Fallon Health

Fallon Medicare Plus Premier HMO
Schedule of Benefits

This *Schedule of Benefits* is part of your
2025 Fallon Medicare Plus Premier HMO Evidence of Coverage.
It describes your costs for health care.

You are a member of Fallon Medicare Plus through an employer group. Under this group plan, you have copayments that are different from those shown in your *2025 Fallon Medicare Plus Premier HMO Evidence of Coverage*. The information in this document replaces any information in your *Evidence of Coverage* that conflicts with it. If you have any questions about your benefits, please call Customer Service at 1-800-325-5669 (TRS 711), 8 a.m.–8 p.m., Monday–Friday, (7 days a week, Oct. 1–March 31). Calls to these numbers are free.

The following changes apply to the Benefits Chart in *Chapter 4: Medical Benefits Chart (what is covered and what you pay)* of your *2025 Fallon Medicare Plus Premier HMO Evidence of Coverage*:

Services that are covered for you	What you must pay when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: emergency services, including emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. Transportation back to the United States from another country is not covered. Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition), routine care/visits, and/or elective procedures are not covered.	You pay a $65 copayment for each Medicare-covered emergency room visit in-network and out-of-network. If you are admitted to the hospital within 72 hours for the same condition, you do not pay the emergency room copayment. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care *For inpatient hospital care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. You are covered for an unlimited number of days in an acute care hospital. This includes substance use disorder services, but it does not include rehabilitation services. You are covered for up to 90 days of care in each benefit period in an inpatient rehabilitation facility or rehabilitation unit of an acute care hospital. If you exceed the 90-day limit in a benefit period, you may use your lifetime reserve days for additional coverage. See Chapter 12 for an explanation of "benefit period." Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If	You pay a $125 copayment for each inpatient admission per benefit period; this includes medical, surgical and rehabilitation services. There is no copayment for substance abuse inpatient admissions when the primary reason is substance detoxification and/or rehabilitation. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	What you must pay when you get these services
Fallon Medicare Plus Premier HMO provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage begins with the first pint of blood that you need. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an *outpatient*. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient services in a psychiatric hospital *For inpatient services in a psychiatric hospital to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include mental health care services that require a hospital stay. • There is a 190-day lifetime limit on mental health care in a psychiatric hospital. You may use your lifetime reserve days for additional coverage once you have used the initial 90 days, if you have not reached your 190-day limit. See Chapter 12 for an explanation of "benefit period." • You are covered for an unlimited number of days of inpatient mental health care in an acute care hospital.	You pay a $125 copayment for each inpatient psychiatric admission per benefit period.
Medicare Part B prescription drugs *For certain Medicare Part B prescription drugs to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* *Certain Part B drugs, including some anti-emetics, anti-inflammatories*	There is no coinsurance, copayment, or deductible for drugs that are administered by a health care professional.

Services that are covered for you	What you must pay when you get these services
and chemotherapy may be subject to Part B step therapy. You can find a list of those drugs at the link below. Part B drugs can be filled for up to a 90-day supply. These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/Immunosuppressive Drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs	You pay a $15 primary care doctor or $25 specialist office visit copayment. There are no service category or plan level deductibles for Part B covered prescription drugs or insulin. You pay up to a $35 copay for one-month's supply of Part B insulin when used with an item of durable medical equipment. **For prescription drugs that are covered under Original Medicare you pay:** *Retail Cost-Sharing* Generic drugs: $10 copay for up to a 30-day supply $20 copay for up to a 60-day supply $30 copay for up to a 90-day supply Brand-name drugs: $50 copay for up to a 30-day supply $100 copay for up to a 60-day supply $150 copay for up to a 90-day supply *Mail-Order Cost-Sharing* Generic drugs: $10 copay for up to a 30-day supply $20 copay for up to a 60-day supply $20 copay for up to a 90-day supply Brand-name drugs: $50 copay for up to a 30-day supply $100 copay for up to a 60-day

Services that are covered for you	What you must pay when you get these services
you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://fallonhealth.org/find-insurance/medicare/covered-meds.aspx We also cover some vaccines under our Part B and most adult vaccines under our Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	supply $100 copay for up to a 90-day supply Additionally, you may pay less for certain Part B rebatable drugs due to the Inflation Reduction Act (IRA) of 2022. The IRA requires drug companies that raise their drug prices faster than the rate of inflation to pay Medicare a rebate, which may lower your cost. CMS will post an updated list of rebatable drugs and corresponding adjustments each quarter as part of the Medicare Part B Quarterly Sales Pricing (ASP) file. Therefore, it is possible that any adjustment could vary from quarter to quarter. Visit https://www.cms.gov/inflation-reduction-act-and-medicare/inflation-rebates-medicare to view the most recent list.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers *For outpatient surgery to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might	You pay a $100 copayment for each Medicare-covered outpatient surgery in an ambulatory surgical center or hospital outpatient facility. You do not pay the outpatient surgery copayment in a hospital outpatient facility if you are admitted to the hospital on the same day of the surgery.

