Fallon Preferred Care
Schedule of Benefits

This Schedule of Benefits is part of your Fallon Preferred Care *Member Handbook/Evidence of Coverage*. It describes your costs for health care. There are no waiting periods or pre-existing condition limitations under this plan. The services listed below are covered when we determine that they are medically necessary for you. If it is determined that services or supplies received were not medically necessary, no benefits will be paid by FHLAC, and you will be responsible for paying the provider for the services or supplies you received. The plan has medical management procedures that you must follow. Some services require notification. All inpatient services as well as some outpatient services require pre-authorization. You should call the appropriate medical management office at least five business days before the service to pre-certify. For more information on prior authorization, refer to the Medical Management section in your *Member Handbook/Evidence of Coverage*. If you do not follow notification and pre-authorization procedures for designated services, your claim may be denied, or you may be responsible for $500 of additional charges, which are in addition to any deductible or coinsurance amounts you must pay and are not counted toward your out-of-pocket maximum. See the Medical Management section in your *Member Handbook/Evidence of Coverage* for information about when claims may be denied and when additional charges may apply.

You will receive the in-network level of benefits when you get your care from a participating provider. You will receive the out-of-network level of benefits when you get your care from a non-participating provider, with the exception of care for an emergency medical condition. Whenever you have an emergency medical condition you should go to the nearest emergency room or call the local emergency medical system (police, fire or 911). Coverage for emergency care will be provided in the same manner and at the same level as if a participating provider had treated you.

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 Web site (www.mahealthconnector.org).

This health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2021 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, 2021. 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 1-617-521-7794 or visiting its Web site at www.mass.gov/doi.

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

Domestic partner coverage
You may include a domestic partner and his/her dependents under your family coverage. A domestic partner is defined as a partner of the same or opposite sex whom you have registered with your employer for eligibility for benefits, and have included under your family coverage for health insurance.

Deductible
There are separate deductible amounts for in-network and out-of-network services. These deductible amounts do not cross accumulate, therefore each deductible amount must be met before you will no longer be responsible for any additional cost-sharing amounts.

Out-of-pocket maximum

There are separate out-of-pocket maximum amounts for in-network and out-of-network services. These out-of-pocket amounts do not cross accumulate, therefore each out-of-pocket maximum amount must be met before you will no longer be responsible for any additional cost-sharing amounts.

It Fits! ™ benefit

Your contract includes coverage for services provided under the It Fits! ™ program to a maximum of $150.

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

Some covered services have a benefit maximum. The benefit maximum includes services you receive from participating providers combined with any services you receive from non-participating providers. We recommend that you do not rely solely on this Schedule of Benefits for information about the plan. Be sure to read all parts of the *Member Handbook/Evidence of Coverage*.

Benefit features	In-network level of benefits (participating providers)	Out-of-network level of benefits (non-participating providers)
Deductible per benefit period, per member/per family	$2,000 per member or $4,000 per family per benefit period	$4,000 per member or $8,000 per family per benefit period
Deductible carryover	YES	YES
Coinsurance amount	N/A	20%
Out-of-pocket maximum per benefit period (includes deductible, copayments and coinsurance), per member/per family	$8,550 per member or $17,100 per family per benefit period	$8,550 per member or $17,100 per family per benefit period
Medical management procedures	YES	YES
Amounts that you may be responsible for if you do not follow medical management procedures (These amounts do not count toward your deductible or out-of-pocket maximum.)	$200 per occurrence Exception: No coverage for nonemergency ambulance transport when not precertified	$500 per occurrence Exception: No coverage for nonemergency ambulance transport when not precertified
Lifetime maximum benefits	Unlimited	Unlimited

