Fallon Community Health Plan, Inc.

# Schedule of Benefits

This Schedule of Benefits is part of your
Community Care *Member Handbook/Evidence of Coverage*.
It describes your costs for health care.

This Schedule of Benefits shows your copayments and coinsurance for the covered services outlined in the Community Care *Member Handbook/Evidence of Coverage*. It also outlines any of your benefits that differ from those shown in the *Member Handbook/Evidence of Coverage*. The information in this document replaces any information in your *Member Handbook/Evidence of Coverage* that conflicts with it. If you have any questions about your benefits, please call Customer Service at 1-800-868-5200 (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, 2023 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, 2023. 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/ Evidence of Coverage*:

## Deductible

**Your deductible is $2,000 per member/ $4,000 per family per benefit period for certain services**. Each member must meet the per-member deductible amount, 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, some services will be covered in full by the plan. For other services, you will be responsible for a copayment or coinsurance when you receive these services. Your costs for covered services are described in this Schedule of Benefits; for detailed information on covered services and any exclusions or limitations that apply, we recommend that you refer to the *Member Handbook/Evidence of Coverage*.

Any deductible amounts paid during the last three months of the benefit period may be applied to your deductible for the next benefit period—we call this the “deductible carryover.” In order for a deductible carryover to apply, the member must have had continuous coverage under the plan through the same employer group at the time the charges for the prior benefit period were incurred. After you receive services, we will send you a letter indicating the amount that has been applied to your deductible.

## 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. **Your out-of-pocket maximum is $9,100 per member or $18,200 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 **$9,100** 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.

## 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.

## It Fits! ™ benefit

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

## Covered services

The following chart shows your costs for covered services. These costs apply to the services in the **Description of benefits** section of your *Member Handbook/Evidence of Coverage*. 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 non-emergency situations, when medically necessary | Covered in full after you meet your deductible |
| **Autism services**<br>*Prior authorization required* | |
| 1. Habilitative and rehabilitative care | $30 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. | $30 copayment per visit |
| **Durable medical equipment and prosthetic/orthotic devices**<br>*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. 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 after you meet your deductible |
| 3. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy | 20% 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 |
| 5. Insulin pump and insulin pump supplies | Covered in full |
| 6. Breast pumps | Covered in full |
| 7. Up to $2,000 per ear for hearing aid device only, every 36 months (must be 21 years of age or younger)<br>• Related services and supplies for hearing aids (not subject to the $2,000 limit) | 20% coinsurance after you meet your deductible |
| 8. Medical and surgical supplies | Covered in full after you meet your deductible |
| **Emergency and urgent care** | |
| 1. Emergency room visits | $350 copayment per visit after you meet 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 | $60 copayment per visit |

| Covered services | Benefits |
|---|---|
| *Emergency and urgent care, continued* | |
| 4. Emergency prescription medication provided out of the Community Care service area as part of an approved emergency treatment | Tier 1: $30 copayment<br>Tier 2: $60 copayment after you meet your deductible<br>Tier 3: $90 copayment after you meet your deductible<br>for up to a 14-day supply |
| 5. Telemedicine visits with physicians through an approved telehealth vendor. Visits are performed by phone, video, or mobile app. | $30 copayment per visit |
| **Enteral formulas and low protein foods**<br>*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**<br>*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**<br>*Referral and prior authorization required* | Covered in full after you meet your deductible |
| **Hospital inpatient services**<br>*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 | $1,000 copayment per admission after you meet your deductible |
| **Infertility/assisted reproductive technology (art) services***<br>*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 | $30 copayment per visit with a PCP and certain other providers<br>$60 copayment per visit with a specialist |

