Member Handbook

Evidence of Coverage

Fallon Preferred Care

Administered by:

Special notice for non-group members
THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, available on request from Fallon Health & Life Assurance Company.

Important!

If you, or someone you're helping, has questions about Fallon Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-868-5200.

Spanish:
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Fallon Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-868-5200.

Portuguese:
Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Fallon Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-868-5200.

Chinese:
如果您，或是您正在協助的對象，有關於[插入項目的名稱 Fallon Health
方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-800-868-5200.

Haitian Creole:
Si oumenm oswa yon moun w ap ede gen kesyon konsènan Fallon Health, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-868-5200.

Vietnamese:
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Fallon Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-868-5200.

Russian:
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Fallon Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-868-5200.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Fallon Health، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب 1-800-868-5200.

Khmer/Cambodian:
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពី Fallon Health នោះ, អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មាន ជាភាសា របស់អ្នក ដោយមិនអស់ប្រាក់ ។

ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូម 1-800-868-5200 ។

French:
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Fallon Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-868-5200.

Italian:
Se tu o qualcuno che stai aiutando avete domande su Fallon Health, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-868-5200.

Korean:
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Fallon Health에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-868-5200로 전화하십시오.

Greek:
Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Fallon Health, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-800-868-5200.

Polish:
Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Fallon Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-868-5200.

Hindi:
यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Fallon Health [के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िुभाषषए से बात करने के लिए ,1-800-868-5200 पर कॉि करें।

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

Laotian:
້າທ່ານ, ຫ ູືຄົນທ ່ທ່ານກໍາລັງຊ່ວຍເຫ ູືອ, ມ ຄໍາຖາມກ່ຽວກັບ Fallon Health, ທ່ານມ ສິດທ ່ຈະໄດ້ຮັບການຊ່ວຍເຫ ູືອແລະຂໍ້ມູນຂ່າວສານທ ່ເປັນພາສາຂອງທ່ານບໍ່ມ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-800-868-5200.

Notice of nondiscrimination

Fallon Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Fallon does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Fallon Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at the phone number on the back of your member ID card, or by email at cs@fallonhealth.org.

If you believe that Fallon Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

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

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

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Compliance Director is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, D.C., 20201

Phone: 1-800-368-1019 (TDD: 1-800-537-7697)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Glossary

Adverse determination: a determination by FHLAC or our designated medical management agent, based upon a review of information, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the coverage requirements for medical necessity, appropriateness of health care setting, level of care or effectiveness.

Allowed charge: the amount that is used to calculate payment of your covered benefits. The allowed charge depends on the type of health care provider that furnishes a covered service to you. For participating providers, the allowed charge is based on the fee schedule negotiated with the provider. For nonparticipating providers, payment will be based on the provider's actual charge or the usual, customary and reasonable charge for that service, whichever is less. Allowed charges do not include charges for services in excess of benefit maximums stated in this *Member Handbook/Evidence of Coverage*, or for services when you have not followed medical management procedures as described in this *Member Handbook/Evidence of Coverage.* If a provider charges more than the usual, customary and reasonable charge, you may have additional financial obligations.

Anniversary date: the date each year when most major changes to your health plan take effect. Groups usually allow subscribers to switch health plans during a designated open enrollment period prior to the anniversary date.

Benefit maximum: the total amount of coverage provided for a particular service.

Benefit Period: The 12 month span of plan coverage, and the time during which the deductible, out-of-pocket maximum and specific benefit maximums accumulate.

Note: The benefit period for plans issued to eligible non-group individuals are on a calendar year basis. Eligible non-group individuals who enroll on a date that is later than January 1 will have a benefit period of less than 12 months.

Coinsurance: your share of the allowed charges for certain covered benefits, expressed as a percentage. For example, if your coinsurance is 20%, you pay 20% of the allowed charges for the services you received, and the plan pays the remaining 80%.

Contract: this *Member Handbook/Evidence of Coverage*, together with your Schedule of Benefits, any addenda, amendments, the subscriber's enrollment form, and the agreement that FHLAC has with your plan sponsor to provide health care benefits to the subscriber and dependents.

Copayment: the amount you pay for certain covered benefits. Copayment amounts for services are listed in the accompanying Schedule of Benefits. The provider usually collects copayments at the time of service.

Cosmetic services: A surgery, procedure or treatment that is performed primarily to reshape or improve the patient's appearance. Cosmetic services are not medically necessary, and are not covered, whether intended to improve an individual's emotional well-being or to treat a mental health condition.

Covered benefits: health care services and supplies that are covered by the plan, as described in this *Member Handbook/Evidence of Coverage*.

Custodial care: a level of care that is chiefly designed to assist a person with the activities of daily life and cannot reasonably be expected to improve a medical condition. Custodial care is not covered by the plan.

Deductible: the amount of allowed charges you pay per benefit period before payment is made by the plan for certain covered services under this plan.

Note: The deductible for plans issued to eligible non-group individuals accumulate on a calendar year basis. Eligible non-group individuals who enroll on a date that is later than January 1 will have to meet the full annual deductible amount even though the coverage was not in effect for a full 12-month period.

Deductible carryover: any deductible amount you incur for covered benefits during the last three months of a benefit period. This amount is applied to your deductible for the next benefit period. Deductible amounts are considered incurred as of the date of service. See your Schedule of Benefits for information on whether your benefits include the deductible carryover feature.

Diagnostic care: Services and tests that are intended to diagnose, check the status of or treat a disease or condition.

Durable Medical Equipment: Medical care-related items that 1) can withstand repeated use (e.g., could normally be rented), 2) are used in a private residence (not a hospital or skilled nursing facility), and 3) are primarily and customarily for a medical purpose and generally not useful to a person in the absence of illness or injury.

Effective date: the date, as shown on our records, on which your coverage begins under this contract or under an amendment to it. If you are a group member, your plan sponsor determines your effective date, in accordance with the group agreement.

Emergency medical condition: a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of prompt medical attention to result in: (1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergency services: inpatient and outpatient services provided in or out of the network, that are needed to evaluate or stabilize an emergency medical condition and furnished by a qualified, licensed provider.

Experimental/Investigational: In cases where a drug, device, treatment or procedure does not meet one or more of our technology criteria, the drug, device, treatment or procedure will be considered experimental or investigational. No coverage is provided for drugs, devices, treatments or procedures that our Technology Assessment Committee considers experimental or investigational.

If the committee determines that a technology is experimental or investigational, Fallon Preferred Care will not pay for any services, including but not limited to drugs, devices, treatments, procedures or facility and professional charges related to that technology.

Facility Fee: When a physician sees you in a hospital owned outpatient setting and receives lower reimbursement, there are typically two bills generated to your insurance company. There is a physician bill and the hospital also bills your insurance company for the staff, supplies, and overhead costs that the hospital is paying so that the hospital based physician has what he/she needs to see you. This second bill from the hospital to your insurance company is called a facility fee.

FHLAC: Fallon Health & Life Assurance Company, Inc. (also referred to as “the plan,” “us,” “we” and “our”).

Formulary: a list of prescription medications that are approved for coverage.

Group: any qualified partnership, organization or corporation that has an agreement with us to pay the plan or its agent the premium charge for a group of subscribers.

Housekeeping services: Those routine and necessary tasks carried out within the home to maintain the functioning of the household. This may include routine housecleaning and related chores; laundry; food preparation and dish washing.

In-network level of benefits: when you obtain services from a participating provider, you receive a higher level of coverage than for services obtained from a nonparticipating provider.

Inpatient: a registered bed patient in a hospital or other health care facility.

Medical and surgical supplies: Special products, such as materials used to repair a wound or instruments used for your care.

Medical management: a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to notification, prior-authorization, concurrent review, case management, discharge planning and retrospective review.

Medically necessary service: health care services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate available supply or level of service for the member considering potential benefits and harms to the individual; (b) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) the service or intervention, if not in widespread use, is based on scientific evidence.

Member: any person who is entitled to services under this contract. This includes the subscriber and any family members covered under the subscriber's contract (also referred to as "you").

Network: a group of health care providers who have contracted with FHLAC, either directly or through our agent, to provide services to members covered by this contract. We call the providers in our network "participating providers."

Notification: for certain types of admissions prior-authorization to determine medical necessity is not required; however, you are required to notify us of your admission by calling the appropriate medical management office.

Nurse Practitioner: A registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under Massachusetts General Laws Chapter 112, Section 80B.

Off-label: The prescribing of a medication in a different dose, for a different duration of time, or for a different medical indication than recommended in the prescribing information.

Open enrollment: A designated period, just prior to a group's anniversary date, when group members may change to another health plan or make changes to their existing health plan contract. Any changes made become effective on the group anniversary date.

Out-of-pocket maximum: The total amount of deductible, coinsurance and copayments you are responsible for in a benefit period. The out-of-pocket maximum does not include your premium charge, charges for which you are responsible due to failure to follow medical management procedures, or any amounts you pay for services that are not covered by the plan. Not all of your copayments, deductibles, or coinsurance payments or other expenses may count toward this limit. See your Schedule of Benefits for additional information.

Note: The out-of-pocket maximum for plans issued to eligible non-group individuals accumulate on a calendar year basis. Eligible non-group individuals who enroll on a date that is later than January 1 will have to meet the full annual out-of-pocket maximum amount even though the coverage was not in effect for a full 12-month period.

Out-of-network level of benefits: when you receive care from a nonparticipating provider, except for emergency care; for coverage of emergency care, see **Emergency and urgent care**. You must first meet the annual deductible before the plan begins paying benefits. Then you and the plan share the cost of the services you receive until you reach the out-of-pocket maximum.

Outpatient: care other than on an inpatient basis, for a patient who is not a registered bed patient in a hospital or other medical facility. This includes in a physician's office, a day surgery or ambulatory care facility, emergency room or observation room, or hospital outpatient department.

Participating provider: a health care provider who, under contract with FHLAC or with a contractor or subcontractor, has agreed to provide covered services to members with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly from FHLAC.

Participating provider arrangement: a contract between or on behalf of FHLAC or our agent and a participating provider that complies with the requirements of the applicable laws and regulations of Massachusetts.

Personal comfort items: Products which do not directly contribute to the treatment of an illness or injury or to the functioning of an injured body part. These include, but are not limited to: air conditioners, recliners, televisions, radios and telephones.

Physical functional impairment: A condition in which the normal or proper action of a body part is damaged. This may include, but is not limited to, problems with ambulation, communication, respiration, swallowing, vision, or skin integrity. A physical functional impairment affects the ability to participate in activities of daily living. A physical functional impairment does not include an individual's emotional well-being or mental health.

Physician Assistant: A person who is a graduate of an approved program for the training of physician assistants who is supervised by a registered physician in accordance with sections 9C to 9H, inclusive, of chapter 112 of the General Laws of Massachusetts, and who has passed the Physician Assistant National Certifying Exam or its equivalent.

Plan sponsor: the organization or group that administers your group plan (if you are a group member) such as designated under the Employee Retirement Income Security Act of 1974 (ERISA). This is usually your employer.

Prior-authorization: a review by a licensed, registered or certified health care professional that occurs prior to the delivery of covered health care services to determine medical necessity.

Preferred provider plan: a health plan that offers members a financial incentive to receive care from the plan's network of participating providers who have agreed to furnish specific covered services.

Premium charge: the amount we charge for your health care coverage provided under this contract.

Preventive care: Services and tests that are intended to screen for diseases or conditions and to improve early detection of disease when there is no diagnosis or symptoms present. This includes immunizations, routine physical exams for adults and children, as well as those mammograms, Pap tests and other tests associated with routine physical exams; prenatal maternity care; well-child care and voluntary family planning. For more information about the services that are considered preventive care, please see the preventive care guidelines on our website at www.fallonhealth.org, or call Customer Service.

Private Healthcare Systems (PHCS): FHLAC has contracted with MultiPlan, Inc. to provide Fallon Preferred Care members with the PHCS network of participating providers.

Provider: a health care professional or facility licensed in accordance with applicable state law to provide health care services, including, but not limited to, physicians, dentists, chiropractors, optometrists, podiatrists, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, physician assistants and behavioral health professionals.

Qualified clinical trial: a clinical trial that is intended to treat cancer or other life-threatening diseases or conditions. (1) It must have been reviewed and approved by one of the following: the U.S. National Institutes of Health (NIH); a cooperative group or center of the NIH; a qualified nongovernmental research entity interested in guidelines issued by the NIH for center support grants; the U.S. Food and Drug Administration pursuant to an investigational new drug exemption; the U.S. Departments of Defense or Veterans Affairs; or with respect to Phase II, III and IV clinical trials only, a qualified institutional review board. (2) The trial must have a therapeutic intent, and, to some extent, assume the effect of intervention. It must not unjustifiably duplicate existing studies. Any available clinical or preclinical data must provide a reasonable expectation that your participation in the trial will provide a medical benefit that is commensurate with the risks of participating in the trial. You must meet the eligibility criteria specified in the protocol, and before beginning treatment you must provide informed consent in a manner that is consistent with legal and ethical standards. (3) The facility and personnel conducting the trial must demonstrate that they are capable by virtue of their experience and training and must treat a sufficient volume of patients to maintain their expertise. With respect to Phase I trials, the facility must be an academic medical center or an affiliated facility, and the clinicians conducting the trial shall have staff privileges at said academic medical center.

Reconstructive surgery: A procedure performed to improve or correct a physical functional impairment resulting from a congenital defect or birth abnormality, accidental injury, prior surgical procedure or disease.

Restorative surgery: The initial procedure to repair or restore appearance that was damaged by an accidental injury. For example, the repair of a facial deformity following a serious automobile accident.

Room and board: Your room, meals and general nursing services while you are an inpatient.

Subscriber: the person who is responsible for the premium charge. On group plans, the subscriber is typically an employee of the plan sponsor.

Technology assessment criteria: Fallon Health & Life Assurance Company (FHLAC) maintains a formal mechanism for evaluating medical technologies through our Technology Assessment Committee. The committee includes physician administrators, practicing physicians from the plan's service area and plan staff. When necessary, the committee seeks the input of specialists or professionals who have expertise in the proposed technology. In all cases, the technology is reviewed against the following technology assessment criteria:

1. The technology must have final approval from the appropriate government regulatory body. This applies to drugs, devices, biologics, and treatments or procedures that must have final approval to market from the U.S. Food and Drug Administration or any other federal governmental body with authority to regulate the technology. Devices must have final FDA approval for the specific indications under evaluation by FHLAC.

2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the study as well as the results are considered in evaluating the evidence. Opinions by national medical associations, consensus panels, or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence.

3. The evidence must show that the technology improves health outcomes. Specifically, the technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.

4. The technology must be at least as effective as the established technology. In addition, the technology must be as cost-effective as any established alternatives that achieve a similar health outcome.

5. The outcome must be attainable outside investigational settings.

Terminal illness: an illness, which results in a life expectancy of less than six months.

Urgent care: care that is needed right away, such as care for cuts that require stitches, a sprained ankle or abdominal pain.

Usual, customary and reasonable charge: an amount that is consistent with the normal range of charges for the same or similar services in the geographical area where the service was provided, as determined by the plan.

About this *Member Handbook/Evidence of Coverage*

This *Member Handbook/Evidence of Coverage* is effective January 1, 2018. There are no waiting periods or pre-existing condition limitations under this contract. You may begin using the services described in this *Member Handbook/Evidence of Coverage* on January 1, 2018, or on your effective date, whichever comes later.

Fallon Preferred Care is a preferred provider plan offered by Fallon Health & Life Assurance Company, Inc. (FHLAC). FHLAC is a wholly owned subsidiary of Fallon Health, with administrative offices located at 10 Chestnut St., Worcester, MA 01608. Fallon Preferred Care is offered as a group health insurance plan to employers in Massachusetts, and as a non-group (consumer) plan to individuals who reside in Massachusetts.

Fallon Preferred Care maintains a network of doctors, hospitals and other health care providers who have agreed to care for you. We call these doctors, hospitals and other health care providers "participating providers." The plan is designed to give you the flexibility of obtaining covered services from a participating provider, or from a nonparticipating provider if you choose. When you get covered benefits from a participating provider your costs will generally be lower than if you get covered benefits from a nonparticipating provider.

This *Member Handbook/Evidence of Coverage* details the benefits and services that Fallon Preferred Care covers, explains our policies and procedures and contains other information such as:

- Definitions of important terms
- Our customer service capabilities
- Medical management procedures
- Your rights and responsibilities
- Claims procedures
- Types of coverage available
- Additional contract provisions
- Covered services
- Exclusions

This *Member Handbook/Evidence of Coverage* is part of your contract with us. Your contract also includes your Schedule of Benefits and any amendments to this *Member Handbook/Evidence of Coverage*, the agreement that we have with your plan sponsor to provide your health care benefits (if you belong to a group), and your signed application.

A Schedule of Benefits is included, which lists your costs for covered services. If you belong to a group that has arranged for additional benefits, or benefits that are different from those described in this *Member Handbook/Evidence of Coverage*, you can find that information in the Schedule of Benefits as well. The information contained in a Schedule of Benefits replaces any information in this *Member Handbook/Evidence of Coverage* that conflicts with it. There also may be addenda included, describing other benefits that are available to you. If we need to update or change your handbook, we will send you, or in the case of a group policy, the group representative, an amendment.

It is important to keep this booklet and your Schedule of Benefits, along with any amendments, in a place for easy reference.

Questions? Just ask.

We are committed to your satisfaction and helping you get the most from your Fallon Preferred Care membership. We offer many resources to help you, including a dedicated Customer Service and Member Appeals and Grievances staff. If you have questions, call or visit:

1-888-468-1541 (TRS 711)
fallonhealth.org

For answers to general questions or inquiries

- See also **inquiries, appeals and grievances**

With questions about your membership card

- If you do not receive a card
- If you lose or damage your card

To notify us of changes

- To report any changes in your name, address, phone number, marital status, number of dependents, or any other pertinent information

To order materials

- The Fallon Preferred Care Provider Directory, which has a list of participating providers in the Fallon Preferred Care provider network.
- Additional copies of the *Member Handbook/Evidence of Coverage*, Schedule of Benefits, and addenda or amendments

Customer Service 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. Eastern time. You'll also find information and answers to many of your questions at our website. You'll also be able to perform a number of transactions.

Our website:
fallonhealth.org

For information on Fallon's products and services, visit us at fallonhealth.org. Our website is where you can learn more about your plan and its benefits and features. It's also a convenient and secure way to communicate with us. You can use the site to:

- **Register and log into *my*Fallon** – a secure area to view your specific benefit information, view your claims, change your PCP, print a temporary ID card and more
- Search for a doctor in the provider directory
- Shop and compare health care costs using Fallon SmartShopper
- Use our online health encyclopedia and reference guide for answers to your health questions
- Contact Customer Service

Can't find what you need online? Use our site search feature or contact the webmaster with your suggestions.