Covered services	In-network level of benefits (participating providers)	Out-of-network level of benefits (non-participating providers)
Ambulance services		
1. Emergency ambulance transport	Covered in full after you meet your deductible	Covered in full after you meet your deductible
2. Non-emergency ambulance transport (prior authorization required)	Covered in full after you meet your deductible	20% coinsurance after you meet your deductible
Autism services *Prior authorization required*		
1. Habilitative and rehabilitative care	$40 copayment per visit	20% coinsurance after you meet your deductible
2. Applied behavior analysis when supervised by a board certified behavioral analyst	Covered in full	20% coinsurance after you meet your deductible
3. Therapeutic care services including speech, physical and occupational therapy	$40 copayment per visit	20% coinsurance after you meet your deductible
Emergency and urgent care		
1. Emergency room visits *(if you are admitted following an emergency room visit you must notify the appropriate medical management offices soon as possible but not later than 72 hours following your admission – see the* ***Medical Management*** *section of your Member Handbook/Evidence of Coverage for details).*	$1,000 copayment per visit after you meet your deductible Note: The emergency room copayment is waived if you are admitted.	$1,000 copayment per visit after you meet your deductible Note: The emergency room copayment is waived if you are admitted.
2. Urgent care in a doctor's office or urgent care facility	$40 copayment per visit	20% coinsurance after you meet your deductible
3. Telemedicine visits with physicians through Teladoc. Visits are performed by phone, video, or mobile app.	$5 copayment per visit	Not covered
Enteral formulas and low protein foods		
1. Nonprescription enteral formulas for home use for which a physician has issued a written order for the treatment of malabsorption and inherited diseases of amino acids and organic acids. (Prior authorization required.)	Covered in full after you meet your deductible	20% coinsurance after you meet your deductible
2. Food products modified to be low in protein for individuals with inherited diseases of amino acids and organic acids. (In-network and out-of-network benefit is combined.)	Covered in full after you meet your deductible	20% coinsurance 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	20% coinsurance 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	20% coinsurance after you meet your deductible

Covered services	In-network level of benefits (participating providers)	Out-of-network level of benefits (non-participating providers)
Home health care services, continued		
3. Home dialysis services and non-durable medical supplies	Covered in full after you meet your deductible	20% coinsurance after you meet your deductible
Hospice care services *Prior authorization required*	Covered in full after you meet your deductible	20% coinsurance after you meet your deductible
Hospital inpatient services *Prior authorization required* 1. Inpatient care for as many days as is medically necessary, including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient.	$1,000 copayment per admission after you meet your deductible	20% coinsurance after you meet your deductible
Infertility/assisted reproductive technology (art) services* *Prior authorization required* 1. Office visits for the diagnosis and treatment of infertility	$40 copayment per visit with a PCP and certain other providers $65 copayment per visit with a specialist	20% coinsurance after you meet your deductible
2. Outpatient procedures related to the diagnosis and treatment of infertility	Covered in full after you meet your deductible	20% coinsurance after you meet your deductible
3. Lab procedures to diagnose and treat infertility	$50 copayment	20% coinsurance after you meet your deductible
4. Radiology procedures to diagnose and treat infertility	$125 copayment after you meet your deductible	20% coinsurance after you meet your deductible
5. Infertility/ART procedures except for those services listed below	Covered in full after you meet your deductible	20% coinsurance after you meet your deductible
6. Infertility/ART procedures for: • In vitro fertilization (IVF-ET) • Gamete intrafallopian transfer (GIFT) • Zygote intrafallopian transfer (ZIFT)	$250 copayment per procedure after you meet your deductible	20% coinsurance after you meet 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	20% coinsurance after you meet your deductible
* See the **Description of Benefits** section in your *Member Handbook/Evidence of Coverage* for a complete list of covered infertility/ART services		

Covered services	In-network level of benefits (participating providers)	Out-of-network level of benefits (non-participating providers)
Maternity services You must notify the appropriate medical management office (*see the **Medical Management** section of your Member Handbook/Evidence of Coverage for details*): • *When your routine childbirth admission continues beyond 48 hours for a vaginal delivery or 96 hours for a Caesarean delivery* • *When you determine by way of a positive pregnancy test that you are pregnant.*		
1. Prenatal and postpartum care	Prenatal care: $40 copayment (first visit only) Postpartum care: $40 copayment per visit	20% coinsurance after you meet your deductible
2. Childbirth and inpatient hospital charges, including routine nursery charges	$1,000 copayment per admission after you meet your deductible	20% coinsurance after you meet your deductible
(Fallon members are eligible for childbirth classes (refresher class or siblings class))	Covered in full through member reimbursement	Covered in full through member reimbursement