| Covered services | Benefits |
|---|---|
| *Infertility/assisted reproductive technology (art) services*, continued* | |
| 2. Diagnostic laboratory services | $50 copayment after you meet your deductible |
| 3. Diagnostic X-ray services | $75 copayment 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:<br>• In vitro fertilization (IVF-ET)<br>• Gamete intrafallopian transfer (GIFT)<br>• Zygote intrafallopian transfer (ZIFT) | $250 copayment per procedure after you meet your deductible |
| 7. Sperm, egg, and/or inseminated egg procurement, assisted hatching, cryopreservation, processing and banking for plan members in an 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/ Evidence of Coverage* for a list of covered infertility/ART services. | |
| **Maternity services** | |
| 1. Obstetrical services including prenatal, childbirth, postnatal and postpartum care | Covered in full |
| 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. The covered length of stay may be reduced if the mother and the attending physician agree upon an earlier discharge. If you or your newborn are discharged earlier, you are covered for home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however that the first home visit shall be conducted by a registered nurse, physician or certified nurse midwife; and provided further, that any subsequent home visit determined to be clinically necessary shall be provided by a licensed health care provider. | $1,000 copayment per admission after you meet your deductible |
| *(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** | |
| **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.<br><br>**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 |
| **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. | $30 copayment per admission |
| 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 | $30 copayment per admission |
| 3. Partial Hospitalization: Short-term day/evening mental health programming available 5 to 7 days per week. | $30 copayment per visit |
| 4. Intensive outpatient programs: Multimodal, inter-disciplinary, structured behavioral health treatment provided 2-3 hours per day, multiple days per week. | $30 copayment per visit |
| 5. Day treatment: Program encompasses some portion of the day or week rather than a weekly visit | $30 copayment per visit |
| 6. Crisis Stabilization: Short-term psychiatric treatment in a structured, community based therapeutic environments. | $30 copayment per visit |
| 7. In-home therapy services | $30 copayment per visit |
| Intermediate services for children and adolescents under the age of 19 | |
| 1. Community-based acute treatment | Covered in full |
| 2. Intensive community-based treatment | Covered in full |
| 3. Intensive Care Coordination | Covered in full |
| 4. Family Stabilization Team (also referred to as In-Home Therapy) | Covered in full |
| 5. In-home Behavioral Services | Covered in full |
| 6. Mobile Crisis Intervention (service available up to seven days). Prior authorization not required. | Covered in full |
| 7. Family support and training | Covered in full |
| 8. Therapeutic mentoring services | Covered in full |
| **Outpatient services** | |
| 1. Outpatient office visits, including individual, group or family therapy. | $30 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. Prior authorization required. | $30 copayment per visit |

| Covered services | Benefits |
|---|---|
| *Mental health and substance use services, continued* | |
| 3. Neuropsychological assessment services when medically necessary. Prior authorization required.<br><br>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. | $30 copayment per visit |
| **Office visits and outpatient services** | |
| 1. Office visits, to diagnose or treat an illness or an injury<br>• Telehealth visits done via a secure, real time Telemedicine platform which is inclusive of both an audio and visual component. | $30 copayment per visit with a PCP and certain other providers<br>$60 copayment per visit with a specialist |
| 2. A second opinion, upon your request, with another plan provider | $30 copayment per visit with a PCP and certain other providers<br>$60 copayment per visit with a specialist |
| 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 | $30 copayment per visit |
| 8. Diagnostic lab services ordered by a plan provider, in relation to a covered office visit | $50 copayment after you meet your deductible |
| 9. Diagnostic X-ray services ordered by a plan provider, in relation to a covered office visit | $75 copayment after you meet your deductible |
| 10. Other diagnostic services including but not limited to, EKG, endoscopy, colonoscopy and ultrasound | Covered in full after you meet your deductible |
| 11. 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.) | $350 copayment per MRI, CT, PET scan or nuclear cardiology image after you meet your deductible |

| Covered services | Benefits |
|---|---|
| *Office visits and outpatient services, continued* | |
| 12. Chiropractic services 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. | $30 copayment per visit |
| • Outpatient lab tests and x-rays | See Diagnostic lab, x-ray and high-tech imaging services |
| 13. Outpatient renal dialysis at a plan-designated center or continuous ambulatory peritoneal dialysis | Covered in full after you meet your deductible |
| 14. Diabetes outpatient self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider | $30 copayment per visit |
| 15. Laboratory tests necessary for the diagnosis or treatment of diabetes, including glycosylated hemoglobin, or HbAlc, tests, and urinary/protein/microalbumin and lipid profiles | $50 copayment after you meet your deductible |
| 16. 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. | $30 copayment per visit |
| 17. Outpatient surgery, anesthesia and the medically necessary preoperative and postoperative care related to the surgery | $500 copayment per surgery after you meet your deductible when provided in a hospital outpatient, day surgery or ambulatory care facility |
| 18. Visit to a contracted limited service clinic. Services are provided for a variety of common illnesses, including, but not limited to:<br>• strep throat<br>• ear, eyes, sinus, bladder and bronchial infections<br>• minor skin conditions (e.g. sunburn, cold sores) | $60 copayment per visit |
| 19. 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**<br>*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 | $60 copayment per visit |
| 2. Surgical treatments of cysts, affecting the teeth or gums, that must be rendered by a plan oral surgeon | $60 copayment per visit |
| 3. Treatment of fractures of the jaw bone (mandible) or any facial bone | $60 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 | $60 copayment per visit |

| Covered services | Benefits |
|---|---|
| *Oral surgery and related services, continued* | |
| 5. Extraction of teeth in preparation for radiation treatment of the head or neck | $60 copayment per visit |
| 6. Surgical treatment related to cancer | $60 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. | $30 copayment per visit to a physician's or dentist's office<br>$350 copayment per visit to an emergency room after you meet your deductible |
| Note: These benefits are for oral surgery services in an office setting. Oral surgery services in a hospital outpatient, day surgery or ambulatory care facility, or as an inpatient are covered in full after you meet your deductible.<br>See **Office visits and outpatient services** for diagnostic lab and X-ray services. | |
| **Organ transplants**<br>*Referral and prior authorization required* | |
| 1. Office visits related to the transplant | $30 copayment per visit with a PCP and certain other providers<br>$60 copayment per visit with a specialist |
| 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 | $1,000 copayment per admission after you meet your deductible |
| 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 | $50 copayment after you meet your deductible |
| **Pediatric dental services***<br>*(for members under the age of 19)* | See Addendum: Pediatric Dental Services |
| **Pediatric vision services***<br>*(for members under the age of 19)* | See Addendum: Pediatric Vision Services |

| Covered services | Benefits |
|---|---|
| **Prescription drugs** | |
| Covered prescription items:<br>• Prescription medication<br>• Prescription contraceptive drugs and devices*<br>• OTC contraceptive (with a prescription)<br>• Hormone replacement therapy for peri- and post-menopausal women<br>• Injectable agents (self-administered**)<br>• Insulin<br>• Syringes (including insulin syringes) or needles when medically necessary<br>• Supplies for the treatment of diabetes, as required by state law, including:<br>– blood glucose monitoring strips<br>– urine glucose strips<br>– lancets<br>– ketone strips<br>• Special medical formulas to treat certain metabolic disorders as required by state law (prior authorization required).<br>• Therapeutic continuous glucose monitors<br>• Supplies used with therapeutic continuous glucose monitors, including:<br>– Transmitters<br>– Sensors<br><br>*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).<br><br>**Injectables administered in the doctor's office or under other professional supervision are covered as a medical benefit. | Network pharmacy:<br>Tier 1: $30 copayment<br>Tier 2: $60 copayment after you meet your deductible<br>Tier 3: $90 copayment after you meet your deductible<br>for up to a 30-day supply<br><br>Mail-order pharmacy:<br>Tier 1: $60 copayment<br>Tier 2: $120 copayment after you meet your deductible<br>Tier 3: $270 copayment after you meet your deductible<br>for up to a 90-day supply |
| Orally administered anticancer medications used to kill or slow the growth of cancerous cells | Covered in full |
| 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.<br><br>**Note:** Medical and surgical supplies obtained through a pharmacy may have a drug prescription benefit cost-sharing applied. | |

| 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. Adult routine eye exams, once in each 12-month period | Covered in full |
| 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:<br>• physical examination<br>• history<br>• measurements<br>• sensory screening<br>• neuropsychiatric evaluation<br>• development screening and assessment | Covered in full |
| 8. Pediatric services including:<br>• appropriate immunizations<br>• hereditary and metabolic screening at birth<br>• newborn hearing screening test performed before the newborn infant is discharged from the hospital or birthing center<br>• tuberculin tests, hematocrit, hemoglobin, and other appropriate blood tests and urinalysis<br>• 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 |
| * Prescription and OTC contraceptive devices are covered under the prescription drug benefit. | |

| Covered services | Benefits |
|---|---|
| **Reconstructive surgery**<br>*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 | $1,000 copayment per admission after you meet your deductible |
| **Rehabilitation and habilitation services**<br>*Referral required* | |
| 1. Physical and occupational therapy services are covered for up to 60 visits combined per benefit period when medically necessary with a PCP referral. After 60 combined physical and occupational therapy visits, prior authorization based on medical necessity is required for additional visits. | $60 copayment per visit |
| 2. 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 a plan provider's office with a PCP referral. After 30 speech therapy visits, prior authorization based on medical necessity is required for additional visits. | $60 copayment per visit |
| 3. Cardiac rehabilitation services to treat cardiovascular disease in accordance with state law and Department of Public Health regulations | $60 copayment per visit |
| 4. 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. | 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 |
| **Telehealth services**<br>Services delivered via telehealth by plan providers | |
| 1. Office visits, to diagnose or treat an illness or an injury | $30 copayment per visit with a PCP and certain other providers<br>$60 copayment per visit with a specialist |
| 2. A second opinion, upon your request, with another plan provider | $30 copayment per visit with a PCP and certain other providers<br>$60 copayment per visit with a specialist |
| 3. Office visits for the evaluation, diagnosis, treatment or management of a mental health, developmental or substance use disorder | $30 copayment per visit with a PCP and certain other providers<br>$60 copayment per visit with a specialist |

| Covered services | Benefits |
|---|---|
| *Telehealth services, continued* | |
| 4. Chronic disease management services, i.e., establishment, implementation, revision, or monitoring of a comprehensive care plan for members with multiple (two or more) chronic conditions, including but not limited to diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, cancer and coronary artery disease. | Covered in full after you meet your deductible |
| 5. Remote patient monitoring, also known as remote physiologic monitoring, or RPM. RPM involves the collection and analysis of physiologic data that are used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. | Covered in full after you meet your deductible |
| **Skilled nursing facility services**<br>*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 | $1,000 copayment per admission after you meet your deductible |

# Addendum
# Pediatric Dental Services

This addendum is part of your *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 fallonhealth.org or call Customer Service at 1-800-868-5200 (TRS 711).

## Preventive and Diagnostic Services

| | Benefits |
|---|---|
| **Preventive and Diagnostic Services**<br>• Comprehensive Evaluation (once per lifetime per provider or location)<br>• Periodic Oral Exams (two per benefit period)<br>• Limited oral evaluation (two per benefit period)<br>• Oral evaluation under 3 years of age (two per benefit period)<br>• Full mouth x-rays (once every 36 months per provider or location)<br>• Panoramic x-rays (once every 36 months per provider or location)<br>• Bitewing x-rays (two per benefit period)<br>• Single tooth x-rays (one per visit)<br>• Teeth cleaning, including minor scaling procedures (two per benefit period)<br>• Fluoride Treatments (one per day per provider or location)<br>• Space maintainers<br>• Sealants (Please note: Sealants are not covered on previously restored teeth) (Once every 36 months per provider or location) | Covered in full |

## Basic Covered Services

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

## Major Restorative Services

| | Benefits |
|---|---|
| **Major Restorative Services**<br>• Crown, resin (once every 60 months per tooth)<br>• Porcelain/ceramic crowns (once every 60 months per tooth)<br>• Porcelain fused to metal/mobile/high noble crowns (once every 60 months per tooth)<br>• Partial and complete dentures (once every 84 months) | 50% coinsurance |

## Orthodontia

| | Benefits |
|---|---|
| **Orthodontia**<br>Coverage is provided for services under the following conditions: only when medically necessary; patient must have severe and handicapping malocclusion. Prior authorization required. | 50% 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 *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 1-800-868-5200 (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 copay;<br>20% off retail price less $120 allowance |
| Lens options | |
| Plastic lenses only. Glass lenses are available to 20% off retail. | $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 under 19) | $0 |
| Plastic photochromic lenses | $0 |
| Other options: | |
| Standard anti-reflective | $45 |
| Blended segment lenses | 80% of retail cost |
| Polarized lenses | 80% of retail cost |
| Premium anti-reflective costin | 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 copay then 100% coverage for provider designated contacts |
| 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 $55 |
| • Up to a 3 month supply of daily disposable single vision spherical contact lenses | 10% discount from retail price<br>85% of retail cost |
| Standard contact lens fit and follow-up<br>Premium contact lens fit and follow-up<br>Additional conventional contact lenses | $0 |
| Medically necessary contact lenses, in place of other eyewear | |
| ***Additional discounts on vision items are available; see a plan provider or contact the plan for details.*** | |

## 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 inclusion resources

At Fallon Health, we believe everyone deserves access to health care without discrimination. We work every day to help people of any age, income level, race, color, ethnicity, national origin, disability, religion, sexual orientation, sex, gender identity, and health status achieve their health goals.

To make sure you have access to all the resources and information necessary to understand and access your health plan benefits, we:

- Provide **free aids and services**—such as qualified sign language interpreters and written information in other formats, including large print, braille, accessible electronic formats and other formats
- Provide **free language services**—such as qualified interpreters and information written in other languages—to people whose primary language is not English.
- Have **dedicated resources, individuals, and teams** that specialize in reviewing our policies to ensure inclusion of the unique needs of our transgender and gender diverse members.

If you need access to or wish to discuss any of this information or resources, **please call us** at the phone number on the back of your member ID card. Or you can email us at cs@fallonhealth.org.

If you believe Fallon or a provider has **discriminated against you or didn't provide these resources,** please tell us. You can write, call, or email us at:

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

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights online 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)

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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 បៅកនុងភាសា រេស់អ្នក បោយមិនអ្ស់ប្ាក់ ។ ប្ែេើមបីនិយាយជាមួយអ្នករកដប្រ 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 कॉ्ि करें।

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

**Laotian:**
้าท่าน, ห ูือคนห ่ท่านกำลังฉ่อยเห ูือ, ม ค่าถามกังวลกับ Fallon Health, ท่านม สิดห ่จะได้รับการฉ่อยเห ูือและข้ำมูนข่าวสารนห ่เป็นภาสาของท่านบ่ม ค่าใช้จ่าย. การโอ้ลมกับนายพาสา, ให้โทหา 1-800-868-5200.

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