Services that are covered for you	What you must pay when you get these services
still be considered an outpatient.	
Physician/Practitioner services, including doctor's office visits *For some outpatient services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan. For more information, see Chapter 3.* *For reconstructive surgery to be covered, your PCP or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: primary care; specialist care; outpatient mental health services; opioid treatment and outpatient substance use disorder services. o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. o Covered telehealth services are limited to those that involve both an audio and video component and must be done in real-time over a secure communication method administered by your provider. These services can replace some in-person visits to your provider. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location	You pay a $15 copayment for each primary care doctor visit for Medicare-covered benefits. You pay a $25 copayment for each specialist visit for Medicare-covered benefits. You pay a $25 copayment for each Medicare-covered diagnostic hearing exam. You pay a $0 copayment for telehealth services from the following: • Primary care provider • Approved telehealth vendor • Outpatient mental health providers • Outpatient substance use disorder providers You pay a $25 copayment for telehealth services from a specialist, except as noted above for outpatient mental health or outpatient substance abuse provider telehealth services. You pay a $25 copayment for Medicare-covered dental benefits. You pay $100 copayment for each Medicare-covered outpatient surgery in an ambulatory surgical center or hospital outpatient facility. You do not pay the outpatient

Services that are covered for you	What you must pay when you get these services

• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  o You have an in-person visit within 6 months prior to your first telehealth visit
  o You have an in-person visit every 12 months while receiving these telehealth services
  o Exceptions can be made to the above for certain circumstances
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:
  o You're not a new patient **and**
  o The check-in isn't related to an office visit in the past 7 days **and**
  o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:
  o You're not a new patient **and**
  o The evaluation isn't related to an office visit in the past 7 days **and**
  o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, internet, or electronic health record
• Second opinion by another network provider prior to surgery
• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)
• Reconstructive surgery
  o Surgery for post-mastectomy patients for reconstruction of the breast on which the mastectomy was performed.
  o Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  o Treatment of any physical complications resulting from the mastectomy including lymphedema.
	surgery copayment in a hospital outpatient facility if you are admitted to the hospital on the same day of surgery.

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care *For skilled nursing facility care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* (For a definition of skilled nursing facility care, see Chapter 12 of this document. Skilled nursing facilities are sometimes called SNFs.) Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	You pay a $20 a day copayment for days one through 6 of each skilled nursing facility admission per benefit period. You pay a $0 a day copayment for days 7 through 100 per benefit period.
Urgently needed services A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine	You pay a $15 copayment for each Medicare-covered urgently needed care visit in the United States and its territories. You pay a $65 copayment for each urgently needed care visit outside of the United States

Services that are covered for you	What you must pay when you get these services
provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable. Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: emergency services, including emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. Transportation back to the United States from another country is not covered. Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition), routine care/visits, and/or elective procedures are not covered.	and its territories.

Chapter 6: What you pay for your Part D prescription drugs explains the six cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each cost-sharing tier.

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost-sharing tier.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	Retail cost-sharing (in-network) (up to a 30-day supply)	Mail-order cost-sharing (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred generic drugs)	$0 copay	$0 copay	$0 copay	$0 copay
Cost-Sharing Tier 2 (Generic drugs)	$10 copay	$10 copay	$10 copay	$10 copay
Cost-Sharing Tier 3 (Preferred brand drugs)	$25 copay	$25 copay	$25 copay	$25 copay
Cost-Sharing Tier 4 (Non-preferred drugs)	$50 copay	$50 copay	$50 copay	$50 copay
Cost-Sharing Tier 5 (Specialty drugs)	$50 copay	$50 copay	$50 copay	$50 copay
Cost-Sharing Tier 6 (Select care drugs (certain vaccines and anti-opioid drugs))	$0 copay	$0 copay	$0 copay	$0 copay

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 9 of this chapter for more information on Part D vaccines cost sharing for Part D vaccines.

Section 5.4 A table that shows your costs for a *long-term* (up to a 100-day) supply of a drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 100-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a long-term supply of a covered Part D prescription drug:

Tier	Retail cost-sharing (in-network) (up to a 100-day supply)	Mail-order cost-sharing (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred generic drugs)	$0 copay for up to a 100-day supply	$0 copay for up to a 100-day supply
Cost-Sharing Tier 2 (Generic drugs)	$30 copay for up to a 90-day supply	$20 copay for up to a 90-day supply
Cost-Sharing Tier 3 (Preferred brand drugs)	$75 copay for up to a 90-day supply	$50 copay for up to a 90-day supply
Cost-Sharing Tier 4 (Non-preferred drugs)	$150 copay for up to a 90-day supply	$100 copay for up to a 90-day supply
Cost-Sharing Tier 5 (Specialty drugs)	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Cost-Sharing Tier 6 (Select care drugs (certain vaccines and anti-opioid drugs))	A long-term supply is not available for drugs in Tier 6.	A long-term supply is not available for drugs in Tier 6.

At a retail pharmacy, you won't pay more than $70 for up to a two-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier. When obtained through mail-order, your cost-sharing for up to a three-month supply of covered insulin will be no more than $70 regardless of the cost-sharing tier.