Fallon Medicare Plus™ Premier
2021 Group Rate and Benefits Agreement

Name of Company: _____ **Effective Date:** _____

Benefit plan year: Jan. 1, 2021 through Dec. 31, 2021

Benefit	Member cost
Monthly premium	$440 per member
Annual Deductible / OOP Max	$0 medical deductible / $3,400 out-of-pocket yearly maximum
Office visits	$15 copay primary care provider / $25 copay specialty care
Inpatient admissions	$250 copay per hospital stay
Skilled nursing facility	$20 copay per day for days 1-10, $0 for days 11-100
Worldwide emergency care	$75 copay
Urgently needed care	$15 copay inside the U.S.; $75 outside the U.S.
Outpatient surgery	$125 copay
Lab and imaging services	$0 copay per service
Vision care	$25 copay per annual supplemental routine exam
Hearing care	$0 copay per annual supplemental routine exam
Part B prescriptions *(Drugs that usually aren't self-administered, and are injected or infused while at a doctor's office, hospital or outpatient facility.)*	$10-$65 for Medicare-covered Part B prescriptions for 30-day supply
Part D Prescriptions *No deductible/No "donut hole" Some prescriptions may have limited order quantities and/or require prior authorization.*	**Retail pick up (up to a 30-day supply)** Tiers 1 and 2: $10 Tier 3: $30 Tiers 4 and 5: $65 Tier 6: $0 **Mail order delivery (90-day supply)** Tiers 1 and 2: $20 Tier 3: $60 Tiers 4 and 5: $162.50 Tier 6: Not available
Part D Catastrophic Coverage	After total prescription costs reach $6,550 during the benefit year, members pay the greater of 5% coinsurance or $3.70 copays for generic or name brand drugs treated as generic or $9.20 copays for all other drugs.
Plan highlight	Benefit Bank—a card that can be used to pay for fitness memberships, dental care and/or eyewear. Members can use the card for one item or service, or a combination.
Plan code	RWf0

Would you like to offer Fallon Medicare Plus Premier Central HMO to retirees who live in Worcester County—in addition to Fallon Medicare Plus Premier HMO?

- ◯ Yes, offer a $500 Benefit Bank and a monthly premium of 370.00
- ◯ No, offer a $250 Benefit Bank and monthly premium of $ 440.00

To complete plan agreement, please see reverse side.

Company Information

Company Name: _____ Phone Number: _____ - _____ - _____

Company Address: _____

City: _____ State: _____ ZIP: _____

Mailing Address (if different from above): _____

City: _____ State: _____ ZIP: _____

Federal Tax ID Number: _____ Total number of employees: _____

Your organization type is: ◯ DBA ◯ LLP ◯ LLC ◯ Inc ◯ Other _____

This Plan is offered to: ◯ Active Employees ◯ Retired Employees ◯ Both

What is the employer contribution? _____

CONTACTS	TITLE	PHONE	EMAIL
EXECUTIVE/OWNER			
BILLING CONTACT			
BENEFITS ADMINSTRATOR			

BROKER INFORMATION (IF APPLICABLE)
PRIMARY BROKER NAME:
BROKER AGENCY:

This agreement is an outline of benefits and services available with this Medicare Advantage HMO benefit plan. Details about specific coverage and service limitations are found in the Plan's Evidence of Coverage. Eligibility and participation are subject to CMS enrollment and termination guidelines.

Signature on this agreement and/or receipt by Fallon Health of the first new-year premium, acknowledges the following*: The Plan will renew as offered in this document; Employer accepts Fallon Health's Administrative Guidelines; Employer is a public agency or private enterprise with an official business office in Massachusetts; Employer follows Medicare Secondary Payer rules related to the use of this plan for Medicare beneficiaries; Employer will allow Fallon Health to share the Employer's Federal Employer ID number (FEIN) with federal and state agencies for required auditing and other purposes; Benefit designs are subject to change each January 1. Fallon Health is an HMO plan with a Medicare contract. Enrollment in Fallon Health depends on contract renewal.*

I certify that the above information is correct to the best of my knowledge. I also acknowledge acceptance of the rates and corresponding designs and have read and acknowledge The Administrative Guidelines.

Name (print) _____ Signature _____ Date _____