Covered services	In-network level of benefits (participating providers)	Out-of-network level of benefits (non-participating providers)
Mental health and substance use services		
Inpatient services *Prior authorization required*		
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. **Note:** Prior authorization will not be required for behavioral health inpatient admission immediately following an emergency room visit.	$1,000 copayment per admission after you meet your deductible	20% coinsurance after you meet your deductible
Intermediate services *Prior authorization required* *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.	$1,000 copayment per admission after you meet your deductible	20% coinsurance after you meet your deductible
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.	$1,000 copayment per admission after you meet your deductible	20% coinsurance after you meet your deductible
3. Partial Hospitalization: Short-term day/evening mental health programming available 5 to 7 days per week.	$40 copayment per visit	20% coinsurance after you meet your deductible
4. Intensive outpatient programs: Multimodal, interdisciplinary, structured behavioral health treatment provided 2-3 hours per day, multiple days per week.	$40 copayment per visit	20% coinsurance after you meet your deductible
5. Day treatment: Program encompasses some portion of the day or week rather than a weekly visit.	$40 copayment per visit	20% coinsurance after you meet your deductible
6. Crisis Stabilization: Short-term psychiatric treatment in a structured, community based therapeutic environments.	$40 copayment per visit	20% coinsurance after you meet your deductible
7. In-home therapy services.	$40 copayment per visit	20% coinsurance after you meet your deductible
Intermediate services for children and adolescents under the age of 19		
1. Community-based acute treatment	Covered in full	20% coinsurance after you meet your deductible
2. Intensive community-based treatment	Covered in full	20% coinsurance after you meet your deductible

Covered services	In-network level of benefits (participating providers)	Out-of-network level of benefits (non-participating providers)
Mental health and substance use services, continued		
3. Intensive Care Coordination	Covered in full	20% coinsurance after you meet your deductible
4. Family Stabilization Team (also referred to as In-Home Therapy)	Covered in full	20% coinsurance after you meet your deductible
5. In-home Behavioral Services	Covered in full	20% coinsurance after you meet your deductible
6. Mobile Crisis Intervention (services available up to seven days). Prior authorization not required.	Covered in full	20% coinsurance after you meet your deductible
7. Family support and training	Covered in full	20% coinsurance after you meet your deductible
8. Therapeutic mentoring services	Covered in full	20% coinsurance after you meet your deductible
Outpatient services		
1. Outpatient services, including individual, family or group therapy.*	$40 copayment per visit	20% coinsurance after you meet your deductible
2. Psychopharmacological services, such as, visits with a physician to review, monitor and adjust the levels of prescription medication used to treat a mental disorder. Prior authorization required.	$40 copayment per visit	20% coinsurance after you meet your deductible
3. Neuropsychological assessment services, when medically necessary. Prior authorization required.	$40 copayment per visit	20% coinsurance after you meet your deductible
* Please see the **Description of Benefits** section in your *Member Handbook/Evidence of Coverage* for a list of non-covered 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.		

Covered services	In-network level of benefits (participating providers)	Out-of-network level of benefits (non-participating providers)
Office visits and outpatient services		
1. Office visits and related services, including: • Office visits to diagnose or treat an illness or injury • Telehealth visits done via a secure, real time Telemedicine platform which is inclusive of both an audio and visual component. • A second opinion • Pediatric specialty care • Respiratory therapy services • Hormone replacement therapy services for peri and post menopausal women	$40 copayment per visit with a PCP and certain other providers $65 copayment per visit with a specialist	20% coinsurance after you meet your deductible
2. Radiation therapy and Chemotherapy	Covered in full after you meet your deductible	20% coinsurance after you meet your deductible
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	20% coinsurance after you meet your deductible
4. Allergy injections	Covered in full	20% coinsurance after you meet your deductible
5. Diagnostic lab services	$50 copayment	20% coinsurance after you meet your deductible
6. Diagnostic x-ray services	$125 copayment after you meet your deductible	20% coinsurance after you meet your deductible
7. Other diagnostic services including but not limited to, EKG, endoscopy, colonoscopy and ultrasound	Covered in full after you meet your deductible	20% coinsurance after you meet your deductible
8. 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.)	$700 copayment per MRI, CT, PET scan or nuclear cardiology image after you meet your deductible	20% coinsurance after you meet your deductible
9. Renal dialysis • Outpatient renal dialysis • Continuous ambulatory peritoneal dialysis (CAPD)	Covered in full after you meet your deductible	20% coinsurance after you meet your deductible
10. Diabetic services • Diabetes self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider	$40 copayment per visit	20% coinsurance after you meet your deductible
• Laboratory tests including glycosylated hemoglobin or HbA1C tests, urinary protein/microalbumin and lipid profiles	$50 copayment per visit	20% coinsurance after you meet your deductible
11. Medical social services	$40 copayment per visit	20% coinsurance after you meet your deductible

