Fallon Medicare Plus Premier HMO
Schedule of Benefits

This *Schedule of Benefits* is part of your
2020 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 *2020 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), Monday-Friday, 8 a.m.-8 p.m. (From Oct. 1-March 31, seven days a week.) 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 *2020 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, 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. Coverage is worldwide.	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.
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*	You pay a $125 copay for each inpatient admission; this includes medical, surgical and rehabilitation services.

Services that are covered for you	What you must pay when you get these services
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 abuse 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 abuse 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 Fallon Medicare Plus Premier HMO provides transplant services at a location outside the pattern of care	There is no copay 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
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://www.medicare.gov/Pubs/pdf/11435.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 mental health care *For inpatient mental health care 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 mental health care admission.
Medicare Part B prescription drugs For Medicare Part B prescription drugs to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan. These drugs are covered under Part B of Original Medicare. Members of	There is no coinsurance, copayment, or deductible for drugs that are administered by a health care professional. You pay a $15 primary care doctor or a $25 specialist

Services that are covered for you	What you must pay when you get these services
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 • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • 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 • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases 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.	office copayment. For prescription drugs that are covered under Original Medicare you pay: *Retail Cost-Sharing:* Tier 1: $10 copayment for up to a 30-day supply; $20 copayment for up to a 60-day supply; $30 copayment for up to a 90-day supply Tier 2: $10 copayment for up to a 30-day supply; $20 copayment for up to a 60-day supply; $30 copayment for up to a 90-day supply Tier 3: $25 copayment for up to a 30-day supply; $50 copayment for up to a 60-day supply; $75 copayment for up to a 90-day supply Tier 4: $50 copayment for up to a 30-day supply; $100 copayment for up to a 60-day supply; $150 copayment for up to a 90-day supply Tier 5: $50 copayment for up to a 30-day supply; $100 copayment for up to a 60-day supply; $150 copayment for up to a

Services that are covered for you	What you must pay when you get these services
	90-day supply Tier 6: $0 copayment for up to a 30-day supply *Mail-order Cost-Sharing:* Tier 1: $10 copayment for up to a 30-day supply; $20 copayment for up to a 60-day supply; $20 copayment for up to a 90-day supply Tier 2: $10 copayment for up to a 30-day supply; $20 copayment for up to a 60-day supply; $20 copayment for up to a 90-day supply Tier 3: $25 copayment for up to a 30-day supply; $50 copayment for up to a 60-day supply; $50 copayment for up to a 90-day supply Tier 4: $50 copayment for up to a 30-day supply; $100 copayment for up to a 60-day supply; $100 copayment for up to a 90-day supply Tier 5: $50 copayment for up to a 30-day supply; $100 copayment for up to a 60-day supply;

Services that are covered for you	What you must pay when you get these services
	$100 copayment for up to a 90-day supply Tier 6: $0 copayment for up to a 30-day supply There is no benefit limit on Medicare Part B covered drugs.
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 still be considered an "outpatient."	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.
Physician/Practitioner services, including doctor's office visits *For some office visits (other than office visits to your PCP) and 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.* 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 • Diagnostic Hearing Exams • 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 for: acute and psychiatric inpatient hospital; skilled nursing facility; emergency/urgently needed care; partial hospitalization; primary care; specialist care; outpatient mental health; opioid treatment; outpatient substance abuse; and diabetes self-management training. You have the option of receiving these services either through an in-person visit or via	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 $15 primary care doctor or $25 specialist copayment for telehealth services. You pay a $25 copayment for Medicare-covered dental benefits. You pay $100 copayment for each Medicare-covered

Services that are covered for you	What you must pay when you get these services
telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that currently offers the service via telehealth. 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 ESRD-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 for diagnosis, evaluation or treatment of symptoms of an acute stroke • Brief virtual (for example, via telephone or video chat) 5-10 minute check-ins with your doctor—if you are an established patient and the virtual check-in is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment • Consultation your doctor has with other physicians via telephone, internet, or electronic health record assessment—if you are an established patient • 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 *(For reconstructive surgery to be covered, your PCP or other plan provider must get prior authorization (approval in advance) from the plan.)* 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.	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 surgery.
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.*	You pay a $20 a day copayment for days 1 through 6 of each skilled nursing facility admission.

Services that are covered for you	What you must pay when you get these services
(For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") You are covered for up to 100 days in each benefit period for skilled nursing facility care. No prior hospital stay is required. 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 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 is living at the time you leave the hospital.	You pay a $0 a day copayment for days 7 through 100 each benefit period.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Coverage is worldwide.	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 and its territories.

Chapter 6: What you pay for your Part D prescription drugs explains the three 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 a copayment.

- "Copayment" means that you pay a fixed amount each time you fill a prescription.

As shown in the table below, the amount of the copayment depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

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

	Retail cost-sharing (in-network) (up to a 30-day supply)	**Mail-order cost-sharing** (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred generic drugs)	$10 copay	$10 copay
Cost-Sharing Tier 2 (Generic drugs)	$10 copay	$10 copay
Cost-Sharing Tier 3 (Preferred brand drugs)	$25 copay	$25 copay
Cost-Sharing Tier 4 (Non-preferred brand drugs)	$50 copay	$50 copay
Cost-Sharing Tier 5 (Specialty drugs)	$50 copay	$50 copay
Cost-Sharing Tier 6 (Select care drugs (certain vaccines and anti-opioid drugs))	$0 copay	$0 copay

Section 5.4 A table that shows your costs for a long-term (90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)

The table below shows what you pay when you get a long-term up to a 90-day supply of a drug.

- Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

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

	Retail cost-sharing (in-network) (up to a 90-day supply)	**Mail-order cost-sharing** (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred generic drugs)	$30 copay	$20 copay
Cost-Sharing Tier 2 (Generic drugs)	$30 copay	$20 copay
Cost-Sharing Tier 3 (Preferred brand drugs)	$75 copay	$50 copay
Cost-Sharing Tier 4 (Non-preferred brand drugs)	$150 copay	$100 copay
Cost-Sharing Tier 5 (Specialty drugs)	$150 copay	$100 copay
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.