Commonwealth of Massachusetts

Member Handbook

Fallon Health
Select Care Network

Effective July 1, 2016

✓ This health plan **meets Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009 the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information, call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2016 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2016. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling 1-617-521-7794 or visiting its website at www.mass.gov/doi.

Fallon Community Health Plan, Inc**.**

This plan includes the tiered provider network. In this plan, members pay different levels of copayments, coinsurance or deductibles depending on the tier of the provider delivering a covered service or supply. This plan may make changes to a provider's benefit tier annually on July 1st. Please consult the provider directory or visit the provider search tool at fallonhealth.org/gic to determine the tier levels of available providers.

Access to health care services

This plan covers emergency care worldwide. When you experience an emergency medical condition, you should go to the nearest emergency room for care or call your local emergency communications system (e.g., police or fire department, or 911) to request ambulance transportation.

You may obtain health care services for an emergency medical condition, including local pre-hospital emergency medical service systems, whenever you have an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency medical services, and we will provide coverage of emergency services from any provider.

Emergency services will be covered from all providers at the cost level of the lowest cost-sharing tier regardless of the tier in which the health benefit plan has classified the provider providing such emergency services within the Tiered Provider Network including for inpatient deductibles if the insured seeking or receiving emergency services is subsequently admitted.

16-672-002

Interpreter services

If you need an interpreter to understand our procedures when doing business with the health plan, we will make the arrangements for interpreter or translation services.

إذا كنت بحاجة إلى مترجم فوري لفهم إجراءاتنا عند التعامل مع الخطة الصحية، فسنتخذ الترتيبات اللازمة لنؤمّن لك مترجما فوريا أو خدمات ترجمة.

បើអ្នកត្រូវការអ្នកបកប្រែដើម្បីឲ្យយល់អំពីដំណើរការរបស់យើងនៅពេលធ្វើការងារទាក់ទងជាមួយគំរោងសុខភាព យើងនឹងរៀបចំរកអ្នកបកប្រែឬកិច្ចបំរើខាងការបកប្រែ ។

Si ou bezwen entèprèt pou ou kapab konprann ki sa pou ou fè lè wap regle nenpòt bagay avèk plan de sante a, nap fè aranjman pou ou jwenn entèprèt oswa sèvis tradiksyon.

ຕ້ອງການນາຍພາສາ ເພື່ອທີ່ຈະເຂົ້າໃຈການດຳເນີນ ວຽກງານທັງຫຼາຍຂອງພວກເຮົາ ເວລາຕິດຕໍ່ວຽກງານ ກັບແຜນປິ່ນປົວສຸຂະພາບ, ພວກເຮົາຈະຈັດຫາບໍລິການແປພາສາໃຫ້ ແບບປາກເປົ່າຫຼືແບບຂຽນ.

Если Вам нужен переводчик, чтобы понять нашу политику, когда Вы имеете дело с планом медицинских услуг, то мы предоставим устного переводчика или услуги письменного перевода.

Si necesita un intérprete para comprender nuestros procedimientos al negociar su plan de salud, solicitaremos los servicios de un intérprete o traductor.

Quando estiver tratando do plano de saúde e por acaso necessitar de um intérprete para melhor entender os nossos procedimentos, nós podemos planejar os serviços de interpretação ou de tradução necessários.

Qualora aveste bisogno di un interprete per meglio comprendere le nostre direttive e le indicazioni del piano preventivo, saremo lieti di assistervi con servizi di interpretariato e traduzione.

Αν χρειάζεστε τις υπηρεσίες διερμηνέα για να καταλάβετε τις διαδικασίες μας όταν εργάζεστε με το πλάνο υγείας, θα κανονίσουμε ώστε να υπάρχουν διαθέσιμες υπηρεσίες διερμηνέα ή μεταφραστή.

Si vous avez besoin d'un interprète pour comprendre nos procédures dans le cadre du plan médical, nous prendrons les dispositions nécessaires pour obtenir les services d'un interprète ou d'un traducteur.

當您與本健保計劃接洽生意時，如果您須要口譯員協助您了解我們的程序，我們會安排口譯或翻譯服務。

Jeśli będzie Pan(i) potrzebował(a) tłumacza, ażeby zorientować się w naszym postępowaniu przy kontaktach z przedstawicielami planu ubezpieczenia medycznego, my załatwimy tłumaczenie lub przekład.

Nếu quí vị cần người thông dịch để hiểu rõ các thể thức của chúng tôi khi liên hệ thương mại về hợp đồng y tế, chúng tôi sẽ sắp xếp để có các dịch vụ thông dịch hay phiên dịch.

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This section contains:

Glossary

About this *Member Handbook/Evidence of Coverage*

Understanding your health care coverage

- Important points to remember
- Your membership card
- Notifying us of changes

Questions? Just ask.

- When and how to contact customer service
- Our website: fallonhealth.org/gic

Glossary

Adverse determination: a determination by Fallon 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, based on the fee schedule we have negotiated with that Select Care provider.

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

Authorization: An assurance by the plan to pay for medically necessary covered benefits provided by a network provider for an eligible plan member. In some instances, PCPs are given authority to issue an authorization for specialty care.

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.

Coinsurance: Your share of the allowed charge for certain covered benefits according to the fixed percentage specified in the “**Your Cost for Covered Services**” section under “**Coinsurance**.”

Commission: The Group Insurance Commission, the agency of the Commonwealth of Massachusetts that administers your group health plan. Also referred to as “plan sponsor.”

Contract: The agreement that Fallon has with the Group Insurance Commission to provide benefits to you and your covered dependents.

Copayment: The fixed-dollar amount you are responsible to pay for certain covered services. The copayment amounts for services are listed in the accompanying Schedule of Benefits. Please note that most of your copayments are determined by plan physician’s and hospital tiering level.

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 services: Health care services or supplies that are covered by the plan, as described in this *Member Handbook/Evidence of Coverage.*

Custodial care: A level of care which: (1) is chiefly designed to assist a person with the activities of daily life, and (2) 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 before payment is made by the plan for certain covered services.

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, determined by the GIC, on which your coverage begins.

Emergency medical condition: 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: (1) serious jeopardy to the health of the member or another person, 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, whether inside or outside the plan service area, that are: (1) furnished by a qualified provider and (2) needed to evaluate or stabilize an emergency medical condition.

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

If the committee determines that a technology is experimental or investigational, Fallon 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: A licensed institution providing health care services or a health care setting, including, but not limited to, hospitals and other inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers and rehabilitation and other therapeutic health settings.

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.

Fallon Health/Fallon: Also referred to as "the plan," "us," "we" and "our".

Select Care service area: The geographical area served by Select Care. The towns and cities in the Select Care service area are included in this *Member Handbook/Evidence of Coverage*.

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

GIC: The Group Insurance Commission, the agency of the Commonwealth of Massachusetts which provides your group health plan. Also referred to as "plan sponsor."

Group: The GIC's program to provide health coverage, in which Fallon is a participating vendor.

Homebound: A member who has an injury/illness that restricts his or her ability to leave home without the aid of supportive devices or the assistance of another person, or if leaving home is medically contraindicated.

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 dishwashing.

Inpatient: A registered bed patient in a licensed hospital or other facility.

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

Medically necessary (service): A service or supply that is consistent with generally accepted principles of professional medical practice, as determined by whether or not: (1) the service is the most appropriate available supply or level of service for the insured in question, considering potential benefits and harms to the individual; (2) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; (3) for services and interventions not in widespread use, is based on scientific evidence.

Member: Any person who has the right to services under this plan, which includes the subscriber and any family members covered under the subscriber's contract (also referred to as "you").

Network provider: A licensed physician or other healthcare professional, or hospital or other healthcare facility, with whom we contract to provide covered benefits to plan members. This includes, but is not limited to, physicians, dentists, chiropractors, optometrists, podiatrists, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, physician assistants and behavioral health professionals.

Network specialist: A licensed specialty physician or other specialty health care professional, with whom we contract to provide health care services to plan members. Specialists typically have a practice concentrated in a field of medicine in which a primary care physician may not have specialized training.

Nurse practitioner: A registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under M.G.L. c.112, § 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 care contract. Any changes made become effective on the anniversary date.

Outpatient: A patient who is not a registered bed patient in a hospital or other medical facility.

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: Fallon Health/Fallon (also referred to as "us," "we,"and "our").

Plan facility: Any inpatient hospital or other medical facility in the Fallon network, with which we contract to provide health care services to members.

Plan pharmacy: A licensed pharmacy in the Fallon network, with whom we contract to provide covered prescription drugs to members.

Plan physician: A licensed physician in the Fallon network, with whom we contract to provide health care services to members.

Plan provider: A licensed physician or other health care professional in the Fallon network, with whom we contract to provide health care services to members. This includes, but is not limited to: doctors of medicine, osteopathy and podiatry; registered nurse anesthetists; nurse practitioners; physician assistants; ambulance companies; and home health care providers.

Plan specialist: A licensed specialty physician or other specialty health care professional in the Fallon network, with whom we contract with to provide health care services to members. A specialist typically has a practice concentrated in a specific field of medicine in which a primary care provider may not have specialized training.

Plan sponsor: The Group Insurance Commission, the organization that provides your group plan.

Premium charge: The amount charged by Fallon for the coverage provided under this contract. (See **How your coverage works for more information**.)

Preventive care: Services, tests and immunizations 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; health maintenance visits (routine physical exams) for adults and children, as well as those mammograms, Pap tests and other tests associated with the health maintenance visit; prenatal maternity care; well child care, including vision and auditory screening; voluntary family planning, including generic contraceptives; nutrition counseling; and health education. For more information about the services that are part of a health maintenance visit, please see the Fallon preventive care guidelines on our website, at fallonhealth.org/gic, or call Customer Service for a copy.

Primary care provider (PCP): A network provider, specializing in internal medicine, family practice pediatrics, geriatric medicine or adolescent medicine whom you choose to work with you to manage your medical care.

Provider: A physician or other health care professional or hospital or other health care facility licensed by the state to deliver or furnish health care services.

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.

Referral: A recommendation by which a physician sends a member to another physician for services that are typically outside the referring doctor's scope of practice. Since plan physicians are freely able to recommend treatment options without restraint from the plan, a referral in and of itself does not guarantee that a recommended treatment is a covered benefit or that the accepting provider is contracted with the plan, and does not obligate the plan to pay for the service. Please note that referrals are not required for behavioral health services. (See **Obtaining specialty care and services** for a complete explanation of the referral and authorization process.)

Reliant Medical Group specialist: A specialist, including physicians, physician assistants, nurse midwives, and nurse practitioners, who is employed by the Reliant Medical Group and who practices within the Reliant Medical Group practice.

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.

Self-referral: The process by which you make an appointment directly with a plan provider without needing a referral from your PCP or an authorization from the plan. (See **Obtaining specialty care and services** for information on the services for which you can self refer.)