Covered services	In-network level of benefits (participating providers)	Out-of-network level of benefits (non-participating providers)
Office visits and outpatient services, continued		
12. Chiropractic services provided by a physician or a chiropractor for acute musculoskeletal conditions. The condition must be new or an acute exacerbation of a previous condition. Chiropractic services will be covered as medically necessary.	$40 copayment per visit	20% coinsurance after you meet your deductible
13. Outpatient surgery, anesthesia and the medically necessary pre and post operative care related to the surgery, provided in a hospital outpatient, day surgery or ambulatory surgical facility (Prior authorization required)	$1,000 copayment per surgery after you meet your deductible when provided in a hospital outpatient, day surgery or ambulatory care facility	20% coinsurance after you meet your deductible
14. Visit to a limited service 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)	$40 copayment per visit	20% coinsurance after you meet your deductible
15. Podiatry care		
• Outpatient lab tests and x-rays	See Diagnostic lab, x-ray and imaging services	See Diagnostic lab, x-ray and imaging services
• Outpatient surgical services	See Outpatient surgery	See Outpatient surgery
• Outpatient medical care services	See Office visits and related services	See Office visits and related services
Oral surgery and related services		
1. Office visits with an oral surgeon for: • The removal or exposure of impacted teeth, including both hard and soft tissue impactions, or an evaluation for the procedure. • The surgical treatment of cysts affecting the teeth or gums that cannot be treated by a dentist. • The treatment of fractures of the mandible (jaw bone) • The evaluation and surgery for the treatment of temporomandibular joint (TMJ) disorder when a medical condition is diagnosed.	$65 copayment per visit	20% coinsurance after you meet your deductible
2. Emergency medical care such as to relieve pain and stop bleeding as a result of accidental injury to the sound natural teeth or tissues when provided as soon as medically possible after injury. This does not include restorative or other dental services.	$40 copayment per visit to a physician's or dentist's office $1,000 copayment per visit to an emergency room after you meet your deductible	20% coinsurance after you meet your deductible

Covered services	In-network level of benefits (participating providers)	Out-of-network level of benefits (non-participating providers)
Organ transplants * *Prior authorization required*		
1. Office visits related to the transplant	$40copayment per visit with a PCP and certain other providers $65 copayment per visit with a specialist	20% coinsurance after you meet your deductible
2. Inpatient hospital charges including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient.	$1,000 copayment per admission after you meet your deductible	20% coinsurance after you meet your deductible
3. Human leukocyte antigen (HLA) or histocompatibility locus antigen testing for A, B, or DR antigens, or any combination thereof, necessary to establish bone marrow transplant donor suitability	$50 copayment	20% coinsurance after you meet your deductible
* See the **Description of Benefits** section in your *Member Handbook/Evidence of Coverage* for a complete list of covered organ transplants		
Pediatric dental services *(for members under the age of 19)*	See Addendum: Pediatric Dental Services	See Addendum: Pediatric Dental Services
Pediatric vision services *(for members under the age of 19)*	See Addendum: Pediatric Dental Services	See Addendum: Pediatric Dental Services

Covered services	In-network level of benefits (participating providers)	Out-of-network level of benefits (non-participating providers)
Prescription drugs Covered prescription items: – Prescription drugs (medications) – Contraceptive drugs and devices* – Self-administered injectable agents** – Hormone replacement therapy – Insulin – Insulin syringes – Supplies for the treatment of diabetes as mandated by Massachusetts law, including blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, and insulin pens – Prescribed oral medications that influence blood sugar levels, for the treatment of diabetes – Special medical formulas to treat certain metabolic disorders as required by state law (prior authorization required) * Generic prescription contraceptive drugs and devices are covered in full. Brand name prescription contraceptive drugs and devices with no generic equivalent are covered in full (prior authorization required). ** Injectables administered in a physician's office or under other professional supervision are covered as a medical benefit.	Network pharmacy: for up to a 30-day supply: Tier 1: $30 copayment Tier 2: $60 copayment Tier 3: $100 copayment Tier 4: $150 copayment Mail order: For up to a 90-day supply: Tier 1: $60 copayment Tier 2: $120 copayment Tier 3: $200 copayment Tier 4: $450 copayment	20% coinsurance after you meet your deductible
Orally administered anticancer medications used to kill or slow the growth of cancerous cells Certain medications cannot be limited to a 30-day supply due to manufacturer packaging, for example, a prefilled syringe. In these cases, you will be charged the applicable copay/coinsurance based on the actual day supply. **Note:** Medical and surgical supplies obtained through a pharmacy may have a drug prescription benefit cost-sharing applied.	Covered in full	20% coinsurance after you meet your deductible

