Fallon Community Health Plan, Inc.

DIRECT CARE AMENDMENTS

- Amendment 7 (eff. 01/01/22)
- Amendment 6
- Amendment 5
- Amendment 4 (eff. 01/01/21)
- Amendment 2 (eff. 01/01/21, part 2)
- Amendment 3 (eff. 10/01/20)
- Amendment 2 (eff. 06/01/20, part 1)
- Amendment 1
Fallon Community Health Plan, Inc.

AMENDMENT 7
This is part of your Direct Care
Member Handbook/Evidence of Coverage
Form #19-730-048
Effective January 1, 2022

This amendment changes certain sections of your Direct Care Member Handbook/Evidence of Coverage. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook, Schedule of Benefits or prior amendments that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TRS 711). Representatives are available Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:

1. The claims process
2. Emergency and urgent care
3. Prescription medication
4. Telehealth services
5. Other plan benefits and features

The following changes apply to your Member Handbook/Evidence of Coverage:

The claims process
Under Claims for Pharmacy Services in The claims process section, replace the entire section with the following:

Pharmacy reimbursement requests must be submitted within 1 year of date of service. Send claims to:

19-730-048_A7_0921
Direct Care

Amendment 7

Write: OptumRx
PO Box 650334
Dallas, TX 75265

Submit through OptumRx Portal: optumrx.com

**Emergency and urgent care**
Under **Emergency and urgent care** in the **Description of benefits** section, under **Covered services** remove the following:

6. Telemedicine visits with physicians through an agreement exclusively with Teladoc. Visits are performed by phone, video, or mobile app. These visits are used to diagnose, treat and prescribe medications (if necessary) for common health issues such as sinus problems, bronchitis, allergies, cold and flu symptoms, respiratory infection, or ear infection.

Teladoc does not replace your primary care physician; it is a convenient option for care. Please visit the Fallon Health website for URL link and additional information on Teladoc. See your Schedule of Benefits for cost-sharing information.

Add the following:

6. Fallon Health will cover telemedicine visits with physicians through an approved telehealth vendor. Visits are performed by phone, video, or mobile app. These visits are used to diagnose, treat and prescribe medications (if necessary) for common health issues such as sinus problems, bronchitis, allergies, cold and flu symptoms, respiratory infection, or ear infection. Please visit the Fallon Health website for information on the approved telehealth vendor, including a URL to access
Direct Care Amendment 7

services from the vendor. See your Schedule of Benefits for cost-sharing information.

Visits with the approved telehealth vendor do not replace your primary care physician; they are a convenient option for urgent care. Your primary care physician may also offer telehealth services. See the Telehealth services section of this Member Handbook/Evidence of Coverage, and the Telehealth section of your Schedule of Benefits, for benefit and cost-sharing information.

**Prescription medication**

Under Where you can fill your prescription in the Prescription medication section, replace the entire section with the following:

You can fill your prescription at a network pharmacy, a network mail-order pharmacy, or a network specialty pharmacy. (Please note that there are some medications that are not available through the mail-order program). Some medications may only be available through the network specialty pharmacy. (See Dispensing Limitations for more information.) We may allow a one-time fill of a specialty drug at a local pharmacy; after the one-time fill, you will receive a letter and a call to set up delivery of your drug through the specialty pharmacy network. See your Direct Care Provider Network directory for a list of network pharmacies or visit fallonhealth.org.

Under Opioid Management Program, replace the entire section with the following:

Opioid painkillers provide needed relief to those with acute or chronic pain. But given their potential for harm, and the very real – and pervasive – problem of misuse and use, ensuring appropriate use is more critical now than ever before. Our standard opioid management program is aligned with the “Guideline for Prescribing Opioids for
Direct Care

Chronic Pain” issued by the Centers of Disease and Prevention (CDC) in March 2016 and includes:

**Inappropriate Drug Therapy Combinations**
The pharmacy may need to contact your prescriber to resolve these issues:

- Opioids & Medication Assisted Treatment (MAT): reject for an opioid claim secondary to a MAT drug (includes only buprenorphine-combination products)
- Opioids & Benzodiazepine: reject for an opioid drug if the member has an existing claim for a benzodiazepine and vice versa
- Opioids & Prenatal Vitamin: reject for an opioid drug if the member has an existing claim for a prenatal vitamin claim and vice versa