Skilled home health care services: Services and/or equipment provided in the member's home, such as intermittent skilled nursing care, home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Subscriber: The person who is responsible for the premium charge. On this plan, this is typically a public employee or a retiree.

Technology Assessment Criteria: Fallon 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 Fallon.
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 as a result of which a member has a life expectancy of less than six months.

Tier: Different levels in which plan specialists and hospitals are placed based on quality and cost-efficiency measures.

Urgent care: Medical care that is needed right away for minor emergencies, such as 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.

Walk In Clinic: Limited service medical clinics. Services are provided for a variety of common illnesses such as strep throat, bronchitis, minor rashes and burns and ear, eye and sinus infections. Services are also provided for routine immunizations and preventative health screenings.

About this *Member Handbook/Evidence of Coverage*

This *Member Handbook/Evidence of Coverage* is effective July 1, 2016. There are no pre-existing condition limitations under this contract. You may use the services described here beginning on July 1, 2016, or on your effective date, whichever comes later.

This *Member Handbook/Evidence of Coverage* details the benefits and services that Fallon covers for persons enrolled through the Group Insurance Commission, explains our policies and procedures and contains other information such as:

- Definitions of important terms (words are defined in our **Glossary**)
- Important points to remember about Fallon
- Our customer service capabilities
- The Fallon service area
- The role of your primary care provider (PCP)
- Referral and authorization procedures
- Your rights and responsibilities
- Types of coverage available
- Claims procedures
- Additional contract provisions
- Covered services
- Your plan benefits

When you joined Fallon, you chose Select Care. You must use the providers in the Select Care network.

If we need to update or change this *Member Handbook/Evidence of Coverage*, we will send you an amendment.

If you have any questions regarding this *Member Handbook/Evidence of Coverage*, please call Fallon Customer Service at 1-866-344-4GIC (4442) (TRS 711).

Understanding your health care coverage

Fallon Health is a health maintenance organization (HMO) that provides health care coverage for its members through a network of health care professionals and hospitals. Fallon is incorporated under the laws of the Commonwealth of Massachusetts as a nonprofit organization, and qualifies under federal law as a health maintenance organization. Our administrative offices are located at Chestnut Place, 10 Chestnut St., Worcester, MA 01608.

As an HMO, Fallon requires you to use specific physicians, hospitals and other providers that are part of your plan. Understanding how your health plan works is important. For one thing, it helps you know what to expect. The following information highlights the most important points about how we work to ensure that you receive quality care and services.

Important points to remember:

- The Select Care provider network includes providers in Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester Counties. In order for you to receive coverage for most services, care must be coordinated by your primary care provider (PCP) and administered by a provider in the Fallon network.
- When you join Fallon, you choose a primary care provider (PCP) who coordinates your health care.
- Fallon requires prior authorization for certain services and the site of where those services will be provided.

Tier 1, 2 and 3 measurements for plan physicians and hospitals

Fallon is committed to giving all our members access to a network of high-quality, cost-efficient plan doctors and hospitals. Fallon Select Care tiers Cardiologists, Endocrinologists, ENTs/Otolaryngologists, Nephrologists, Neurologists, Ob/Gyns, Pulmonologists and Rheumatologists based on quality and cost-efficiency measures. The following specialties are tiered on cost-efficiency measures only: gastroenterology, hematology/oncology, orthopedics, allergy/immunology, urology and podiatry. All other specialists are not tiered and have a $60 copay. Select Care also tiers hospitals based on cost efficiency. The tiering works are as follows:

Tier 1 * (Excellent):** Plan specialists and hospitals practicing at an excellent level of quality and/or cost-efficiency. You will pay the lowest copayment when you see a Tier 1 specialist or hospital.

Tier 2 ** (Good): Plan specialists and hospitals practicing at a good level of quality and/or cost-efficiency. You will pay the prevalent, mid-level copayment when you see a Tier 2 specialists or hospital.

Tier 3 * (Standard): Plan specialists and hospitals practicing at a standard level of quality and/or cost-efficiency. You will pay a higher copayment when you see a Tier 3 specialist or hospital.

NT/ID: This designation includes specialists that did not have sufficient data for tiering and providers that belong to a specialty or subspecialty that is not being tiered by Fallon. These providers are subject to a $60 copayment.

- You may change your PCP at any time.
- A referral is not required to see a Reliant Medical Group specialist if you have a Reliant Medical Group PCP.
- For other covered services, you should obtain a referral from your PCP, and in some cases, your physician will obtain authorization from the health plan.
- Fallon maintains a formulary, or a list of medications, approved for coverage.

Your membership card

When you enrolled in Fallon , 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, changes, or if you lose or damage your card, contact Customer Service to request a new card.

Notifying us of changes

Call Customer Service to notify changes in primary care providers, and the Group Insurance Commission to report any changes in your name, address, phone number, number and status of dependents, or any other pertinent information. If there is a change to your family status that would require a change in contract type (for example, you have an individual contract, but you marry or have children), request a change in status through the Group Insurance Commission within 60 days of the event.

Whenever you change to a new primary care provider, we recommend that you have your medical records transferred to your new provider. Please note that Fallon does not cover any cost associated with having your records copied.

Questions? Just ask.

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

Customer Service
1-866-344-4GIC (4442) (TRS 711)

For answers to general questions or inquiries

Also see **Inquiries, appeals and grievances.**

For help in choosing or changing your PCP

Also see **Choosing a primary care provider.**

With questions about your membership card

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

Contact the GIC

- To report any changes in your name, address, phone number, number of dependents, or any other pertinent information
- To change your contract type because of a change in your individual or family status
- Active employees should contact their GIC coordinator, retirees should contact the GIC

To order materials

- The Select Care Provider Network directory, which has a list of plan providers in the Fallon provider network
- Additional copies of this *Member Handbook/Evidence of Coverage* and any applicable amendments
- Weight Watchers® coupons

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

Our website: fallonhealth.org/gic

Our website is where you can learn more about your plan and its beneftis and features. It's also a convenient and secure way to communicate with us. You can use the site to:

- **Register and log into the Member portal** – 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

You can also learn more about our preventive health care guidelines; read issues of Healthy Communities, our quarterly member health guide; and use our online health encyclopedia and reference guide for answers to your health questions. Can't find what you need online? Use our site search feature or contact the Webmaster with your suggestions.

This section contains:

Choosing a primary care provider (PCP)

Obtaining specialty care and services

- Self-referral
- PCP referrals
- Plan prior authorization

Choosing a primary care provider (PCP)

When you join Fallon, you must choose a plan provider as your primary care provider (PCP). Your relationship with your PCP is very important, because he or she will work with us to provide or arrange most of your health care.

PCP choices

Each covered family member should choose his or her own PCP. This provider can be a:

- Family practice doctor (for members of all ages)
- Doctor of internal medicine (for members over 18)
- Pediatrician (for members under 18)
- Doctor of geriatric medicine
- Doctor of adolescent medicine
- A nurse practitioner (in appropriate primary care provider specialty listed above)
- Physician assistant (must be in a primary care practice)

The Select Care Provider Network directory contains the names of plan providers who are available as PCPs, along with their address, admitting hospital(s) and tiering level. If you haven't selected a PCP and you don't have a plan provider list, Customer Service will send you a free directory, or provide you with further information on plan providers. You can also visit our website at fallonhealth.org/gic to obtain names of plan providers in your area.

You may change your PCP at any time by either calling Customer Service or completing the "Change provider" form on fallonhealth.org/gic.

Make an appointment

Once you have selected a PCP, please notify Customer Service of your selection. It's also a good idea to schedule an initial appointment. This will allow your PCP to learn about you and your medical history and to begin assisting you with the coordination of any medical care that you may need. He or she can also help you with questions on

- Preventive care
- Prescriptions
- Specialty care
- Urgent care services
- Management of your ongoing medical needs

Keep your PCP's phone number handy

It's also a good idea to keep your PCP's telephone number in your wallet and at home by your phone. If you need to see someone right away, your PCP (or an on-call provider) will direct you. Plan providers' telephones are answered 24 hours a day, seven days a week for emergencies and urgent care needs.

Fallon requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Fallon designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Fallon Customer Service at 1-866-344-4442 (TRS 711) or visit our website at fallonhealth.org/gic to obtain a list of PCPs in your area. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Fallon or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Fallon Customer Service at 1-866-344-4442 (TRS 711), or visit our website at fallonhealth.org/gic.

Obtaining specialty care and services

When you have health care concerns, a good place to start is by contacting your PCP. Much of the time your PCP can provide the care that you need. Sometimes, however, you may need specialty care or services that your PCP does not provide.

If you and your PCP decide that a visit with a network specialist is medically necessary, your PCP will make the arrangements for you. For some services, your PCP is authorized to give you a referral to see a specialist. (See **PCP referral**.) For other services, your PCP must get authorization from the plan before giving you the referral. (See "**Plan prior authorization**" below.) If you receive services from any doctor, hospital or other health care provider without getting a referral from your PCP, you will have to pay for these services yourself (with the exception of those services listed under **Self-referral** below).

When you joined Fallon, you chose Select Care. This means that you must use the health care professionals and facilities in the Select Care network. Remember, your copayments for physician specialist visits are determined by the specialist's tiering level. You will pay the lowest copayment when you see a Tier 1 *** (excellent) specialty physician. You will pay the prevalent, mid-level copayment when you see a Tier 2 ** (good) specialty physician. You will pay a higher copayment when you see a Tier 3 * (standard) specialty physician.

Note: Please be aware that specialty physician's tiering levels will be re-evaluated on an annual basis. The re-evaluation may result in a change in the specialty physician's tiering level; this change takes effect annually on July 1. You should check the annual provider directory or the GIC member portal at fallonhealth.org/gic for annual tiering level changes to specialty physicians.

Self-referral

In certain instances, you can "self-refer" to a Select Care network specialist. This means that you can call the specialist and make the appointment yourself. You do not need a referral from your PCP, but you must see a Select Care network provider.

Services you can self-refer for:

- Office visits with a Select Care network obstetrician, gynecologist, certified nurse-midwife or family practitioner, including annual preventive gynecological examination and any subsequent gynecological services determined to be necessary as a result of such examination; services for acute or emergent gynecological conditions; and maternity care. It does not include inpatient admissions or infertility treatment (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP).
- Office visits with a Reliant Medical Group specialist (physician, physician assistant, nurse midwife or nurse practitioner only) if you have a Reliant Medical Group PCP.
- Office visits to a Select Care network oral surgeon for extraction of impacted teeth. (Note: visits to an oral surgeon for any other procedure require authorization)
- Routine eye examinations with a Select Care network ophthalmologist or optometrist.
- Outpatient mental health and substance abuse services with network providers. For assistance in finding a network provider, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660).
- Visit to a contracted limited service clinic (appointments not required).