Covered services	In-network level of benefits (participating providers)	Out-of-network level of benefits (non-participating providers)
Preventive care		
1. Physical exams for the prevention and detection of disease, for members age six and older, including routine immunizations	Covered in full	20% coinsurance after you meet your deductible
2. Routine eye exam, once in each 12-month period.	Covered in full	20% coinsurance after you meet your deductible
3. Mammography: • One baseline mammogram for women ages 35-40 • One mammogram annually for women age 40 and older	Covered in full	20% coinsurance after you meet your deductible
4. Routine gynecological care including annual exam and Pap smear	Covered in full	20% coinsurance after you meet your deductible
5. Preventive care services for children from birth to age six	Covered in full	20% coinsurance after you meet your deductible
6. Female consultations, examinations, procedures, contraceptive devices, and medical services related to the use of all contraceptive methods*	Covered in full	20% coinsurance after you meet your deductible
7. Tobacco counseling sessions with your primary physician or other provider designed to create a plan to stop smoking	Covered in full	20% coinsurance after you meet your deductible
* Prescription contraceptive drugs and devices are covered under the prescription drug benefit.		

Covered services	In-network level of benefits (participating providers)	Out-of-network level of benefits (non-participating providers)
Prosthetic/orthotic devices and durable medical equipment *Prior authorization required*		
1. The purchase or rental of prosthetic/ orthotic devices and durable medical equipment (including the fitting, preparing, repairing and modifying of the appliance).	30% coinsurance after you meet your deductible	30% coinsurance after you meet your deductible
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 one scalp hair prosthetic (wig) per member per benefit period. (In-network and out-of-network benefit is combined.)	30% coinsurance after you meet your deductible	30% coinsurance after you meet your deductible
3. Breast prosthesis that is medically necessary after a covered reconstructive surgery following mastectomy	30% coinsurance after you meet your deductible	30% coinsurance after you meet your deductible
4. Prosthetic limbs which replace, in whole or in part, an arm or leg.	20% coinsurance after you meet your deductible	40% coinsurance after you meet your deductible
5. Insulin pumps and insulin pump supplies	Covered in full	20% coinsurance after you meet your deductible
6. Breast pumps	Covered in full	20% coinsurance after you meet your deductible
7. Up to $2,000 per ear for hearing aid device only, every 36 months (must be 21 years of age or younger) • Related services and supplies for hearing aids (not subject to the $2,000 limit)	30% coinsurance after you meet your deductible	30% coinsurance after you meet your deductible
8. Medical and surgical supplies	Covered in full after you meet your deductible	20% coinsurance after you meet your deductible
Reconstructive surgery* *Prior authorization required*		
1. Reconstructive surgery provided in a hospital outpatient, day surgery or ambulatory care facility, including anesthesia and the medically necessary pre and post operative care related to the surgery	$1,000 copayment per surgery after you meet your deductible	20% coinsurance after you meet your deductible
2. Inpatient hospital services, including room and board in a semi-private room, and the services and supplies that would ordinarily be furnished to you while you are inpatient, including Massachusetts mandated services for cleft lip and cleft palate	$1,000 copayment per admission after you meet your deductible	20% coinsurance after you meet your deductible
* See the **Description of Benefits** section of your *Member Handbook/Evidence of Coverage* for a complete list of covered reconstructive surgeries.		

Covered services	In-network level of benefits (participating providers)	Out-of-network level of benefits (non-participating providers)
Rehabilitation and habilitation services		
1. Physical and occupational therapy services are covered for up to 60 visits combined per benefit period when medically necessary. After 60 combined physical and occupational therapy visits within a benefit period, prior authorization based on medical necessity is required for additional visits within the benefit period. (In-network and out-of-network benefit is combined.)	$40 copayment per visit after you meet your deductible	20% coinsurance after you meet your deductible
2. The diagnosis and treatment of speech, hearing and language disorders. After 30 speech therapy visits within a benefit period, prior authorization based on medical necessity is required for additional visits within the benefit period.	$40 copayment per visit after you meet your deductible	20% coinsurance after you meet your deductible
3. Cardiac rehabilitation for persons with documented cardiovascular disease.	$40 copayment per visit after you meet your deductible	20% coinsurance after you meet your deductible
4. Early intervention services for children from birth to their third birthday.	Covered in full	Covered in full
5. 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	20% coinsurance after you meet your deductible
Skilled nursing facility services *Prior authorization required* 1. Care in a skilled nursing facility on an inpatient basis, including room and board in a semi-private room, and the services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to nursing care, physical, occupational and speech therapy, and medical supplies and equipment. Coverage is provided for up to a maximum of 100 days per benefit period. (In-network and out-of-network benefit is combined.)	$1,000 copayment per admission after you meet your deductible	20% coinsurance after you meet your deductible

Fallon Health and Life Assurance Co., Inc.

Addendum
Pediatric Dental Services

This addendum is part of your Fallon Preferred *Care Member Handbook/Evidence of Coverage*. This addendum provides you with the cost-sharing that you are responsible for when you get covered pediatric dental care from a plan dentist for members under the age of 19. For a list of plan dentists, go to fchp.org or call Customer Service at 1-888-468-1541 (TRS 711).

Preventive and Diagnostic Services

	Benefits
Preventive and Diagnostic Services • Comprehensive Evaluation (once per lifetime per provider or location) • Periodic Oral Exams (two per benefit period) • Limited oral evaluation (two per benefit period) • Full mouth x-rays (once every 36 months per provider or location) • Panoramic x-rays (once every 36 months per provider or location) • Bitewing x-rays (two per benefit period) • Single tooth x-rays (one per visit) • Teeth cleaning, including minor scaling procedures (two per benefit period) • Fluoride Treatments (one per day per provider or location) • Space maintainers • Sealants (Please note: Sealants are not covered on previously restored teeth) (Once every 36 months per provider or location)	In-network Covered in full Out-of-network 20% coinsurance

Basic Covered Services

	Benefits
Basic Covered Services • Amalgam restorations (once per benefit period per tooth) • Composite resin restorations (once per benefit period per tooth) • Recement crowns/onlays • Rebase or reline dentures (once every 24 months) • Root canals on permanent teeth (once per lifetime per tooth) • Prefabricated stainless steel crowns (once per lifetime per tooth) • Periodontal scaling and root planning (once every 36 months) • Simple extractions (once per lifetime per tooth, erupted or exposed root) • Surgical extractions (once per lifetime per tooth) • Vital pulpotomy • Apeicocectomy • Palliative care • Anesthesia	In-network 25% coinsurance Out-of-network 45% coinsurance

Major Restorative Services

	Benefits
Major Restorative Services • Crown, resin (once every 60 months per tooth) • Porcelain/ceramic crowns (once every 60 months per tooth) • Porcelain fused to metal/mobile/high noble crowns (once every 60 months per tooth) • Partial and complete dentures (once every 84 months)	In-network 50% coinsurance Out-of-network 70% coinsurance

Orthodontia

	Benefits
Orthodontia Coverage is provided for services under the following conditions: only when medically necessary; patient must have severe and handicapping malocclusion as defined by HLD index score of 28 and/or one or more auto qualifiers. Prior authorization required.	In-network 50% coinsurance Out-of-network 70% coinsurance

Related exclusions

1. Any service that is not listed in this addendum is not covered.

Addendum
Pediatric Vision Services

This addendum is part of your Fallon Preferred Care *Member Handbook/Evidence of Coverage*.

This addendum provides you with the cost-sharing that you are responsible for when you get covered pediatric vision care from a plan vision provider for members under the age of 19. For more information about your eye and vision care benefits, including a list of plan vision providers, go to fallonhealth.org or call Customer Service at 1-888-468-1541 (TRS 711).

Service	Member cost
Eye exam	
Exam with dilation as necessary, once per calendar year	$0
Frames	
One designated set, once per calendar year	$0
Lenses:	
Standard lenses	
Single vision	$0
Bifocal	$0
Trifocal	$0
Lenticular	$0
Progressive lenses	
Standard	$0
Premium	$0 for first $120 of retail cost, 80% of any additional retail cost.
Lens options	
Choice of plastic or glass lenses	$0
UV treatment	$0
Tint – includes fashion and gradient tinting, and oversized and glass-grey #3 prescription sunglass lenses	$0
Standard plastic scratch coating	$0
Standard polycarbonate (kids)	$0
Plastic photosensitive lenses	$0
Other options:	
Intermediate vision lenses	$0
Standard anti-reflective	$45
Photochromic plastic	80% of retail cost
Blended segment lenses	80% of retail cost
Polarized lenses	80% of retail cost
Premium anti-reflective costing	80% of retail cost
Ultra anti-reflective coating	80% of retail cost
Hi-Index lenses	80% of retail cost
Other add-ons	80% of retail cost
Additional complete pairs of eyewear	60% of retail

Contact lenses	
One pair of conventional contact lenses, in place of eyeglass lenses	$0 for first $150 of retail cost, 75% of any additional retail cost.
In place of a pair of conventional contact lenses, the member may elect either of the following options: • Up to a 6 month supply of monthly or two-week single vision spherical or toric contact lenses • Up to a 3 month supply of daily disposable single vision spherical contact lenses	Up to $55
Standard contact lens fit and follow-up	10% discount from retail price
Premium contact lens fit and follow-up	85% of retail cost
Additional conventional contact lenses	$0
Medically necessary contact lenses, in place of other eyewear	
Low vision services	$0
• One comprehensive low vision evaluation, once every five years, when medically necessary	$0
• Follow-up care, four visits in any five year period, when medically necessary	25% of retail cost
• Low vision aids, such as high-power spectacles, magnifiers, and telescopes, once every 24 months, when medically necessary	
Additional discounts on vision items are available; see a plan provider or contact the plan for details.	

Out-of-network benefits

Fallon Preferred Care is a preferred provider plan. As with other services covered by the plan, you may choose to obtain covered pediatric vision services from providers who do not participate in the plan. If you do, these services will be covered at a lower out-of-network level of benefits, as follows:

- If you are responsible for paying 80% or more of the retail cost for a covered service in-network, you will pay the same percentage of the retail cost if you receive that service from an out-of-network provider.
- If you are responsible for paying between 60% and 80% of the retail cost for a covered service in-network, you will pay 80% of the retail cost if you receive that service from an out-of-network provider.
- If you are responsible for paying 25% of the retail cost for a covered service in-network, you will pay 45% of the retail cost if you receive that service from an out-of-network provider.
- For all other services, you will pay 20% of the retail cost if you receive that service from an out-of-network provider.

Related exclusions

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses.
2. Medical and/or surgical treatment of the eye, eyes or supporting structures.
3. Any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment; Safety eyewear.

4. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
5. Non-prescription lenses and/or contact lenses.
6. Non-prescription sunglasses.
7. Two pair of glasses in lieu of bifocals.
8. Services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order.
9. Services or materials provided by any other group benefit plan providing vision care.
10. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit period when vision materials would become available.

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,
អ្នកម្នាសិេធិេេួលជំនួយនិងព័ែ៌ម្នា ជៅកនុងភាសា ររស់អ្នក ជោយមិនអ្ស់ប្ាក់ ។
បែេើមបីនិយាយជាមួយអ្នកែកដប្រ 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 위해서는 1-800-868-5200로 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 રહ્યાાં તેમ ાંથી કોઇને Fallon Health વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિિ નો અવિક ર છે. તે ખર્ચ વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર્ છે. ૬ ભ વષર્ો િ ત કરિ મ ટે,આ 1-800-868-5200 પર કોલ કરો.

Laotian:
้าท่าน, ท ูีคนท ่ท่านกำลังช่วยเท ูีอ, ม คำถามกังวลกับ Fallon Health, ท่านม สิดท ่จะได้รับการช่วยเท ูีอและข้อมูลข่าวสารท ่เป็นภาสาของท่านบ่ม ค่าใช้จ่าย. การโอ้วมกับบายภาสา, โท้โทท 1-800-868-5200.