**Inappropriate opioid quantities or dosing**
The pharmacy may need to contact your prescriber to resolve these issues:

- Members already on opioids: reject for a cumulative Short Acting Opioid/Long Acting Opioid dose check for >90 MME*/day
- Members new to opioids: reject for a cumulative Short Acting Opioid/Long Acting Opioid dose check for >50 MME*/day
- Members new to opioids: reject for Short Acting Opioid prescriptions for >7-day supply
- Members new to opioids: reject for a Long Acting Opioid with no paid claim for a Short Acting Opioid

The following requires prior authorization from your prescriber:

- Members already on opioids: Prior Authorization required for a cumulative Short Acting Opioid/Long Acting Opioid dose check for >180 MME*/day
Therapeutic Dose Limit
The pharmacy may need to contact your prescriber to resolve this issue:
- Cumulative acetaminophen dose check (with opioid-containing drugs) >4 grams/day (reject)

Refill Threshold
- This edit narrows the refill window for Schedule II-V controlled drugs to a 90% threshold at retail pharmacy and 80% at mail order

Opioid Management Edits
The following require prior authorization from your prescriber if exceeding the limit:
- Members new to opioids: Short Acting Opioids maximum 50 MME*/day
- Members new to opioids: Short Acting Opioids 7-day supply limit
- Members already on opioids: Short Acting Opioids maximum 90 MME*/day
- All members: use of Short Acting Opioids required before Long Acting Opioids
- All members: Quantity Limits on all Long Acting Opioids based on FDA maximum dosing frequency (i.e. once daily)
- All members: Maximum 2 opioid fills within a 60-day time period

Pediatric (≤19 years of age) Edits
The following require prior authorization from your prescriber if exceeding the limit:
- All pediatric members: PA required for all opioid containing cough and cold medications
- Pediatric members new to opioids: 3-day supply limit
*Morphine Milligram Equivalents are a way to compare different opioid medications based on their strength as compared to morphine.

Under **Mail-order prescriptions**, replace the second paragraph with the following:

When you fill your prescription through our mail-order program, you may order up to a 90-day supply of most medications. Certain opioid medications are limited to a 30-day supply at mail-order. Certain narcotic medications cannot be filled for a 90-day supply per Massachusetts law. Per Massachusetts state law, certain contraceptives may be available for up to a 12 month supply. You will be responsible for the appropriate cost-sharing amount, as noted in your Schedule of Benefits. Medications required to be obtained from the network specialty pharmacy (noted as “SP” on the on-line formulary) can only be obtained up to a one-month supply at a time. (See **Dispensing Limitations** for more information.)

Under **Prior Authorization Process**, replace the first paragraph with the following:

Prior authorization (PA) is required for any medication (including compounds) exceeding the cost threshold and any medication noted with a “PA”, “QL”, or “ST” on the Fallon Health formulary. A PA may also be required for a drug that exceeds our Opioid Management Strategy limits (See **Opioid Management Program** for more information) and for formulary exception requests. Before we will pay for these medications, your provider must fill out a Fallon Health prescription prior authorization form. This form will be reviewed by clinical pharmacists and compared to our clinical criteria. Requests are processed within 2 business days from the date of receipt of a complete request. Both the provider and member will receive written confirmation of approval or denial of the request. If the request is approved, you may fill your prescription at a network
pharmacy. If the request is denied, you and your provider will receive detailed denial information that includes your rights to appeal our decision.

Under **Exception Request for Contraceptives**, replace the entire paragraph with the following:

Generic contraceptives are covered in full. Brand name contraceptives generally require cost sharing such as a copayment. However, if your attending provider indicates you must use an FDA-approved brand contraceptive due to medical necessity you may make an exception request to have the brand name contraceptive covered with no cost sharing. Your attending provider should submit a PA to Fallon per the normal PA process and request an exception request for contraceptive cost sharing due to medical necessity. Examples of medical necessity include severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to appropriate use of the item or service.