PCP referral

In some instances your PCP may refer you to a specialist. Your PCP is responsible to ensure that the provider to whom you are referred is within the Select Care network. In most cases, your PCP will refer you for care with specialists and hospitals with whom they have an affiliation. This helps your PCP coordinate and maintain the quality of your care. This means that the PCP you select determines the specialists and hospitals from whom you will receive care.

In the rare event that you need specialty care that is not available within your PCP's affiliations, your PCP will refer you to another specialist within the Select Care network. When selecting a specialist for you, your PCP will consider your clinical needs and any active and long-standing relationships with a Select Care network provider.

Services that need a PCP referral, but do not need authorization from the plan:

- Office visits with a Select Care network specialist, with the exception of office visits with a Reliant Medical Group specialist *if you have a Reliant Medical Group PCP*. In some instances, your PCP may give you a "standing referral" to a Select Care network specialist for covered services. For a standing referral, your PCP and specialist must agree on a treatment plan, and the specialist must keep your PCP up to date on your treatment. Standing referrals are valid for up to 12 months, as long as the services are medically necessary.
- Podiatric care. Your PCP will give you a referral to a Fallon Select Care network podiatrist. The referral is good for a maximum of one year, or until the condition is corrected, whichever comes first.
- Chiropractic care. Your PCP will give you a referral to a Fallon Select Care network chiropractor which may cover up to 12 visits, if medically necessary.
- Physical, occupational and speech therapy. Your PCP will provide you with a written order to take to a Fallon Select Care physical, occupational or speech therapist. For physical and occupational therapy, the written order covers medically necessary services up to your benefit maximum.

Plan prior authorization

For certain types of specialist visits and for certain specialty services, your PCP or specialist will need to obtain authorization from the plan **before** giving you a referral. An authorization is an assurance by the plan to pay for medically necessary covered services provided by a Fallon Select Care network provider to an eligible plan member.

When a service requires authorization, your PCP or specialist will send a request for services to the plan. We will review the request and make an authorization decision within two business days of receipt of all the necessary information. For the purposes of this section, "necessary information" may include the results of any face-to-face clinical evaluation or second opinion that may be required. We will inform your PCP of our decision within 24 hours of the time that we make the decision. If we authorize the service, we will send you and your PCP an authorization letter within two business days thereafter. When you get the letter, you can call a plan specialist to make the appointment. If you do not get an authorization letter, you will be responsible for paying for the services.

The authorization letter will state the services the plan has approved for coverage. Make sure that you have this authorization letter before any services requiring authorization are furnished to you. If the specialist feels you need services beyond those authorized, the specialist will ask for authorization directly from the plan. If we approve the request for additional services, we will send both you and your PCP an authorization letter.

If we do not authorize a service, we will send you and your PCP a denial letter within one business day of the decision. The denial letter will explain our reasons for the decision and your right to file an appeal. (For information on filing an appeal, see **Inquiries, appeals and grievances**.) Pending the outcome of the appeal process, in certain circumstances, such as for immediate or urgently needed services, the plan will provide for

an automatic reversal of a denial of coverage for services or durable medical equipment, within 48 hours, or sooner for durable medical equipment, if your PCP tells us that in his or her opinion the provision of such service or durable medical equipment should not await the outcome of the normal appeal process and that the service or durable medical equipment is medically necessary and that immediate and severe harm will result if you do not receive the service within 48 hours or sooner for durable medical equipment.

The plan will provide the coverage until we notify you of the outcome of your appeal. Please refer to **Expedited review** for additional circumstances for which you are entitled to request an expedited appeal.

Services requiring authorization from the plan include:

- Non-emergency admissions to a hospital or other inpatient facility
- Some same-day surgery (outpatient) and ambulatory procedures
- Services with a non-plan provider
- Organ transplant evaluation and procedures
- Reconstructive and restorative services
- Infertility/assisted reproductive technology services
- Oral surgery (with the exception of the extraction of impacted teeth)
- Genetic testing
- Neuropsychological testing
- Prosthetics/orthotics and durable medical equipment
- Hospice care
- Non-emergency ambulance
- High tech radiology, including, but not limited to, all outpatient MRI/MRA, CT/CTA, PET and nuclear cardiology imagining studies
- Sleep study and/or sleep therapy
- Oxygen
- Outpatient mental health services (including intermediate care), beyond eight sessions
- Speech therapy
- Habilitative or rehabilitative care, including but not limited to ABA therapy, for the treatment of autism
- Therapeutic care for the treatment of autism
- 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.
- Enteral formulas and special medical formulas
- 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
- Second opinion and access to specialty care from Dana Farber Cancer Institute
- 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.

Please note:
If a physician or other health care provider discusses a treatment option with you, this does not necessarily make that treatment a covered service. Physicians and other health care providers are freely able to discuss treatment options without restraint from the plan. However, services or supplies that are not described as covered in the **Description of benefits** section of this *Member Handbook/Evidence of Coverage* and that do not receive any necessary authorization from the plan are not covered services. Services that are not medically necessary are not covered services. Services and supplies you receive from providers who are not network providers are not covered services, unless you received authorization from the plan to go to that provider.

This section contains:

Medical management

- Utilization management
- Quality management
- Assessing new technologies
- Services

Medical management

Utilization management

The objectives of the utilization management review process are to ensure that the medical services provided to members are medically necessary and appropriate, that medical services meet nationally recognized standards for quality care, and that medical services are provided at the appropriate level of care and at the appropriate site of service.

The program is staffed by licensed registered nurse case managers, physician reviewers and specialists who are in routine contact with our health care plan providers. They use national, evidence-based criteria that are reviewed annually by a committee of health plan and community-based physicians to determine the medical appropriateness of selected services requested by your physician. These criteria are approved as being consistent with generally accepted standards of medical practice, including prudent layperson standards for emergency room care.

Fallon also develops in-house criteria, making use of local specialist input and current medical literature, as well as guidelines from Medicare and the Commonwealth of Massachusetts.

To obtain information about the status or outcome of a utilization review decision, call Fallon at 1-866-344-4GIC, ext. 69915 (TRS 711).

The plan does not provide compensation or other financial incentive or reward to its in-plan providers or staff who conduct utilization management review that is based on the quantity or type of denial decisions rendered.

Quality management

Fallon's Quality Services Program systematically measures, monitors, evaluates and improves the performance of the managed care organization with respect to clinical care and service received by its members. Components of the program include careful attention to credentialing and recredentialing of plan providers, evaluation of all member complaints related to quality of care, and a formal peer review program to identify opportunities for improved care (on both an individual-practitioner level and a system-wide level). The plan also conducts focused performance projects related to plan-specific opportunities and formal chronic disease management programs appropriate to the plan's membership. With respect to service quality, the plan monitors and assures appropriate access to its contracted practitioners as well as complaints related to quality of service. A team of physicians, licensed registered nurses, and specialists create and regularly update clinical guidelines that are then shared with our contracted practitioners to promote preferred medical practices and to improve the quality of care. These guidelines are designed to complement rather than replace your doctor's clinical judgment.

Assessing new technologies

Fallon maintains a formal mechanism for evaluation of new medical and behavioral health technologies, the new application of existing technologies, and the review of special cases, through our Technology Assessment Committee. The committee includes physician administrators, practicing physicians from the plan's service area, and plan staff who perform extensive literature review regarding the proposed technology, including review of information from governmental agencies, such as the U.S. Food and Drug Administration (FDA), and published scientific evidence. We make use of external research organizations, which perform reviews of all 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 and develops written technology assessment criteria in accordance with standards developed by the National Committee for Quality Assurance (NCQA) for those technologies that can offer improved outcomes to our members without substantially increasing the risks of treatment. Criteria are reviewed at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted practice.

Fallon has a separate but similar process for evaluation of new drugs and medications, with reviews performed by our Pharmacy & Therapeutics Committee.

Services

Whenever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to you within the Select Care network, 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 Select Care network.

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 1-866-344-4GIC (4442) (TRS 711) 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.

This section contains:

Your rights and responsibilities

Notice of Group Insurance Commission privacy practices

Confidentiality of member information

Inquiries, appeals and grievances

- Making an inquiry
- Filing an appeal: internal appeal review
- Filing an appeal: external appeal review
- Filing a grievance

Massachusetts Office of Patient Protection

Member rights and responsibilities

Member rights

As a Fallon member, you have the right to …

- Be informed about Fallon and covered services.
- Receive information about the managed care organization, its services, its practitioners and plan providers, and members' rights and responsibilities.
- Be informed about how medical treatment decisions are made by the contracted medical group or Fallon, including payment structure.
- Choose a qualified contracted primary care provider and contracted hospital.
- Know the names and qualifications of physicians and health care professionals involved in your medical treatment.
- Receive information about an illness or condition, 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 your 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 the managed care organization 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 and its contracted providers.
- Make recommendations regarding Fallon members' rights and responsibilities policies.

Member responsibilities

As a Fallon member, you have the responsibility to …

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

For answers to questions

About your rights or responsibilities as a member of Fallon Health:
Fallon Health
10 Chestnut St., Worcester, MA 01608
1-866-344-4GIC (4442) (TRS 711)

About care provided by a plan physician or for physician profiling information:
Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01881
1-781-876-8200

NOTICE OF GROUP INSURANCE COMMISSION PRIVACY PRACTICES

Effective September 3, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

Payment Activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

To Provide You Information on Health-Related Programs or Products: Such information may include alternative medical treatments or programs or about health-related products and services, subject to limits imposed by law as of September 23, 2013

Other Permitted Uses and Disclosures: The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made by you or on your behalf (such as appeals);
- to enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws**;**
- for data breach notification purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access or disclosure of your health information;
- to verify agency and plan performance (such as audits);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- for judicial and administrative proceedings (such as in response to a court order);

- for research studies that meet all privacy requirements; and
- to tell you about new or changed benefits and services or health care choices.

Required Disclosures: The GIC **must** use and share your PHI when requested by you or someone who has the legal right to make such a request on your behalf (your Personal representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations That Assist Us: In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive notification of any breach of your unsecured PHI.
- Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our website at www.mass.gov/gic.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617)-227-8583.

Confidentiality of member information

Maintaining the confidentiality of our members' personal health data is of the utmost importance to us. At Fallon, we have developed policies and procedures protecting you from unauthorized individuals gaining access to or altering your medical records. We follow strict guidelines to ensure the privacy and confidentiality of your PHI (protected health information, such as your name or medical information). These guidelines require that your PHI be used only for purposes of treatment, payment and health plan operations, and not for purposes unrelated to health care.

We also ensure that our contracted providers extend the same protections to all personal health information under their control.

Fallon's *Notice of Privacy Practices* details how we use and share your information. This notice is provided to all members and is available on the Fallon website, fallonhealth.org/gic, or from Customer Service at 1-866-344-4GIC (4442) (TRS 711).

The *Notice of Privacy Practices* also provide information regarding your rights to access your own records, grant others access to your records and restrict access to your records by others. Fallon has developed forms to assist us in providing you with the level of access you require. These forms are available at fallonhealth.org/gic.

Customer Service also will mail you a copy of any of the following forms upon request:

- **Access request for personal information form**: To request a copy of certain personal information.
- Amendment request for personal information form: To request changes to your record if you think it is inaccurate or incomplete. This form is not required for corrections to your address, date of birth or name.
- **Authorization for release of personal information form**: To allow another individual/entity to receive your personal information from Fallon (such as your employer, if they are working on your behalf to resolve a claim issue).
- **Personal representative authorization form**: To identify a personal representative—someone Fallon can release your personal information to. Complete a form for each person you want to have as a representative.
- **Request for an accounting of disclosures of personal information form:** To request a listing of who Fallon has shared your information with (since April 14, 2003) for reasons other than treatment, payment or health care operations.
- **Restriction form**: To request a limit on how we use or share your personal information.

Inquiries, appeals and grievances

Whenever you have a question or need help using plan providers and services, Fallon 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.

An adverse determination means a determination by Fallon or our designated medical management agent, 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: 1-866-344-4442 (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: contactcustomerservice@fchp.org/gic
Write: Fallon Health
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, Fallon may need to do more research before Fallon completes your request. In these cases, Fallon will make every effort to provide you with a response within three business days. If Fallon has not been able to provide a satisfactory response to your inquiry within this time period, Fallon 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 Fallon that you want to have your issue handled as a grievance, Fallon 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 Fallon.

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
- The Fallon 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:

Write:	Fallon Health Member Appeals and Grievances Department 10 Chestnut St. Worcester, MA 01608
Call:	1-866-344-4442 (TRS 711) Monday through Friday 8:30 a.m. to 5:00 p.m.
E-mail:	grievance@fchp.org/gic
Fax:	1-508-755-7393
In person:	Fallon Health Member Appeals and Grievances Department 10 Chestnut St. Worcester, MA 01608

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 Fallon 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 Fallon 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, Fallon 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, Fallon 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 Fallon. 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, Fallon would agree in writing to a new time period for review. This would not be longer than 30 days from the date Fallon 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 certifies that:
   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 Fallon 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 Fallon, for further review. The conference will be scheduled within 10 days of receiving your request unless your treating physician determines, after discussion with the Fallon 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 Fallon 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 days 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 Fallon
- 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 Fallon 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
Member Appeals and Grievances Department
10 Chestnut St.
Worcester, MA 01608

Call: 1-866-344-4442 (TRS 711)
Monday through Friday, 8:30 a.m. to 5:00 p.m.

E-mail: grievance@fchp.org/gic

Fax: 1-508-755-7393

Walk-in: Fallon Health
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. Fallon can extend this 180-day limit if you have a good reason. If you do, state the reason when you file your grievance.

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 Relations 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.

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 managed care plans accessible to consumers, assist consumers with questions and concerns related to managed care, monitor quality-related plan information relating to managed care practices and regulate the external review process. Fallon and other Massachusetts plans provide the following information to OPP by April 1st of each year:

- Member satisfaction rates and quality of care rates for the plan
- The number of physicians who voluntarily or involuntarily left the plan network last year
- The percentage of plan premium revenue that went towards health care compared to the amount that went towards 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 OPP.

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

This section contains:

The claims process

Claims, reimbursements and refunds

Coordination of benefits

Subrogation and Reimbursement

Workers' compensation

Medicare

Important Notice from the Group Insurance Commission (GIC) About Your Prescription Drug Coverage and Medicare

The claims process

Claims, reimbursements and refunds

Your plan provider has an agreement with the plan to send claims directly to us. If you receive a claim from a plan provider for something other than cost sharing, write your Fallon coverage information on the back of the claim and return it to the plan provider's office with a request to bill us directly.

Claims from non-plan providers

There are certain circumstances in which you may receive services from non-plan providers. Non-plan providers are providers who are not contracted with Fallon and are not in our HMO network:

Emergency Services in an Emergency Department of a Hospital and Stabilization Services: If you received emergency services in an emergency department of a hospital or services to stabilize that emergency medical condition from a non-plan provider, we will pay the greater of (a) the median amount negotiated with in-network providers for the emergency services furnished, (b) the usual, reasonable and customary charge, or (c) the amount that would be paid by Medicare (less any cost sharing). If the non-plan provider bills you for more than the amount Fallon paid, you are responsible for paying the provider the balance.

Non-emergency Out-of-network Services: Under most circumstances, non-emergency services received from non-plan providers are not covered without prior authorization. If Fallon decides it will pay for these services, Fallon will pay the usual, reasonable and customary charges (less any cost sharing). If the non-plan provider bills you for more than the usual, reasonable and customary charge, you are responsible for paying the non-plan provider the balance. Fallon reserves the right to pay you directly for these charges. If Fallon pays you directly, you will be responsible for submitting payment to the non-plan providers.

Claims from non-plan providers must be submitted to Fallon within one year of the date of service. Claims submitted more than one year after the date of service will not be paid. You may submit the claim yourself, or the provider may submit it directly. All claims should include a description of the services, the diagnosis, the dates of services and the charge for each service. Send bills to:

Fallon Health
Claims Department
P.O. Box 15121
Worcester, MA 01615-0121

Care in foreign countries

You may submit claims for urgent or emergency services in a foreign country if the services are not provided free of charge by that 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 any money you owe to us, a health plan physician, or a health plan facility, or any other person or facility providing services to you on behalf of the plan. We will 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.

Claims questions/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 discrepancies in the effective date of your coverage or your contract type, send a letter to:

Fallon Health
Customer Service Department
10 Chestnut St.
Worcester, MA 01608

We will not approve an adjustment or refund if it is for something that took place more than one year before we receive 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 plan covers a service. This includes plans that provide benefits for hospital, medical 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 (the secondary carrier) pays the balance of covered charges. The primary and secondary carriers are determined by the standard rules that are used by all insurance companies.

We have the right to exchange benefit information with any other group plan, insurer, organization or person to determine benefits payable using 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 the plan to the extent necessary to satisfy the intent of COB. If we pay benefits in good faith to a 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 or arrange 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 the individual or organization 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

The plan 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, Medicare 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 the plan might be primary over Medicare. Your age, work status and (if you are eligible for Medicare due to disability) 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 provided to you by us or a provider you see on a referral, if the services are covered by Medicare.

Important Notice from the Group Insurance Commission (GIC) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Fallon Select Care plan and your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a non-GIC Medicare drug plan. If you are considering joining a non-GIC plan, you should compare your current coverage – particularly which drugs are covered, and at what cost – with that of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage can be found at the end of this notice.

FOR MOST PEOPLE, THE DRUG COVERAGE THAT YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE NON-GIC MEDICARE PART D DRUG PLANS.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When Can You Join A Medicare Part D Drug Plan?

You can join a non-GIC Medicare drug plan when you first become eligible for Medicare and each subsequent year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period to join a non-GIC Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Non-GIC Medicare Drug Plan?

- If you enroll in another Medicare prescription drug plan or a Medicare Advantage plan with or without prescription drug coverage, you will be disenrolled from the GIC-sponsored Select Care plan. If you are disenrolled from the Select Care plan, you will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you are the insured and decide to join a non-GIC Medicare drug plan, both you and your covered spouse/dependents will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at **www.socialsecurity.gov** or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with a GIC plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage….
Contact the GIC at (617) 727-2310, extension 1. **NOTE:** You will receive this notice each year and if this coverage through the Group Insurance Commission changes. You may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for the telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048.

If you have limited income and assets, extra help paying for Medicare prescription drug coverage is available. For information about the Extra Help program, visit Social Security online at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

This section contains:

How your coverage works

- Eligibility
- Premium charges
- Types of coverage
- Adding dependents
- Changing your coverage
- Special enrollment rights
- Medicaid and the Children's Health Insurance Program (CHIP)
- Age limits for dependent children
- Disabled dependents
- Continuing coverage for former dependents
- Surviving dependents
- Divorce
- The Uniformed Services Employment and Reemployment Rights Act (USERRA)
- Marketplace Notice

How your coverage works

Eligibility

You are eligible to enroll in the plan as a subscriber as long as you live in the Select Care service area and you meet the GIC's eligibility requirements..

In general, you may make changes to your insurance coverage only once a year during a designated "open enrollment" period prior to the anniversary date. Any changes that you make become effective on the anniversary date. If you have any questions about your group's enrollment period or anniversary date, please contact the GIC.

You may enroll in this plan during open enrollment, or within 31 days of the date you are first eligible. Coverage will begin on the first day of the month following 60 days of employment or two calendar months, whichever is less. You may also be eligible to enroll at a later date under the following circumstances:

- You declined this coverage when first eligible because you or your eligible dependent were covered under another group health plan or another health insurance coverage, but the other coverage has ended. You and your dependent may enroll in this plan within 31 days of your termination of coverage under the other health plan by providing proof that is satisfactory to the GIC.
- You declined this coverage when first eligible, but have since acquired a dependent through marriage, birth or adoption. You or your dependent may enroll within 31 days of the date of the marriage, birth or adoption (including any probationary period).

Except for the above circumstances, employees who choose not to join the plan when first eligible must wait until the next open enrollment period to join.

Premium charge

As a Fallon subscriber, you are enrolled in a health plan that provides comprehensive benefits and quality care. In order to provide this plan for you, the Group Insurance Commission pays Fallon a monthly premium charge. Your coverage may be terminated if the GIC fails to pay, even if they have charged you all or part of the premium charge (for example, by withholding it from your pay). For the plan year beginning July 1, 2016, and ending June 30, 2017, this amount will be:

$688.25 per month for individual coverage
$1,651.76 per month for family coverage

Failure to pay premiums

If we or our agent do not receive the premium charge by the time it is due, your coverage will be suspended and your contract terminated as described in **Cancellation by Fallon**. There is a 15-day grace period, following 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 on the last day for which payment was received.

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 may cover:

- The subscriber
- The subscriber's legal spouse
- Dependent children who meet the plan's age limit
- A former spouse, as long as the divorce decree allows for it, and neither the subscriber nor the former spouse has not remarried

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 enrolled and meets the eligibility regulations under the Massachusetts state mandate. (See **Age limits for dependent children**.)

Adding dependents

The subscriber may change to family coverage, or add additional 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. If a former spouse has been covered prior to the subscriber's marriage, the former spouse may, if the divorce judgment so permits, continue coverage under an individual policy with a separate premium for that policy. Coverage ends if the former spouse remarries or moves out of the Fallon service area.
- Birth or adoption of a child. The subscriber may change to family coverage, or add any additional dependents to family coverage at this time. Coverage will be retroactive to the newborn's date of birth. (See **Changing your coverage**.)
- 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 only those dependents who have lost their other coverage. If the previous coverage was not through Fallon, we will require notification from the prior insurance company.
- A spouse and/or child(ren) who formerly lived outside the Select Care service area move into the service area. The subscriber may add only those dependents who have just moved into the service area.
- The GIC determines that a court order permits the subscriber 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. (For information on nongroup enrollment, see **Changing to a consumer plan**.)

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. You must notify the GIC of the change 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 anniversary date.

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

If you qualify under Public Law 111-3-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.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP program. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information visit www.healthcare.gov

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor electronically at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2016. Contact your State for further information on eligibility –

ALABAMA – Medicaid	**GEORGIA** – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA** – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	
FLORIDA – Medicaid	**MONTANA** – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

IOWA – Medicaid	**NEBRASKA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633
KANSAS – Medicaid	**NEVADA** – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone:1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	
LOUISIANA – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
MAINE – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	
MINNESOTA – Medicaid	**NEW YORK –** Medicaid
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
OKLAHOMA – Medicaid and CHIP	**NORTH DAKOTA** – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OREGON – Medicaid	**UTAH** – Medicaid and CHIP
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669

PENNSYLVANIA – Medicaid	**VERMONT**– Medicaid
Website: http://www.dhs.pa.us/hipp Phone: 1-800-692-7462	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
RHODE ISLAND – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: www.eohhs.ri.gov Phone: 401-462-5300	Medicaid Website: http://www.coverva.org/programs_premuim_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS – Medicaid	**WISCONSIN** – Medicaid and CHIP
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
	WYOMING – Medicaid
	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other States have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Age limits for dependent children

Coverage for a dependent child under the 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. 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 physically or mentally disabled child age 26 and older who was incapable of self-support before his/her 19th birthday may obtain Handicapped Dependent Coverage. Application must be made to the GIC to obtain this coverage. Coverage is subject to GIC approval and the insured parent's continued coverage with the GIC.

Dependents 26 and Over (Continued Coverage for Dependents)

A dependent child who reaches age 26 is no longer automatically eligible for coverage under this Plan. A full-time student at an accredited educational institution at age 26 or over may continue to be covered as a Dependent family member, but must pay 100% of the required monthly individual premium. That student must file a written application with the GIC within 30 days of his or her 26th birthday, and the application must be approved by the GIC. Full-time students age 26 and over are not eligible for continued coverage if there has been a two year break in the Dependent's GIC coverage. If the application is submitted late, your Dependent may have a gap in coverage.

Surviving dependents

In the case of the death of an employee or retiree, the surviving spouse may continue coverage until remarriage. The surviving spouse must apply to the GIC for this coverage within 60 days of the date of death.

Dependent children, where there is no surviving parent, may continue coverage under this program until age 26. Applications for continued coverage must be made within 60 days of the death of the insured parent.

Divorce

In the event of divorce, the subscriber's former spouse may remain under the family coverage. Coverage may continue, with no additional premium due, unless: (1) the divorce decree specifically states that the subscriber is not required (or is no longer required) to maintain health insurance coverage for the former spouse, or (2) either the subscriber or the former spouse remarries.

If the subscriber remarries and wishes to add his or her new spouse to the family coverage, the former spouse remains eligible for the subscriber's coverage. However, the former spouse must move from family coverage to individual coverage and he or she will pay the full cost of the premium; the former spouse only remains eligible under the group if the divorce decree provides for such coverage. If the former spouse remarries or moves out of the Fallon service area, 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 **Conversion options** for more information.)

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

> If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
>
> Service members who elect to continue their GIC health coverage are required to pay the employee's share for such coverage.
>
> Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information about your GIC coverage, please contact the Group Insurance Commission at (617) 727-2310, ext. 1.

Overview of Health Insurance Marketplaces

YOU ARE RECEIVING THIS NOTICE AS REQUIRED BY THE NEW NATIONAL HEALTH REFORM LAW (ALSO KNOWN AS THE AFFORDABLE CARE ACT OR ACA)

On January 1, 2014, the Affordable Care Act (ACA) was implemented in Massachusetts and across the nation. The ACA brought many benefits to Massachusetts and its residents, helping us expand coverage to more Massachusetts residents, making it more affordable for small businesses to offer their employees healthcare, and providing additional tools to help families, individuals and businesses find affordable coverage. This notice is meant to help you understand health insurance Marketplaces, which are required by the ACA to make it easier for consumers to compare health insurance plans and enroll in coverage. In Massachusetts, the state Marketplace is known as the Massachusetts Health Connector. While you may or may not qualify for health insurance through the Health Connector, it may still be helpful for you to read and understand the information included here.

Overview: There is an easy way for many individuals and small businesses in Massachusetts to buy health insurance: the Massachusetts Health Connector. This notice provides some basic information about the Health Connector, and how coverage available through the Health Connector relates to any coverage that may be offered by your employer. You can find out more by visiting: **MAhealthconnector.org**, or for non-Massachusetts residents, **Healthcare.gov** or (1-800-318-2596; TTY: 1-855-889-4325).

What is the Massachusetts Health Connector? The Health Connector is our state's health insurance Marketplace. It is designed to help individuals, families, and small businesses find health insurance that meets their needs and fits their budget. The Health Connector offers "one-stop shopping" to easily find and compare private health insurance options from the state's leading health and dental insurance companies. Some individuals and families may also qualify for a new kind of tax credit that lowers their monthly premium right away, as well as cost sharing reductions that can lower out-of-pocket expenses. This new tax credit is enabled by §26B of the Internal Revenue Service (IRS) Code.

Open enrollment for individuals and families to buy health insurance coverage through the Health Connector occurs every year. You can find out more by visiting **MAhealthconnector.org** or calling **1-877-MA ENROLL** (1-877-623-6765).

Can I qualify for federal and state assistance that reduces my health insurance premiums and out-of-pocket expenses through the Health Connector?

Depending on your income, you may qualify for federal and/or state tax credits and other subsidies that reduce your premiums and lower your out-of-pocket expenses if you shop through the Health Connector. You can find out more about the income criteria for qualifying for these subsidies by visiting **MAhealthconnector.org** or calling **1-877-MA ENROLL** (1-877-623-6765).

Does access to employer-based health coverage affect my eligibility for subsidized health insurance through the Health Connector?

An offer of health coverage from the Commonwealth of Massachusetts, as the employer, could affect your eligibility for these credits and subsidies through the Health Connector. If your income meets the eligibility criteria, you will qualify for credits and subsidies through the Health Connector if:

- **The Commonwealth of Massachusetts does not offer coverage to you**, or

- **The Commonwealth of Massachusetts offers you coverage, but:**
  - The coverage the Commonwealth of Massachusetts provides you (not including other family members) would require you to spend more than 9.5 percent of your household income for the year; or
  - The coverage the Commonwealth of Massachusetts provides does not meet the "minimum value" standard set by the new national health reform law (which says that the plan offered has to cover at least 60 percent of total allowed costs)

If you purchase a health plan through the Health Connector instead of accepting health coverage offered by the Commonwealth of Massachusetts please note that you will lose the employer contribution (if any) for your health insurance. Also, please note that the amount that you and your employer contribute to your employer-sponsored health insurance is often excluded from federal and state income taxes. Health Connector premiums have different tax treatment.

As part of considering whether the ACA and Marketplaces will affect you as an employee it is important to understand what the Commonwealth of Massachusetts offers you.

- The Commonwealth offers benefited employees health coverage through the Group Insurance Commission. To be eligible for GIC health insurance, a state employee must work a minimum of 18 ¾ hours in a 37.5 hour workweek or 20 hours in a 40 hour workweek. The employee must contribute to a participating GIC retirement system, such as the State Board of Retirement, a municipal retirement board, the Teachers Retirement Board, the Optional Retirement Pension System for Higher Education, a Housing, Redevelopment Retirement Plan, or another Massachusetts public sector retirement system (OBRA is not such a public retirement system for this purpose. Visit www.mass.gov/gic or see your GIC Coordinator for more information.
- Temporary employees, contractors, less-than-half time part time workers, and most seasonal employees are not eligible for GIC health insurance benefits. These employees may shop for health insurance through the Health Connector and may be eligible for advanced premium federal tax credits and/or state subsidies if their gross family income is at or below 400% Federal Poverty Level (which is approximately $46,000 for an individual and $94,000 for a family of four). Visit www.MAhealthconnector.org or call 1-877-MA-ENROLL for more information.

If there is any confusion around your employment status and what you are eligible for, please email healthmarketplacenotice@massmail.state.ma.us or contact your HR department or GIC Coordinator.

This section contains:

Fallon contract arrangements

- Changes in your coverage
- Fallon contracting arrangements
- When your provider no longer has a contract with us
- Continuation of services with a non-plan provider
- Responsibility for the acts of providers
- Circumstances beyond our control

Fallon contract arrangements

Changes in your coverage

We may change part of your coverage. If we do, the change will apply to all contracts of this type, not just your contract. We will send you 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.

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 the contract. If your name and mailing address change, let us know so that our records can be updated. Be sure to give us your old name and address as well as the new information.

Fallon contracting arrangements

The plan contracts with individual physicians, medical groups, hospitals and ancillary providers to provide care to members. Fallon negotiates with providers to agree upon a contracted payment rate. The providers then accept that payment for their services. When you obtain a covered service, the only payment that a provider will collect from you for a covered service is the copayment amount shown in this *Member Handbook/Evidence of Coverage,* in your Schedule of Benefits or in any applicable amendments.

Fallon pays its providers using various payment methods including fee for service, capitation and per diem. Fee for service means payments are based on an agreed upon fee schedule. Capitation means paying a fixed dollar amount per month for each member assigned to the provider. Per diem means paying a fixed dollar amount per day for all services rendered.

When your provider no longer has a contract with us

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

If the plan provider whose contract we are ending is your PCP, we will notify you in writing at least 30 days prior to the date of the end of his or her contract, except where the contract has been ended for reasons involving fraud, patient safety or quality of care. If your PCP ends his or her contract with us, we will notify you of the change either 30 days prior to the date the contract ends, or as soon as we are notified of the termination, whichever is sooner.

If our contract with your PCP ends, you will be required to select a new PCP. We will also notify you if you are receiving regular care from a specialist, and that specialist will no longer be under contract with us.

We will continue to pay for services of your provider after our contract with the provider ends, in the following circumstances only:

- If our contract with your PCP ends, you may continue to receive treatment from that provider for 30 days beyond the end of the contract, except in circumstances of gross misconduct.
- 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 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.

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 referrals and prior authorization. You will be eligible for benefits as if the provider had remained under contract with us.

If your provider is no longer under contract with us, call Customer Service for assistance in choosing a new PCP or to request a provider directory. You also can get provider information and choose a new PCP on our website, at fallonhealth.org/gic.

Continuation of services with a non-plan provider

Once you become a plan member, we will generally only pay for services that you receive from plan providers. However, there are some circumstances in which we will temporarily pay for services that you receive from a non-plan provider, if you had been receiving care from that provider prior to becoming a member:

- If your prior PCP is not a participating provider in any health insurance plan that your plan sponsor offers, we will pay for services from that provider for 30 days from your effective date.
- 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 pay for services from that provider for 30 days from your effective date.
- 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 pay for services from that provider through your postpartum period.
- 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 pay for your services from that provider until your death.

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 obtaining appropriate referrals and prior authorizations. You will be eligible for benefits as if the provider was under contract with us, and your copayments will be at the Tier 2 base copayment amount.

Responsibility for the acts of providers

The arrangement between the plan, plan providers and the plan facilities 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 plan providers are freely able to recommend treatment options without restraint from the health plan, a referral or recommendation in and of itself does not guarantee that a referral or recommended treatment is a covered benefit or that the accepting provider is contracted with the plan, 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 did not receive any necessary authorization from the plan, 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 natural disasters, epidemics or pandemics
- In the case of a war, riot, civil insurrection or acts of terrorism

This section contains:

Leaving Fallon

- Ineligibility for you or a dependent
- Cancellation by Fallon
- Involuntary member cancellation rate
- Disenrollment by the subscriber
- Eligibility for Medicare
- Changing to other health insurance
- Obtaining a certificate of creditable coverage

Leaving Fallon

Ineligibility for you or a dependent

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

- Is terminated from employment
- Leaves a job
- Loses coverage due to a reduction in work hours
- No longer lives in the Select Care service area

A dependent's membership may end because of

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

Dependent coverage under the plan will cease on the last day of the month when a family member no longer qualifies as a dependent under the rules and regulations of the GIC or applicable state law (e.g., attainment of age 26 or two years following loss of dependent status under IRS guidelines, whichever comes first, loss of eligibility due to 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, or conversion to a consumer plan, see **Conversion options**.)

Cancellation by Fallon

You do not have to worry that Fallon will cancel your coverage because you are using services or because you will need more services in the future. We will cancel coverage only for the following reasons:

- You or a family member no longer live in the Fallon Select Care service area. Notify the GIC within 60 days of the date you move.
- You made some misrepresentation or you conspired with another party to defraud the plan. 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, the health plan may deny enrollment to you in the future.
- Your premium charge is not paid within the grace period appropriate for your health plan. (See **How your coverage works** for information about grace periods and nonpayment of premium.) The plan will notify you of the effective date of the cancellation, in accordance with Massachusetts insurance regulations.
- You commit an act of physical or verbal abuse that poses a threat to a plan provider, a plan employee 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 GIC cancels its group service agreement with Fallon. In the event that your group coverage is canceled because the GIC fails to pay the premium charge to us, you may apply for short-term (60-day) conversion coverage. To apply for this coverage, send us a written request within 60 days of the day you receive our notice of the group's cancellation. The 60-day conversion 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 conversion coverage, if you would like to remain a Fallon Health member, you can join a consumer plan. (See **Changing to a consumer plan** for more information.)
- As allowed by state or federal law or regulation

In accordance with state law, Fallon 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 member cancellation rate

For the calendar year 2015, Fallon's involuntary cancellation or disenrollment rate was 0.0%. The involuntary disenrollment rate includes any members disenrolled by the plan due to misrepresentation or fraud on the part of the member or the commission of acts of verbal or physical abuse. For calendar year 2015, Fallon's voluntary disenrollment rate was 0.07%.

Disenrollment by the subscriber

To cancel your contract, the subscriber or the GIC must give us notice in writing 30 days prior to cancellation. 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 GIC cancels the contract, we will not provide benefits for services, supplies or medication received after the cancellation date.

Eligibility for Medicare

If you are a member age 65 or older, 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 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™, our Medicare Advantage product, either through the GIC or directly with Fallon. 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 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 contract.

Once you have retired and become eligible for Medicare, you may elect to continue with the plan 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 and live in the Fallon Senior Plan™ service area and pay the premium charge when it's due. If you have a spouse and/or dependents who were covered under your group membership before you turned 65, they may continue coverage in that group for as long as they are eligible.

Changing to other health insurance

As long as the GIC agrees, you may change your coverage to any other health benefits plan offered where you work. 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 Fallon and your group.
- The day you move to a place outside the Select Care service area
- The date you become eligible to enroll in another federally qualified health maintenance organization within the Select Care service area for which you were not formerly eligible because of where you live
- The date we are no longer a part of the health benefits plan offered where you work
- The date the plan 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, we will send you a HIPAA 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.

This section contains:

Conversion options

Group health continuation coverage under COBRA

Family and medical leave act

Changing to a consumer plan

Conversion options

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

GENERAL NOTICE

This notice explains your COBRA rights and what you need to do to protect your right to receive it. You will receive a COBRA notice and application if the Group Insurance Commission (GIC) is informed that your current GIC coverage is ending due either to (1) end of employment, (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This COBRA notice contains important information about your right to temporarily continue your health care coverage in the Group Insurance Commission's (GIC's) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete the GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

WHAT IS COBRA COVERAGE? The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts or municipality covered by the GIC's health benefits program, you have the right to choose COBRA coverage if

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth or participating municipality ends for any reason other than gross misconduct or his/her hours of employment are reduced; or
- You and your spouse legally separate or divorce.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents legally separate or divorce; or
- The dependent ceases to be a dependent child under GIC eligibility rules

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage**.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts or your municipal employer no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage**.

In considering whether to elect COBRA coverage you should take into account that you have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your GIC coverage ends due to a qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you get continuation coverage for the maximum time available to you.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically; current COBRA rates are included with this notice.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. Alternately, if you are a Massachusetts resident, you may purchase health insurance through the Commonwealth's Health Connector Authority, or for employees in other states, through a Health Insurance Marketplace where available. The GIC has no involvement in conversion programs, and only very limited involvement in Health Connector programs. You pay the premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the GIC of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  - The employee's job terminates or his/her hours are reduced;
  - The insured dies;
  - The insured becomes legally separated or divorced;
  - The insured or insured's former spouse remarries;
  - A covered child ceases to be a dependent under GIC eligibility rules;
  - The Social Security Administration determines that the employee or a covered family member is disabled; or
  - The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. ***To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114.***

If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617/727-2301, ext. 1 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa** or call their toll free number at 866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit **www.healthcare.gov** or, in Massachusetts visit, **www.mahealthconnector.org**.

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 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 group coverage is cancelled for any reason during your leave, you may resume coverage when you return to work without waiting for an open enrollment period.

Changing to a consumer plan

If your eligibility for health insurance coverage through the GIC ends, you may be eligible to join a consumer plan. Contact Fallon at 1-888-797-3247 to find out more about the options available to you. You may not convert to a consumer plan if your group coverage ended because of fraud on your part.

This section contains:

Select Care service area

Your costs for covered services

Description of benefits

Select Care service area

Please note: When you are outside the Select Care service area, you are only covered for emergency services and urgent care services.

The Select Care service area includes all cities and towns in the following Counties: Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester.

Your costs for covered services

The following section contains a description of your covered services as a member of Fallon, including any limitations or exclusions related to each specific benefit. **Please note:** Our **General exclusions and limitations** section contains additional limitations that you should be aware of.

Covered services are health care services or supplies for which the plan will pay benefits. A service is covered according to the terms and conditions described in this *Member Handbook/Evidence of Coverage* only if it is medically necessary, provided by your PCP or another plan provider (except in emergency situations), and in some cases, authorized by the plan. The following section describes your costs for the benefits that you use.

Copayment maximum

You are responsible for a maximum of one inpatient copayment per member in each calendar year quarter, and four outpatient surgery copayments per member in each calendar year. (Note that if you are re-admitted within a 30-day period, we will waive the second copayment.)

Fallon will track the copayments that apply to the calendar year limit. When you reach the maximum for any service, we will send you a letter that indicates the date of the last required copayment for that service. For the rest of the calendar year, you may present a copy of the letter to the cashier who will not take a copayment for the specified services. If you do not bring the letter with you to the appointment, you may be asked to pay the copayment.

If you pay any copayments that you are not responsible for, you may send a letter to the Claims Manager at Fallon requesting reimbursement of those copayments. Include your name, address, membership number, proof of payment (encounter form, receipt, check, etc.) and an address to which the reimbursement should be sent. You must file a claim within two years of the date of service.

Coinsurance

Coinsurance is your share of the allowed charge for certain covered benefits, usually expressed as a percentage. For example, if you need durable medical equipment, your coinsurance amount is 20%, you pay 20% of the allowed charges for the purchase or rental of covered durable medical equipment you receive, and the plan pays the remaining 80%.

As a member of this plan, you are responsible for coinsurance for the following:

- Durable medical equipment
  Plan pays: 80% of the purchase price or rental cost;

  You pay: 20% of the purchase price or rental cost.
- Hearing aids for members age 22 and over (once per two-year period)
  Plan pays: 100% of the first $500 of the purchase price; and 80% of the next $1,500 of the purchase price, up to a maximum benefit of $1,700;

  You pay: 20% of the purchase price between $501 and $2,000 plus all additional costs.

Acute inpatient rehabilitation services

Acute inpatient rehabilitation services, whether provided in the setting of a hospital or a distinct unit, provide an intense program of coordinated and integrated medical and rehabilitative care. Acute inpatient rehabilitation services are provided for up to 100 days in each benefit period. The practitioners who comprise the interdisciplinary team have special training and experience in evaluating, diagnosing, and treating persons with limited function as a consequence of diseases, injuries, impairments, or disabilities. Further, acute inpatient rehabilitation care is provided to patients who are at high risk of potential medical instability, have a potential for needing skilled nursing care of a high medical acuity, and require a coordination of services, level of intensity and setting as follows:

a) Regular, direct individual contact by a physiatrist or physician of equivalent training and/or experience in rehabilitation who serves as their lead provider;

b) Daily rehabilitation nursing for multiple and/or complex needs;

c) A minimum of three hours of physical or occupational therapy per day, at least five days per week, in addition to therapies or services from a psychologist, a social worker, a speech-language pathologist, and a therapeutic recreation specialist, as determined by their individual needs; and

d) Based on their individual needs, other services provided in a health care facility that is licensed as a hospital.

Related exclusions (please see **General exclusions and limitations** for additional limitations)

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

Emergencies:

In emergencies, where a prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm, the plan covers ambulance transportation from the place where a person is injured or stricken by illness to the nearest hospital where treatment can be given. Call your local emergency communications system (e.g., police or fire department, or 911) to request an ambulance. (For more information about emergency situations, see **Emergency and urgent care.**)

Emergency services do not require referral or authorization, but you must notify the plan of any emergency services that you receive. (See **Emergency care**.) The type of ambulance used (air ambulance, land ambulance, etc.) must be appropriate to medical and geographic conditions. Note: You may be responsible for additional costs if you specifically request a form of ambulance transport that the plan deems inappropriate for your situation.

Non-emergency situations:

Ambulance service for medical treatments and procedures may be provided for certain non-emergency situations, when medically necessary. Any such services must be referred by a plan physician and authorized by the plan prior to the transportation date or occurrence. Transportation by any other means must be contraindicated by your medical condition in order to be considered for potential authorization approval.

Non-emergency transportation may also be considered if a member requires a medically necessary treatment or procedure and is nonambulatory both before and after the ordered treatment or procedure. Chair van or medivan transportation may be authorized in lieu of ambulance transportation if criteria are met for consideration of transportation approval. We reserve the right to determine the appropriate vehicle that meets criteria for transportation.

Services

1. Ambulance transportation for an emergency
2. Ambulance transportation for preauthorized non-emergency transfers

Related exclusions (please see **General exclusions and limitations** for additional limitations)

1. Ambulance, chair van and/or medivan use for patient convenience, nonclinical reasons, or transportation services only, including elective chair van transport from long-term care facilities to medical appointments
2. Transfers between hospitals when your medical condition does not warrant that you be transported to another facility
3. Transportation that can be planned ahead of time to or from a doctor’s office, clinic or other place for medical care
4. Air ambulance, when not appropriate to medical or geographic conditions
5. Commercial airline transportation

Autism services

The plan covers benefits for the diagnosis and treatment of autism spectrum disorder. 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.

Services

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. Coverage shall not be 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 (ABA): 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.

Related exclusions (please see **General exclusions and limitations** for additional limitations)

1. Equine therapy
2. Aqua therapy

Durable medical equipment and prosthetic/orthotic devices

The plan covers durable medical equipment and prosthetic/orthotic devices as described below. The plan pays 80% for most covered items, and you are responsible for the remaining 20%. Hearing aids and scalp hair prostheses (wigs) are subject to a benefit period maximum.

This plan covers prosthetic limbs which replace, in whole or in part, an arm or leg. These devices will be subject to 20% coinsurance.

Most services require referral and authorization. (See **Obtaining specialty care and services** for more information.)

Durable medical equipment is defined as an item for external use that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Durable medical equipment includes, but is not limited to, such items as:

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

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 and hair prosthesis
- 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:

- A form neck collar for cervical support
- A molded body jacket for curvature of the spine (scoliosis)
- An elbow or leg brace
- Back, neck or leg braces with rigid supports, including orthopedic shoes that are part of braces
- Splints

Covered services

1. The purchase or rental of durable medical equipment and prosthetic/orthotic devices(including the fitting, preparing, repairing and modifying of the appliance).

2. Hearing aid(s) when prescribed by a plan physician and obtained from a network provider. Age 22 and over: the Plan pays 100% of the first $500 of the purchase prices; 80% of the next $1,500 of the purchase price, up to a maximum benefit of $1,700 (Coverage is limited to once each two year period). Age 21 and younger: the Plan pays for the cost of one hearing aid per hearing impaired ear up to $2,000. Coverage is limited to once every 36 months. Deductible and coinsurance apply. (See your Schedule of Benefits.)
    - Related services and supplies for hearing aids (not subject to the $2,000 limit)
3. Scalp hair prostheses (wigs) for individuals who have suffered hair loss as a result of the treatment of 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.
4. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy
5. Oxygen and related equipment
6. Prosthetic limbs which replace, in whole or in part, an arm or leg.
7. Insulin pumps and insulin pump supplies. These items are covered in full.

Related exclusions (please see **General exclusions and limitations** for additional limitations)

1. 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. Items that are not covered include, but are not limited to:
    - Adjustable shoe-styling positioning devices, such as the Bebax™ shoe.
    - Air conditioners, air cleaners or purifiers, dehumidifiers, humidifiers, HEPA filters and other filters, and portable nebulizers
    - Alcohol and alcohol wipes
    - Arch supports, foot orthotics or orthopedic shoes (except when part of a brace or for diabetic foot care) or other supportive devices for the feet
    - Articles of special clothing, mattress and pillow covers, including hypoallergenic versions
    - Bed pans and bed rails
    - Bidets, bath and/or shower chairs
    - Comfort or convenience items such as telephone arms and over-bed tables
    - Dentures
    - Ear plugs (such as to prevent fluid from entering the ear canal during water activities or for sound/noise control)
    - Elevators, ramps, stair lifts, chair lifts, strollers and scooters
    - Eyeglasses and contact lenses
    - Heating pads, hot water bottles and paraffin bath units
    - Home blood pressure monitors and cuffs
    - Any home adaptations, including but not limited to, home improvement and home adaptation equipment
    - Hot tubs, saunas, Jacuzzis, swimming pools or whirlpools
    - Incontinence products
    - Items that are considered experimental, investigational, or not generally accepted in the medial community
    - Items not listed, or listed as “not covered,” on the durable medical equipment (DME) and medical and surgical supplies list

- Items that do not meet the coverage criteria previously listed
- Venous pressure stockings (such as TEDS or Jobst stockings)
- Raised toilet seats
- Safety equipment, such as grab bars, car seats, seizure helmets, safety belts or harnessess, or vests

3. Oxygen and related equipment, when obtained from a non-plan provider. This includes oxygen and related equipment that you are supplied with while you are out of the Select Care service area.
4. Services that are not determined to be medically necessary. This applies even if the plan benefit period limits have not been reached.
5. Charges for hearing aids in excess of $1700, with the first $500 covered at 100% and the next $1500 covered at 80% for members age 22 and older; charges in excess of $2,000 for members age 21 and younger.

Emergency and urgent care

Emergency care

The plan covers 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 communications system (e.g., police or fire department, or 911).

An emergency medical condition is a 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 member or another person (or unborn child),
2. serious impairment to bodily functions, or
3. serious dysfunction of any bodily organ or part.

Examples of covered emergencies include, but are not limited to, stroke, unconsciousness, heart attack symptoms or severe bleeding.

Emergency services do not require referral or prior authorization, but you must notify the plan of any emergency services that you receive. Your PCP should be notified so that arrangements can be made for any follow-up or continuing care that is medically necessary for you. You should be aware that follow-up care in an emergency room often will not meet a prudent layperson definition and that most emergency room follow-up care can be provided in a setting other than an emergency room.

Emergency services will be covered from all providers at the cost level of the lowest cost-sharing tier regardless of the tier in which the health benefit plan has classified the provider providing such emergency services within the Tiered Provider Network including for inpatient deductibles if the insured seeking or receiving emergency services is subsequently admitted.

Urgent care

Sometimes you may need care right away for minor emergencies such as cuts that require stitches, a sprained ankle or abdominal pain. These situations may not pose as much of a threat as the emergency situations discussed above, but they still require fast treatment to prevent serious deterioration of your health.

If you are within the Select Care service area, call your PCP's office for information on how and where to seek treatment. If your doctor is not available, an on-call doctor will make arrangements for your care. Telephones are answered 24 hours a day seven days a week. Explain the medical situation to the doctor and state where you are calling from, so that the doctor can refer you to the most appropriate facility. You may also call the Reliant Medical Group Urgent Care Department directly for an appointment for urgent care services *if you have a Reliant Medical Group PCP.*

If you are outside the Select Care service area, go to the nearest medical facility for care. If you need follow-up care, you should contact your PCP for assistance.

Covered services

1. Emergency room visits
2. Emergency room visits when you are admitted to an observation room
3. Emergency room visits when you are admitted as an inpatient
4. Urgent care visits in a provider's office or at an urgent care facility. For a list of urgent care facilities visit fallonhealth.org/gic.
5. Emergency prescription medication provided out of the Select Care service area as part of an approved emergency treatment

Related exclusions (please see **General exclusions and limitations** for additional limitations)

1. Unauthorized in-area urgent care visits (unless received at the Reliant Medical Group Urgent Care Department and *you have a Reliant Medical Group PCP*)
2. Out-of-area care or services that could have been anticipated before leaving the Select Care service area
3. Follow-up care, unless provided by your PCP, a Reliant Medical Group specialist if you have a *Reliant Medical Group PCP*, or authorized by the plan. This exclusion includes follow-up care in an emergency room setting.
4. Non-emergency prescription medication outside the Select Care service area such as medication for a chronic condition or a maintenance supply. You may use the prescription medication mail-order program to fill medication refills. (See **Prescription medication**.)
5. Care from a non-plan or out-of-area provider once you are medically able to return to the service area

Enteral formulas and low protein foods

The plan covers enteral formulas and low protein foods listed below.

Enteral formulas require referral and authorization. (See **Obtaining specialty care and services** for more information on referrals and authorization.)

Service

1. Enteral formulas, upon a physician's written order, for home use in 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.

Related exclusions (please see **General exclusions and limitations** for additional limitations)

1. Nutritional supplements, medical foods and formulas unless described above as covered
2. Dietary supplements, specialized infant formulas (such as Nutramigen, Elecare and Neocate), vitamins and/or minerals taken orally to replace intolerable foods, supplement a deficient diet, or provide alternative nutrition for conditions such as hypoglycemia, allergies, obesity and gastrointestinal disorders. These products are not covered even if they are required to maintain weight or strength.

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.

Home health care services must be ordered by a plan physician. Home care provided by in plan providers no longer requires authorization by the plan. DME provided in conjunction with home health care requires prior authorization. (See **Obtaining specialty care and services** and **Durable medical equipment** for more information.) Members receiving skilled services must meet the homebound criteria.

Covered services

1. Part-time or intermittent skilled nursing care and physical therapy provided in your home by a home health agency
2. Additional services and supplies that are determined to be a medically necessary component of skilled nursing care and physical therapy

Related exclusions (please see **General exclusions and limitations** for additional limitations)

1. Personal comfort items
2. Meals
3. Housekeeping services and/or homemaking services
4. Custodial care services and/or unskilled home health care, whether at home or in a facility setting

Hospice care

Hospice is a coordinated program of palliative and supportive care provided to plan members who are terminally ill and their families. Rather than trying to cure the illness, the goal of hospice is to make the plan member as comfortable as possible, ease pain and other troublesome symptoms and support the family through a difficult time.

Hospice care is provided by an interdisciplinary hospice team who understand the needs of patients who are terminally ill. The team includes doctors, nurses, social workers, spiritual counselors, home health aide, bereavement counselors and volunteers. Most hospice patients receive hospice care while continuing to live in the comfort of their own home. The hospice team will visit the home regularly and provide medical and nursing care, emotional support and counseling, instruction and practical help.

Hospice care requires a PCP referral and prior authorization. (See **Obtaining specialty care and services** for more information.)

Covered service

Hospice care provided at home, in the community and in facilities.

Hospital inpatient services

The plan covers inpatient care for as many days as your condition requires. Your plan provider will work with the plan's Care Coordination Department to develop a treatment plan for you.

If you are in a hospital or other medical facility when your coverage takes effect, you will be covered by the plan as of your effective date as long as you notify us as soon as medically possible that you are an inpatient. You must also allow a plan physician to assume further care. If medically appropriate, you may be transferred to a plan facility.

Hospital inpatient services require referral and authorization. (See **Obtaining specialty care and services** for more information on referral and authorization.) Whenever you need to be admitted to a hospital for a medical procedure, your PCP and specialty care physician will work with us to obtain authorization at a plan facility to which your physician admits. Your physician and the plan will also monitor the care that you receive as an inpatient and coordinate your discharge from the hospital. While you are an inpatient, our case management program will review and evaluate the inpatient care that you receive to make sure that you receive appropriate care. (For more information about case management review, see the **Utilization management** section.)

Please be sure to check the tier designation of any hospital you plan on utilizing for services. You will be required to pay the copyament amount for the service you receive based on the tier designation of the hospital. You can check the hospital tier designation in the provider directory or the GIC member portal at fallonhealth.org/gic. Be sure to check your Schedule of Benefits for the copayment amount based on the tier designation of the hospital.

Covered services

1. Room and board in a semiprivate room or a private room when medically necessary

   * Limited to one copayment per calendar year quarter. Please contact Customer Service if you are re-admitted within a 30-day period in order for the second copayment to be waived.

2. 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, pathology and X-ray services; anesthesia services; short-term rehabilitation; and operating and recovery room services.
3. Physician and surgeon services
4. General nursing services
5. Intensive and/or coronary care
6. Dialysis services
7. Medical, surgical or psychiatric services
8. Nursing services provided by a certified registered nurse anesthetist
9. Bariatric weight loss surgery (Prior authorization required and is contingent upon review by an Fallon Health medical director)

Related exclusions (please see **General exclusions and limitations** for additional limitations)

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. Personal comfort items such as telephone, radio or television

3. Charges that you incur for services not determined to be medically necessary by a plan physician and the plan, or when you choose to stay beyond the hospital discharge hour for your own convenience
4. Rest or custodial care, or long-term care
5. Autologous blood donation or storage for use during surgery or other medical procedures
6. Unskilled nursing home care
7. Services that are considered experimental or investigational.
8. 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.

Approval for coverage of assisted reproductive technology (ART) is contingent upon review by a Fallon Health medical director. Fallon's coverage guidelines for all ART services are available by contacting the Customer Service Department.

Infertility services require referral and authorization unless provided by a Reliant Medical Group specialist (if you have a Reliant Medical Group PCP). Certain fertility medications also require authorization; some may have a quantity limit for each prescription as well. (See **Obtaining specialty care and services** for more information on referral and authorization.)

Covered services

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-EP)
    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

Related exclusions (please see **General exclusions and limitations** for additional limitations)

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
    a. In the absence of documented male factor infertility, as evidenced by abnormal semen analysis.
    b. 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 above under **Service.**
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. Treatment to reverse voluntary sterilization.
12. Infertility services that are necessary as a result of a prior voluntary sterilization in the absence of a successful reversal procedure.
13. Supplies that may be purchased without a physician's written order, such as ovulation test kits.
14. Services related to achieving pregnancy through a surrogate or gestational carrier.
15. Charges for the storage of donor sperm, eggs or embryo that remain in storage after the completion of an approved series of infertility cycles.
16. 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).
17. 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.
18. Infertility medication for donors
19. Donation or sale of gametes or embryos
20. Medications for ART cycles/attempts without prior authorization
21. Clinical or laboratory research

Maternity services

The plan covers maternity and obstetrical services in accordance with the General Laws of Massachusetts. Routine obstetrical and maternity care does not require a referral or authorization, but you need to see a plan provider who is an obstetrician, certified nurse midwife or family practice physician. (See **Obtaining specialty care and services** for more information.)

Service

1. Obstetrical services including prenatal, childbirth, postnatal and postpartum care
2. Inpatient maternity and newborn child care for a minimum of 48 hours of care following a vaginal delivery, or 96 hours of care following a Caesarean section delivery. The covered length of stay may be reduced if the mother and the attending physician agree upon an earlier discharge. If you or your newborn are discharged earlier, you are covered for home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however that the first home visit shall be conducted by a registered nurse, physician or certified nurse midwife; and provided further, that any subsequent home visit determined to be clinically necessary shall be provided by a licensed health care provider
3. Charges for the following services when provided during an inpatient maternity admission: childbirth, nursery charges, circumcision, routine examination, hearing screening, and medically necessary treatments of congenital defects, birth abnormalities or premature birth.
4. Lactation support and counseling services provided by a certified lactation counselor. Please contact Customer Service at 1-866-344-4GIC (4442) (TRS 711), or visit the Fallon website fallonhealth.org/gic for more information.

Related exclusions (please see **General exclusions and limitations** for additional limitations)

1. Routine maternity care when you are traveling outside the plan service area. This includes prenatal, delivery and admission, and postpartum care
2. Delivery outside the plan service area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery
3. Routine circumcision performed after an infant's discharge from a maternity hospital admission (unless determined to be medically necessary prior to discharge)
4. Charges for a home birth
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.
6. Any and all costs associated with any form of surrogacy, specifically including, but not limited to, costs of prenatal, delivery-related and postnatal professional and facility-related care of gestational carriers.

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 Mental Disorders* published by the American Psychiatric Association and that is determined as such by a plan provider and the plan. The level of care needed is authorized by a plan provider. Treatment may be provided by a psychiatrist, psychologist, psychotherapist, licensed nurse, mental health clinical specialist, licensed independent clinical social worker, mental health counselor, pediatric specialist, certified alcohol and drug abuse counselor, marriage and family therapist or other provider as authorized by the plan.

A member who loses eligibility as a dependent upon reaching age 19 and is receiving ongoing mental health treatment at the time may be eligible to continue coverage for the treatment. Call Customer Service for more information. (Members who lose eligible as a dependent may also continue full coverage under COBRA; see **Conversion options**.)

For mental health and substance abuse emergencies, follow the same procedures as for any other medical emergency, as outlined in **Emergency and urgent care**.

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. For substance abuse treatment, no prior authorization will be required if the provider is certified or licensed by the Massachusetts Department of Public Health (MDPH). Additionally, no prior authorization is required for the first 14 days of acute treatment services or for clinical stabilization services; for the services, the facility must notify Fallon within 48 hours of admission and utilization review may commence on the 7th day.

Inpatient services

The plan covers mental health services in an inpatient or alternative (diversionary) setting, when authorized by the plan. The plan does not require prior authorization, for the first 14 days of acute treatment services for addiction treatment or clinical stabilization services for post-detoxification treatment, as discussed above. The plan does not require prior authorization where the substance abuse provider is certified or licensed by MDPH, as discussed above.To access services and obtain authorization, call 1-888-421-8861 (TDD/TTY: 781-994-7660). Unlimited coverage is provided for inpatient care when medically necessary in a licensed general hospital, a psychiatric hospital or a substance abuse facility (or its equivalent in an alternative program). Levels vary from least to most restrictive and include: respite or crisis stabilization; day or evening treatment or partial hospitalization; short-term residential treatment; and hospital-based programs.

Covered services

1. Inpatient hospital care for as many days as your conditions requires, including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, individual, family and group therapy, pharmacological therapy, and diagnostic laboratory services.
2. Professional services provided by physicians or other health care professionals for the treatment of mental conditions while you are an inpatient.

Intermediate services

Members may receive mental health care in an alternative setting in lieu of inpatient hospitalization. This may include, but is not limited to, the following services:

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

2. Clinically managed detoxification services: 24-hour, 7-day-a-week, clinically managed detox services in a licensed non-hospital setting that include 24 hours per day supervision
3. Partial hospitalization: Short-term day/evening mental health programming available 5 to 7 days per week.
4. Intensive outpatient programs: Multimodal, inter-disciplinary, structured behavioral health treatment provided 2-3 hours per day, multiple days per week.
5. Day treatment: Program encompasses some portion of the day or week rather than a weekly visit
6. Crisis stabilization: Short-term psychiatric treatment in a structured, community based therapeutic environments.
7. In-home therapy services

Outpatient services

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

Services

1. Outpatient office visits, including individual, group or family 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. Prior authorization is not required beyond the initial eight for outpatient substance abuse services provided by MDPH certified or licensed providers.
2. Psychopharmacological services, such as visits with a physician to review, monitor and adjust the levels of prescription medication to treat a mental condition
3. Neuropsychological assessment services when medically necessary (prior authorization required)
4. Medication-assisted treatments including methadone (prior authorization not required)

Related exclusions (please see **general exclusions and limitations** for additional limitations)

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) or vocational counseling
4. Services that do not include face-to-face participation by the member, such as “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. Some examples of services or programs 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.

Office visits and outpatient services

The plan provides coverage for the services listed below. Coverage is provided on a nondiscriminatory basis for services delivered or arranged by a nurse practitioner or physician assistant. Pediatric specialty care, including mental health care, is covered when provided to a member requiring such services by a provider with recognized expertise in specialty pediatrics.

You may self-refer to your PCP. You may self-refer to any Reliant Medical Group specialist (physician, physician assistant, or nurse practitioner) if you have a Reliant Medical Group PCP. Specialty services with a specialist other than a Reliant Medical Group specialist generally require referral and authorization. (See **Obtaining specialty care and services** for more information on referral and authorization.)

The plan covers the costs for patient care services and routine patient costs furnished to members enrolled in certain qualified cancer clinical trials to the same extent as they would be covered if the member did not receive 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, including, but not limited to, provisions requiring the use of Fallon Select Care providers.

Covered services

Office visits and related services

1. Office visits to diagnose or treat an illness or an injury
2. A second opinion, upon your request, with another plan provider
3. Injections and injectables that are included in the formulary, that are for covered medical benefits, and that are ordered, supplied and administered by a plan provider (requires prior authorization)
4. Allergy injections
5. Radiation therapy
6. Respiratory therapy
7. Hormone replacement services in the doctor's office for perimenopausal and postmenopausal women
8. Audiological examination for the purpose of prescribing a hearing aid. Coverage is limited to one exam every two years.

Diagnostic lab and x-ray services

9. Diagnostic lab and X-ray services ordered by a plan provider, in relation to a covered visit

Chiropractic services

10. Chiropractic services for acute musculoskeletal conditions. The condition must be new or an acute exacerbation of a previous condition. Coverage is provided for up to 12 office visits in each benefit period, when medically necessary.

Renal dialysis

11. Outpatient renal dialysis at a plan-designated center or continuous ambulatory peritoneal dialysis. (Please see **Medicare** under **the claims process** section for more information.)

Diabetic services

12. