fallon health

2026 Fallon Medicare Plus™ Premier Group Rate and Benefits Agreement

Company name: _____ Group number: _____

Monthly premium: _____

Benefit	Member cost
Plan year	January 1, 2026 – December 31, 2026
Effective date	January 1, 2026
Plan code	
Annual deductible / OOP max	$0 medical deductible / $3,400 annual out-of-pocket maximum
Office visits	$15 copay PCP / $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 in the U.S. and its territories; $75 outside the U.S. and its territories
Outpatient surgery	$125 copay
Lab and imaging services	$0 copay per service
Vision care	$25 copay for annual supplemental routine exam
Hearing care	$0 copay for annual supplemental routine exam
Part D prescriptions *No deductible* *Some prescriptions may have utilization management applied to them, such as limited order quantities and/or require prior authorization.*	**Retail pick-up (up to a 30-day supply)** Tier 1: $0; Tier 2: $10; Tier 3: $30; Tiers 4 and 5: $65; Tier 6: $0 Insulin (regardless of tier): No more than $35 **Mail-order delivery (90-day supply)** Tier 1: $0; Tier 2: $20; Tier 3: $60; Tier 4: $162.50; Tiers 5 and 6: up to a 30-day supply only Insulin (regardless of tier): No more than $70 Most Part D vaccines are covered at no cost to members in all coverage stages. Members will pay no more than $35 for a 30-day supply of covered insulin drugs, regardless of the drug coverage stage.
Plan highlights	**The Benefit Bank:** Members can pay for dental care, prescription eyewear and hearing aids, and fitness/gym memberships—with the Benefit Bank card. Fallon Health preloads money onto the card, and members choose how to use it. They can pay a portion—or the full cost—of an eligible item or buy a combination of items. Annual allowance is $250. In addition to the Benefit Bank, plans include the following benefits: • Preventive and comprehensive dental care • Hearing aid coverage with copays ranging from $695 to $2,645 • $150 toward eyewear, every year

Would you like to offer Fallon Medicare Plus Premier HMO at ($ per month)?

☐ Yes ☐ No

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 Administrator			

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 acknowledged The Administrative Guidelines.

Name (print) **Signature** **Date**

This is not an approved marketing, advertising, or outreach document. It is not intended for use with plan members/Medicare beneficiaries.