, sinus, bladder and bronchial infections
- minor skin conditions (e.g. sunburn, cold sores)
This amendment changes certain sections of your Fallon Health & Life Assurance Company Member Handbook. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:

1) Definition of cosmetic surgery, physical functional impairment, reconstructive surgery, and restorative surgery
2) Disenrollment rates for the year 2007
3) Hospice care
4) Prescription medication
5) Reconstructive surgery
6) Inpatient acute rehabilitation services
7) Changes to our general exclusions and limitations

The following changes apply to your Member Handbook/Evidence of Coverage:

Add the following definitions to the glossary:
**Cosmetic services:** A surgery, procedure or treatment that is performed primarily to reshape or improve the patient’s appearance. Cosmetic services are not medically necessary, and are not covered, whether intended to improve an individual’s emotional well being or to treat a mental health condition.

**Physical functional impairment:** A condition in which the normal or proper action of a body part is damaged. This may include, but is not limited to, problems with ambulation, communication, respiration, swallowing, vision, or skin integrity. A physical functional impairment affects the ability to participate in activities of daily living. A physical functional impairment does not include an individual’s emotional well-being or mental health.

**Reconstructive surgery:** A procedure performed to improve or correct a physical functional impairment resulting from a congenital defect or birth abnormality, accidental injury, prior surgical procedure or disease.

**Restorative surgery:** The initial procedure to repair or restore appearance that was damaged by an accidental injury. For example, the repair of a facial deformity following a serious automobile accident.

**2007 disenrollment rates**
Under involuntary cancellation rate in leaving fallon health & life assurance company, replace the entire paragraph with the following:

For the calendar year 2007, FHLAC’s involuntary cancellation or disenrollment rate was 0.0%. The involuntary disenrollment rate includes any members disenrolled by the plan due to misrepresentation or fraud on the part of the member or commission of acts of
verbal or physical abuse. For the calendar year 2007, FHLAC’s voluntary disenrollment rate was 0.4%.

Under hospice care in the benefits section, change exclusion number 4 to read:

1. “Vitamins and minerals, whether or not a prescription is required, are excluded from coverage, unless listed in the FCHP drug formulary.”

Under prescription medication in the benefits section, change exclusion number 5 to read:

5. “Vitamins and minerals, whether or not a prescription is required, are excluded from coverage, unless listed in the FCHP drug formulary.”

changes in reconstructive surgery

- Under reconstructive surgery in the benefits section, replace the entire section with the following:

reconstructive and restorative services

The plan covers reconstructive services to improve or correct a physical functional impairment resulting from a congenital defect or birth abnormality, accidental injury, prior surgical procedure or disease.

The plan covers restorative services to repair or restore appearance damaged by accidental injury. Only the initial repair is covered.

Services performed to improve appearance in the absence of any signs and or symptoms of physical functional impairment, are considered cosmetic and are not covered (with the exception of services performed to repair or restore appearance after accidental injury).
Services required to treat a complication that arises as a result of a prior non-covered surgery/procedure, may be covered when medically necessary in all other respects.

In accordance with the Women’s Health & Cancer Rights Act of 1998, coverage is provided for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications of all stages of mastectomy, including lymphadema.

Services
1. Office visits related to covered reconstructive and restorative services
2. Inpatient hospital services including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient
3. Professional services provided to you while you are an inpatient, including, but not limited to medical, surgical and psychiatric services

related exclusions
1. Cosmetic surgery, cosmetic treatments, cosmetic procedures, cosmetic medications and cosmetic supplies, including, but not limited to: otoplasty for protruding ears; ear piercing; abdominoplasty; chemical peel (dermal and epidermal); microdermabrasion; and hair removal.
2. Services related to cosmetic surgery, cosmetic treatments, and cosmetic procedures are not covered. This includes but is not limited to: physician charges, hospital charges, charges for anesthesia, drugs, etc.
3. 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, even when part of a covered medical procedure, such as a cleft lip/palate repair. 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). (Some plan members may have a dental rider which provides coverage for certain preventive and minor restorative dental services, such as periodic cleanings and fillings. The services that are covered are listed in the Dental Addendum “Covered Dental Services Copayments.”)

4. Surgery, treatments, procedures, medications, and supplies related to gender reassignment or the reversal of gender reassignment.

5. Surgery, treatments, procedures, medications, and supplies to prevent snoring.

6. Removal of intact breast implants for suspected autoimmune or connective tissue disease or for breast cancer prevention because these indications are considered experimental/investigational.

7. Removal of an intact breast implant that has shifted. Implant shifting in the absence of refractory infection or Stage IV capsular contracture is not medically necessary.

8. Liposuction, also known as suction lipectomy or suction assisted lipectomy, is the surgical excision of subcutaneous fatty tissue. Liposuction (CPT codes 15876-15879) is not covered. However, liposuction is an integral part of certain covered services, such as the surgical removal of excessive skin (CPT codes 15830-15839), but is not separately reimbursed.
9. Treatments for acne scarring including, but not limited to subcutaneous injections to raise acne scars, chemical exfoliation (CPT 17360), and dermabrasion.

10. The following treatments for active acne are not covered: acne surgery (CPT code 10040), cryotherapy for acne (CPT code 17340), chemical exfoliation for acne (CPT code 17360), and laser and light-based therapies, including but not limited to blue light therapy, pulsed light, and diode laser treatment.

- Add the following to the benefits section:

**inpatient acute rehabilitation services**
The plan covers inpatient acute rehabilitative care in a licensed rehabilitation hospital or a rehabilitation unit in an acute care hospital for up to 100 days per calendar year. These services require an intensity, frequency and duration as to make it impractical for the patient to receive services in a less intense care setting, such as a skilled nursing facility. Rehabilitative services may include physical, speech, and occupational therapy services.

**related exclusions**
1. chronic rehabilitation services
2. services beyond 100 days in each calendar year
3. services that are not deemed to be medically necessary, even if the plan limit of 100 days per calendar year has not been reached

**changes to our general exclusions and limitations**
In general exclusions and limitations, the following changes apply:

- Delete exclusion number 52.
- Delete exclusion number 88.
• Change exclusion number 93 to read: “Vitamins and minerals, whether or not a prescription is required, are excluded from coverage, unless listed in the FCHP drug formulary.”

• Replace the entire cosmetic services section with the following:

**cosmetic services**

Cosmetic surgery, cosmetic treatments, cosmetic procedures, cosmetic medications and cosmetic supplies are not covered (even when intended to improve self-esteem or treat a mental health condition). In addition, drugs, biologicals, facility/hospital charges, laboratory and radiology charges, and charges for surgeons, assistant surgeons, anesthesiologists, and any other incidental services which are directly related to the cosmetic surgery/procedure are not covered. However, services required to treat a complication that arises as a result of a prior non-covered surgery/procedure, may be covered when medically necessary in all other respects.

Below are some examples of procedures that are considered cosmetic in nature and are not covered:

• Botox injections for cosmetic purposes
• Breast implants
• Chemical exfoliation for acne
• Chemical peel
• Chin implant (unless for the correction of a deformity that is secondary to disease, injury or congenital defect)
• Collagen implant (e.g., Zyderm)
• Correction of diastasis recti abdominis
• Dermabrasion for removal of acne scars
• Earlobe repair to close a stretched or torn ear pierce hole
- Electrolysis for hirsutism
- Excision or repair of keloid
- Grafts, fat
- Otoplasty
- Reduction of labia minora
- Removal of spider angiomata
- Revisions of previously performed restorative surgery (unless to improve or correct a physical functional impairment)
- Rhytidectomy
- Salabrasion
- Suction-assisted lipectomy

This list is not exhaustive; any procedure considered cosmetic in nature will be excluded.
This amendment changes certain sections of your Fallon Health & Life Assurance Company Member Handbook. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Your Member Handbook has been amended to include information on the following:
1) Appeals and grievances process
2) Reference to closed plans
3) Prosthetic limbs
4) Insulin and insulin pump supplies
5) Lost/mishandled medications
6) Change to our general exclusions and limitations

The following changes apply to your Member Handbook:

appeals and grievances process

- Throughout the book, change any reference to the inquiries and grievances section with inquiries, appeals and grievances.
- Replace the entire inquiries and grievances section with the following:
inquiries, appeals and grievances
Whenever you have a question or need help using plan providers and services, FHLAC encourages you to contact Customer Service. If you have a question or concern regarding an adverse determination or if you would like to file an appeal or grievance, contact Member Relations.

An adverse determination means that FHLAC has made a decision, based on the review of information provided to us, that denies, reduces, modifies or terminates coverage for health care services because the treatment does not meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

making 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 Representatives in the following ways:

Call: 1-800-868-5200
(TDD/TTY: 1-877-608-7677)
Monday through Friday,
8 a.m. to 6 p.m.