Understanding your health care coverage

Fallon Preferred Care is a preferred provider plan. The plan provides two levels of benefits. You receive the in-network level of benefits when you obtain covered services from providers who have agreed to participate in the plan. You receive the out-of-network level of benefits when you obtain covered services from nonparticipating providers, with the exception of services for an emergency medical condition (see **emergency and urgent care**). Benefit levels for covered services with nonparticipating providers are not less than 80% of the benefit levels for the same covered services with participating providers, excluding deductibles and copayments.

Your membership card

When you enrolled in Fallon Preferred Care, we mailed a membership card for each covered family member. Please carry the card with you at all times. Providers may ask you for your membership card when you seek medical care, or you may be asked for your card when you fill a prescription at a plan pharmacy.

You should receive your card within 30 days of the date that we receive and verify your enrollment request. If you do not receive a card, if the information on your card is incorrect, or if you lose or damage your card, contact Customer Service to request a new card.

Notifying us of changes

Contact customer service to report any changes in your name, address, phone number, marital status, number and status of dependents or any other pertinent information. If there is a change to your family status that would require a change to your contract type (for example, you have an individual contract, but you marry or have children), group members should request a change in status through their employer plan sponsor within 30 days of the event. Individual non-group members enrolled in a consumer plan should request a change in status within 60 days of the event.

In- and out-of-network coverage

Fallon Preferred Care is a preferred provider plan, and as such, we contract with a network of participating providers (health care professionals and hospitals) that have agreed to provide health care services to our members. Your use of participating providers is strictly voluntary, but will affect the level of benefits you receive.

When you obtain covered services from participating providers you will receive the in-network level of benefits. Fallon Preferred Care pays participating providers directly; you will not have to file claims when you use participating providers. You get the out-of-network level of benefits whenever you obtain covered services from nonparticipating providers. You may need to submit claims for covered benefits you receive from nonparticipating providers. (For information on claims submission, see **the claims process**.)

Covered services may be subject to either a copayment or a deductible. For services subject to a deductible, after your deductible is met, you will generally be responsible for paying the coinsurance amount. Coinsurance is your share of the cost of covered benefits and is expressed as a percentage, for example, 20%. There is a limit to the amount you will be required to pay in deductibles and coinsurance. This is called your out-of-pocket maximum. Your individual copayments, deductible, coinsurance amounts and out-of-pocket maximum are listed in the enclosed Schedule of Benefits.

Deductible

Each member must meet the per-member deductible, unless the family deductible applies. The family deductible is considered met when any combination of members in a family reaches the family deductible amount.

If you are covered under a qualified high deductible plan, any one member in a plan that is subject to the family deductible who accumulates services totaling the minimum family deductible amount allowed under IRS guidelines in the applicable benefit period has met the deductible, and will receive benefits for covered services less any applicable copayments or coinsurance. The remaining members in a plan that is subject to a family deductible must fulfill the balance of the family plan deductible amount.

Once you have satisfied your deductible, you will receive benefits based on the cost sharing amounts listed in your Schedule of Benefits until (1) the end of the benefit period or (2) you reach your out-of-pocket maximum.

Deductible carryover

See your Schedule of Benefits for information on whether your benefits include the deductible carryover feature. If your benefits include deductible carryover, any deductible amounts you pay during the last three months of the benefit period will be applied to your deductible for the next benefit period. Deductible amounts are incurred as of the date of service. If your benefits do not include deductible carryover, your deductible amounts cannot be carried over under any circumstances.

Out-of-pocket maximum

Each member must meet the out-of-pocket maximum, unless the family out-of-pocket maximum applies. The family out-of-pocket maximum is considered met when any combination of members in a family reaches the family out-of-pocket maximum amount. No individual family member will pay more than the per member out-of-pocket maximum in a benefit period.

Once you have met your out-of-pocket maximum, you will receive full benefits, up to the allowed charge, to the end of the benefit period.

Medical management procedures

Whether you obtain care from participating providers or nonparticipating providers, there are medical management procedures for certain services. See the glossary of this *Member Handbook/Evidence of Coverage* for a definition of medical management.

If you do not follow medical management procedures (prior-authorization and notification), you will be responsible for additional charges. These amounts are in addition to any deductible or coinsurance amounts you must pay, and are not counted toward your out-of-pocket maximum. See the Schedule of Benefits for more information.

Know your covered benefits

Only medically necessary services and supplies, described in this *Member Handbook/Evidence of Coverage*, are covered under this plan. If the plan determines that a service or supply was not medically necessary, no benefits will be paid. Additionally, this plan has medical management features. Medical management determines whether a covered benefit is medically necessary for you. The **medical management** section includes more detailed information on medical management procedures. Certain services require prior-authorization. This means that you must have the plan review your request for care before you receive it. It is important that you read and understand this *Member Handbook/Evidence of Coverage* to familiarize yourself with the way this plan works. If you fail to follow medical management procedures (prior-authorization and notification) as described, you will be responsible for additional charges.

These amounts are in addition to any deductible or coinsurance amounts you must pay, and are not counted toward your out-of-pocket maximum. See the Schedule of Benefits for more information.

The participating provider network

FHLAC has contracted with providers directly, through MultiPlan, Inc. (Private Health Care Systems Network), through Beacon Health Strategies (Behavioral Health), and through American Specialty Health Networks (chiropractic), to provide a comprehensive network of participating providers. Whether you choose to get your health care from a participating provider or a nonparticipating provider will not affect the covered benefits that are available to you. However, your costs will generally be lower if you get your care within the network of participating providers. To find a participating provider, you can search online at fallonhealth.org, or call Customer Service to request a printed copy of the provider directory. Customer Service representatives also can assist you in locating a participating provider.

When you receive in-network and out-of-network coverage for the same condition

Under some circumstances, you may receive services from both a participating and nonparticipating provider for the same medical condition. When this occurs, your level of coverage depends on the participation status of the individual provider. For example, you may be receiving treatment from a participating provider. The services of that provider would be covered at the in-network level of benefits.

Your participating physician may then choose to admit you to a nonparticipating hospital. In this case, the participating physician's charges would be covered at the in-network level of benefits, and the nonparticipating hospital's charges would be covered at the out-of-network level of benefits. It is your responsibility to find out prior to receiving services if the provider is in the Fallon Preferred Care network.

Coverage of care for an emergency medical condition

An emergency medical condition is defined as a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity (including severe pain), such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of prompt medical attention to result in serious jeopardy to the health of the individual (or unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Examples of covered emergencies are stroke, unconsciousness, heart attack symptoms or severe bleeding.

If you have an emergency medical condition, you should go to the nearest emergency room for treatment, or you or someone acting on your behalf should call the local emergency medical system (police, fire department or 911).

When you need emergency services and cannot reasonably reach a participating provider, coverage will be provided at the same level and in the same manner as if a participating provider had treated you. After your emergency medical condition has been evaluated in the emergency room, you may be ready to go home or you may need further care.

If your condition requires that you be admitted directly from the emergency room to the hospital for inpatient emergency care, such as emergency surgery, you or someone acting on your behalf must notify the appropriate medical management office as soon as possible, but not later than 72 hours following your admission.

- If you are a Massachusetts resident, notify Fallon Health medical management at 1-800-868-5200 (except for mental health or substance abuse conditions).
- If you are a Massachusetts resident, and you are hospitalized for mental health or substance abuse conditions, notify Beacon Health Strategies medical management at 1-888-421-8861.
- If you are a resident of any other state (outside of Massachusetts), notify American Health Holding medical management at 1-866-353-1787.

If you do not notify the appropriate medical management office, you will be responsible for additional charges. These amounts are in addition to any deductible or coinsurance amounts you must pay, and are not counted toward your out-of-pocket maximum. See the Schedule of Benefits for more information.

Medical management

Fallon Preferred Care uses medical management procedures to help ensure the quality of the health care services available to you. Medical management is a process of reviewing the use of covered benefits to determine medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Fallon Preferred Care medical management includes prior-authorization, notification, concurrent review and retrospective review.

The appropriate medical management office to contact depends on whether you are a Massachusetts resident, and what service you are seeking. FHLAC has arranged for the following entities to provide medical management services for Fallon Preferred Care members:

- Fallon Health, FHLAC's parent company, provides medical management services for Massachusetts residents, except for services received for mental health and substance abuse conditions, high-tech radiology and sleep study therapy. To reach Fallon, call 1-800-868-5200.
- Beacon Health Strategies (Beacon) provides medical management services for Massachusetts residents for mental health and substance abuse conditions. To reach Beacon, call 1-888-421-8861.
- eviCore provides medical management services for all members (in state and out-of-state) for high-tech radiology services, including, but not limited to, all outpatient MRI/MRA, CT/CTA, PET and nuclear cardiology imaging studies. To reach eviCore call 1-888-693-3211.
- Sleep Management Solutions provides medical management services for all members (in state and out-of-state) for sleep study and/or sleep therapy services. To reach SMS call 1-866-827-2469 (Monday – Friday, 8:00 a.m. – 5:00 p.m. EST).
- American Health Holding, Inc. (AHH) provides all medical management services including mental health and substance abuse conditions for members who live outside of Massachusetts, with the exception of high-tech radiology and sleep studies (see above bullets). To reach AHH, call 1-866-353-1787.

Prior authorization

Certain services require prior authorization. We will review these services and let you know if they are covered and medically necessary before you have the service. In order to do this review, you or someone acting on your behalf must call the appropriate medical management office at least five business days before the service.

The services that need prior authorization are:

- Admissions to all inpatient facilities, including admissions for medical and surgical care, skilled nursing and rehabilitation, and mental health and substance abuse (including intermediate care)
- Outpatient surgery
- Infertility/assisted reproductive technology services
- Organ transplants
- Hospice care
- Prosthetics/orthotics and durable medical equipment
- Medically necessary nonemergency ambulance transport
- Genetic testing
- Neuropsychological testing
- Anesthesia for GI endoscopy procedures
- Habilitative or rehabilitative care, including but not limited to ABA therapy, for the treatment of autism
- Therapeutic care for the treatment of autism
- Oral surgery (with the exception of the extraction of impacted teeth)
- Enteral formulas and special medical formulas
- High-tech radiology, including, but not limited to, all outpatient MRI/MRA, CT/CTA, PET and nuclear cardiology imaging studies

- Sleep study and/or sleep therapy
- Injections and injectables that are included on the formulary, that are for covered medical benefits, and that are ordered, supplied and administered by a plan provider
- Reconstructive and restorative services
- Oxygen
- Outpatient mental health services (including intermediate care), beyond eight sessions
- Pulmonary rehabilitation services for chronic obstructive pulmonary disease (COPD)
- Intensity modulated radiation therapy (IMRT) of the breast
- Proton beam therapy
- Stereotactic radiosurgery and stereotactic body radiotherapy
- Treatment of cleft lip and cleft palate
- Brand name prescription contraceptive drugs and devices with no generic equivalent
- Bariatric Weight Loss Surgery
- Gender reassignment, gender identity or gender dysphoria and related health care services

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 abuse services. We will not require prior authorization for substance abuse services in any circumstances where this is not allowed by Chapter 258.

Anyone—a member, family member, provider, provider designee, nurse or hospital admissions personnel—may call, but it is your responsibility to ensure that the services receive prior-authorization. If you do not call for prior-authorization and do not receive approval for the above services before you receive them, you will be responsible for additional charges. These amounts are in addition to any deductible or coinsurance amounts you must pay, and are not counted toward your out-of-pocket maximum. See the Schedule of Benefits for more information.

Medical management offices are staffed with customer service representatives, registered nurse care coordinators and physician advisors. When you call, a customer service representative will review your request. In some cases, the customer service representative will certify the request immediately. In other cases, the customer service representative will refer you to a care coordinator who may ask you or your provider for additional clinical information that will be reviewed against medical criteria. Occasionally, a physician advisor will review the case to make a determination. In all cases, a prior-authorization decision will be made within two business days of receipt of all the necessary information. For the purposes of this section, necessary information includes the results of any face-to-face clinical evaluation or second opinion that may be required.
Medical management offices will notify the provider rendering the service by telephone within one business day, and will send written or electronic confirmation to you and the provider within two business days thereafter. Written confirmation will include the services prior-authorization, and any other pertinent information such as location of care and length of stay.

Any decision to deny a request for care is called an adverse determination. Only a physician advisor can make an adverse determination regarding a request for care. When a physician advisor makes an adverse determination, he or she will notify the provider rendering the service by telephone within one business day, and will send written confirmation of the telephone notification to you and the provider within one business day thereafter.

The written notification of an adverse determination will explain our decision and provide a description of our internal grievance review process as well as the procedure for requesting an external review from the Massachusetts Office of Patient Protection. (For more information on internal and external grievance review processes see **inquiries, appeals and grievances**.)

To obtain information on the status of your request for care or to discuss the outcome of a medical management decision, call the appropriate medical management office. Please identify yourself as a Fallon Preferred Care member.

Notification

In some cases we need to be notified of your admission. You must notify the appropriate medical management office as soon as possible, but not later than 72 hours following:

- An emergency admission
- When your routine maternity admission continues beyond 48 hours for a vaginal delivery or 96 hours for a Caesarean delivery

Anyone—a member, a family member, provider, provider designee, nurse or hospital admissions personnel—may call, but it is your responsibility to ensure that the appropriate medical management office is notified of the services. If you do not call with notification of the above services in the time frames shown, or if you do not follow medical management procedures, you will be responsible for additional charges. These amounts are in addition to any deductible or coinsurance amounts you must pay, and are not counted toward your out-of-pocket maximum. See the Schedule of Benefits for more information.

Concurrent review, discharge planning and case management

While you are an inpatient, your care will be monitored to ensure that treatment continues to be medically necessary and that the length of stay and location of care are appropriate to your condition. In certain conditions, such as for a severe illness or injury, case managers will be involved in coordinating your care while you are an inpatient and arranging your transfer to a rehabilitation or skilled nursing facility, or discharge to home when appropriate. In addition to managing inpatient care, a case manager will coordinate home care and hospice services to ensure that your health care needs are met after you are discharged. In some instances, you may need to request an extension of your hospital stay or request additional services beyond what was authorized at the time of the initial determination. In these cases, the medical management office will notify the provider within one business day, and provide written confirmation to the member and the provider within one business day thereafter. The written confirmation will include specific information on the new length of hospital stay or other services approved. The services you are receiving will be covered until you receive notification of the determination.

Any decision to deny continued coverage is called an adverse determination. Only a physician advisor can make an adverse determination. When a physician advisor makes an adverse determination, he or she will notify the provider rendering the service by telephone within one business day, and will provide written or electronic confirmation of the telephone notification to you and the provider within one business day thereafter. The written notification of an adverse determination will explain our decision and provide a description of our internal grievance review process as well as the procedure for requesting an external review from the Massachusetts Office of Patient Protection. (For more information on internal and external grievance review processes, see **inquiries, appeals and grievances**.)

Retrospective review

Retrospective review evaluates care that you have already received to ensure that the service is a covered benefit and to determine that the service was medically necessary for the member. The plan conducts retrospective review at the point when the claim is presented for payment. If we determine that your care was not a covered benefit or that it does not meet criteria for medical necessity, we will deny the claim, and you will be responsible for paying the provider for the services you received.

Medical necessity

Medical criteria are a set of guidelines used to determine if the service you are requesting is medically necessary. Medical criteria are developed by a committee with the input of practicing physicians from the service area to ensure that care is consistent with the generally accepted standards of medical practice. The committee updates medical criteria at least annually or more often, as new treatments or technologies are adopted as generally accepted professional medical practice. All services are subject to review for medical necessity. If it is determined that services received were not medically necessary, you will be responsible for paying the provider for the services you received.

Quality management
FHLAC's Quality Management Program systematically measures, monitors, evaluates and improves the performance of Fallon Preferred Care with respect to the care and service received by its members. Components of the program include careful attention to credentialing and recredentialing of providers, and evaluation of all member complaints. The plan also monitors and assures appropriate access to participating providers and periodically assesses member satisfaction with the plan.

Assessing new technologies
FHLAC maintains a formal mechanism for evaluation of new medical technologies through the Technology Assessment Committee. The committee includes physician administrators, practicing physicians, and plan staff who perform extensive literature review regarding the proposed technology, including information from governmental agencies, such as the U.S. Food and Drug Administration (FDA), and published scientific evidence. We also make use of external research organizations that perform reviews of available literature regarding a given procedure. When necessary, the committee seeks input from specialists or professionals who have expertise in the proposed technology.

The committee recommends for health plan coverage those procedures that can offer improved outcomes to our members without substantially increasing the risks of treatment.

FHLAC has a separate but similar process for evaluation of new drugs and medications, with reviews performed by the Pharmacy and Therapeutic Committee.

Services
Whenever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to you within the network of participating providers, we will cover the out-of-network admission, procedure or service and you will not be responsible to pay more than the amount which you would be required for similar admissions, procedures or services offered within the network of participating providers.

Whenever a location is part of our network, we will cover medically necessary covered benefits delivered at that location and you will not be responsible to pay more than the amount required for network services even if part of the medically necessary covered benefits are performed by out-of-network providers unless you have a reasonable opportunity to choose to have the service performed by a plan provider.

You may contact our toll free number 1-888-468-1541 or visit our website at www.fallonhealth.org to obtain 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.

Member rights and responsibilities

As a Fallon Preferred Care member, you have the right to:

- Be informed about Fallon Preferred Care and covered services.
- Receive information about Fallon Preferred Care, its services, its practitioners and providers, and members' rights and responsibilities.
- Be informed about how medical treatment decisions are made by the contracted medical group or Fallon Preferred Care, including payment structure.
- Your choice of practitioners and hospitals.
- Know the names and qualifications of participating physicians and health care professionals involved in your medical treatment.
- Receive information about an illness, the course of treatment and prospects for recovery in terms that you can understand.
- Actively participate in decisions regarding your own health and treatment options, including the right to refuse treatment.
- Receive emergency services when you, as a prudent layperson acting reasonably, would have believed that an emergency medical condition existed.
- Candidly discuss appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage, presented by your provider in a manner appropriate to your condition and ability to understand.
- Be treated with dignity and respect, and to have your privacy recognized.
- Keep your personal health information private as protected under federal and state laws—including oral, written and electronic information across the organization. Unauthorized people do not see or change your records. You have the right to review and get a copy of certain personal health information (there may be a fee for photocopies).
- Make complaints and appeals without discrimination about Fallon Preferred Care or the care provided, and expect problems to be fairly examined and appropriately addressed.
- Exercise these rights regardless of your race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care. Expect these rights to be upheld by both Fallon Preferred Care and its participating providers.
- Make recommendations regarding Fallon Preferred Care's member rights and responsibilities policies.

