Fallon Health & Life Assurance Co., Inc.

Schedule of Benefits

This Schedule of Benefits is part of your
The Group Insurance Commission Group Welfare Benefit Plan
Direct Care *Member Handbook*.
It describes your costs for health care.

This Schedule of Benefits shows your copayments and coinsurance for the covered services outlined in the Group Insurance Commission Group Welfare Benefit Plan Direct Care *Member Handbook*. It also outlines any of your benefits that differ from those shown in the *Member Handbook*. The information in this document replaces any information in your *Member Handbook* that conflicts with it. If you have any questions about your benefits, please call Customer Service at 1-866-344-4GIC (4442) (TRS 711).

This health plan **meets Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009 the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information, call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2020 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2020. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

The following apply to your *Member Handbook*:

Copayments

This plan includes three different tiers for office specialist visit copayments. The amount of your copayment you pay depends on the tiering level of the plan specialist you visit.

Tier 1: This tier includes plan specialists who meet excellent quality and/or cost efficiency standards. You will pay the lowest copayment when you see a Tier 1 specialist.

Tier 2: This tier includes plan specialists who meet good quality and/or cost efficiency standards. You will pay the mid-level copayment when you see a Tier 2 specialist.

Tier 3: This tier exclusively includes plan specialists contracted through an Academic Medical Center or specialty hospital that participate in the Peace of Mind program or provide tertiary services. You will pay a higher copayment when you see a Tier 3 specialist.

Note: Fallon Direct Care plan tier the following specialists: Allergy/Immunologists, Cardiologists, Dermatologists, Endocrinologists, ENTs/Otolaryngologists, Gastroenterologists, General Surgeons, Hematologists/Oncologists, Nephrologists, Neurologists, Ob/Gyns, Ophthalmologists, Orthopedists, Podiatrists, Pulmonologists, Rheumatologists and Urologists.

- You have a $15 copayment for office visits with your PCP.
- You have a $10 (Tier 1), $15 (Tier 2) or $25 (Tier 3) copayment for prenatal and postnatal visits.

- You have a $30 (Tier 1), $60 (Tier 2) or $75 (Tier 3) copayment for office visits with specialty physicians.

Not Tiered (NT): This designation includes plan providers that belong to a specialty or subspecialty that is not being tiered by Fallon. If you see an NT physician you will pay a Tier 2 copay.

This plan includes a limit to the copayments you pay for inpatient admission copayments and outpatient surgery copayments. You are responsible for a maximum of one inpatient admission copayment per calendar quarter. You are responsible for a maximum of four outpatient surgery copayments per calendar year.

This plan includes a deductible. Your deductible is $400 per member/ $800 per family per benefit period for certain services, (If you are in a two person family contract your deductible is $800). Once you have met your deductible, you may still be responsible for a copayment when you receive certain services. After you receive services, we will send you a letter indicating the amount that has been applied to your deductible.

This plan includes an out-of-pocket maximum. There is a limit to your out-of-pocket costs each benefit period. This is called your out-of-pocket maximum. The out-of-pocket maximum includes your deductible, coinsurance and copayments you pay. It does not include your plan premium. Deductibles and copayments you pay for prescription drugs during the year count toward this limit. Once you reach the limit, your prescription drugs are covered at 100%. Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out of-pocket limit. **Your out-of-pocket maximum is $5,000 per member or $10,000 per family.** Each member must meet the per-member out-of-pocket maximum, unless the family out-of-pocket maximum applies. The family out-of-pocket maximum is considered met when any combination of members in a family reaches the family out-of-pocket maximum. Please note that once any one member in a family accumulates **$5,000** in out-of-pocket costs, that family member's out-of-pocket maximum is considered met, and that family member will have no additional out-of-pocket costs for the remainder of the benefit period.

Prescription medication deductible

Before the plan will begin to provide coverage for prescription medications, you must first meet a benefit period deductible. This deductible only applies to covered prescription medications, including prescription medications you obtain from the plan's mail order service. **Your benefit period deductible is $100 per member/$200 per family per benefit period**. Each member must meet the per-member deductible unless the family deductible applies. The family deductible is considered met when any combination of members in a family reaches the family deductible amount. No individual family member will pay more than the per-member deductible in a benefit period. **After you have met your deductible, you will still be responsible for the corresponding cost-sharing for each covered prescription.**

Please note: You do not have coverage for prescription medication through Fallon Health. Express Scripts is the pharmacy benefit manager for your prescription drug benefit plan. If you have any questions about your prescription drug benefits, contact Express Scripts Member Services toll free number at 855-283-7679.

Services that require plan prior authorization

The following covered services require prior authorization from the plan. Prior authorization must be requested by your PCP, or in some cases, your specialist.

- Non-emergency admissions to a hospital or other inpatient facility
- Some same-day surgery (outpatient) and ambulatory procedures
- Services with a non-plan provider
- Organ transplant evaluation and services
- Reconstructive and restorative services
- Infertility/assisted reproductive technology services

- Oral surgery (with the exception of the extraction of impacted teeth)
- Genetic testing
- Neuropsychological testing
- Prosthetics/orthotics and durable medical equipment
- Non-emergency ambulance
- High tech radiology, including, but not limited to, all outpatient MRI/MRA, CT/CTA, PET and nuclear cardiology imaging studies
- Sleep study and/or sleep therapy
- Oxygen
- Speech therapy
- Habilitative or rehabilitative care, including but not limited to applied behavioral analysis therapy, for the treatment of autism
- Therapeutic care for the treatment of autism
- Certain drugs covered under medical benefits, and that are ordered, supplied and administered by a plan provider
- Enteral formulas and special medical formulas
- Intensity modulated radiation therapy (IMRT) of the breast
- Proton beam therapy
- Stereotactic radiosurgery and stereotactic body radiotherapy
- Treatment of cleft lip and cleft palate
- Bariatric Weight Loss Surgery
- Gender-affirmation surgeryand related health care services
- Home health care

Diagnostic imaging services
You have a $100 copayment for MRIs, CT scans and PET scans, then subject to your deductible. This is limited to one copayment per day for these services.

It Fits! ™ benefit
Your contract includes additional coverage for services provided under the It Fits! ™ program to a maximum of $200 per member/$400 per family.

Healthy Health Plan program
Your contract includes coverage for services provided under the Healthy Health Plan program. See your *Member Handbook* for details.

SmartShopper program
Your contract includes coverage for services provided under the SmartShopper program. Please go to the Fallon Health website at www.fallonhealth.org and visit the member portal for details.

Covered services
The following chart shows your costs for covered services. These costs apply to the services in the Description of benefits section of the Group Insurance Commission Group Welfare Benefit Plan *Member Handbook*. In summary, your responsibilities are as follows:

Covered services	Benefits
Ambulance services	
1. Ambulance transportation for an emergency	Covered in full after you meet your deductible
2. Ambulance transportation for preauthorized non-emergency transfers	Covered in full after you meet your deductible
Autism services *Prior authorization required*	
1. Habilitative and rehabilitative care	$15 copayment per visit
2. Applied behavior analysis when supervised by a board certified behavioral analyst	Covered in full
3. Therapeutic care, services including speech, physical and occupational therapy.	$15 copayment per visit
Durable medical equipment and prosthetic/orthotic devices *Referral and prior authorization required for most services*	
1. The purchase or rental of durable medical equipment and prosthetic/orthotic devices (including the fitting, preparing, repairing and modifying of the appliance).	20% coinsurance after you meet your deductible
2. Hearing aid(s)	
• Age 22 and older: benefit available once every 24 months	The first $500 of the purchase price is covered in full; you pay 20% of the next $1,500 of the purchase price plus all additional costs. Up to a total benefit limit of $1,700 every 24 months.
• Age 21 and under: Up to $2,000 per ear for hearing aid device only, benefit available once every 24 months • Related services and supplies for hearing aids (not subject to the $2,000 limit)	20% coinsurance after you meet your deductible
3. 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 one scalp hair prosthetic (wig) per member per benefit period when the prosthesis is determined to be medically necessary by a plan physician and the plan.	20% coinsurance
4. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy	Covered in full after you meet your deductible
5. Oxygen and related equipment	20% coinsurance after you meet your deductible
6. Insulin pump and insulin pump supplies	Covered in full
7. Breast pumps	Covered in full
8. Portable oxygen concentrator	20% coinsurance after you meet your deductible

Covered services	Benefits
Emergency and urgent care	
1. Emergency room visits	$100 copayment per visit then subject to your deductible
2. Emergency room visits when you are admitted to an observation room	Covered in full after you meet your deductible
3. Urgent care visits in a doctor's office or at an urgent care facility	$15 copayment per visit
4. Emergency prescription medication provided out of the Direct Care service area as part of an approved emergency treatment	Participating Retail Pharmacy: Tier 1: $10 copayment Tier 2: $30 copayment Tier 3: $65 copayment after the prescription deductible is met for up to a 14-day supply
5. Telemedicine visits with physicians through Teladoc. Visits are performed by phone, video, or mobile app	$15 copayment per visit
Enteral formulas and low protein foods *Referral and prior authorization required for enteral formulas*	
1. Enteral formulas, upon a physician's written order, for home use in the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids	Covered in full after you meet your deductible
2. Food products that have been modified to be low in protein for individuals with inherited diseases of amino acids and organic acids. You may be required to purchase these products over the counter and submit claims to the plan for reimbursement.	Covered in full after you meet your deductible
Home health care services *Prior authorization required*	
1. Part-time or intermittent skilled nursing care and physical therapy provided in your home by a home health agency	Covered in full after you meet your deductible
2. Additional services and supplies that are determined to be a medically necessary component of skilled nursing care and physical therapy	Covered in full after you meet your deductible
3. Home dialysis services and non-durable medical supplies	Covered in full after you meet your deductible
Hospice care services *Referral required*	Covered in full
Hospital inpatient services *Referral and prior authorization required*	
1. 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	$275 copayment per admission then subject to your deductible (*you are responsible for up to one copayment per member per calendar quarter*)

Covered services	Benefits
Infertility/assisted reproductive technology (art) services* *Referral and prior authorization required (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP)*	
1. Office visits for the consultation, evaluation and diagnosis of fertility	$15 copayment per visit with your PCP and certain other providers Specialist: Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit
2. Diagnostic laboratory services	Covered in full after you meet your deductible
3. Diagnostic X-ray services	Covered in full after you meet your deductible
4. Artificial insemination, such as intrauterine insemination (IUI)	Covered in full after you meet your deductible
5. Assisted reproductive technologies* except for those services listed below	Covered in full after you meet your deductible
6. Assisted reproductive technologies for: • In vitro fertilization (IVF-ET) • Gamete intrafallopian transfer (GIFT) • Zygote intrafallopian transfer (ZIFT)	$250 copayment per procedure then subject to your deductible
7. Sperm, egg, and/or inseminated egg procurement, assisted hatching, cryopreservation, processing and banking for plan members in active infertility treatment to the extent that such costs are not covered by the donor's insurer	Covered in full after you meet your deductible
* See the **Description of benefits** section of your *Member Handbook* for a list of covered infertility/ART services.	
Maternity services	
1. Obstetrical services including prenatal, childbirth, postnatal and postpartum care	Prenatal (first visit only): Tier 1: $10 copayment Tier 2: $15 copayment Tier 3: $25 copayment Postnatal (per visit): Tier 1: $10 copayment Tier 2: $15 copayment Tier 3: $25 copayment
2. Inpatient maternity and newborn child care for a minimum of 48 hours of care following a vaginal delivery, or 96 hours of care following a Caesarean section delivery, including charges for the following services when provided during an inpatient maternity admission: childbirth, nursery charges, circumcision, routine examination, hearing screening and medically necessary treatments of congenital defects, birth abnormalities or premature birth.	$275 copayment per admission then subject to your deductible *(you are responsible for up to one copayment per member per calendar quarter)*
(Fallon Health members are eligible for childbirth classes (refresher class or siblings class))	Covered in full through member reimbursement

Covered services	Benefits
Mental health and substance use services Note: Effective for plan years beginning on or after October 1, 2015, Massachusetts state law (Chapter 258 of the Acts of 2014) restricts the circumstances in which insurers may require prior authorization for substance use services. We will not require prior authorization for substance use services in any circumstances where this is not allowed by Chapter 258. Please see the Fallon Handbook or call Fallon for more information.	
Inpatient services *Prior authorization required for the services below, except:* • *The first 14 days of acute treatment services or clinical stabilization services for substance use or addiction; the admitting facility must notify Fallon of admission.* • *Substance use services where the services are provided by a Massachusetts Department of Public Health licensed provider.* *Please contact Fallon with any questions about prior authorization requirements.*	
1. Inpatient hospital care for as many days as your condition 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.	Covered in full
2. Professional services provided by physicians or other health care professionals for the treatment of mental conditions while you are an inpatient.	Covered in full
Intermediate services *Prior authorization required for the services below, except:* • *The first 14 days of acute treatment services or clinical stabilization services for substance use or addiction; the admitting facility must notify Fallon of admission.* • *Substance use services where the services are provided by a Massachusetts Department of Public Health licensed provider.* *Please contact Fallon with any questions about prior authorization requirements.* *Intermediate services include but are not limited to:*	
1. Acute and other residential treatment-Mental health services provided in a 24-hour setting therapeutic environments.	Covered in full
2. Clinically managed detoxification services-24 hour, 7 days a week, clinically managed de-tox services in a licensed non-hospital setting that include 24 hour per day supervision	Covered in full
3. Partial Hospitalization-Short-term day/evening mental health programming available 5 to 7 days per week.	$15 copayment per visit
4. Intensive outpatient programs-Multimodal, inter-disciplinary, structured behavioral health treatment provided 2-3 hours per day, multiple days per week.	$15 copayment per visit
5. Day treatment-program encompasses some portion of the day or week rather than a weekly visit	$15 copayment per visit
6. Crisis Stabilization-Short-term psychiatric treatment in a structured, community based therapeutic environments.	$15 copayment per visit
7. In-home therapy services	$15 copayment per visit

Covered services	Benefits
Mental health and substance use services, continued	
Outpatient services	
1. Outpatient office visits, including individual, group or family therapy.	$15 copayment per visit
2. Psychopharmacological services, such as visits with a physician to review, monitor and adjust the levels of prescription medication to treat a mental condition	$15 copayment per visit
3. Neuropsychological assessment services when medically necessary	$15 copayment per visit
Office visits and outpatient services	
1. Office visits, to diagnose or treat an illness or an injury	$15 copayment per visit with your PCP and certain other providers
• Telehealth visits done via a secure, real time Telemedicine platform which is inclusive of both an audio and visual component.	Specialist: Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit
2. A second opinion, upon your request, with another plan provider	$15 copayment per visit with your PCP and certain other providers Specialist: Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit
3. Certain drugs covered under medical benefits, and that are ordered, supplied and administered by a plan provider	Covered in full after you meet your deductible
4. Allergy injections	Covered in full
5. Radiation therapy and Chemotherapy	Covered in full after you meet your deductible
6. Respiratory therapy	Covered in full after you meet your deductible
7. Hormone replacement services in the doctor's office for perimenopausal or postmenopausal women	$15 copayment per visit Specialist: Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit
8. Audiological examination for the purpose of prescribing a hearing aid. Coverage is limited to one exam every two years.	$15 copayment per visit
9. Diagnostic lab services ordered by a plan provider, in relation to a covered office visit	Covered in full after you meet your deductible
10. Diagnostic X-ray services ordered by a plan provider, in relation to a covered office visit	Covered in full after you meet your deductible
11. Other diagnostic services including but not limited to, endoscopy, colonoscopy and ultrasound	Covered in full after you meet your deductible
12. High-tech imaging services, including but not limited to, MRI/MRA, CT/CTA, PET scans and nuclear cardiology imaging. Limited to one copayment per day when performed at the same facility for the same diagnosis. (Prior authorization required.)	$100 copayment per MRI, CT, PET scan or nuclear cardiology image then subject to your deductible

Covered services	Benefits
Office visits and outpatient services, continued	
13. Electrocardiogram (EKG)	Covered in full
14. Chiropractic services for acute musculoskeletal conditions. The condition must be new or an acute exacerbation of a previous condition. Coverage is provided for up to 12 office visits in each benefit period. The actual number of visits provided is based on medical necessity as determined by your plan provider and the plan.	$15 copayment per visit
• Outpatient lab tests and x-rays	See Diagnostic lab, x-ray and high-tech imaging services
15. Outpatient renal dialysis at a plan-designated center or continuous ambulatory peritoneal dialysis	Covered in full after you meet your deductible
16. Diabetes outpatient self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider	$15 copayment per visit
17. Laboratory tests necessary for the diagnosis or treatment of diabetes, including glycosylated hemoglobin, or HbAlc, tests, and urinary/protein/ microalbumin and lipid profiles	Covered in full after you meet your deductible
18. Medical social services provided to assist you in adjustment to your or your family member's illness. This includes assessment, counseling, consultation and assistance in accessing community resources.	$15 copayment per visit
19. Consultations, examinations, procedures and medical services related to: • genetic counseling; • elective sterilization • termination of pregnancy (abortion) in an office setting (Note: Termination of pregnancy or other procedures provided in a hospital outpatient, day surgery or ambulatory care facility are subject to the outpatient surgery copayment.)	$15 copayment per visit
20. Outpatient surgery, anesthesia and the medically necessary preoperative and postoperative care related to the surgery, except Eye and Gastrointestinal procedures.	$250 copayment per surgery then subject to your deductible when provided in a hospital outpatient, day surgery or ambulatory care facility (*you are responsible for up to four copayments per member per calendar year)*
Eye and Gastrointestinal procedures in a Non-Hospital Setting	$150 copayment then subject to deductible
Eye and Gastrointestinal procedures in a Hospital Setting	$250 copayment then subject to deductible
21. Visit to a contracted urgent care clinic. Services are provided for a variety of common illnesses, including, but not limited to: • strep throat • ear, eyes, sinus, bladder and bronchial infections • minor skin conditions (e.g. sunburn, cold sores)	$15 copayment per visit

Covered services	Benefits
Office visits and outpatient services, continued	
22. Podiatry care	
• Outpatient lab tests and x-rays	See Diagnostic lab, x-ray and imaging services
• Outpatient surgical services	See Outpatient surgery
• Outpatient medical care	See Office visits
Oral surgery and related services *Referral and prior authorization required (except for extraction of impacted teeth or lingual frenectomy)*	
1. Removal or exposure of impacted teeth, including both hard and soft tissue impactions, or an evaluation for this procedure	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit
2. Surgical treatments of cysts, affecting the teeth or gums, that must be rendered by a plan oral surgeon	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit
3. Treatment of fractures of the jaw bone (mandible) or any facial bone	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit
4. Evaluation and surgery for the treatment of temporomandibular joint disorder when a medical condition is diagnosed, or for surgery related to the jaw or any structure connected to the jaw	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit
5. Extraction of teeth in preparation for radiation treatment of the head or neck	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit
6. Surgical treatment related to cancer	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit
7. Emergency medical care, such as, to relieve pain and stop bleeding as a result of accidental injury to sound natural teeth or tissues, when provided as soon as medically possible after the injury. This does not include restorative or other dental services. No referral or authorization is required. Go to the closest provider. Note: Benefits are provided for the dental services listed below only when the Member has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease.	$15 copayment per visit to a physician's or dentist's office $100 copayment per visit to an emergency room then subject to your deductible
8. Removal of 7 or more permanent teeth	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit
9. Gingivectomies (including osseous surgery) of two or more gum quadrants	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit

Covered services	Benefits
Oral surgery and related services, continued	
10. Excision of radical cysts, affecting the roots of 3 or more teeth or gums, that must be rendered by a plan oral surgeon	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit
11. Removal of one or more impacted teeth	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit
See **Office visits and outpatient services** for diagnostic lab and X-ray services.	
Organ transplants *Referral and prior authorization required*	
1. Office visits related to the transplant	$15 copayment per visit with your PCP and certain other providers Specialist: Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $75 copayment per visit
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	$275 copayment per admission then subject to your deductible (*you are responsible for up to one copayment per member per calendar quarter)*
3. Human leukocyte antigen (HLA) or histocompatability locus antigen testing for A, B or DR antigens, or any combination thereof, necessary to establish bone marrow transplant donor suitability of a member	Covered in full after you meet your deductible
Limited to one inpatient copayment per calendar quarter. If you are re-admitted within a 30-day period in the same calendar year, we will waive the second copayment.	

Covered services	Benefits
Prescription drugs	
Tier 1 – Generic Drugs Tier 2 – Preferred Brand-Name Drugs Tier 3 – Non-Preferred Drugs	Participating Retail Pharmacy: Tier 1: $10 copayment Tier 2: $30 copayment Tier 3: $65 copayment after you meet your prescription deductible for up to a 30-day supply Mail Order or CVS Pharmacy: Tier 1: $25 copayment Tier 2: $75 copayment Tier 3: $165 copayment after you meet your prescription deductible for up to a 90-day supply
ADHD Medications – may be filled through mail order or any network pharmacy*	Tier 1: $20 copayment Tier 2: $60 copayment Tier 3: $130 copayment after you meet your prescription deductible per 60-day supply *Limited to a 60-day supply per state statutes
Other • Orally-administered anti-cancer drugs • Generic drugs to treat opioid use disorder (generic buprenorphine-naloxone, naloxone, and naltrexone products) • Preventive drugs: Refer to the “Preventive Drugs” section of your *Member Handbook*	Covered in full
Specialty drugs – must be filled only through Accredo, a specialty pharmacy	Tier 1: $10 copayment Tier 2: $30 copayment Tier 3: $65 copayment after you meet your prescription deductible for up to a 30-day supply
Orally-administered anti-cancer specialty drugs	Covered in full for up to a 30-day supply
Please note: *Specialty medications may be dispensed up to a 30-day supply; some exceptions may apply.*	

Covered services	Benefits
Preventive care	
1. Routine physical exams for the prevention and detection of disease	Covered in full
2. Immunizations that are included on the formulary, that are for covered medical benefits and that are ordered, supplied and administered by a plan physician. If administered by a plan specialist, you will generally need to obtain a referral to see the specialist.	Covered in full
3. A baseline mammogram for women age 35 to 40, and a yearly mammogram for women age 40 and older	Covered in full
4. Routine gynecological care services, including an annual Pap smear (cytological screening) and pelvic exam	Covered in full
5. Routine eye exams, once in each 24-month period	$15 copayment per visit
6. Hearing and vision screening	Covered in full
7. Well-child care and pediatric services, at least six times during the child's first year after birth, at least three times during the next year, then at least annually until the child's sixth birthday. This includes the following services, as recommended by the physician and in accordance with state law: • physical examination • history • measurements • sensory screening • neuropsychiatric evaluation • development screening and assessment	Covered in full
8. Pediatric services including: • appropriate immunizations • hereditary and metabolic screening at birth • newborn hearing screening test performed before the newborn infant is discharged from the hospital or birthing center • tuberculin tests, hematocrit, hemoglobin, and other appropriate blood tests and urinalysis • lead screening	Covered in full
9. Female consultations, examinations, procedures, contraceptive devices, and medical services related to the use of all contraceptive methods*	Covered in full
10. Tobacco counseling sessions with your primary physician or other provider designed to create a plan to stop smoking.	Covered in full
* See your *Member Handbook* for benefit details regarding prescription contraceptive devices.	

Covered services	Benefits
Reconstructive surgery *Referral and prior authorization required (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP)*	
1. 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, including Massachusetts mandated services for cleft lip and cleft palate	$275 copayment per admission then subject to your deductible (*you are responsible for up to one copayment per member per calendar quarter)*
Rehabilitation and habilitation services *Referral required*	
1. Physical therapy to restore function after medical illness, accident or injury. Coverage is provided for as many visits as are medically necessary per acute episode within a 90-day period per injury or illness, beginning with the first office visit. Visits after 90 days require prior authorization.	$15 copayment per visit
2. Occupational therapy to restore function after medical illness, accident or injury. Coverage is provided for as many visits as are medically necessary per acute episode within a 90-day period per injury or illness, beginning with the first office visit. Visits after 90 days require prior authorization.	$15 copayment per visit
3. Medically necessary services for the diagnosis and treatment of speech, hearing and language disorders when services are provided by a plan provider who is a speech-language pathologist or audiologist; and at a plan facility or plan provider's office with a PCP referral. After 30 speech therapy visits, prior authorization based on medical necessity is required for additional visits.	$15 copayment per visit
4. Cardiac rehabilitation services to treat cardiovascular disease in accordance with state law and Department of Public Health regulations	Covered in full after you meet your deductible
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. Early intervention services include applied behavior analysis (ABA) therapy. See the **Autism services** section of your Evidence of Coverage for details. Benefits are only available to members who are residents of Massachusetts or whose principal place of employment is in Massachusetts. Services require prior authorization.	Covered in full
6. Pulmonary rehabilitation services for chronic obstructive pulmonary disease (COPD) are covered for up to two one-hour sessions per day, for up to 36 lifetime sessions.	Covered in full after you meet your deductible
Skilled nursing facility services *Referral and prior authorization required*	
1. Inpatient hospital services, for up to 100 days per benefit period provided criteria is met, 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	Covered in full after you meet your deductible

Notice of nondiscrimination

Fallon Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Fallon does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Fallon Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Customer Service at the phone number on the back of your member ID card, or by email at cs@fallonhealth.org.

If you believe that Fallon Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Compliance Director
Fallon Health
10 Chestnut St.
Worcester, MA 01608

Phone: 1-508-368-9988 (TRS 711)
Email: compliance@fallonhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Compliance Director is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, D.C., 20201

Phone: 1-800-368-1019 (TDD: 1-800-537-7697)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Important!

If you, or someone you're helping, has questions about Fallon Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-868-5200.

Spanish:
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Fallon Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-868-5200.

Portuguese:
Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Fallon Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-868-5200.

Chinese:
如果您，或是您正在協助的對象，有關於[插入項目的名稱 Fallon Health
方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字1-800-868-5200.

Haitian Creole:
Si oumenm oswa yon moun w ap ede gen kesyon konsènan Fallon Health, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-868-5200.

Vietnamese:
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Fallon Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-868-5200.

Russian:
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Fallon Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-868-5200.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Fallon Health، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب 1-800-868-5200 .

Khmer/Cambodian:
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងដែជួយ ម្នាសំណួរអ្ំពី Fallon Health បេ, អ្នកម្នាសិេធិេេួលជំនួយនិងព័ែ៌ម្នាន ជៅកនុងភាសា ររស់អ្នក ជោយមិនអ្ស់ប្ាក់ ។ បែេើមបីនិយាយជាមួយអ្នករកដប្រ សូម 1-800-868-5200។

French:
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Fallon Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-868-5200.

Italian:
Se tu o qualcuno che stai aiutando avete domande su Fallon Health, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-868-5200.

Korean:
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Fallon Health에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-800-868-5200로 전화하십시오.

Greek:
Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Fallon Health, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-800-868-5200.

Polish:
Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Fallon Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-868-5200.

Hindi:
यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Fallon Health [के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी ि ुभाषषए से बात करने के लिए , 1-800-868-5200 पर कॉि करें।

Gujarati:
જો તમે અથવા તમે કોઇને મદદ કરી રહ્ાાાં તેમ ાાંથી કોઇને Fallon Health વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળવિ નો અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ મ ાાં પ્র મ કરી શક ર્ છે. દ ભ વષર્ો િ ત કરિ મ ટે,આ 1-800-868-5200 પર કોલ કરો.

Laotian:
ົ້າທ່ານ, ຫ ຼືຄົນ ່ທ່ານກໍາລັງຊ່ວຍ ຼືອ, ມ ຄໍາຖາມກ່ຽວກັບ Fallon Health, ທ່ານມ ສິດ ່ຈະໄດ້ຮັບການຊ່ວຍ ຼືອແລະຂໍ້ມູນຂ່າວສານ ່ເປັນພາສາຂອງທ່ານບໍ່ມ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-800-868-5200.

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