E-mail: contactcustomerservice@fchp.org

Write: 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 outlined below.

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.

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. FHLAC can extend this 180-day limit if you have a good reason. If you do, state the reason when you file your grievance.

If you file an appeal, be sure to give us all of the following information:
• The member’s name
• The FHLAC 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 Relations Department
10 Chestnut St.
Worcester, MA 01608

Call: 1-800-333-2535, extension 69950
(TDD/TTY: 1-877-608-7677)
Monday through Friday,
8:30 a.m. to 5:00 p.m.

E-mail: grievance@fchp.org

Fax: 1-508-755-7393

In person: Fallon Health & Life Assurance Company, Inc.
Member Relations 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.

In some cases, FHLAC will need medical records to complete our review of your appeal. If we do, we will 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, 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 be a health care professional who is actively practicing in the same or similar specialty that is the subject of your appeal.

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 grievance 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 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 grievance 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.

**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 45 days 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.

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:

Department of Public Health
Office of Patient Protection
250 Washington St., Second floor
Boston, MA 02108
For more information about this process, or to file an external review, please contact OPP at 1-800-436-7757 (www.state.ma.us/dph/opp).

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 FCHP
- 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.

filing a grievance
A grievance is the type of complaint you make if you have any other type of problem with FHLAC or one of our plan providers. 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 Relations 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 Relations Department
   10 Chestnut St.
   Worcester, MA 01608
Call: 1-800-333-2535, extension 69950
   (TDD/TTY: 1-877-608-7677)
   Monday through Friday,
   8:30 a.m. to 5:00 p.m.
E-mail: grievance@fchp.org
Fax: 1-508-755-7393
   Member Relations 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. FHLAC can extend this 180-day limit if you have a good reason. If you do, state the reason when you file your grievance.

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 Relations 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.

erisa
If you are a participant or a beneficiary of an employee welfare benefit plan under ERISA (Employee Retirement Income Security Act of 1974), you may have a right to bring a civil action under ERISA section 502(a) following an adverse benefit determination. Please see your Summary Plan Description provided by your employer for a complete statement of your rights.

references to closed plans
The following changes apply:

- In the glossary, delete the definition for FCHP Independent Care. This plan is no longer available.

- Throughout the book, change any reference to “FCHP Independent Care” to “consumer plan.”

- Throughout the book, change any reference to “guaranteed issue plan” or “individual guaranteed issue plan” to “consumer plan.”
• In conversion options, replace the entire changing to fchp independent care section with the following:

changing to a consumer plan
If your eligibility for health insurance coverage through your plan sponsor ends, you may be eligible to join a consumer plan. Contact FCHP at 1-888-PWR-FCHP to find out more about the options available to you. You may not convert to a consumer plan if your group coverage ended because of fraud on your part.

prosthetic devices
The following change applies:

• Under prosthetic/orthotic devices and durable medical equipment in benefits, delete the ninth bullet (“Electric and myoelectric artificial limbs”) under exclusion number 3.

insulin pumps and insulin pump supplies
Note: This part of the amendment is effective October 1, 2007.
The following changes apply:

• Under prosthetic/orthotic devices and durable medical equipment in benefits, add the following bullet to the list of covered durable medical equipment:
  • Insulin pumps and insulin pump supplies

• Under prosthetic/orthotic devices and durable medical equipment in benefits, replace the services with the following:

services
  1. Up to $1,500 in each calendar year for the purchase or rental of durable medical equipment and prosthetic/orthotic devices (including the
fitting, preparing, repairing and modifying of the appliance) other than those specified in services 5 and 6 below. Coverage of these devices is unlimited when provided as a medically necessary part of your home health care benefit.

2. Scalp hair prosthesis (wigs) for individuals who have suffered hair loss as a result of the treatment of any form of cancer or leukemia. Coverage is provided for up to $350 per member per calendar year when the prosthesis is determined to be medically necessary by a plan physician and the plan.

3. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy

4. Oxygen and related equipment

5. Prosthetic limbs which replace, in whole or in part, an arm or leg. These items are covered with 20% coinsurance.

6. Insulin pumps and insulin pump supplies. These items are covered in full.

- Under prosthetic/orthotic devices and durable medical equipment in benefits, add the following to the list under exclusion number 3:
  - Alcohol and alcohol wipes

- Under prescription medication in benefits, delete “Insulin pumps and insulin pump supplies” from the list of covered supplies for the treatment of diabetes.

replacement of lost medications
The following change applies to your Member Handbook as modified by Amendment 1:
• Under **prescription medication** in **benefits**, change exclusion number 14 to read:

  14. Replacement of more than one lost/mishandled medication per prescription per calendar year

**change to our general exclusions and limitations**

In **general exclusions and limitations**, the following change applies:

• Insert new exclusion number 110: “Home video EEG monitoring”
fallon health & life assurance company, inc.

AMENDMENT 1
This is part of your Fallon Health & Life Assurance Company Member Handbook
Form #07-670-366

This amendment changes certain sections of your Fallon Health & Life Assurance Company Member Handbook. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

The following changes apply to your Fallon Health & Life Assurance Company Member Handbook:

change in dependent eligibility
The following changes apply:

- Under *certify dependent status in how your coverage works*, replace the third paragraph with the following:

  The subscriber is responsible for notifying us of a dependent’s changes in status. We will send a recertification form at the beginning of each calendar year. If you return the form stating that the dependent is no longer a dependent based on IRS guidelines (or has not been within the last two years), dependent coverage will end. If the form is not returned by the date specified on the form, we will assume that the dependent is no longer eligible for
coverage and coverage will end effective April 1. In all of these cases, we will send a letter of termination of coverage to the subscriber. Please see the conversion options section of this Member Handbook for an explanation of your dependent continuation rights.

- Under ineligibility for you or a dependent in leaving fallon health & life assurance company, replace the fifth bullet with the following:

- Attainment of age 26 or two years following loss of dependent status under IRS guidelines, whichever comes first

prosthetic devices
The following changes apply:

- Under durable medical equipment and prosthetic/orthotics devices in the description of benefits, replace the services with the following:

services
1. Up to $1,500 in each calendar year for the purchase or rental of durable medical equipment and prosthetic/orthotic devices (including the fitting, preparing, repairing and modifying of the appliance) other than those mentioned in service 5 below. Coverage of these devices is unlimited when provided as a medically necessary part of your home health care benefit.

2. Scalp hair prosthesis (wigs) for individuals who have suffered hair loss as a result of the treatment of any form of cancer or leukemia. Coverage is provided for up to $350 per member per calendar year when the prosthesis is determined to be
medically necessary by a plan physician and the plan.

3. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy

4. Oxygen and related equipment

5. Prosthetic limbs which replace, in whole or in part, an arm or leg. These items are covered with 20% coinsurance.

• Under durable medical equipment and prosthetic/orthotics devices in the description of benefits, replace the first item in the list of related exclusions with the following:

1. Durable medical equipment or prosthetic/orthotic devices in excess of $1,500 per member per calendar year. This limit does not apply to prosthetic limbs which replace, in whole or in part, an arm or leg.

replacement of lost medications
The following change applies:

• Under prescription medication in the description of benefits, add the following to the list of related exclusions:

15. Replacement of more than one lost/misplaced medication per prescription per calendar year
combination drugs and medical foods
The following changes apply:

• Under *prescription medication* in the *description of benefits*, add the following to the list of *exclusions*:

  8. Prescription drugs that are a combination of a covered prescription item and an item that is specifically excluded, such as vitamins, minerals, medical foods or formulas

• Under *special formulas* in the *description of benefits*, change the first item in the list of *exclusions* to read:

  1. Nutritional supplements, medical foods and formulas unless described above as covered

• Under *general exclusions and limitations*, change exclusion number 3 to read:

  3. Services or supplies that are not medically necessary for the prevention, detection or treatment of an illness, injury or disease as determined by a FHLAC medical director. Some examples include (but are not limited to): plastic or cosmetic surgery, autopsies, routine circumcision performed after an infant’s discharge from a maternity admission, ear plugs to prevent fluid from entering the ear canal during water activities, charges for travel time and related expenses for you or a provider and nutritional supplements, medical foods or formulas for adults or children (unless described in *special formulas* as covered). Services or supplies that do not meet FHLAC’s medical criteria are not considered to be medically necessary.
changes to our general exclusions and limitations

In general exclusions and limitations, the following changes apply:

- Insert new exclusion number 107: “White noise machines”
- Insert new exclusion number 108: “Auditory integration therapy, such as Berard auditory integration therapy”
- Insert new exclusion number 109: “Total body photography”