As a Fallon Preferred Care member, you have the responsibility to:

- Provide, to the extent possible, information that Fallon Preferred Care, your physician or other care providers need in order to care for you.
- Do your part to improve your own health condition by following any treatment plan, instruction and care that you have agreed on with your physician(s).
- Understand your health problems, and participate in developing new and existing mutually agreed upon treatment goals to the degree possible.

For questions about your rights or responsibilities as a member of Fallon Preferred Care:

Fallon Health & Life Assurance Company
10 Chestnut St.
Worcester, Massachusetts 01608
Toll-free phone: 1-888-468-1541 (TRS 711)
fallonhealth.org

For questions about a Massachusetts physician (including physician profiling information):

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01881
Phone: 1-781-876-8200
Fax: 1-781-876-8383
mass.gov/massmedboard

Confidentiality of member information

In support of our commitment to protect our members' privacy, FHLAC has in place a comprehensive, corporate-wide privacy and security program. The ultimate goal of FHLAC's privacy and security program is to safeguard our members' protected health information (PHI) from inappropriate access, use, and disclosure while permitting appropriate access in order to provide the highest quality health care coverage for our members.

Our numerous privacy and security policies and procedures address the protection of PHI in all forms—oral, written, and electronic—across the organization. We define the appropriate uses and disclosures of information, such as members have the right to authorize the disclosure of PHI for certain non-routine uses and disclosures, and employers' right to access PHI for enrollment and disenrollment purposes and under other limited circumstances. Our policies and procedures also address the rights members have with respect to their PHI.

You can be confident that all of us at Fallon Health & Life Assurance Company are committed to safeguarding the privacy and security of our members' PHI. For details on how we use and share your information, please read FHLAC's Notice of Privacy Practices. The Notice of Privacy Practices also provides information regarding the rights members have with respect to their PHI and how members can invoke those rights. For example, members have the right to access most PHI FHLAC has about them, grant others access to their PHI, and request restrictions on who can access their PHI.

This notice is provided to all new subscribers upon enrollment and is available on the Fallon website, fallonhealth.org (keyword: "privacy policies"), or, for a printed copy, call our Customer Service Department at 1-888-468-1541 (TRS 711).

Inquiries, appeals and grievances

Whenever you have a question or need help using plan providers and services, FHLAC encourages you to contact Customer Service. If you have a question or concern regarding an adverse determination or if you would like to file an appeal or grievance, contact the Member Appeals and Grievances Department.

An adverse determination means a determination by FHLAC or our designated medical management agents, based upon a review of information that denies, reduces, modifies or terminates coverage for health care services. This includes, but is not limited to, cases where the treatment does not meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness. A rescission of coverage may also be appealed.

Making an inquiry

If you have a question or need help with an issue that is not about an adverse determination, contact Customer Service. You can reach our Customer Service Representatives in the following ways:

Call: 1-888-468-1541 (TRS 711)
Monday, Tuesday, Thursday, and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

E-mail: cs@fallonhealth.org

Write: Fallon Health & Life Assurance Company
Fallon Preferred Care
Customer Service Department
10 Chestnut St.
Worcester, MA 01608

In most cases, our Customer Service Representatives will be able to answer your question or handle your request the first time you call. In some cases, however, FHLAC may need to do more research before FHLAC completes your request. In these cases, FHLAC will make every effort to provide you with a response within three business days. If FHLAC has not been able to provide a satisfactory response to your inquiry within this time period, FHLAC will send you a letter explaining your right to continue with the inquiry process or to have your request handled as a grievance. If you tell FHLAC that you want to have your issue handled as a grievance, FHLAC will proceed to the grievance procedure. (See **Filing a grievance**).

Filing an appeal: internal appeal review

If you disagree with an adverse determination about coverage related to your care, you may file an appeal. An appeal is a request to change a previous decision made by FHLAC.

You may file the appeal yourself, or with the completion of the appropriate authorization form, you may have someone else (e.g., a family member, friend, physician/practitioner) do this for you. You must file your appeal within 180 calendar days from when you received the written denial.

If you file an appeal, be sure to give us all of the following information:

- The member’s name
- Fallon Preferred Care member identification number
- The facts of the request
- The outcome that you are seeking
- The name of any representative with whom you have spoken

You can file an appeal in any of the following ways:

If you are a Massachusetts resident:

Write: Fallon Health & Life Assurance Company, Inc.
Member Appeals and Grievances Department
10 Chestnut St.
Worcester, MA 01608

Call: 1-800-333-2535, ext. 69950 (TRS 711)
Monday through Friday, 8:00 a.m. to 5:00 p.m.

E-mail: grievance@fallonhealth.org

Fax: 1-508-755-7393

In person: Fallon Health & Life Assurance Company, Inc.
Member Appeals and Grievances Department
10 Chestnut St.
Worcester, MA 01608

If you are not a Massachusetts resident:

Write: American Health Holding, Inc.
Appeals Department
100 West Old Wilson Bridge Road, 3rd floor
Worthington, OH 43085

Call: 1-800-641-5566
Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time

Fax: 1-614-818-3237

Appeals for non-Massachusetts residents related to adverse determination for high-tech radiology (MRI/MRA, CT/CTA, PET, nuclear cardiology imaging studies:

Write: eviCore
Attn: Appeals Unit
730 Cool Springs Boulevard, Suite 800
Franklin, TN 37067

Call: 1-888-693-3211

Hours: 9:00 a.m. to 6:00 p.m., Eastern Time

Fax: 1-888-693-3209

Appeals for non-Massachusetts residents related to adverse determination for sleep studies and/or sleep therapy:

Write: Sleep Management Solutions Appeals Department
Fallon Health Sleep Program
15 Kenny Roberts Memorial Drive Unit 2
Suffield, CT 06078

Call: 1-866-827-2469
Monday through Friday, 8:00 a.m. to 5:00 p.m.

If you send us a written or electronic appeal, we will acknowledge your request in writing within 15 business days from the date we receive the request, unless you and the plan both agree in writing to waive or extend this time period. We will put an oral appeal made by you or your authorized representative in writing and send the written statement to you or your authorized representative within 48 hours of the time that we talked to you, unless you and the plan both agree in writing to waive or extend this time period.

We will complete our review and send you a written response within 30 calendar days from the date that we receive your request. If the appeal followed from an unresolved inquiry, the 30-day period will start three business days from the date FHLAC received the inquiry or on the day you advise us that you are not satisfied with the results of your inquiry, whichever comes first. These time limits may be waived or extended if you and the plan both agree in writing to the change. This agreement must note the length of the extension, which can be up to 30 days from the date of the agreement.

You have the right to provide any additional information, including evidence and allegations of fact or law, in support or your appeal. This may be done in person or in writing. Any new information received by FHLAC during the course of the appeal may be sent to you for review. At any point before or during the appeal process, you may examine your case file, which may include medical records or any other documentation and records considered during the appeals process.

In some cases, FHLAC will need medical records to complete our review of your appeal. If we do, we may ask you to sign a form to authorize your provider to release the records to us. If you do not send this form within 30 calendar days from receipt of your appeal, FHLAC will complete the review based on the information that we do have, without the medical records.

Your appeal will be reviewed by individuals who are knowledgeable about the matters at issue in the appeal. If your appeal is about an adverse determination, the reviewer will be an individual who did not participate in any of the plan's prior decisions on the issue. The reviewer will consult with a health care professional who is actively practicing in the same or similar specialty that is the subject of your appeal.

If the subject matter of the internal review involves the termination of ongoing services, the disputed coverage or treatment shall remain in effect at our expense through completion of the internal appeal process regardless of the final appeal decision. The appeal must be filed on a timely basis, based on the course of treatment. This includes only that medical care that, at the time it was initiated, was authorized by FHLAC. It does not include medical care that was terminated due to a specific exclusion in your benefits.

Our response will describe the specific information we considered as well as an explanation for the decision. If the appeal is about an adverse determination, the written response will include the clinical justification for the decision, consistent with generally accepted principles of professional medical practice; the information on which the decision was based; pertinent information on your condition; alternative treatment options as appropriate; clinical guidelines or criteria used to make the decision; and your right to request external review and the process for doing so.

Opportunity for reconsideration

If relevant information was received too late, or is expected to become available within a reasonable time period, for internal review, you may ask for a reconsideration of a final adverse determination. In this case, FHLAC would agree in writing to a new time period for review. This would not be longer than 30 days from the date FHLAC agrees to the reconsideration.

Expedited review

You can request an expedited (fast) review either orally or in writing concerning coverage for immediate and urgently needed services.

1. Inpatient admission: During your inpatient admission and prior to discharge, a written decision will be provided to you. If the expedited review results in a denial of coverage regarding the continuation of inpatient care, you will have the opportunity to request an expedited external review and the opportunity to request continuation of services through the external review process available through the Office of Patient Protection (OPP).

2. Immediate and urgent services: You will receive a written determination within 48 hours, if your treating physician certifies that the treatment or proposed treatment is:
   a. Medically necessary;
   b. A denial of coverage for the services would create a substantial risk of serious harm to you; and
   c. Such risk of serious harm is so immediate that the services should not await the outcome of the standard appeal process.

If the expedited review process results in an adverse determination, you will be informed of the opportunity to request an expedited external review through the Office of Patient Protection. If your review involves the termination of ongoing services, you will be notified about the opportunity to request continuation of services.

3. Durable medical equipment: You will receive a written determination within less than 48 hours, if your physician:
   a. Certifies that this equipment is medically necessary;
   b. Certifies that that the denial of the equipment would create a substantial risk of serious harm;
   c. Certifies that such risk of serious harm is so immediate that the services should not await the outcome of the standard appeal process;
   d. Describes the specific immediate and severe harm if no action is taken within the 48 hour time period; and
   e. Specifies a reasonable time period in which FHLAC must respond.

If the expedited review process results in an adverse determination, you will be informed of the opportunity to request an expedited external review through the Office of Patient Protection. If your review involves the termination of ongoing services, you will be notified about the opportunity to request continuation of services.

In the specific instances noted above, you will receive a response within 48 hours. In all other expedited reviews, you will receive a response within 72 hours of receipt of your request.

Expedited review for terminally ill members

If you are terminally ill, you can request an expedited review of your appeal. A determination will be provided to you within five business days from receipt of your appeal request, and will include the specific medical and scientific reasons for denying coverage or treatment, along with information on any covered alternative treatments, services or supplies.

If your request for coverage or treatment is denied, you may request and attend a conference at FHLAC, for further review. The conference will be scheduled within 10 days of receiving your request unless your treating physician determines, after discussion with the FHLAC Medical Director or designee, that an immediate conference is necessary. In that case, the conference will be held within five business days. You may participate at the conference in person or via telephone; however, your attendance is not required. If the conference results in a final adverse determination, you may request an expedited external review through the Office of Patient Protection. If your appeal involves the termination of ongoing coverage or treatment, this coverage or treatment will continue at the plan’s expense until we complete our review, regardless of the final decision.

Filing an appeal: external appeal review

An external appeal is a request for an independent review of the final decision made by FHLAC through its internal appeal process. If your appeal involved an adverse determination, and you are not satisfied with our final decision, you have the right to file the case with an external review agency. You must request this in writing within four months from receiving the written notice of the final adverse determination.

If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage or treatment. You must file this request by the end of the second business day after receiving the final adverse determination. If the external review agency finds that termination of services would cause you substantial harm, they may order continuation of coverage at our expense, regardless of the final external review determination.

In any case where we fail to meet our internal timelines, you have the right to file an external review, even if you have not yet exhausted our internal appeals process.

Expedited external review

You may request an expedited (fast) external review. In this case you must submit a written certification from your physician stating that a delay in providing or continuing the health care services that are the subject of a final adverse determination would pose a serious and immediate threat to your health.

You must file your request for external review or expedited external review with:

Health Policy Commission
Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109

For more information about this process, or to file an external review, please contact OPP at 1-800-436-7757 (www.mass.gov/hpc/opp) Fax: 1-617-624-5046.

Your request should:

- Be on the form determined by the Office of Patient Protection
- Include your signature or your authorized representative's signature
- Include a copy of the written final adverse determination made by FHLAC
- Include the $25 fee required. The fee may be waived by the Office of Patient Protection if it determines that the payment of the fee would result in an extreme financial hardship to the member.

You may file an expedited external review even if you have not received a decision through our internal appeals process.

Filing a grievance

A grievance is the type of complaint you make if you have any other type of problem with FHLAC or one of our plan providers. You would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office.

If you have a grievance, our Member Appeals and Grievances coordinators are available to assist you in accordance with your rights and in confidence.

You can file a grievance in any of the following ways:

Write: Fallon Health & Life Assurance Company, Inc.
Member Appeals and Grievances Department
10 Chestnut St.
Worcester, MA 01608

Call: 1-888-468-1541 (TRS 711)
Monday through Friday, 8:00 a.m. to 5:00 p.m.

E-mail: grievance@fallonhealth.org

Fax: 1-508-755-7393

Walk-in: Fallon Health & Life Assurance Company, Inc.
Member Appeals and Grievances Department
10 Chestnut St.
Worcester, MA 01608

You may file the grievance yourself, or with the completion of the appropriate authorization form, you may have someone else (e.g., a family member, friend, physician/practitioner) do this for you. You must file your grievance within 180 calendar days.

If you file a grievance, be sure to provide all of the following information:

- Member name
- Member identification number
- Facts of the request
- Outcome that you are seeking
- Name of any representative with whom you have spoken

A Member Appeals and Grievances Representative will acknowledge your oral grievance within 24 to 48 hours of receipt. Written grievances will be acknowledged within 15 calendar days of receipt. We will contact you within 30 calendar days of receiving your grievance to discuss a possible resolution of your concern.

Failure to meet time limits

If we do not complete a review in the time limits specified above, the decision will automatically be in favor of the member. Time limits include any extensions made by mutual written agreement between you or your authorized representative and the plan.

ERISA

If you are a participant or a beneficiary of an employee welfare benefit plan under ERISA (Employee Retirement Income Security Act of 1974), you may have a right to bring a civil action under ERISA section 502(a) following an adverse benefit determination. Please see your Summary Plan Description provided by your employer for a complete statement of your rights.

Massachusetts Office of Patient Protection

The Office of Patient Protection (OPP) is located within the Health Policy Commission as required under Chapter 224 of the Acts of 2012. The OPP will make information on health plans accessible to consumers, assist consumers with questions and concerns related to health care, monitor quality-related information relating to practices and regulate the external review process. The OPP can provide you with the following:

- Member satisfaction rates and quality of care rates for the plan
- The number of physicians, nurse practitioners and physician assistants who voluntarily or involuntarily left the plan during the previous plan year
- The percentage of plan premium revenue that went toward health care compared to the amount that went toward plan administrative expenses
- The number of grievances filed in the last year by plan members, and the outcome of those grievances. This will include: the total number of grievances filed, grievances that were approved internally, grievances withdrawn before resolution, and external reviews filed with the OPP.

The Office of Patient Protection can be reached by phone 1-800-436-7757; by fax at 1-617-624-5046; or via their website www.mass.gov/hpc/opp.

The claims process

Claims for covered services with participating providers
When you obtain a covered service, the only payment that a participating provider will collect from you is the copayment, coinsurance or deductible amounts shown in your Schedule of Benefits. Your participating provider has an agreement to submit claims for covered services directly to us. If you receive a claim from a plan provider for something other than cost sharing, write your coverage information on the back of the claim and return it to the provider's office with a request to bill us directly.

Claims for covered services with nonparticipating providers
You should file a claim as soon as possible after you receive covered services with a nonparticipating provider for an illness or injury. Claims received more than one year after a service is rendered will not be paid.

Either you or your provider may file a claim. All claims should include an itemized description of the services, the diagnosis, the dates of services and the charge for each service. If your provider does not have an appropriate form, we will furnish one to you. Call Customer Service at 1-888-468-1541 and ask for a Request for Payment of Medical Services form. A form will be sent to you within 15 days.

Send claims to:

Fallon Health & Life Assurance Company
P. O. Box 211308
Eagan, MN 55121-2908

When you receive care from a nonparticipating provider, the provider may ask you to pay the entire charge at the time of the visit. Send a completed Request for Payment of Medical Services form, a copy of your itemized claim, and proof of payment to the address above. We will make payment directly to the provider unless you prove that you have already paid the claim.

We will pay for the usual, customary and reasonable cost of services, or apply this amount towards your deductible and/or your out-of-pocket maximum. Payment (or credit towards your deductible or out-of-pocket maximum) will not be more than the usual, customary and reasonable charge in the community where the services were provided. If a non-participating provider bills you for more than the usual, customary and reasonable charge, you will be responsible for the balance. Any such balance billed by a nonparticipating provider does not count towards your deductible or out-of-pocket maximum.

Claims process
We will respond to any claim submission by either 1) paying the claim; 2) denying the claim with written notification of the reason for the denial; or 3) issuing written notification explaining what additional information is necessary to process the claim. In any case where we fail to take any of the above actions within 45 days of our receipt of the claim, interest will accrue on the claim in accordance with Massachusetts state law. Claims which are being investigated due to suspected fraud are excepted from the above.

We have the right to examine any person whose illness or injury is the basis of a claim, while the claim is pending. This will be done at our expense.

Service area and care in foreign countries
The service area for Fallon Preferred Care is the United States. The only services covered for care received in foreign countries are emergency services.

You may submit claims for emergency services in a foreign country if the services are not provided free of charge by the country. The claims must be itemized and in (or translated into) English. Payment will be made to you, and you must pay the provider.

Recovering money owed

We have the right to recover from you any money you owe to us for services that we determine should not have been paid. An example would be if we pay for services that occurred during a period when your coverage was not in effect. We may do so by offsetting the amount you owe us with any reimbursement payments we may owe you. This will satisfy our obligation to pay for services you receive.

Questions regarding claims or refunds

If you have a question regarding a claim, you should contact Customer Service. If you feel you are entitled to an adjustment or refund due to a discrepancy in the effective date of your coverage or your contract type, send a letter to:

Fallon Health & Life Assurance Company
Fallon Preferred Care
Customer Service Department
10 Chestnut St.
Worcester, MA 01608

If you are a member through a group, you should notify your plan sponsor (generally your employer) instead. Adjustments or refunds will be approved in accordance with our underwriting guidelines. We will not approve an adjustment or refund if it is for something that took place more than one year before we received your letter, or if it is for an amount less than $5.

Coordination of benefits

Coordination of benefits (COB) takes place when more than one health insurance company covers a service. This includes companies that provide benefits for hospital, medical, dental or other health care expenses. We will coordinate payment of covered services with other plans under which you are covered. Other plans include personal injury protection insurance, automobile insurance, medical payments coverage, homeowner's insurance, school insurance and other plans that pay medical expenses. To the extent permitted by law, medical payments coverage and benefits available under an auto, homeowners or commercial policy shall be primary to this Plan.

Under COB, one plan pays full benefits as the primary carrier. The other (secondary carrier) pays the balance of covered charges. The primary and secondary carriers are determined by standard rules that are used by all insurance companies.

When you enroll, you must include information on your enrollment application about any other health insurance you may have, and you must advise us of any changes to your other health insurance coverage.

We have the right to exchange benefit information with any other group plan, insurer, organization or person to determine benefits payable under COB. We have the right to obtain reimbursement from you or another party for services provided to you. You must provide information and assistance, and sign the necessary documents to help us receive payment. You must not do anything to limit this repayment. If payments have been made under any other plan that should have been made under this plan, we have the right to reimburse that plan to the extent necessary to satisfy the intent of COB. If we pay benefits in good faith to another plan, we will not have to pay such benefits again. We also have the right to recover any overpayment made because of coverage under another plan.
We will not duplicate payment for any service. We will not make payment for more than the full benefit available under this contract. If we provide services when another carrier is primary, we have the right to recover any overpayment from the primary carrier or other appropriate party. If we do not receive the necessary documentation from you, we may deny your claim.

In order to obtain all the benefits available, you must file claims under each plan.

Subrogation and Reimbursement

Subrogation (a process of substituting one creditor for another) applies if you have a legal right to payment from an individual or organization because another party was responsible for your illness or injury. Immediately upon payment by us of any covered services, we shall be subrogated and succeed to all rights of recovery for the reasonable value of the services and benefits we provided to you or on your behalf related to an injury, illness or condition. Our subrogation and reimbursement rights apply to benefits provided to all injured parties covered by the Plan, and our rights are fully enforceable against any party who possesses funds owed to us, including an injured party's guardian, representative or estate.

In addition to our subrogation rights, we have the right to be reimbursed from you or any entity or person that caused your injury or illness and any insurance carrier, including your insurance carrier to the extent permitted by law. If you receive any payment from any party or insurance coverage as a result of an injury, illness or condition, we have the right to recover from you or your representative 100% of the reasonable value of the services and benefits we provided or expenses incurred by us. Our right to repayment comes first, even if you are not paid for all your claims against the other party, or if the payment you receive is described as partial compensation or payment for other than health care expenses. We are entitled to be fully reimbursed for 100% of the value of services provided or paid and we shall not be responsible for the payment of fees or costs, including attorney's fees, incurred in connection with your recovery. We shall be entitled to enforce our subrogation and reimbursement rights, with or without your consent, to recover the reasonable value of injury or accident-related services or benefits we have provided on your behalf. Any recovery from your personal injury protection coverage under a Massachusetts automobile policy shall be in accordance with the law.

You agree to cooperate with us in enforcement of our subrogation and reimbursement rights. Your cooperation includes providing us with all necessary documentation and information and the assignment to us of reimbursements received and the right to reimbursements up to the full value of the services and benefits that we have provided. If we do not receive the necessary documentation from you, we may deny your claim.

Workers' compensation

This policy does not cover any services or supplies that are covered by workers' compensation insurance or a similar program. If you are eligible for workers' compensation or a similar employer's liability coverage, we may request information from you before processing claims. If we do not receive the necessary documentation from you, we may deny your claim.

Medicare

If you are entitled to Medicare, it is generally considered to be your primary health insurance, even if you also have health coverage provided by the plan. However, there are some circumstances in which this plan might be primary over Medicare. Your age, work status and the presence of specific disabling medical conditions may affect which coverage is considered to be your primary insurance.

If you are covered under a group health plan and are eligible for Medicare only because of End Stage Renal Disease (ESRD), we will be the primary payer for covered services for a period of 30 months starting with the date you become eligible for Medicare coverage. After 30 months, Medicare will become the primary payer and we will become the secondary payer. As the secondary payer, our payments will be reduced by the Medicare allowed amount for the same covered services. Payments will be reduced if you are eligible for ESRD Medicare coverage, even if you decline to enroll.

If you are entitled to Medicare, and Medicare is your primary carrier, we have a legal right to obtain reimbursement for services for which FHLAC paid benefits, if Medicare covers the services.

How your coverage works

Eligibility
You are eligible to enroll in Fallon Preferred Care as long as you (and your group, if applicable) meet FHLAC's underwriting guidelines. In general, you may make changes to your insurance coverage only once during a year—on your anniversary date. During a designated open enrollment period prior to the anniversary date, any changes that you make become effective on the anniversary date. If you are a member through a group and you have any questions about your group's enrollment period or anniversary date, please contact your employer or plan sponsor.

For information on non-group enrollment through a consumer plan, see **Changing to a consumer plan**.

Premium charges
Group plans
Most members are enrolled through group plans. Plan sponsors usually pay the premium charge for their members. If your plan sponsor pays the premium charge for you, we will send the bill to your plan sponsor (usually your employer). Your coverage may be terminated if your plan sponsor fails to pay, even if the plan sponsor has charged you all or part of the premium charge (for example, by withholding it from your pay).

We will send you a letter each year around your anniversary date that will tell you the premium charge that your plan sponsor pays us. For any other information about your current premium charge, you should consult your plan sponsor.

Non-group members
If you are a non-group (consumer plan) member, we will send you a bill stating the premium charge and the date your payment is due. For information about your current premium charge, call the Premium Billing department at 1-888-468-1541, ext. 79350 (TRS 711).

Premium changes
We may change the premium we charge for your coverage. If so, the change will apply to all contracts of this type, not just your contract. Each time we change the premium charge, we will send you or your plan sponsor a notice at least 30 days before the change takes effect.

Failure to pay premiums
If we or our agent do not receive the premium charge by the time it is due, your coverage may be suspended and your contract terminated as described in **cancellation by FHLAC**. For group contracts, there is a 15-day grace period, after which the contract will be suspended for nonpayment of the premium charge. Group contracts will be cancelled on the 30th day after the due date if the premium charge is not received. You will be covered through midnight of the last day for which payment was received.

For individual non-group members, if your premium charge is not paid within 30 days following the date it is due, your coverage will be suspended for nonpayment of the premium charge. Individual contracts will be cancelled on the 60th day after the due date if the premium charge is not received.

If you are receiving Advanced Premium Tax Credits (APTC) and your share of the premium charge is not paid within 30 days following the date it is due, we may pend claims for services rendered to you during the second and third months of this grace period. If you settle all outstanding premium payments by the end of the grace period, all pended claims will be paid. If you do not settle all outstanding payments by the end of the three month grace period, your coverage will be terminated and you will be responsible for paying providers for any services received during the second or third months of the grace period.

Types of coverage

The subscriber may choose between individual coverage and family coverage.

If a subscriber chooses individual coverage, the contract covers only the subscriber. If a subscriber chooses family coverage, the contract covers:

- The subscriber
- The subscriber's legal spouse
- Dependent children who meet the plan's age limit
- Dependent children who are mentally or physically incapable of earning a living
- A former spouse, as long as the divorce decree allows for it, and the subscriber has not remarried and added a new spouse to the family contract

Dependent children include your or your spouse's children by birth or adoption and children who are under your or your spouse's legal guardianship. Adopted children are included from the date of placement in the home or, in the case of a foster child, from the date of the filing of the petition to adopt.
If your dependent child has a child, that child is included as a family member as long as your dependent child remains eligible. (See **age limits for dependent children**.)

Adding dependents

The subscriber may always change to family coverage, or add additional dependents to family coverage, during open enrollment. Changes made during the open enrollment period will be effective on the subscriber's anniversary date.

In addition, the subscriber may change to family coverage or add dependents to family coverage at the time of the following qualifying events:

- The subscriber marries. The subscriber may change to family coverage, or add any additional dependents to family coverage at this time. (See **changing your coverage** for more information.)
- Birth or adoption of a child. The subscriber may change to family coverage, or add any additional dependents to family coverage at this time. The effective date of coverage for a newborn child will be the date of birth if the subscriber formally notifies the plan sponsor within 30 days of the date of birth. (A claim for the enrolled mother's maternity admission may be considered a notice when the subscriber's membership under the FHLAC contract is a family plan.) (See **changing your coverage** for more information.)
- Loss of other health insurance coverage by a spouse and/or child(ren) who are not currently covered under the subscriber's contract. The subscriber may add any additional dependents to family coverage at this time. If the previous coverage was not through FHLAC, we will require notification from the prior insurance company. (See **changing your coverage** for more information.)
- The subscriber is ordered by a court to provide coverage for a spouse, former spouse, or child(ren). (See **divorce** for more information about coverage of former spouses in the event of divorce.)

Hospital charges for the routine care of a newborn following delivery are covered under either individual or family coverage. Any other services for your newborn children or other new dependents are covered only if the dependent is enrolled under your family coverage.

Individual non-group limited open enrollment periods

Eligible individuals may also enroll or change from one non-group individual consumer plan to another as a result of any of the following events:

- A loss of minimum essential coverage.
- An individual experiences an error in enrollment.
- An individual adequately demonstrates that we substantially violated a material provision of their contract.
- An individual becomes newly eligible or newly ineligible for advanced premium tax credits or cost-sharing reductions.
- New coverage becomes available to an individual as a result of a permanent move.

Changing your coverage

A change made at the time of a qualifying event will be effective on the date of the qualifying event if the premium is paid when due. If you are a group member, you must notify your plan sponsor of the change within 30 days of the event. Non-group members should notify FHLAC within 30 days of the event. If you do not request the change within the 30-day period, you may not make a change until your next anniversary date.

If you are not enrolled through a group, but are instead enrolled in a non-group individual consumer plan, you must notify Fallon within 60 days of the event. If you do not request the change within the 60-day period, you may not make a change until your next designated open enrollment period.

Special enrollment rights in case of Medicaid and Children's Health Insurance Program

If you qualify under Public Law 111-3, enacted Feb. 4, 2009, your plan sponsor shall permit you if you are eligible, but not enrolled (or your dependent if your dependent is eligible, but not enrolled), to enroll under the group health plan in the following circumstances:

- You or your dependent loses coverage under a Medicaid or CHIP program (in Massachusetts, MassHealth) due to a loss of eligibility. You have 60 days from the date of termination of coverage to request coverage under the group health plan for you or your dependent.
- You or your dependent becomes newly eligible for a premium assistance subsidy program under Medicaid or CHIP. You have 60 days after the date you or your dependent is determined to be eligible for the premium assistance subsidy to request coverage under the group health plan.

Age limits for dependent children

Coverage under the family or adult/child(ren) contract ends on midnight of the last day of the month of his or her 26th birthday. Dependent children may be eligible to remain under the family coverage indefinitely if they are disabled; see the following sections for more information.

A dependent child who is no longer eligible due to age also may be eligible for continuation of coverage. (See **options for continuing coverage** for more information). Whenever a dependent child's coverage under the family coverage ends, the coverage for any offspring of that dependent child also ends.

Disabled dependents

A dependent child who is mentally or physically disabled when he or she reaches the age limit for dependent children, and is not capable of earning his or her own living, can remain on the family or adult/child(ren) contract. The subscriber must apply within 30 days of the last day of the month in which he or she reaches age 26.

The plan determines eligibility for disabled children. The subscriber must supply us with any medical or other information that may be needed to determine if the child is eligible to continue coverage under the family coverage.

Continuing coverage for former dependents
A dependent child who is no longer eligible for coverage may be eligible for continuation of coverage or conversion to a consumer plan. (See **options for continuing coverage** for more information.)

Surviving dependents
A dependent's coverage ends if the subscriber dies. The dependent may be eligible for continuation of coverage or conversion to a consumer plan. (See **options for continuing coverage** for more information.)

Divorce
In the event of divorce, the subscriber's former spouse may remain covered under the family coverage. Coverage may continue, with no additional premium due, unless: (1) the divorce decree does not require (or no longer requires) the subscriber to maintain health insurance coverage for the former spouse, or (2) either the subscriber or the former spouse remarry.
If the subscriber remarries and wishes to add his or her new spouse to the family coverage, the former spouse remains eligible for coverage under the subscriber's group. However, the former spouse must move from family coverage to individual coverage and additional premium will be required; the former spouse only remains eligible under the group if the divorce decree provides for such coverage. If the former spouse remarries, the former spouse's eligibility ends.

Notice of cancellation of coverage of a former spouse will be mailed to the former spouse at his or her last known address, along with notice of any applicable right to reinstate coverage retroactively to the date of cancellation. The former spouse may be eligible for continuation of coverage or conversion to a consumer plan (see **options for continuing coverage** for more information).

Small group and non-group members
If you are a non-group member, your coverage under this policy may not be less favorable to you in any respect than established by the provisions of Massachusetts General Laws Chapter 175, Section 108, Subsection 3 (a). See the Appendix for further details.

If you are a non-group member, or a member through a small group, issue and renewal of your policy is guaranteed except in those circumstances specified under Massachusetts insurance regulations.

FHLAC contract provisions

Changes in your contract

We may change part of your contract. If we do, the change will apply to all contracts of this type, not just your contract. We will send your plan sponsor notice of any material modifications to your coverage within 60 days of the change. The contract will be changed whether or not you receive the notice. The notice will indicate the effective date of the change.

If you pay your premium charge yourself, we will usually include the notice with your bill. If a plan sponsor pays the premium for you, we will send the notice to your plan sponsor instead. It will be the plan sponsor's responsibility to notify you. When we send you a notice, we will mail it to the most recent address on file. This includes your bill for premium charges and any notices informing you about changes in the premium charge or changes in your contract. If your name and mailing address change, let us know so that your records can be updated. Be sure to give us your new name and address as well as the new information.

FHLAC contracting arrangements

FHLAC has contracted with MultiPlan, Inc., and Private Healthcare Systems, Inc. (PHCS), to provide a network of participating providers. MultiPlan and PHCS contract with individual physicians, medical groups and hospitals to provide care to members. These contracted providers are also called participating providers. FHLAC, MultiPlan and PHCS negotiate with participating providers to agree upon a contracted payment rate. The participating providers then accept that payment for their services. When you obtain a covered service, the only payment that a participating provider will collect from you for a covered service is any required payment amount shown in this *Member Handbook/Evidence of Coverage*, in your Schedule of Benefits, or in any applicable amendments.

When your participating provider no longer has a contract with us

We cannot guarantee that any one physician, hospital or other provider will be available and/or remain under contract with us. We reserve the right at any time to end our contract with any provider who may be furnishing you with treatment. If this occurs, we will generally no longer pay for services provided to you by that provider at the in-network level of benefits, except in the circumstances listed below.

If you are in the second or third trimester of pregnancy when our contract with a provider from whom you are receiving pregnancy-related treatment ends, you may continue to receive treatment from that provider, at the in-network level of benefits, through your postpartum period.

If you are terminally ill and our contract with a provider from whom you are receiving treatment related to that illness ends, you may continue to receive treatment from that provider, at the in-network level of benefits.

In all cases, the provider must agree to accept reimbursement for services at the rates in effect when our contract with the provider ended, and to adhere to our quality assurance standards, and other policies and procedures such as medical management procedures. You will be eligible for benefits as if the provider had remained under contract with us. If you learn that a treating provider is no longer a participating provider, please contact Customer Service for assistance in determining your eligibility for any continuity of care provisions.

Continuation of services with a nonparticipating provider

Once you become a Fallon Preferred Care member, we will generally only pay in-network benefits for services that you receive from participating providers. However, there are some circumstances in which we will temporarily cover services that you receive from a nonparticipating provider, at the in-network level of benefits, if you had been receiving care from that provider prior to becoming a member:

- If you are receiving an ongoing course of treatment from a provider who is not a participating provider in any health insurance plan that your plan sponsor offers, we will cover services at the in-network level of benefits, from that provider, for 30 days from the effective date of your coverage.

- If you are in the second or third trimester of pregnancy, and you are receiving services related to your pregnancy from a provider who is not a participating provider in any health insurance plan that your plan sponsor offers, we will cover services at the in-network level of benefits, from that provider, through your first postpartum visit.
- If you are terminally ill, and you are receiving ongoing treatment from a provider who is not a participating provider in any health insurance plan that your plan sponsor offers, we will cover services at the in-network level of benefits, for your care from that provider until your death.

These provisions only apply to group members receiving coverage through an employer. In all cases, the provider must agree to accept reimbursement for services at our rates, and to adhere to our quality assurance standards, and other policies and procedures such as medical management procedures. In addition, you must contact the plan's customer service team to determine your eligibility for these continuity of care provisions. You will be eligible for coverage at the in-network level.

Responsibility for the acts of providers

The arrangement between FHLAC and participating providers is that of independent contractors. They are not our agents. We are not liable for injuries or damages resulting from acts or omissions by them or by any other institution or person providing services to you. You should not rely on providers or facilities for any assurances or interpretation of plan policies or benefits. We will not interfere with the ordinary relationship between providers and their patients except in circumstances in which a provider does not comply with health plan policies.

If you are admitted to a hospital or other facility as an inpatient, or if you are an outpatient, you will be subject to all of that facility's rules. This includes rules on admission, discharge and the availability of services.

If a provider recommends or provides a specific treatment, this does not necessarily make that treatment a covered benefit. Since providers are freely able to recommend treatment options without restraint from FHLAC, a physician recommendation in and of itself does not guarantee that a recommended treatment is a covered benefit or that a recommended provider is a participating provider in Fallon Preferred Care, and does not obligate the plan to pay for the service. Services or supplies that are not described as covered in this *Member Handbook/Evidence of Coverage*, or that are not determined to be medically necessary, are not covered benefits.

Circumstances beyond our control

Under extraordinary circumstances that are beyond our control, we may have to delay your services, or we may be unable to provide them at all. We will not be liable for failing to provide, or for a delay in providing, services in the cases described below. We will, however, make a good faith effort to provide or arrange for services in these situations, limited by available facilities and personnel:

- In the case of major natural disasters, epidemics or pandemics
- In the case of a war, riot, civil insurrection or acts of terrorism

Leaving Fallon Preferred Care

Ineligibility for you or a dependent

A group subscriber's membership may end because he or she:

- Is laid off
- Leaves a job
- Loses coverage due to a reduction in work hours
- No longer lives or works in the Preferred Care service area (the United States)

A dependent's membership may end because of:

- Loss of the subscriber's eligibility
- The subscriber's death
- Age – last day of the month in which he or she attains age 26
- Divorce

If a subscriber's group coverage ends, the subscriber and any dependents may have a right to choose continued group coverage to the extent required by state and federal law. Contact your plan sponsor for information on eligibility and continued enrollment. (For more information about continuation of coverage once you are no longer eligible through your group, see **options for continuing coverage**.)

Cancellation by Fallon Preferred Care

You do not have to worry that FHLAC will cancel your coverage because you are using services or because you will need more services in the future. We may cancel your coverage only as allowed under state and federal law, including, but not limited to, the following reasons:

- You made some misrepresentation or you conspired with another party to defraud FHLAC. An example is an incorrect or incomplete statement on your application form that indicated that you were eligible for coverage when you were not. In such a case, cancellation will be as of your effective date or other date we determine appropriate. We will refund the premium charge you have paid if applicable. Any payments made for claims under this contract will be subtracted from the refund. If we have paid more for claims under this contract than you have paid in premium charges, we have the right to collect the excess from you. In any case of misrepresentation, FHLAC and its affiliates may deny enrollment to you in the future.
- Your premium charge is not paid within the grace period appropriate for your plan. (See **how your coverage works** for information about grace periods and nonpayment of premium.) FHLAC will notify you of the effective date of the cancellation, in accordance with Massachusetts regulations.
- You commit an act of physical or verbal abuse that poses a threat to a Fallon Preferred Care provider, a FHLAC employee or agent or another plan member. In such an instance, we must determine that the act of abuse was not related to your physical or mental condition.
- The group through which you receive your coverage cancels its group service agreement with FHLAC. In the event that your group coverage is canceled because the group fails to pay the premium charge to us, you may apply for short-term (60-day) Temporary Continuation of Coverage. To apply for this coverage, send us a written request within 60 days of the date of the letter notifying you of the group's cancellation. The 60-day Temporary Continuation of Coverage will be available at the same cost and coverage level as you previously had under your group coverage. At the end of your 60-day Temporary Continuation of Coverage, if you would like to remain a Fallon Preferred Care member you can join a consumer plan. (See **Changing to a consumer plan** for more information.)
- As otherwise allowed by state or federal law or regulation.

In accordance with Massachusetts state law, and the Federal Genetic Information Nondiscrimination Act, FHLAC will not require genetic testing or the submission of genetic information as a condition of initial or continued enrollment. We will not discriminate or make any distinction among members based on any genetic test or information.

Involuntary disenrollment rate

For calendar year 2016, FHLAC'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 2016, FHLAC's voluntary disenrollment rate was 0.40%.

Disenrollment by the subscriber

To cancel your coverage when you are enrolled through a group, you must notify your plan sponsor. The plan sponsor will submit a transaction request in accordance with the group agreement.

If you are enrolled as a non-group member, the subscriber must send a request for termination in writing within 30 days of the requested termination date. If the premium charge is paid for a period beyond the cancellation date, we will refund the premium charge for that period.

If the subscriber or the plan sponsor cancels the contract, we will not provide benefits for services, supplies or medications received after the cancellation date.

Eligibility for Medicare

If you are a subscriber age 65 or older covered under a group contract, your eligibility may change in one of the ways shown below.

- If you are employed after age 65, you and your dependents may remain covered under this contract as long as you are an active employee.
- If you are a group member, you become eligible for Medicare and you are no longer employed, you are no longer eligible for coverage under this contract. You may be eligible for enrollment in Fallon Senior Plan, Fallon Health's Medicare Advantage product, either through your employer or directly with Fallon. To enroll, you must have both Medicare parts A and B, live in the Fallon Senior Plan service area and pay the premium charge when applicable. Please contact our Customer Service Department for more information.
- If you are not eligible for Medicare upon reaching age 65, you may continue to be covered under this plan.

Once you have retired and become eligible for Medicare, you may elect to continue coverage through Fallon Senior Plan. You may join Fallon Senior Plan even if enrollment is closed to the general public. To enroll, you must have both Medicare Part A and Part B, live in the Fallon Senior Plan service area and pay the premium charge when it is due. You must write to us within 90 days or reaching age 65 and pay the premium charge when it is due. If you have a spouse and/or dependents who were covered under your group coverage before you turned 65, they may continue coverage in that group for as long as they are eligible.

Changing to other health insurance

If you are a group member, you may change your coverage to any other health benefits plan offered where you work, as long as your group and its other insurers agree. You may do this within 30 days of any of the following:

- The anniversary date of your group. There will generally be an open enrollment period preceding your group's anniversary date, during which you can arrange for changes that will be effective on the anniversary date. There also may be a special enrollment period determined by FHLAC and your group.
- The date you become eligible to enroll in a federally qualified health maintenance organization for which you were not formerly eligible because of where you live
- The date FHLAC is no longer a part of the health benefits plan offered where you work
- The date FHLAC stops operation

Please note: Nothing in this section changes the application of the coordination of benefits between the plan and any other health benefits plan.

Obtaining a certificate of creditable coverage

If you cancel your enrollment with Fallon Preferred Care, we will send you a Certificate of Creditable Coverage, free of charge. This certificate gives you proof of continued coverage that can help you obtain other coverage. You may request additional copies of the certificate by calling Customer Service.

Options for continuing coverage

COBRA (Consolidated Omnibus Budget Reconciliation Act—U.S. Public Law 99-272)

If you are a member through a group of 20 or more employees, and your contract for health insurance through your plan sponsor is terminated, but you still live in the FHLAC service area, you may change to a COBRA membership. You will not be subject to any health screenings, tests or other pre-existing medical condition requirements when converting to a COBRA contract. Your COBRA benefits/coverage will be identical to similarly enrolled individuals.

To change to a COBRA contract, notify your plan sponsor within 60 days of the date your group coverage ends. COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. You will be responsible for paying the premium charge that will be due for your new membership to the plan sponsor. Your COBRA benefits/coverage will be effective on the date your group coverage ends. You may not convert to COBRA membership if your group coverage ended because of fraud on your part or if your plan sponsor no longer offers group coverage.

General Laws of Massachusetts, Chapter 176J, Section 9

If you are a member through a small group employer that has from two to 19 employees, and your contract for health insurance through your plan sponsor is terminated, you may choose to continue coverage through the group.

To do so, you must have lost your coverage due to one of the qualifying events listed below:

Qualifying event	Qualified beneficiary	Length of time coverage must be offered
Death of subscriber	Spouse Dependent child	36 months
Termination of subscriber's employment (other than for reason of employee's gross misconduct)	Subscriber Spouse Dependent child	18 months
Reduction in hours worked by subscriber	Subscriber Spouse Dependent child	18 months
Divorce or legal separation of the subscriber from his/her spouse	Spouse Dependent child	36 months
Subscriber becomes entitled to Medicare	Spouse Dependent child	36 months
Dependent child is no longer considered to be dependent under the small group health benefit plan	Dependent child	36 months

Notification of a qualifying event

The small group employer will notify us within 30 days of an employee's death, termination of employment, reduction in work hours or Medicare eligibility.

Options for continuing coverage

You must notify your employer within 60 days of a divorce, legal separation or loss of a child's dependent status. You will then be notified of your right to continuation of coverage. Within 60 days of the qualifying event, or within 60 days of the date notification to continue coverage is sent to you (whichever is later), you must fill out the written election form and send it to the employer.

You may waive your right to continuation of coverage. If you waive this right and then change your mind, you may revoke the waiver before the end of the 60-day election period. In this case, the start date of your coverage will be the date the waiver is revoked. If you do not elect continuation coverage within the 60-day election period, your plan coverage will end.

Paying premiums
The first premium charge is due within 45 days of the due date you sign the election form. You pay the premium charge to the employer who then forwards it to us. You must pay the employer for the premium charge every month. The employer may not pay us the premium charge unless the employer receives it from you.

Coverage time frames
If you choose continuation coverage due to termination of employment or reduction in work hours, you may continue coverage for up to 18 months. In the case of any other qualifying event, you may continue coverage for up to 36 months. If a second qualifying event (such as death, divorce, legal separation or Medicare entitlement) occurs within the 18-month period, you may extend your coverage for up to 36 months from the date of the original qualifying event. You should notify us if a second qualifying event occurs.

If you are considered disabled under the Social Security Act at the time of a qualifying event that involves termination or reduction in work hours, you may extend coverage to up to 29 months. You must notify your employer within 60 days of the date of determination of disability and before the end of the 18-month period. In this case, your premiums will be 150% of the premium, for the period after the 18-month period. If you are no longer disabled, you must notify your plan sponsor within 30 days of the final determination that you are no longer disabled.

Your continuation of coverage will end if:

- The maximum time period expires.
- FHLAC no longer provides a small group health benefit plan to similarly-situated eligible employees.
- You become covered under another health benefit plan that does not contain a preexisting condition clause.
- You do not pay your premium charge in a timely manner.
- You become entitled to Medicare.

Family and Medical Leave Act

Under the Family and Medical Leave Act, you may be able to take up to 12 weeks of unpaid leave from your employment due to certain family or medical circumstances. Contact your plan sponsor to find out if you qualify. If you do, you may continue your group health coverage during your leave, but you must continue to pay the portion of the premium that you would pay if you were actively working. Your coverage will be subject to suspension or cancellation if you fail to pay your premium on time (see **how your coverage works**). If you take a leave and coverage is cancelled during your leave, you may resume coverage when you return to work without waiting for an open enrollment period.

General Laws of Massachusetts, Chapter 175, Section 110D and 110G

If you lose eligibility for health insurance because you leave your group, you may elect to continue your group coverage under this policy for 31 days. Contact your plan sponsor for more information. You must continue to pay the portion of the premium charge that you would have been required to pay if you were still actively working. If you obtain new employment before the 31-day period is up, and you become eligible for health coverage through your new employer, your eligibility to continue your previous coverage ends.

If you are a member through a group with 50 or more employees, and you lose your employment (and your eligibility for health insurance) due to a plant closing in Massachusetts, you may be eligible to continue your coverage for up to 90 days, under state law. Contact your plan sponsor for more information. You must continue to pay the portion of the premium that you would have been required to pay if you were still actively working. If you obtain new employment before the 90-day period is up, and you become eligible for health coverage through your new employer, your eligibility to continue your prior coverage ends.

If you lose your employment and your eligibility for group health insurance due to an involuntary layoff (or, if you are a dependent who loses eligibility for health insurance due to death of the insured), you may be eligible to continue your group coverage for up to 39 weeks, under state law. Contact your plan sponsor for more information. You must continue to pay the portion of the premium charge that you would have been required to pay if you (or the insured) were still actively working. If you obtain new employment before the 39-week period is up, and you become eligible for health coverage through your new employer, your eligibility to continue your prior coverage ends.

Changing to a consumer plan

If your eligibility for health insurance coverage through your plan sponsor ends, you may be eligible to join a consumer plan. In order to be eligible to enroll in a consumer plan you must first be an eligible individual. An eligible individual is defined as: individual who is a resident of the commonwealth.

If you are an eligible individual who does not meet the standards for immediate enrollment into a consumer plan, you may only enroll during the mandated open enrollment period. Please check the Massachusetts Health Connector website at betterhealthconnector.com for the open enrollment period or contact their Customer Service at 1-877-623-6765.

In order to be eligible for immediate enrollment outside an open enrollment period you must have:

- had a prior creditable coverage that was terminated no more than 63 days before the date of submission of the application; and
- you were not terminated from the prior coverage due to fraud or non-payment of premium

Contact Fallon at 1-888-797-3247 to find out more about the options available to you.

Description of benefits

This section of your *Member Handbook/Evidence of Coverage* contains a description of the benefits you are entitled to as a member of this plan. To be covered, all services and supplies must be medically necessary and described as “covered”.

If you get your covered benefits from a participating provider, your costs will generally be less than if you get your covered benefits from a nonparticipating provider. To get the in-network level of benefits, a participating provider must provide your care. If you receive care from a nonparticipating provider, your benefits will be covered at the out-of-network level, except in a medical emergency. (For coverage of emergency care see **Emergency and urgent care** section.) Your costs for the benefits that you use are described in the Schedule of Benefits enclosed with this *Member Handbook/Evidence of Coverage*.

In all cases where a benefit maximum exists, the benefits you receive from participating providers are combined with the benefits you receive from nonparticipating providers. For example, if a service is limited to 20 visits per benefit period, you may choose to have 10 visits with a participating provider and 10 visits with a nonparticipating provider. At this point you would have reached your benefit maximum and will no longer have coverage for that benefit for the remainder of the benefit period. If you do not use up your benefits for one benefit period, you may not carry them over to the following benefit period.

Acute inpatient rehabilitation services

The plan covers acute inpatient rehabilitative care in a licensed rehabilitation hospital or a rehabilitation unit in an acute care hospital for up to 100 days per benefit period. These services require an intensity, frequency and duration as to make it impractical for the patient to receive services in a less intense care setting, such as a skilled nursing facility. Rehabilitative services may include physical, speech, and occupational therapy services.

All inpatient admissions require prior-authorization. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office at least five business days prior to the scheduled date of service. For more information, refer to the “Medical management” section.

Exclusions

1. Chronic rehabilitation services
2. Services beyond 100 days in each benefit period
3. Services that are not deemed to be medically necessary, even if the plan limit of 100 days per benefit period has not been reached

Ambulance services

In emergencies, you are covered for ambulance transportation to the nearest appropriate facility. Call your local emergency communications system (e.g., police, fire department or 911) to request an ambulance. The type of ambulance used (for example, air ambulance or land ambulance) must be appropriate to the medical condition and geographic location.

Ambulance services may be covered for certain nonemergency situations, such as from one inpatient facility to another or when transportation by any other means would be contraindicated by your medical condition.

Nonemergency ambulance transportation requires prior-authorization. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office at least five business days prior to the scheduled date of service. For more information, refer to the “Medical management” section.

Covered

1. Emergency ambulance transport
2. Medically necessary nonemergency ambulance transport when pre-authorized

Exclusions

1. Ambulance use for transportation services only or in situations in which an ambulance is not medically necessary
2. Transfers between hospitals, or other inpatient facilities, when your medical condition does not warrant that you be transferred to another facility
3. Air ambulance, when not appropriate to medical condition or geographic location
4. Commercial airline transportation
5. Elective transfers between hospitals or other inpatient facilities
6. Nonemergency transport when not pre-authorized

Autism services

The following benefits are provided for the diagnosis and treatment of autism spectrum disorder in individuals. Benefits are only available to members who are residents of Massachusetts or whose principal place of employment is in Massachusetts. Diagnosis includes medically necessary assessments, evaluations including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has one of the autism disorders. Treatment includes care prescribed, provided or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary.

Some autism services require prior-authorization. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office at least five business days prior to the scheduled date of service. For more information, refer to the "Medical management" section.

Covered

1. Habilitative or rehabilitative care, professional counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst. Services require prior authorization.

2. Therapeutic care, services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers. Therapeutic care requires prior authorization.

3. Pharmacy care, medications prescribed by a licensed physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the contract for other medical conditions.

4. Psychiatric care, direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

5. Psychological care, direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Coverage for the diagnosis and treatment of autism spectrum disorders is not subject to any annual or lifetime dollar or unit of service limitation which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions, nor is it subject to a limit on the number of visits an individual may make to an autism services provider.

The following terms shall have the following meaning:

Applied behavior analysis: The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism services provider: A person, entity or group that provides treatment of autism spectrum disorders.

Autism spectrum disorders: Any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

Board certified behavior analyst: A behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.

Exclusions

1. Equine therapy
2. Aqua therapy

Emergency and urgent care

Emergency care
You are covered for emergency care worldwide. When you have an emergency medical condition you should go to the nearest emergency room for care or call your local emergency medical system (e.g., police, fire department or 911).

An emergency medical condition is defined as a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of prompt medical attention to result in:

- Serious jeopardy to the health of the member or another person (unborn child)
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Examples of covered emergencies are stroke, unconsciousness, heart attack symptoms or severe bleeding.

If you need emergency care and cannot reasonably reach a participating provider, coverage for your emergency care will be made at the same level and in the same manner as if a participating provider had treated you. After your emergency medical condition has been evaluated in the emergency room, you may be ready to go home or you may need further care. If your condition requires that you be admitted directly from the emergency room to the hospital for inpatient emergency care, such as emergency surgery, you or someone acting on your behalf must notify the appropriate medical management office as soon as possible, but not later than 72 hours following your admission. If you do not notify the appropriate medical management office, coverage of your inpatient hospitalization will be subject to additional charges.

Urgent care
Sometimes you may need care right away for urgent situations such as cuts that need stitches, a sprained ankle or abdominal pain. These situations may not pose as much of a threat as the emergencies discussed above, but they still require fast treatment to prevent serious deterioration of your health. You may arrange for urgent care in a doctor's office or urgent care facility.

You or someone acting on your behalf must notify the appropriate medical management office as soon as possible, but not later than 72 hours following an emergency admission. For more information, refer to the "Medical management" section.

Covered

1. Emergency room visits
2. Urgent care in a doctor's office or urgent care facility
3. 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. The corresponding cost-sharing, as noted in your Schedule of Benefits, will be the same cost-sharing as a primary care visit to your doctor.

Enteral formulas and low protein foods

The plan covers enteral formulas and low protein foods listed below.
Enteral formulas require prior-authorization. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office at least five business days prior to the scheduled date of service. For more information, refer to the "Medical management" section.

Covered

1. Nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids
2. Food products that have been modified to be low in protein for individuals with inherited diseases of amino acids and organic acids. You may be required to purchase these products over the counter and submit claims to the plan for reimbursement.

Exclusions

1. Nutritional supplements, medical foods and formulas unless described above as covered

Home health care services

The plan covers medically necessary part-time or intermittent skilled nursing care and physical therapy provided in your home by a home health agency. Additional services such as occupational therapy, speech therapy, medical social work, nutritional consultation, the services of a home health aide, and the use of durable medical equipment and supplies are covered to the extent that they are determined to be a medically necessary component of skilled nursing care and physical therapy. To be eligible for home health care, you must be confined to your home due to illness or injury and your doctor must establish a treatment plan that requires services including, but not limited to, nursing care and physical therapy.

Covered

1. Part-time or intermittent skilled nursing care and physical therapy provided in your home by a home health agency
2. Additional services such as occupational and speech therapy, medical social work, nutrition consultation, home health aide services, medical and surgical supplies and the use of durable medical equipment are covered to the extent that they are determined to be a medically necessary component of skilled nursing care and physical therapy.
3. Home dialysis services and non-durable medical supplies (such as dialysis membrane and solution, tubing, and drugs that are needed during dialysis); the cost to install the dialysis equipment in your home; and the cost to maintain or to fix the dialysis equipment.

Exclusions

1. Personal comfort items such as a telephone, radio or television
2. Meals, housekeeping services or custodial care

Hospice care

The plan covers licensed hospice services for terminally ill members. Hospice is a type of care that emphasizes supportive services in a home setting and pain control, rather than the cure oriented services provided in a hospital. Hospice services include, but are not limited to, physician's services; nursing care provided by or under the supervision of a registered professional nurse; dietary, occupational, physical, speech and respiratory therapy for the purposes of symptom control or to enable the individual to maintain activities of daily living; medical supplies and appliances; drugs that cannot be self-administered; medical social services; counseling services provided by professional or volunteer staff under professional supervision; volunteer services and respite care.

Hospice care requires prior-authorization to determine medical necessity. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office. For more information, refer to the "Medical management" section.

Covered

1. Hospice services provided in your home by a home health agency
2. Physician's services provided in your home
3. Short-term inpatient care for the control of pain and management of acute and severe clinical problems that cannot be managed in a home setting

Exclusions

1. Long-term rehabilitative care
2. Personal comfort items such as telephone, radio or television

Hospital inpatient services

The plan covers hospital inpatient services. If you are in a hospital or other medical facility when your coverage takes effect, you will be covered as of your effective date as long as you notify the appropriate medical management office as soon as medically possible that you are an inpatient.

In some instances, hospitalization may be necessary when a member has a medical condition that requires inpatient care while receiving noncovered services, such as dental care. In these cases, the normal hospital charges are covered, but the charges for the noncovered services, such as dental care, are excluded.

All inpatient admissions require prior-authorization. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office at least five business days prior to the scheduled date of service. For more information, refer to the "Medical management" section.

Covered

1. Inpatient hospital care for as many days as medically necessary, including: room and board in a semiprivate room (or private room if medically necessary) and the services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, diagnostic lab and X-ray services; anesthesia services; medications; meals; nursing care; physical, occupational and speech therapy; medical and surgical supplies; oxygen and respiratory therapy; blood and its administration; and operating and recovery room services.
2. Professional services provided while you are an inpatient, including, but not limited to, medical, surgical or psychiatric physicians services; and the services of a certified registered nurse anesthetist, nurse practitioner or physician assistant.
3. Bariatric weight loss surgery (Prior authorization required and is contingent upon review by a Fallon Health medical director)

Exclusions

1. Private room, unless medically necessary. If you want a private room and it is not medically necessary, you pay all additional room charges above the semiprivate room charge.
2. Personal comfort items such as telephone, radio or television
3. Charges that you incur for services that are not determined to be medically necessary, or when you choose to stay beyond the hospital discharge hour for your own convenience
4. Services that are considered experimental or investigational.
5. Bariatric weight loss surgery for morbid obesity for individuals not meeting the medical criteria for coverage.
   - Unstable coronary artery disease (CAD), severe pulmonary disease, portal hypertension with gastric or intestinal varices, and other conditions thought to seriously compromise anesthesia or wound healing risk
   - Pregnancy
   - Inability to comprehend basic principles of the procedure or to follow basic postoperative instructions

Infertility/assisted reproductive technology services

Infertility means the condition of an individual who is unable to conceive or produce conception during a period of one year if the female is age 35 or younger or during a period of six months if the female is over the age of 35. If a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one year or six month period, as applicable.

The plan covers the infertility/assisted reproductive technology (ART) services described below. Approval for coverage of assisted reproductive technology (ART) is contingent upon review by the FHLAC/Fallon medical director. FHLAC/Fallon's coverage guidelines for all ART services are available by contacting the Customer Service.

Infertility/ART services require prior-authorization to determine medical necessity. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office at least five business days prior to the scheduled date of service. For more information, refer to the "Medical management" section.

Covered

1. Office visits for the consultation, evaluation and diagnosis of infertility
2. Diagnostic laboratory and X-ray services
3. Artificial insemination, such as intrauterine insemination (IUI)
4. Assisted reproductive technologies including, but not limited to:
    a. In vitro fertilization (IVF-ET)
    b. Gamete intrafallopian transfer (GIFT)
    c. Zygote intrafallopian transfer (ZIFT)
    d. Intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility or when preimplantation genetic diagnosis (PGD) testing is covered
    e. PGD when the partners are known carriers for certain genetic disorders
5. Sperm, egg, and/or inseminated egg procurement, assisted hatching, cryopreservation, processing and banking for plan members in active infertility treatment to the extent that such costs are not covered by the donor's insurer.

Exclusions

1. Services that are considered experimental or investigational.
2. Services for a member who is not medically infertile.
3. Services for a partner who is not a member.
4. Services for women who are menopausal, except those women who are experiencing premature menopause.
5. Donor sperm in the absence of documented male factor infertility, as evidenced by abnormal semen analysis or in men with genetic sperm defects
6. Chromosome studies of a donor (sperm or egg)
7. Preimplantation genetic diagnosis (PGD) for aneuploidy screening or other indications not listed under **Covered services**.
8. Gender selection in the absence of a documented X-linked disorder.

9. Treatments requested solely for the convenience, lifestyle, personal or religious preference of the member in the absence of medical necessity.
10. Transportation costs to and from the medical facility.
11. Infertility services that are necessary as a result of a prior voluntary sterilization or unsuccessful sterilization reversal procedure.
12. Supplies that may be purchased without a physician's written order, such as ovulation test kits.
13. Services related to achieving pregnancy through a surrogate or gestational carrier.
14. Charges for the storage of donor sperm, eggs or embryo that remain in storage after the completion of an approved series of infertility cycles.
15. Service fees, charges or compensation for the recruitment of egg donors (this exclusion does not include the charges related to the medical procedure of removing an egg for the purpose of donation when the recipient is a member of the plan).
16. Sperm, egg and/or inseminated egg procurement, processing and banking of sperm or inseminated eggs, to the extent such costs are covered by the donor's insurer.
17. Infertility medication for donors
18. Donation or sale of gametes or embryos
19. Medications for ART cycles/attempts without prior authorization
20. Clinical or laboratory research

Maternity services

The plan covers the cost of care related to pregnancy and childbirth including associated medically necessary hospital, surgical and medical care of the member and her well newborn. Medically necessary care of the newborn, such as the medical or surgical treatment for congenital defects, birth abnormalities or premature birth, is covered when the newborn is enrolled as a dependent under the subscriber's family coverage. (For more information on adding dependents, see **How your coverage works** section.)

You must notify the appropriate medical management office as soon as possible, but not later than 72 hours following:

- *When your routine childbirth admission continues beyond 48 hours for a vaginal delivery or 96 hours for a Caesarean delivery*

For more information, refer to the "Medical management" section.

Covered

1. Prenatal and postpartum care provided by a licensed physician or certified nurse midwife
2. Inpatient hospital charges for childbirth including room and board in a semiprivate room for a minimum of 48 hours of care following a vaginal delivery or 96 hours of care following a Caesarean section delivery; all professional and ancillary charges related to the delivery (see **Hospital inpatient services** for a list of covered services and supplies); and nursery care for a well newborn following delivery including routine care by a pediatrician, circumcision and newborn hearing screening test. The length of stay may be shortened if both the mother and the attending physicians for both the mother and newborn agree upon an earlier discharge. For the purposes of this section, "attending physician" shall include an obstetrician, pediatrician or certified nurse midwife attending the mother and newborn.

   If you or your newborn is discharged early, you are entitled to one home visit by a registered nurse, physician or certified nurse midwife. Additional services available in the event of an early discharge include parent education, assistance and training in breast or bottle feeding, and the performance of any necessary and appropriate clinical tests. Any subsequent home visit determined to be clinically necessary will be performed by a licensed health care provider.
3. Professional services related to the delivery provided by physicians or other licensed health care professionals
4. Lactation support and counseling services provided by a certified lactation counselor. For a listing of certified lactation counselors visit zipmilk.org. Eligible members will receive a breast pump. Please contact Customer Service at 1-888-468-1541 (TRS 711), or visit the Fallon website fallonhealth.org, for more information.

Exclusions

1. Private room, unless medically necessary. If you want a private room and it is not a medical necessity, you pay all additional room charges above the semiprivate room charge.
2. Personal comfort items such as telephone, radio or television
3. Charges incurred when you choose to stay beyond the hospital discharge hour for your own convenience
4. Charges for home births
5. Services for a well newborn who has not been enrolled as a member, other than nursery charges for routine services provided to a well newborn.

Mental health and substance abuse services

The plan covers the diagnosis and treatment of mental conditions on an outpatient and inpatient basis. A mental condition is defined as a condition that is described in the most recent edition of the *Diagnostic and Statistical Manual of Medical Disorders* published by the American Psychiatric Association and that is determined as such by the plan. Any determination of medical necessity of mental health services will be made in consultation with a licensed mental health professional.

A range of inpatient, intermediate, and outpatient services are available that permit treatment to take place in the least restrictive clinically appropriate setting. A licensed mental health professional acting within the scope of his or her license may provide treatment. Licensed mental health professionals include:

- Psychiatrists
- Psychologists
- Psychotherapists
- Licensed nurse mental health clinical specialists
- Licensed independent clinical social workers
- Licensed mental health counselors
- Pediatric specialists
- Certified alcohol and drug abuse counselors
- Marriage and family therapist
- Other providers as authorized by the plan

For mental health emergencies, follow the same procedures as for any other medical emergency, see **Emergency and urgent care** section.

Note: Effective for plan years beginning on or after October 1, 2015, Massachusetts state law (Chapter 258 of the Acts of 2014) restricts the circumstances in which insurers may require prior authorization for substance abuse services. We will not require prior authorization for substance abuse services in any circumstances where this is not allowed by Chapter 258.

Prior authorization is not required for acute treatment services and clinical stabilization services for 14 consecutive days.

Inpatient services

The plan covers mental health services in an inpatient or alternative (intermediate) setting, when authorized by the plan. Coverage is provided for inpatient care in a licensed general (acute care) hospital, a psychiatric hospital or a substance abuse facility (or its equivalent in an alternative program) for as many days as are determined to be medically necessary to treat your condition. 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.

Inpatient mental health services, including intermediate care, require prior-authorization to determine medical necessity. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office at least five business days prior to the scheduled date of service. For more information, refer to the “Medical management” section.

Covered

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. (See **Hospital inpatient services** section for a list of covered services and supplies.) These include, but are not limited to, psychopharmacological and neuropsychological assessment services; individual, family and group therapy, and diagnostic laboratory services.
2. Professional services provided by physicians or other licensed health care professionals for the treatment of mental conditions while you are an inpatient

Outpatient services
The plan covers outpatient mental health services provided in person in an ambulatory care setting for as many visits as are determined to be medically necessary to treat your condition. Outpatient services may be in a licensed hospital, a mental health or substance abuse clinic licensed by the Department of Public Health, a public community mental health center, or a professional office; provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his or her license.

Outpatient mental health services, including intermediate care, require prior-authorization for any continuing services beyond eight sessions. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office at least five business days prior to the scheduled date of service.

For more information, refer to the "Medical management" section.

Covered

1. Outpatient services, including individual, family or group therapy. The actual number of visits authorized beyond the initial eight is based on medical necessity as determined by the plan, and may include individual, group or family therapy.
2. Psychopharmacological services, such as visits with a physician to review, monitor and adjust the levels of prescription medication used to treat a mental disorder
3. Neuropsychological assessment services, when medically necessary
4. Intermediate services such as day treatment/evening treatment and/or partial hospitalization for a full or partial day. Any of these services require prior-authorization from the plan.

Exclusions

1. Mediation (dispute resolution) or intervention services
2. Vocational evaluation, vocational counseling, vocational rehabilitation, and/or vocational training
3. Faith-based counseling (e.g., "Christian counseling")
4. Services that do not include face-to-face participation by the member (e.g., "phone therapy")
5. Residential halfway house services
6. Acupuncture, biofeedback and biofeedback devices for home use, or any other alternative treatment for the treatment of a mental health or substance abuse condition
7. Services or programs that are not medically necessary for the treatment of a mental health or substance abuse condition. Examples of services that are not covered include (but are not limited to) at-risk youth expeditions, Outward Bound-type programs, and wilderness programs
8. Services or programs that are provided in an educational, vocational or recreational setting
9. Services or programs that provide primarily custodial care
10. Evaluation and therapy for central auditory processing difficulties
11. Inpatient charges for a private room, unless medically necessary (if you want a private room and it is not a medical necessity, you pay all additional charges above the semiprivate room charge); charges for personal comfort items such as telephone, radio or television; and charges that you incur when you choose to stay beyond the hospital or program discharge hour for your own convenience

Office visits and outpatient services

The plan covers the following services in an office or outpatient setting. Coverage is provided on a nondiscriminatory basis for services delivered or arranged by a nurse practitioner or a physician assistant.

The plan covers patient care services and routine patient costs furnished to members enrolled in certain qualified clinical trials to the same extent as they would be covered if the member did not receive the care in a qualified clinical trial. To be eligible for coverage, you must have been diagnosed with cancer or other life-threatening diseases or conditions and the clinical trial must be one that is intended to treat cancer or other life-threatening diseases or conditions. Coverage for patient care services and routine patient costs provided to you while you are enrolled in the clinical trial is subject to all the terms and conditions of the plan.

Some outpatient services require prior-authorization to determine medical necessity. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office at least five business days prior to the scheduled date of service. For more information, refer to the "Medical management" section.

Covered

1. Office visits and related services, including:
   - Office visits to diagnose or treat an illness or an injury
   - A second opinion
   - Pediatric specialty care, including mental health care, by a provider with recognized expertise in specialty pediatrics
   - Respiratory therapy services
   - Hormone replacement therapy services for perimenopausal and postmenopausal women
2. Radiation therapy and Chemotherapy. Benefits include chemotherapy furnished by a covered provider including but not limited to a physician; or a nurse practitioner; or a free-standing radiation therapy and chemotherapy facility; or a hospital; or a covered provider who has a recognized expertise in specialty pediatrics. This coverage includes:
   - Radiation therapy using isotopes, radium, radon, and other ionizing radiation.
   - X-ray therapy for cancer or when it is used in place of surgery.
   - Drug therapy for cancer (chemotherapy)
3. Injections and injectables that are supplied and administered by a licensed provider and that are not ordinarily dispensed from a pharmacy
4. Allergy testing and allergy injections
5. Diagnostic lab and X-ray services
6. Chiropractic services for acute musculoskeletal conditions. The condition must be new or an acute exacerbation of a previous condition. This coverage includes: diagnostic lab tests (such as blood tests); diagnostic x-rays other than magnetic resonance imaging (MRI), computerized axial tomography (CT scans), and other imaging tests; and outpatient medical care services, including spinal manipulation. Your coverage for these services may have a benefit limit. If it does, the Schedule of Benefits for your plan option describes the benefit limit that applies for these services.
7. Renal dialysis (Please see **Medicare** under the **claims process** section for more information.)
   - Outpatient renal dialysis
   - Continuous ambulatory peritoneal dialysis (CAPD)
8. Diabetic services
   - Diabetes self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider
   - Laboratory tests including glycosylated hemoglobin, or HbA1C tests; urinary protein/microalbumin and lipid profiles

9. Medical social services provided to assist you in adjusting to your or your family member's illness. This includes assessment, counseling, consultation and assistance in accessing community resources.
10. Outpatient surgery, anesthesia and the medically necessary pre- and postoperative care related to the surgery, provided in a hospital outpatient, day surgery or ambulatory surgical facility
11. Visit to a walk in clinic. Services are provided for a variety of common illnesses, including, but not limited to:
    - Strep throat
    - Ear, eyes, sinus, bladder and bronchial infections
    - Minor skin conditions (e.g. sunburn, cold sores)
12. Podiatry Care covers non-routine (foot) care. This may include (but is not limited to): a physician; or a podiatrist. This coverage includes: diagnostic lab tests; diagnostic x-rays; surgery and necessary postoperative care; and other medically necessary foot care such as treatment for hammertoe and osteoarthritis.

Exclusions

1. Routine foot care services such as trimming of corns, trimming of nails, and other hygienic care, except when the care is medically necessary because you have systemic circulatory disease (such as diabetes); and certain non-routine foot care services and supplies such as foot orthotics, arch supports, shoe (foot) inserts, orthopedic and corrective shoes that are not part of a leg brace (except as described in this *Member Handbook/Evidence of Coverage* for **Prosthetic/orthotic devices and durable medical equipment**), and fittings, castings, and other services related to devices for the feet.
2. Exams or treatment required by a third party unless medically necessary as determined by a licensed physician and the plan. Examples include pre-employment or school physicals, premarital medical tests, court-ordered treatment or immunizations required due to your job or work conditions.
3. Acupuncture or massage therapy
4. Virtual colonoscopy
5. Laboratory tests to evaluate cardiovascular disease risk, such as Lipoprotein, The PLAC test, and NMR Lipoprofil

Oral surgery and related services

The plan covers the following oral surgery services when provided by an oral surgeon or physician in an office setting. If you have a complicating medical condition, such as heart disease, and the plan determines that oral surgery cannot be performed safely in an office setting, coverage will be provided for oral surgery services in a medically appropriate setting.

Oral surgery requires prior-authorization. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office at least five business days prior to the scheduled date of service. For more information, refer to the “Medical management” section.

Covered

1. Office visits with an oral surgeon for:
   - The removal or exposure of impacted teeth, including both hard and soft tissue impactions, or an evaluation for this procedure
   - The surgical treatment of cysts affecting the teeth or gums that cannot be treated by a dentist
   - The treatment of fractures of the mandible (jaw bone)
   - Outpatient services to diagnose and/or treat temporomandibular joint (TMJ) disorders that are caused by or result in specific medical condition (such as degenerative arthritis and jaw fractures or dislocations). The medical condition must be proven to exist by means of diagnostic x-ray tests or other generally accepted diagnostic procedures. This coverage includes:
     a. Diagnostic x-rays
     b. Surgical repair or intervention
     c. Non-dental medical care services to diagnose and treat a TMJ disorder
     d. Splint therapy (This includes measuring, fabricating, and adjusting the splint.)
     e. Physical therapy (See **Rehabilitation and Habilitation services**)

2. Emergency medical care such as to relieve pain and stop bleeding as a result of accidental injury to the sound natural teeth or tissues when provided as soon as medically possible after injury. This does not include restorative or other dental services.

Exclusions

1. Procedures or services related to dental care, including but not limited to routine dental care, root canals, extractions, orthodontia, periodontal surgery, endodontic or prosthodontic services, bonding or devices such as bridges, dentures, crowns or caps
2. TMJ disorders that are not proven to be caused by or to result in a specific medical condition; appliances, other than a mandibular orthopedic repositioning appliance (MORA); and services, supplies, or procedures to change the height of teeth or otherwise restore occlusion (such as bridges, crowns, or braces).

Organ transplants

The plan covers certain human solid organ, bone marrow and stem cell transplants. This includes bone marrow transplant or transplants for persons who have been diagnosed with breast cancer that has progressed to metastatic disease.

If you are the recipient of a transplant, the services for the donor are covered including the evaluation and preparation, and the surgery and recovery directly related to the donation, except for those services covered by another insurer. If you are the donor and the transplant recipient is not a member of the plan, no coverage is provided for either the recipient or the donor, except for human leukocyte antigen or histocompatibility locus antigen testing described in Covered Service number 4 below.

Organ transplant services require prior-authorization. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office at least five business days prior to the initial consultation visits and any subsequent services. For more information, refer to the "Medical management" section.

Covered

1. Office visits related to the transplant.
2. Inpatient hospital services, including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient.
3. Professional services provided to you while you are an inpatient, including, but not limited to medical, surgical and psychiatric services.
4. Human leukocyte antigen (HLA) or histocompatibility locus antigen testing for A, B or DR antigens, or any combination thereof, necessary to establish bone marrow transplant donor suitability of a member.

Exclusions

1. Investigational/experimental or unproven transplant procedures, including but not limited to:
   - The transplant of partial pancreatic tissue or islet cells
   - A pancreatic transplant that does not follow a kidney transplant or that is not part of a combined pancreas-kidney transplant
2. Bioartificial transplantation, such as the transplant of a total artificial heart.
3. Xenotransplantation, such as the transplant of animal tissues or organs into a human.
4. Services for an organ donor that are covered by another insurer.
5. Services for an organ donor if the recipient is not a plan member.
6. Transportation or housing costs for the recipient or donor.
7. House cleaning costs incurred in preparation for a transplant recipient's discharge.

Prescription drugs

The plan covers medically necessary drugs and supplies that are prescribed by a licensed health care provider. All drugs and supplies must be approved for sale by the U. S. Food and Drug Administration and used for the purpose indicated.

The prescription drug formulary
The prescription drug formulary is a list of generic and brand name drugs that shows the applicable cost-sharing tier and prior authorization requirements for each medication. Each drug in the prescription drug formulary is assigned to a tier based on cost and efficacy. A committee of doctors and pharmacists reviews and updates the formulary regularly.

The prescription drug formulary has a multi-tiered costs-sharing structure for the in-network level of benefits. The prescription drug formulary is available online at fallonhealth.org. If you do not have access to our website or if you have any questions about the formulary, call Customer Service.

Prior authorization
Certain drugs are designated in the formulary as requiring prior authorization. Coverage for these drugs is provided when your provider receives prior authorization from the plan before issuing the prescription.

In certain circumstances your provider may want to prescribe a drug that is not listed in the formulary. A drug may not be included in the formulary because it is new or very infrequently used. Coverage for these drugs also requires prior authorization from the plan.

Prior authorization request procedure

1. Provider completes Prior Authorization Prescription Request form. (To obtain a form or for more information call Customer Service.)
2. Provider sends form to: Department of Pharmacy Services, Fallon Health & Life Assurance Company, 10 Chestnut St., Worcester, MA 01608; or faxes form to: 1-508-791-5101.
3. The Department of Pharmacy Services reviews the request, based on established medical criteria for each drug, and notifies the provider.

Urgent requests are handled on a same-day basis.

Brand-name and generic drugs
Brand-name drugs are drugs that are produced and sold under the original manufacturer's brand name. A generic drug is a drug product that is equivalent to a brand-name drug in terms of quality and performance. A generic drug contains the same amount of the same active drug ingredient as the brand-name drug. Most generic drugs are sold under their chemical names. Both brand-name and generic drugs must meet the approval of the U. S. Food and Drug Administration.

Generic drugs cost less. You should discuss generic drug alternatives with your physician or pharmacist. You will generally receive a generic drug from network pharmacies any time one is available, unless your doctor has directed the pharmacist to only dispense a specific brand-name drug.

However, there are some brand-name drugs that do not have a generic equivalent. In this case you will be responsible for the cost-sharing that applies to the actual drug dispensed.

Off-label use of drugs to treat cancer or HIV/AIDS
The plan will cover drugs that are approved by the U.S. Food and Drug Administration (FDA) and the costs to administer such drugs, if your doctor prescribes them for the treatment of cancer or HIV/AIDS, even if the FDA has not approved the drug for that use. In no event will the plan pay for experimental drugs, which have not been approved for use by the FDA.

Dispensing limitations

When you fill a covered prescription at a participating pharmacy, you will pay the corresponding cost-sharing for each 30-day supply. Occasionally, for safety reasons or as directed by your provider, the length of therapy may be less than 30 days. If your doctor prescribes an amount of medication that is less than a 30-day supply (or for other prescription items, such as inhalers, that are dispensed as single units), you must still pay the corresponding cost-sharing for each prescription.

We follow FDA dispensing guidelines. You generally cannot refill a prescription until most of the previous supply has been used.

Mail-order

You may also get your prescription drugs through our mail-order prescription service. You may have your prescription mailed directly to your home. Most medications can be mailed; however, there are some that cannot be mailed. Also, some diabetic supplies are not available through mail-order. Your pharmacist will make the determination.

When you fill a prescription through our mail-order service, you will be charged a fixed cost-sharing amount for up to a 90-day supply. Please see the enclosed Schedule of Benefits to determine your cost-sharing for prescriptions obtained through mail-order.

Covered

1. Prescription medication, except those listed as excluded below
2. Contraceptive drugs and devices
3. Self-administered injectable agents*
4. Hormone replacement therapy
5. Insulin
6. Syringes (including insulin syringes) or needles when medically necessary
7. Supplies for the treatment of diabetes as mandated by Massachusetts law, including:
   - Blood glucose monitoring strips
   - Urine glucose strips
   - Ketone strips
   - Lancets
   - insulin pens
8. Prescribed oral medications that influence blood sugar levels, for the treatment of diabetes
9. Orally administered anticancer medications used to kill or slow the growth of cancerous cells
10. Long-term antibiotic therapy for a patient with Lyme disease when determined to be medically necessary and ordered by a licensed physician after making a thorough evaluation of the patient's symptoms, diagnostic test results or response to treatment. An experimental drug shall be covered as a long-term antibiotic therapy if it is approved for an indication by the United States Food and Drug Administration.
11. FDA-approved tobacco cessation medications, no prior authorization required:
    - Nicotine patch
    - Nicotine oral or nasal spray
    - Nicotine inhaler
    - Bupropion
    - Varenicline

* *Injectables administered in a physician's office or under other professional supervision are covered as a medical benefit.*

Over-the-Counter Medications
FHALC will cover over-the-counter preventive medications as required by the Patient Protection and Affordable Care Act. Over-the-counter medications must be prescribed by a health care provider. Covered over-the-counter medications include aspirin, iron supplementation, folic acid and gum/lozenges for nicotine replacement therapy. You must submit your prescription and your receipt to the FHLAC Claims Department for reimbursement.

FHLAC will also cover over-the-counter women's contraceptive methods such as sponges and spermicides that are FDA –approved and prescribed by a woman's health care provider. You must submit your prescription and your receipt to the FHLAC Claims Department for reimbursement.

Special Medical Formulas
Special medical formulas which are approved by the Massachusetts Department of Public Health and prescribed by a physician, and are medically necessary for the treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic academia, or methylmalonic academia in infants and children or when medically necessary to protect the unborn fetuses of pregnant women with phenylketonuria. Prior-authorization required.

Exception Request
If a clinically appropriate drug is excluded from our formulary you may make an exception request if you are covered under a small group or individual non-group plan (merged market). Please contact our pharmacy benefit manager, CVS Caremark at 1-855-582-2022 to request an exception request.

Standard Exception Request
You or your prescribing physician may make a standard exception request. Your prescriber must support the request by providing a statement that provides justification for supporting the need for the non-formulary 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 non-formulary drug, or would have adverse effects. A determination on your standard exception request will be made and you and your prescribing physician will be notified within 72 hours of receipt of information sufficient to begin our review.

Expedited 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. A determination on your expedited exception request will be made and you and your prescribing physician will be notified within 24 hours of receipt of information sufficient to begin our review.

External Exception Request
If you disagree with the decision on your standard or expedited exception request above, you may file an external exception request. If you would like 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.

Exception Request for Contraceptives
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 contact CVS Caremark by telephone at 1-866-772-9538 or Fax 1-888-836-0730 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.

Exclusions

1. Drugs that you can buy without a prescription, unless included on the Fallon formulary or specifically described as covered in the above Over-the-Counter Medications section. This exclusion does not apply to insulin and other diabetes-related medication that is shown above as a covered item.
2. Drugs that are investigational or that have not been approved for general sale and distribution by the U.S. Food and Drug Administration
3. Drugs that require prior authorization if prior authorization is not received
4. Drugs not listed in *Fallon's Prescription Drug Formulary* unless prior authorization is received
5. Drugs prescribed for purposes that are not medically necessary. This includes, but is not limited to, drugs for cosmetic purposes, to enhance athletic performance, for appetite suppression or for other noncovered conditions. This also includes drugs that do not meet medical criteria for coverage.
6. Vitamins and minerals, whether or not a prescription is required, unless listed in the Fallon Preferred Care prescription drug formulary
7. Over-the-counter birth control preparations or devices, unless specifically described as covered in the above Over-the-Counter Medications section.
8. Replacement of more than one lost/mishandled medication per prescription per benefit period
9. Prescription drugs that are a combination of a covered prescription item and an item that is specifically excluded, such as vitamins, minerals, medical foods or formulas
10. Bio-identical hormone replacement therapy.
11. The following Proton Pump Inhibitors: Prevacid, Iansoprazole, Protonix, Zegerid, Prilosec.
12. The following nonsedating antihistamines: Allegra, Allegra ODT, Cetirizine HCl, Clarinex, Claritin, Claritin Reditabs, Fexofenadine HCl, Xyzal and Zyrtec.
13. Vimovo
14. Medical marijuana
15. Duexis (ibuprofen/famotidine)
16. Omeclamox (amoxicillin/clarithromycin/omeprazole) Therapy Pack
17. Vascepta (icosapent ethyl)
18. Liptruzet (atorvastatin/ezetimibe)
19. Diclegis (doxylamine/pyriodoxine)
20. Acticlate (doxycycline Hyclate)
21. Jublia (efinaconazole soln)
22. Durlaza (aspirin 162.5mg)
23. Cuprimine (penicillamine) capsules
24. Glumetza (metformin) tablets
25. Fortamet (metformin SR 24h osmotic) tablets
26. Sernivo (betamethasone dipropionte spray emulsion) 1.5% Spray
27. Bonjesta (doxylamine/pyridoxine)
28. Yosprala (aspirin/omeprazole)

Preventive care

The plan covers preventive care services under the United States Preventive Services Task Force (USPSTF), Health Resources and Services Administration (HRSA) and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP) as required by the Patient Protection and Affordable Care Act of 2010. In addition to the services listed in this section, you may visit our website at www.fallonhealth.org for more information on these guidelines.

Covered

1. Physical exams for the prevention and detection of disease, for members age 6 and older, including routine immunizations
2. Routine eye exam once in each 12-month period
3. Mammography:
   a. One baseline mammogram for women ages 35 to 40
   b. One mammogram annually for women age 40 and older
4. Routine gynecological care including annual exam and Pap smear
5. Preventive care services for children from birth to age 6, including physical examination, history, measurements, sensory screening, and neuropsychiatric evaluation and development screening and assessment at the following intervals: six times during the child’s first year after birth, three times during the next year, and annually until age 6. Such services also include hereditary and metabolic screening at birth, appropriate immunizations, and screening for lead poisoning, tuberculin tests, hematocrit, hemoglobin and other appropriate blood tests and urinalysis as recommended by the pediatric health care provider.
6. Voluntary family planning services, including:
7. Consultations, examinations, procedures and medical services related to the use of all contraceptive methods
8. Contraceptive drugs and devices supplied by a licensed health care provider during a covered office visit. (Prescription contraceptive drugs and devices are covered under the prescription drug benefit.)

Exclusions

1. More than one routine eye exam in each 12-month period, or eye exam/fitting for contact lenses
2. Eyeglasses or contact lenses, except intraocular lenses implanted following cataract surgery
3. Exams or treatment required by a third party unless medically necessary as determined by the plan. Examples are pre-employment or school physicals, court ordered treatments or immunizations required due to your job or work conditions.
4. Immunizations provided by the state
5. Routine eye exams not provided by an optometrist or ophthalmologist contracted with EyeMed. See the Fallon “Find a doctor” tool at fallonhealth.org for details.

Prosthetic/orthotic devices and durable medical equipment

The plan covers durable medical equipment (DME) and prosthetic/orthotic devices, including prosthetic limbs which replace, in whole or in part, an arm or leg.

The purchase or rental of prosthetic/orthotic devices and durable medical equipment requires prior-authorization to determine medical necessity. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office as soon as the item has been prescribed by the provider. For more information, refer to the "Medical management" section.

Prosthetic devices are devices that replace all or part of an organ or body part (other than dental). Some examples are:

- Artificial limbs and eyes
- Implanted corrective lenses needed after a cataract operation
- Breast prostheses
- Electric speech aids
- Therapeutic/molded shoes and shoe inserts for the treatment of severe diabetic foot disease

Orthotic devices are "rigid or semi-rigid" devices that support part of the body and/or eliminate motion. Some examples are:

- Form neck collars for cervical support
- Molded body jackets for curvature of the spine (scoliosis)
- Elbow or leg braces
- Back, neck and leg braces with rigid supports, including orthopedic shoes that are part of braces
- Splints

Durable medical equipment is defined as medical care-related items that 1) can withstand repeated use (e.g., could normally be rented), 2) are used in a private residence (not a hospital or skilled nursing facility), and 3) are primarily and customarily for a medical purpose and generally not useful to a person in the absence of illness or injury. Durable medical equipment includes such items as:

- Oxygen and oxygen equipment
- Respiratory equipment
- Hospital beds
- Wheelchairs
- Crutches, canes and walkers
- Breast pumps
- Blood glucose monitors for home use, for the treatment of diabetes
- Visual magnifying aids and voice synthesizers for blood glucose monitors, for use by diabetics who are legally blind
- Insulin pumps and insulin pump supplies
- Medically necessary Habilitative devices

Covered

1. The purchase or rental of prosthetic/orthotic devices and durable medical equipment (including the fitting, preparing, repairing and modifying of the appliance).
2. Scalp hair prosthesis (wig) for an individual who has suffered hair loss as a result of the treatment or any form of cancer or leukemia. Coverage is provided for one scalp hair prosthetic (wig) per member per benefit period when the prosthesis is determined to be medically necessary by a plan physician and the plan.
3. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy.

4. Oxygen and related equipment
5. Prosthetic limbs which replace, in whole or in part, an arm or leg.
6. Insulin pumps and insulin pump supplies.
7. Coverage for hearing aids for individuals age 21 or younger for the cost of 1 hearing aid per hearing impaired ear up to $2,000 for each hearing aid device only, every 36 months.
   - Related services and supplies for hearing aids (not subject to the $2,000 limit)

Exclusions

1. Coverage for scalp hair prosthesis in excess of one scalp hair prosthetic (wig) per member per benefit period or for medical conditions other than those described above
2. Custom breast prosthesis
3. Items that are not covered include, but are not limited to: adjustable shoe-style positioning devices (such as the Bebax™ shoe) air conditioners, air purifiers, alcohol and alcohol wipes, arch supports, ear plugs (i.e., to prevent fluid from entering the ear canal during water activities), foot orthotics, orthopedic shoes (except when part of a brace) or other supportive devices for the feet, articles of special clothing, compression garments, bed pans, raised toilet seats, dehumidifiers, dentures, elevators, safety grab bars, car seats, seizure helmets, heating pads, hot water bottles, exercise equipment or similar devices.
4. Hearing aids for individuals over age 21

Reconstructive and restorative services

The plan covers reconstructive services to improve or correct a physical functional impairment resulting from a congenital defect or birth abnormality, accidental injury, prior surgical procedure or disease.

The plan covers restorative services to repair or restore appearance damaged by accidental injury. Only the initial repair is covered.

Services performed to improve appearance in the absence of any signs and or symptoms of physical functional impairment, are considered cosmetic and are not covered (with the exception of services performed to repair or restore appearance after accidental injury). Services required to treat a complication that arises as a result of a prior non-covered surgery/procedure, may be covered when medically necessary in all other respects.

In accordance with the Women's Health and Cancer Rights Act of 1998, coverage is provided for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications of all stages of mastectomy, including lymphedema.

Reconstructive surgery requires prior-authorization to determine medical necessity. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office at least five business days prior to the scheduled date of service. For more information, refer to the "Medical management" section.

Covered

1. Office visits related to covered reconstructive and restorative services
2. Inpatient hospital services including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient
3. Professional services provided to you while you are an inpatient, including, but not limited to medical, surgical and psychiatric services
4. Benefits are provided for the treatment of cleft lip and cleft palate for children under the age of 18. The coverage shall include benefits for medical, dental, oral and facial surgery, surgical management and follow-up care by oral and plastic surgeons, orthodontic treatment and management, preventative and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy, speech therapy, audiology, and nutrition services. Payment for dental or orthodontic treatment not related to the management of the congenital conditions of cleft lip and cleft palate will not be covered. Prior authorization is required.
5. Medical or drug treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome including, but not limited to, reconstructive surgery, such as assisted lipectomy, other restorative procedures and dermal injections or fillers for reversal of facial lipoathrophy.

** Coverage for prostheses is described under prosthetic/orthotic devices and durable medical equipment .*

Exclusions

1. Cosmetic surgery, cosmetic treatments, cosmetic procedures, cosmetic medications and cosmetic supplies, including, but not limited to: otoplasty for protruding ears; ear piercing; abdominoplasty; chemical peel (dermal and epidermal); microdermabrasion; and hair removal.
2. Services related to cosmetic surgery, cosmetic treatments, and cosmetic procedures are not covered. This includes but is not limited to: physician charges, hospital charges, charges for anesthesia, drugs, etc.
3. Care of the teeth and supporting structures, including reconstructive, major restorative or cosmetic dental services, such as dental implants (also known as osseointegrated or titanium implants), dentures, crowns, and orthodontics. Care of the teeth and supporting structures is not covered (unless related to the management of the congenital conditions of cleft lip and cleft palate). Similarly, medical or surgical procedures in preparation for a dental procedure are also not covered (for example, a bone graft to prepare for a dental implant).
4. Surgery, treatments, procedures, medications, and supplies to prevent snoring.

5. Removal of intact breast implants for suspected autoimmune or connective tissue disease or for breast cancer prevention because these indications are considered experimental/investigational.
6. Removal of an intact breast implant that has shifted. Implant shifting in the absence of refractory infection or Stage IV capsular contracture is not medically necessary.
7. Liposuction, also known as suction lipectomy or suction assisted lipectomy, is the surgical excision of subcutaneous fatty tissue. Liposuction (CPT codes 15876-15879) is not covered. However, liposuction is an integral part of certain covered services, such as the surgical removal of excessive skin (CPT codes 15830-15839), but is not separately reimbursed.
8. Treatments for acne scarring including, but not limited to subcutaneous injections to raise acne scars, chemical exfoliation (CPT 17360), and dermabrasion.
9. The following treatments for active acne are not covered: acne surgery (CPT code 10040), cryotherapy for acne (CPT code 17340), chemical exfoliation for acne (CPT code 17360), and laser and light-based therapies, including but not limited, to blue light therapy, pulsed light, and diode laser treatment.

Cosmetic services
Cosmetic surgery, cosmetic treatments, cosmetic procedures, cosmetic medications and cosmetic supplies are not covered (even when intended to improve self-esteem or treat a mental health condition). In addition, drugs, biologicals, facility/hospital charges, laboratory and radiology charges, and charges for surgeons, assistant surgeons, anesthesiologists, and any other incidental services which are directly related to the cosmetic surgery/procedure are not covered. However, services required to treat a complication that arises as a result of a prior non-covered surgery/procedure, may be covered when medically necessary in all other respects.

Below are some examples of procedures that are considered cosmetic in nature and are not covered:

- Botox injections for cosmetic purposes
- Breast implants
- Chemical exfoliation for acne
- Chemical peel
- Chin implant (unless for the correction of a deformity that is secondary to disease, injury or congenital defect)
- Collagen implant (e.g., Zyderm)
- Correction of diastasis recti abdominis
- Dermabrasion for removal of acne scars
- Earlobe repair to close a stretched or torn ear pierce hole
- Electrolysis for hirsutism
- Excision or repair of keloid
- Grafts, fat
- Otoplasty
- Reduction of labia minora
- Removal of spider angiomata
- Revisions of previously performed restorative surgery (unless to improve or correct a physical functional impairment)
- Rhytidectomy
- Salabrasion
- Suction-assisted lipectomy

This list is not exhaustive; any procedure considered cosmetic in nature will be excluded.

Rehabilitation and Habilitation services

The plan covers the outpatient rehabilitation services shown below. Rehabilitation services must be medically necessary.

The plan covers habilitation services. Habilitation services help a person keep, learn or improve skill and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Covered

1. Physical and occupational therapy services for up to 60 visits combined per benefit period when medically necessary. After 60 combined physical and occupational therapy visits within a benefit period, prior authorization based on medical necessity is required for additional visits within the benefit period.
2. Medically necessary services for the diagnosis and treatment of speech, hearing and language disorders when services are provided by a provider who is a speech-language pathologists or audiologist or audiologist. After 30 speech therapy visits within a benefit period, prior authorization based on medical necessity is required for additional visits within the benefit period.
3. Cardiac rehabilitation for persons with documented cardiovascular disease, provided in accordance with standards developed by the Massachusetts Commissioner of Public Health. Rehabilitation is to be initiated within 26 weeks after the diagnosis of cardiovascular disease.
4. Medically necessary early intervention services delivered by a certified early intervention specialist, according to operational standards developed by the Massachusetts Department of Public Health, for children from birth to their third birthday.

   Early intervention services include applied behavior analysis (ABA) therapy. (See the **Autism services** section of your *Evidence of Coverage* for details.) Benefits are only available to members who are residents of Massachusetts or whose principal place of employment is in Massachusetts. Services require prior authorization.
5. Pulmonary rehabilitation services for chronic obstructive pulmonary disease (COPD) are covered for up to two one-hour sessions per day, for up to 36 lifetime sessions.

Exclusions

1. Long-term rehabilitation services
2. Services that are not determined to be medically necessary
3. The diagnosis or treatment of speech, hearing or language disorders in a school-based setting
4. Massage therapy, including myotherapy (unless provided by a physician or physical therapist with one-to-one patient contact) or acupuncture
5. Early intervention services for children beyond their third birthday
6. Pulmonary rehabilitation services for chronic obstructive pulmonary disease beyond 36 lifetime sessions.
7. Pulmonary maintenance

Skilled nursing facility services

The plan covers inpatient services in a skilled nursing facility. You may be admitted to a skilled nursing facility if based on your medical condition, you need daily skilled nursing care, skilled rehabilitation services or other medical services that may require access to 24-hour medical or nursing care but does not require the specialized care provided in an acute care hospital.

Skilled nursing facility services require prior-authorization to determine medical necessity. To obtain prior-authorization, you or someone acting on your behalf must call the appropriate medical management office as soon as this level of service has been requested or ordered by the provider. For more information, refer to the "Medical management" section.

Covered

1. Care in a skilled nursing facility provided on an inpatient basis, including room and board in a semiprivate room (or private room if medically necessary) and the services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, nursing care, physical, occupational and speech therapy, and medical supplies and equipment. Coverage is provided up to the benefit maximum described in your Schedule of Benefits.
2. Professional services provided while you are an inpatient, including, but not limited to medical, surgical and psychiatric services

Exclusions

1. Private room, unless medically necessary. If you desire a private room and it is not a medical necessity, you pay all additional room charges above the semiprivate room charge.
2. Skilled nursing facility services beyond the limit described in your Schedule of Benefits
3. Services that are not determined to be medically necessary even if your benefit maximum has not been reached
4. Custodial care
5. Personal comfort items, such as telephone, radio or television
6. Charges that you incur when you choose to stay beyond the facility's discharge hour for your own convenience or charges for services that are not medically necessary

Wellness

Fitness and Weight Loss Essential Health Benefits (EHBs)

- One Weight Watchers Monthly Pass reimbursement per subscriber for 5 months. Subscriber must be a Fallon Health member for 3 months or longer.
- One YMCA or YWCA fitness membership reimbursement per subscriber for 3 months. Subscriber must be a Fallon Health member for 3 months or longer. Subscriber must have a fitness membership with the YMCA or YWCA for at least 3 months before eligible for reimbursement.

It Fits

- It Fits! reimburses eligible members for participating in a variety of health activities: membership at local fitness centers, home fitness equipment, aerobics, Pilates and yoga classes when taught by a certified instructor, Weight Watchers® programs, and local town and school sports programs for all ages when they include an aerobic and instructional component. Aerobic activities for the whole family include: baseball, Softball, Soccer, Football, Dance Classes, Ski Lessons, Golf Lessons, Swimming Lessons, Tennis, and Sports Camps.

Fallon Healthy Health Plan program

The Healthy Health Plan program provides an incentive payment to subscribers and their covered spouses at least 18 years of age who complete an online Health Risk Assessment. Please review your Schedule of Benefits to determine if the plan design you selected includes the Healthy Health Plan program (Please note, not all plan designs include this program).

Log onto Fallon's Healthy Health Plan portal and complete the HRA to receive your $100 incentive payment. Your incentive payment will be made by check. You are eligible for the incentive payment once per plan year.

Other plan benefits and features

- Disease care services support members who have chronic conditions like asthma, congestive heart failure, coronary artery disease and diabetes.
- Eyewear discounts from contracted vendors
- Naturally Well offers discounts on acupuncture, massage therapy and chiropractic care.
- Nurse care specialists support members in need of more complex care by serving as their personal health advisor
- Oh Baby! gives participants prenatal vitamins, a child care book, a convertible car seat, and more.
- Tobacco Treatment Program helps members develop a stop-smoking plan and gives them the tools they need to succeed.
- With Nurse Connect, you get free access, by phone to experienced registered nurses 24 hours a day, 7 days a week to answer your health questions.
- Caremark ExtraCare Health Card® 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
- Family Fun program, free or discounted admission at local family fun spots.
- Our SmartShopper program allows eligible members the opportunity to receive incentive reimbursements when they choose to receive certain designated services from cost efficient providers. Incentive reimbursements are paid by check to members 18 and over (incentive reimbursements for members under age 18 are paid directly to the subscriber). Go to the member portal section of our website at fallonhealth.org for details on the services included in the SmartShopper program and incentive reimbursement amounts. Not all group accounts have chosen to participate in the SmartShopper program, please review your Schedule of Benefits to determine if your employer is participating in SmartShopper. Tax rewards you receive are generally considered taxable. Fallon SmartShopper provides year-end information for you to claim incentives on your tax returns. If you receive over $600 in incentive rewards you will receive a 1099 tax form.

  Certain services require prior authorization. Call 1-888-468-1541 for more information or review the Prior authorization section in your *Member Handbook/Evidence of Coverage.*

  1. You can shop for services using the Fallon SmartShopper tool by clicking the link on fallonhealth.org/members or by calling 1-866-228-1525. Certain services require prior authorization. Using Fallon SmartShopper, you can identify a low cost provider from where you would like to receive services.
  2. If the service requires prior authorization, and your treating physician has already received prior authorization approval for the service at a particular location, which is different from the low cost facility you have identified by using Fallon SmartShopper, a new prior authorization will be needed before you receive services at the lower costing facility.
  3. You will need to contact your physician to let them know the facility you would like to have the service performed at. The physician will need to request a new prior authorization at the new location on your behalf.
  4. If your physician will not change the location and request a new prior authorization, please call Fallon Health at 1-888-468-1541 and we will facilitate the process for you to obtain the new prior authorization approval.

  Once the new prior authorization approval is received, you can obtain services from the low cost provider identified by Fallon SmartShopper.

Call Customer Service at 1-888-468-15410 (TRS 711), or visit the Fallon website at fallonhealth.org, for more information on these programs.

General exclusions and limitations

You are not covered for the following services. These are in addition to the exclusions listed in the individual benefit sections of this handbook, as well as any additional exclusions listed on your Schedule of Benefits. However, this is not an exhaustive list.

1. Services or supplies that are not described as covered in this *Member Handbook/Evidence of Coverage*
2. Acne-related services, including the removal of acne cysts, cosmetic surgery or dermabrasion. (Benefits are provided for outpatient medical care to diagnose or treat the underlying condition identified as causing the acne.)
3. ALCAT test for food sensitivity
4. Alternative therapies such as acupuncture, biofeedback and biofeedback devices for home use, neurofeedback, and aquatic (when not provided as part of your covered physical therapy benefit), art, herbal, massage (when not provided as part of your covered physical therapy benefit) music or telephone therapy
5. Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment or vocational counseling and training, or educational therapy for learning disabilities
6. Any experimental procedure or service that is not generally accepted medical practice. (This does not include the off-label uses of covered prescription drugs used in the treatment of HIV/AIDS or cancer; nor to bone marrow transplants for breast cancer as required by state law.)
7. Any service or supply related to a non-covered condition
8. Any services furnished by any provider not having a license or approval, under applicable state law, to furnish that type of service
9. Any services that are the legal liability of workers' compensation insurance or other third party insurer; any illness or injury that we determine arose out of or in the course of your employment
10. Auditory integration therapy, such as Berard auditory integration therapy
11. Autologous blood donation or storage for use during surgery or other medical procedures
12. Care that we determine is custodial. Custodial care is defined as a level of care that: (a) is chiefly designed to assist a person with the activities of daily life; and (b) cannot reasonably be expected to greatly improve a medical condition.
13. Charges after the date on which your membership ends
14. Charges that you incur for services not determined to be medically necessary by a plan physician and the plan, such as personal comfort items, or when you choose to stay beyond the hospital discharge hour for your own convenience
15. Contact lenses are covered only for: cataract after extraction; 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.
16. Cosmetic or beautifying surgeries, procedures, drugs, services, or appliances
17. Dermatoscopy for detection of melanoma
18. Diagnostic tests analyzed in functional medicine laboratories including but not limited to:
    - Genova Diagnostics
    - Commonwealth Laboratories
    - Dunwody Laboratories
    - Diagnos-Techs Inc.
    - Red Path Integrated Pathology

19. Educational services or testing, except services covered under the benefit for early intervention services described in **rehabilitation services**
20. Elective long-term psychotherapy
21. Elective treatment or surgery not required by your medical condition, according to the judgment of the plan
22. Experimental implants are not covered. Nonexperimental implants are covered only when medically necessary due to a functional defect of a bodily organ and when the implant will serve to restore full normal function. (Note: This refers to implants. Coverage and exclusions for transplants are described in **organ transplants**)
23. Extracorporeal Shock Wave Therapy (ESWT) for chronic plantar fasciitis
24. Holistic treatments
25. Home video EEG monitoring
26. Inpatient dental care (except for inpatient hospital services at a plan hospital required when you have a nondental medical condition that requires you to be an inpatient when you receive dental services)
27. Laser vision correction surgery
28. Maintenance treatment or services
29. Medical care that Fallon determines is experimental/investigational, or not generally accepted in the medical community. Experimental means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that are considered to be unsafe, experimental, or investigational. This is determined by, among other sources, formal or informal studies, opinions and references to or by the American Medical Association, the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies, experts in the field, and any other association or federal program or agency that has the authority to approve medical testing or treatment.
30. Medical expenses incurred in any government hospital or facility or for services of a government doctor or other government health professional
31. Nonemergency care provided in an emergency room
32. Nutritional supplements or formulas for adults or children unless they are described in this *Member Handbook/Evidence of Coverage* as covered
33. Orthodontics
34. Provider charges for shipping or copying medical records, or for failing to keep an appointment
35. Psychological testing or neuropsychological assessments unless determined to be medically necessary
36. Reduction mammoplasty for male gynecomastia
37. Removal of nonimpacted wisdom teeth
38. Rest care or long-term care
39. Routine foot care. This includes, but is not limited to:
    a. Cutting or removal of corns, calluses or plantar keratoses
    b. Trimming, cutting and clipping of nails
    c. Treatment of weak, strained, flat, unstable or unbalanced feet
    d. Other hygienic and preventive maintenance care considered self-care (i.e., cleaning and soaking the feet, and the use of skin creams to maintain skin tone)
    e. Any service performed in the absence of localized illness, injury or symptoms involving the foot

40. Routine maternity care when you are traveling outside the plan service area. This includes prenatal, delivery and admission, and postpartum care.
41. Sclerotherapy, joint and ligamentous injections (prolotherapy) for non-symptomatic varicose veins
42. Sensory integration therapy
43. Services and supplies received for reasons of preference or convenience
44. Services and treatment not in keeping with national standards of practice, as determined by Fallon, including, but not limited to: nutritional-based therapies, non-abstinence-based substance abuse care, crystal healing therapy, Rolfing®, regressive therapy, EST, and herbal therapy
45. Services authorized to be provided under MGL Chapter 71B in Massachusetts (referred to as "Chapter 766"). These services include, for example:
    a. Adaptive physical education
    b. Physical and occupational therapy
    c. Psychological counseling
    d. Speech and language therapy
    e. Transportation

    Members who believe that their child may be disabled (physical disability, mental retardation, learning problem, or behavioral problem) should seek a Chapter 766 evaluation. Members must make appropriate and reasonable efforts to obtain benefits available under state law.
46. Services covered under the plan that are performed by a member of your family or household, unless that person is a licensed health care provider who would otherwise have been gainfully employed performing these services
47. Services for cosmetic reasons
48. Services for nonacute (chronic) conditions. Chronic conditions are those that exist for an extended time or continue past the expected recovery time for acute or short-term conditions. For example, the plan defines chronic pain as continuing for more than three months after the injury of illness causing the original pain.
49. Services furnished to someone other than the member
50. Services in a residential halfway house
51. Services or supplies that are furnished or paid for, or with respect to which payments are actually provided, under any law of a government (national or otherwise) by reason of the past or present service of any person in the armed forces of a government
52. Services or supplies that are not medically necessary for the prevention, detection or treatment of an illness, injury or disease as determined by a plan physician and the plan. Some examples include (but are not limited to): autopsies, ear plugs to prevent fluid from entering the ear canal during water activities, and nutritional supplements or formulas for adults or children unless described as covered within this *Member Handbook/Evidence of Coverage*. Services or supplies that do not meet the plan's medical criteria are not considered to be medically necessary.
53. Services or supplies that are not provided by or authorized by a plan provider, plan dental provider or the plan, except in the emergency situations described in **emergency and urgent care**
54. Services or supplies, that are paid for, or with respect to which benefits are actually provided, under any law of a government (national or otherwise) except where such payments are made or such benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents
55. Services received after the date that coverage ends

56. Services that a third party or court order requires. Examples are employment, school, sports, premarital and/or summer camp examinations or tests; court-ordered treatment or evaluations; competency, adoption or child custody/ visitation evaluations; and any immunizations required by an employer, related to your job and/or work conditions.
57. Services that are considered experimental or which have not been approved by a plan medical director
58. Services that are covered by another insurer
59. Services that have not been authorized by the plan, including services beyond the plan benefit limits
60. Services to reverse a voluntary sterilization
61. Special duty or private duty nursing and attendant services
62. Specialty clothing appropriate to specific medical conditions
63. Tinnitus masker
64. Total body photography
65. Travel, transportation and lodging expenses for a member and/or a member's family as a course of treatment or to receive consultation or treatment.
66. Treatment by telephone with providers not contracted through Teladoc
67. Treatment for complications resulting from noncovered cosmetic procedures
68. Treatment for personal growth, or other treatment that is not medically necessary, or not in keeping with national standards of practice
69. Unauthorized in-area urgent care visits
70. Unskilled nursing home care
71. Vision therapy or services (also referred to as orthoptics)
72. Vocational rehabilitation, including job retraining, or vocational and driving evaluations focused on job adaptability, or therapy to restore function for a specific occupation
73. White noise machines
74. Interspinous process decompression (or the X-Stop® interspinous process decompression device)
75. Naturopath services (uses natural or alternative treatments)

Appendix – M.G.L. Chapter 175, Section 108, Subsection 3(a)

If you are a non-group member, your coverage under this policy may not be less favorable to you in any respect than established by the provisions of Massachusetts General Laws Chapter 175, Section 108, Subsection 3 (a). These provisions are detailed below. Where you are given greater rights by another provision of this policy, those rights will supersede what is shown in this appendix.

Entire Contract; Changes. -- This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Time Limit on Certain Defenses. -- After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability as defined in the policy commencing after the expiration of such two-year period.

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of Massachusetts General Laws Chapter 175, Section 108, Subsection 3 (b), in the event of misstatement with respect to age or occupation or other insurance.

Reinstatement. -- If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

Notice of Claim. -- Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Claim Forms. -- The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss. -- Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claims. -- Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims. -- Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

Physical Examinations. -- The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder.

Legal Actions. -- No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

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