Under **Non-Covered Items** (Amendment 5), replace the entire section with the following:

**Non-Formulary:**
Medications not on the formulary are considered non-formulary and are not covered.

**Exclusions:**
Medications listed below under “**Related Exclusions**” are considered excluded and are not covered.

If your provider feels that the medications on our formulary are not appropriate for your condition there is an exception request process available. Your prescriber must support the request by providing a statement that provides justification for supporting the need for the excluded drug to treat your condition, including a statement that all covered formulary drugs on any tier will be or have
been ineffective, would not be as effective as the excluded drug, or would have adverse effects. This request must be approved by Fallon Health before we will pay for the drug. Your attending provider should submit a PA to Fallon per the normal PA process and request an exception request. You or your prescribing physician may make an expedited exception request if exigent circumstances exist. Exigent circumstances exist when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug. You will be notified within 72 hours of receipt of information sufficient to begin our review for a standard request, or 24 hours of receipt of information sufficient to begin our review for an expedited request. If you disagree with the decision on your standard or expedited exception request above, you may file an external exception request. To file a standard or expedited external exception request please contact Fallon Health at 1-800-333-2535 or email us at grievance@fallonhealth.org. We will forward your external exception request to an independent review organization for a review and determination. The same standards and time frames outlined above will apply to standard and expedited external review requests.

If approved, a non-formulary or excluded drug will incur a copay associated with your highest generic (if the drug is a generic) or brand (if the drug is a brand) copay tier.

**Telehealth services**
After *Skilled nursing facility* in the Description of benefits section, add the following:
Telehealth Services
The plan provides coverage for clinically appropriate, medically necessary health care services delivered via telehealth by plan providers, when:

1. The health care services are covered when provided in-person, and
2. The health care services may be appropriately provided through the use of telehealth.

Telehealth is defined as the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including, but not limited to interactive audio video technology; remote patient monitoring devices; audio-only telephone and online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring a plan member’s physical health, oral health, mental health or substance use disorder condition. Most specialist visits require a PCP referral and some specialty services require prior authorization. (See Obtaining specialty care and services for additional information.)

Note: Not all providers offer a telehealth option. Please contact the providers’ office to find out if they offer telehealth services.

Covered services
The following services may be delivered via telehealth by plan providers:

1. Office visits with your primary care provider (PCP)
2. Office visits with a specialist
3. Office visits for the evaluation, diagnosis, treatment or management of a mental health, developmental or substance use disorder.
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.

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.

In addition to covering services delivered via telehealth by plan providers, the plan covers telehealth visits through an approved telehealth vendor. Refer to the Emergency and urgent care section of this Member Handbook/Evidence of Coverage for more information on telehealth services delivered by an approved telehealth vendor.

Exclusions
1. Health care services delivered via telehealth by non-plan providers without prior authorization from the plan

Other plan and benefits features
Under Other plan features in the Other plan benefits and features section, replace bullet 7 with the following:

- With Care Connect, you get free access, by phone to experienced registered nurses 24 hours a day, 7 days a week to answer your health questions.

Remove the following bullet:

- Caremark ExtraCare Health Care® discount, eligible members receive a CVS Caremark ExtraCare Health Card which allows them to receive a 20% discount on certain items at any CVS/pharmacy® store or online at www.cvs.com
AMENDMENT 6
This is part of your Direct Care
Member Handbook/Evidence of Coverage
Form #19-730-048

This amendment changes certain sections of your Direct Care Member Handbook/Evidence of Coverage. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook, Schedule of Benefits or prior amendments that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TRS 711). Representatives are available Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:

1. Our website
2. Medical management
3. Disenrollment rates
4. General exclusions and limitations

The following changes apply to your Member Handbook/Evidence of Coverage:

Questions? Just ask.
Effective immediately the following change applies:

Under Our website in the Questions? Just Ask. section, replace the first bullet with the following:

- Get online access to your claims, benefits and more–at any time of day or night

Log into MyFallon, our secure member portal, to see your copayments, track deductibles and out-of-pocket-maximums, change your PCP, check

19-730-048_A6_0121
authorizations and more. Visit fallonhealth.org/myfallon to register and log in.

**Medical management**
Effective immediately the following change applies:

Under **Services** in the **Medical management** section, replace the third paragraph with the following:

You may contact our toll free number 1-800-868-5200 or visit our website at www.fallonhealth.org to obtain the network status of an identified health care provider, an estimate for a proposed admission, procedure or service and the estimated amount you will be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit. Estimates will be based on the information available to us at the time you make your request. All costs are estimated, and the actual amount you pay may vary due to unforeseen services that arise out of the proposed admission, procedure or service.

**2020 Disenrollment rates**
Effective immediately the following change applies:

Under **Involuntary cancellation rate** in the **Leaving Fallon** section, replace entire paragraph with the following:

For the calendar year 2020, Fallon’s involuntary cancellation or disenrollment rate was 0.00%. The involuntary disenrollment rate includes any members disenrolled by the plan due to misrepresentation or fraud on the part of the member or commission of acts of verbal or physical abuse. For calendar year 2020, Fallon’s voluntary disenrollment rate was 0.03%.

**General exclusions and limitations**
Effective July 1, 2021 the following change applies:

Under **General exclusions and limitations** section (Amendment 4), replace bullet 13 with the following:
13. Contact lenses are covered only for: keratoconus; aphakia; or following a cornea transplant, for up to one year, if medically necessary. A lens applied as a bandage lens following an eye injury or to treat a diseased cornea is covered. Multifocal, astigmatism-correcting and presbyopia-correcting intraocular lenses are not covered.
This amendment changes certain sections of your Direct Care Member Handbook/Evidence of Coverage. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook, Schedule of Benefits or prior amendments that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TRS 711). Representatives are available Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:

1. Obtaining specialty care and services
2. Mental health and substance use services
3. Prescription medication

The following changes apply to your Member Handbook/Evidence of Coverage:

**Obtaining specialty care and services**

Effective October 1, 2020 the following change applies:

Under **Prior authorization** in the **Obtaining specialty care and services** section (Amendment 2), remove the following bullet:

- Neuropsychological testing

Add the following bullets:

- Electroconvulsive Therapy (ECT)
• Intermediate services for mental health and substance use treatment
• Psychological and Neuropsychological testing
• Transcranial Magnetic Stimulation (TMS)

**Mental health and substance use services**
Effective October 1, 2020 the following change applies:

Under **Mental health and substance use services** in the **Description of Benefits** section (Amendment 2), replace the entire section up to **Related exclusions** with the following:

The plan covers the diagnosis and treatment of mental health and substance use conditions on an outpatient and inpatient basis. A mental health and substance use condition is defined as a condition that is described in the most recent edition of the *Diagnostic and Statistical Manual* of Mental Disorders published by the American Psychiatric Association and that is determined as such by a plan provider and the plan. The level of care needed is authorized by a plan provider. Treatment may be provided by a psychiatrist, psychologist, psychotherapist, licensed nurse, mental health clinical specialist, licensed independent clinical social worker, mental health counselor, pediatric specialist, certified alcohol and drug abuse counselor, marriage and family therapist or other provider as authorized by the plan.

For mental health emergencies, follow the same procedures as for any other medical emergency, as outlined in **Emergency and urgent care**. Prior authorization will not be required for behavioral health inpatient admission after treatment in an emergency department.

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.

**Inpatient services**
The plan covers mental health services in an inpatient setting when authorized by the plan. To access services and obtain prior authorization, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660). Inpatient admissions generally require prior authorization. Prior authorization will not be required for behavioral health inpatient admissions after treatment in an emergency department, however. Prior authorization also will not be required for inpatient substance abuse services in any circumstances where this is not allowed by Massachusetts state law, including acute treatment services and clinical stabilization services for up to 14 consecutive days.

Unlimited coverage is provided for inpatient care when medically necessary in a licensed general hospital, a psychiatric hospital or a substance use facility (or its equivalent in an alternative program). Levels vary from least to most restrictive and include: respite or crisis stabilization; day or evening treatment or partial hospitalization; short-term residential treatment; and hospital-based programs.

**Covered service**
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.

2. Professional services provided by physicians or other health care professionals for the treatment of mental conditions while you are an inpatient.
Intermediate services
Members may receive mental health and substance use treatment in an alternative setting in lieu of inpatient hospitalization. Intermediate services may occur in 24-hour, non-24-hour and community based settings. Intermediate services generally require prior authorization. To access services and obtain prior authorization, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660).

Covered services
1. Acute and other residential treatment: Mental health services provided in a 24-hour setting therapeutic environments.

2. Clinically managed detoxification services: 24-hour, 7 days-a-week, clinically managed detox services in a licensed non-hospital setting that include 24-hour per day supervision.

3. Partial hospitalization: Short-term day/evening mental health programming available 5 to 7 days per week.

4. Intensive outpatient programs: Multimodal, inter-disciplinary, structured behavioral health treatment provided 2-3 hours per day, multiple days per week.

5. Day treatment: Program encompasses some portion of the day or week rather than a weekly visit.


7. In-home therapy services
Intermediate services for children and adolescents under the age of 19. Benefits are only available to members who are residents of Massachusetts or whose principal place of employment is in Massachusetts.

Direct Care Amendment 5
1. **Community-based acute treatment (CBAT):** provided in a staff-secure setting on a 24-hour basis to provide intensive therapeutic services including, but not limited to daily medication monitoring; psychiatric assessment; nursing availability; specialing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed.

2. **Intensive community-based treatment (ICBAT):** providing the same services as CBAT but for higher intensity—including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery.

3. **Intensive Care Coordination (ICC):** a collaborative service that provides targeted case management services to children and adolescents with a serious emotional disturbance, including individuals with co-occurring conditions, in order to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality, cost-effective outcomes. This service includes an assessment, the development of an individualized care plan, referrals to appropriate levels of care, monitoring of goals, and coordinating with other services and social supports and with state agencies, as indicated. The service shall be based upon a system of care philosophy and the individualized care plan shall be tailored to meet the needs of the individual. The service shall include both face-to-face and telephonic meetings, as indicated and as clinically appropriate. ICC is delivered in office, home or other settings, as clinically appropriate.

4. **Family Stabilization Team (FST):** FST (also referred to as In-Home Therapy), is an intensive family therapy model focused on youth who are most at risk for out-of-
home placement due to behaviors in the home. Youth and family engage in intensive family therapy, as well as some individual skill building to improve functioning. This service is implemented by a two-person team; a master's-level clinician creates the treatment plan and provides the clinical interventions while a paraprofessional conducts skill building activities with individuals, dyads, or groups within the family system.

5. **In-home Behavioral Services (IHBS):** a combination of medically necessary behavior management therapy and behavior management monitoring; provided, however, that such services shall be available, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. In-home behavioral services include:

- **Behavior management monitoring** - monitoring of a child's behavior, the implementation of a behavior plan and reinforcing implementation of a behavior plan by the child's parent or other caregiver.

- **Behavior management therapy** - therapy that addresses challenging behaviors that interfere with a child's successful functioning; provided, however, that "behavior management therapy" shall include a functional behavioral assessment and observation of the youth in the home and/or community setting, development of a behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy; and provided further, that "behavior management therapy" may include short-term counseling and assistance.
6. **Mobile Crisis Intervention (MCI):** a short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, 7 days a week to a child experiencing a behavioral health crisis. Mobile crisis intervention is used to identify, assess, treat and stabilize a situation, to reduce the immediate risk of danger to the child or others, and to make referrals and linkages to all medically necessary behavioral health services and supports and the appropriate level of care. The intervention shall be consistent with the child's risk management or safety plan, if any. Mobile crisis intervention includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan. Prior authorization not required for MCI.

**Outpatient services**
The plan covers services provided in person in an ambulatory care setting. Outpatient services may be provided in a licensed hospital, a mental health or substance use clinic licensed by the department of public health, a public community mental health center, or a professional office. Members may self-refer for outpatient mental health and substance use services. For assistance in finding a plan provider, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660).

The following outpatient behavioral health services require prior authorization:

- Psychological and Neuropsychological Testing
- Transcranial Magnetic Stimulation (TMS)
- Electroconvulsive Therapy (ECT)

The plan covers medically necessary mental health and substance use services from a plan provider, in an outpatient setting, as follows:
Covered services

1. Outpatient office visits, including individual, group or family therapy.

2. Psychopharmacological services, such as visits with a physician to review, monitor and adjust the levels of prescription medication to treat a mental condition

3. Neuropsychological assessment services when medically necessary

Effective January 1, 2021 the following change applies:

Under Intermediate services for children and adolescents add the following:

7. Family support and training: medically necessary services provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to ameliorate or resolve the child’s emotional or behavioral needs; provided, however, that such service shall be provided where the child resides, including in the child’s home, a foster home, a therapeutic foster home, or another community setting. Family support and training addressed one or more goals on the youth’s behavioral health treatment plan and may include educating parents/caregivers about the youth’s behavioral health needs and resiliency factors, teaching parents/caregivers how to navigate services on behalf of the child and how to identify formal and informal services and supports in the communities, including parent support and self-help groups.

8. Therapeutic mentoring services: medically necessary services provided to a child, designed to support age-appropriate social functioning or to ameliorate deficits in the child’s age-appropriate
social functioning resulting from a DSM diagnosis; provided, however, that such services may include supporting, coaching, and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution, and relating appropriately to other children and adolescents and to adults. Such services shall be provided, when indicated, where the child resides, including in the child’s home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service addressing one or more goals on the youth’s behavioral health treatment plan. It may also be delivered in the community, to allow the youth to practice desired skills in appropriate setting.

**Prescription medication**

Effective immediately the following changes apply:

Under **Prescription medication** in the **Description of Benefits** section (Amendment 4), add the following under **Covered items**:

Note: Compound medications (a drug that is specifically mixed and prepared for you, based on a prescription from your doctor) will incur a copay associated with your highest brand tier (typically, the non-preferred brand tier).

Under **Non-Covered Items** add the following under **Exclusions**:

If approved, a non-formulary drug will incur a copay associated with your highest generic (if the drug is a generic) or brand (if the drug is a brand) copay tier.
Fallon Community Health Plan, Inc.

AMENDMENT 4
This is part of your Direct Care 
Member Handbook/Evidence of Coverage 
Form #19-730-048 
Effective January 1, 2021

This amendment changes certain sections of your Direct Care Member Handbook/Evidence of Coverage. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook, Schedule of Benefits or prior amendments that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TRS 711). Representatives are available Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:

1. Glossary
2. Medical management
3. Durable medical equipment and prosthetic/orthotic devices
4. Prescription medication
5. General exclusions and limitations

The following changes apply to your Member Handbook/Evidence of Coverage:

Glossary
Under the Glossary section, replace Medical and surgical supplies definition with the following:

Fallon Health covers medical and surgical supplies that are necessary to meet a medical or surgical purpose and are non-reusable and disposable. Medical and surgical supplies include but are not limited to dressings,
antiseptics, blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, syringes, insulin pump supplies, insulin pens, ostomy and colostomy supplies, and supplies for continuous glucose monitors. Medical and surgical supplies must be obtained from a vendor that has an agreement with Fallon to provide such supplies. Your plan provider must order medical and surgical supplies. Some medical and surgical supplies require prior authorization.

**Note:** Medical and surgical supplies obtained through a pharmacy may have a drug prescription benefit cost-sharing applied. See your Schedule of Benefits for cost-sharing information.

**Medical management**
Under **Utilization management** in the **Medical management** section, add the following after the last paragraph:

**Infusions of certain drugs**
Fallon prefers infusions of certain drugs to be given by home infusion. Please refer to the Medical benefit formulary on our website for the drugs included in this program. Home infusions are provided by Fallon preferred home infusion providers. For outpatient hospital administration, the first doses may be given at facility of choice by the physician; all subsequent doses are preferred to be given by home infusion. Our home infusion service program will outreach to the member and provider to help determine if home infusion is the best option for the member or if there are exceptions that would require the member to receive the infusion in the hospital outpatient setting. Please note: certain members’ benefits may have a preferred infusion suite (rather than home infusion) for certain drugs.
Durable medical equipment and prosthetic/orthotic devices
Under Covered services in the Durable medical equipment and prosthetic/orthotic devices section, add the following:

8. Medical and surgical supplies

Prescription medication
Under Dispensing limitations in the Prescription medication section, add the following after the first paragraph:

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.

If you fill a prescription for an opioid (a covered drug that is a narcotic substance contained in U.S. Drug Enforcement Administration Schedule II), you may choose to obtain a fill in a lesser quantity than the full amount prescribed. If you do, you may then choose to later obtain the remainder of the prescribed fill. You will not be responsible for any copayment amount beyond the amount that would normally apply if you obtained the entire fill at once.

Under Covered items (Amendment 3), replace bullet 11 with the following:

- Prior authorization is required for blood glucose meters and supplies that are non-preferred brands, continuous or require adaptive features.

Blood glucose meters are limited to OneTouch® glucose meters and test strips manufactured by LifeScan. Plan members can obtain a OneTouch® glucose meter at network pharmacies, by calling LifeScan at 1-877-356-8480 (TTY: 711), order code number 160FCH002 or by going to the LifeScan website, www.onetouch.orderpoints.com and input
order code 160FCH002. Continuous blood glucose monitors are limited to the Freestyle Libre System. Members may obtain Freestyle Libre at network durable medical equipment suppliers or pharmacies.

Members with a demonstrated need, including having a severe visual impairment or impaired manual dexterity, may require a blood glucose meter with adaptive features, such as an integrated voice synthesizer or integrated lancing device. Prior authorization is required.

Under **Preventive medications**, add the following bullet:

- Certain medications for pre-exposure prophylaxis (PrEP) to prevent HIV infection

**General exclusions and limitations**

Under **General exclusions and limitations** section, replace bullet 13 with the following:

13. Contact lenses are covered only for: keratoconus; aphakia; or following a cornea transplant, for up to one year, if medically necessary. A lens applied as a bandage lens following an eye injury or to treat a diseased cornea is covered. Multifocal and presbyopia-correcting lenses are not covered.
Fallon Community Health Plan, Inc.

AMENDMENT 2
This is part of your Direct Care Member Handbook/Evidence of Coverage Form #19-730-048 Effective January 1, 2021

This amendment changes certain sections of your Direct Care Member Handbook/Evidence of Coverage. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook, Schedule of Benefits or prior amendments that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TRS 711). Representatives are available Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:

1. Mental health and substance use services

The following changes apply to your Member Handbook/Evidence of Coverage:

**Mental Health and substance use services**
For policies issued or renewed coincident with or following January 1, 2021, the following changes apply:

Under **Outpatient community-based services for children and adolescents** add the following:

5. **Family support and training:** medically necessary services provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to ameliorate or resolve the child’s emotional or behavioral needs; provided, however, that such service shall be provided where the child resides, including in the child’s home, a foster home, a therapeutic foster home, or another community setting. Family support
and training addressed one or more goals on the youth’s behavioral health treatment plan and may include educating parents/caregivers about the youth’s behavioral health needs and resiliency factors, teaching parents/caregivers how to navigate services on behalf of the child and how to identify formal and informal services and supports in the communities, including parent support and self-help groups.

6. **Therapeutic mentoring services:** medically necessary services provided to a child, designed to support age-appropriate social functioning or to ameliorate deficits in the child’s age-appropriate social functioning resulting from a DSM diagnosis; provided, however, that such services may include supporting, coaching, and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution, and relating appropriately to other children and adolescents and to adults. Such services shall be provided, when indicated, where the child resides, including in the child’s home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service addressing one or more goals on the youth’s behavioral health treatment plan. It may also be delivered in the community, to allow the youth to practice desired skills in appropriate setting.

Under **Related exclusions** remove the following:

10. Family support and training for children and adolescents under the age of 19

11. Therapeutic mentoring services for children and adolescents under the age of 19
This amendment changes certain sections of your Direct Care Member Handbook/Evidence of Coverage. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook, Schedule of Benefits or prior amendments that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TRS 711). Representatives are available Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:

1. Prescription medication

The following changes apply to your Member Handbook/Evidence of Coverage:

**Prescription medication**

Under **Covered items** in the **Prescription Medication** section, replace bullet 11 with the following:

- Preferred Blood Glucose Meters covered are limited to OneTouch® glucose meters and test strips manufactured by LifeScan. You can obtain a OneTouch® glucose meter at network pharmacies or by calling LifeScan at 1-877-356-8480, (TTY: 711), order code number 160FCH002 or by going to the LifeScan website, www.onetouch.orderpoints.com and input order code 160FCH002. LifeScan test strip quantities over 5 per day and other brand meters and test strips
require prior authorization. Continuous blood glucose monitors may be obtained at network durable medical equipment suppliers or pharmacies and require prior authorization.
This amendment changes certain sections of your Direct Care Member Handbook/Evidence of Coverage. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook, Schedule of Benefits or prior amendments that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TRS 711). Representatives are available Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:

1. Obtaining specialty care and services
2. Mental health and substance use services

The following changes apply to your Member Handbook/Evidence of Coverage:

**Obtaining specialty care and services**
Under Prior authorization in the Obtaining specialty care and services section, after bullets add the following:

*Prior authorization will not be required for inpatient behavioral health admissions after treatment in an emergency department.

**Mental Health and substance use services**
Under Mental Health and substance use services in the Description of benefits section, replace the second paragraph with the following:
For mental health emergencies, follow the same procedures as for any other medical emergency, as outlined in Emergency and urgent care. Prior authorization will not be required for behavioral health inpatient admission after treatment in an emergency department.

Under Inpatient services replace the first paragraph with the following:

The plan covers mental health services in an inpatient setting when authorized by the plan. To access services and obtain prior authorization, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660). Prior authorization will not be required for inpatient behavioral health admissions after treatment in an emergency department.
This amendment changes certain sections of your Direct Care Member Handbook/Evidence of Coverage. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook, Schedule of Benefits or prior amendments that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TRS 711). Representatives are available Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

Your Member Handbook/Evidence of Coverage has been amended to include information on the following:

1. Obtaining specialty care and services
2. Disenrollment rates
3. Mental health and substance use services
4. Preventive care

The following changes apply to your Member Handbook/Evidence of Coverage:

**Obtaining specialty care and services**

Effective April 1, 2020 the following change applies:

Under **Self-referral** in the **Obtaining specialty care and services** section, replace bullet number five with the following:

- Outpatient mental health and substance use services with plan providers. For assistance in finding a network provider call: 1-888-421-8861 (TDD/TTY: 1-781-994-7660).
Under **Prior authorization** section remove the following:

- Outpatient counseling for mental health and substance use conditions beyond eight visits
- Intermediate and outpatient community-based mental health services for children and adolescents under the age of 19

Add the following:

- Intermediate community-based mental health services for children and adolescents under the age of 19

### 2019 Disenrollment rates

Under **Involuntary cancellation rate** in the **Leaving Fallon** section, replace entire paragraph with the following:

For the calendar year 2019, Fallon’s involuntary cancellation or disenrollment rate was 0.00%. The involuntary disenrollment rate includes any members disenrolled by the plan due to misrepresentation or fraud on the part of the member or commission of acts of verbal or physical abuse. For calendar year 2019, Fallon’s voluntary disenrollment rate was 0.03%.

### Mental Health and substance use services

Effective April 1, 2020 the following change applies:

Under **Outpatient services** in the **Mental Health and substance use services** section, replace the first paragraph with the following:

The plan covers services provided in person in an ambulatory care setting. Outpatient services may be provided in a licensed hospital, a mental health or substance use clinic licensed by the department of public health, a public community mental health center, or a professional office. Members may self-refer for outpatient mental health and substance use services. For assistance in finding a plan provider, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660).
The plan covers medically necessary mental health and substance use services from a plan provider, in an outpatient setting, as follows:

Under **Covered services** replace number one with the following:

1. Outpatient office visits, including individual, group or family therapy.

**Preventive care**

The following change is effective immediately.

Under **Preventive care** in the **Description of Benefits** section, add the following under **Covered services**:

12. Tobacco counseling sessions with your primary physician or other provider designed to create a plan to stop smoking.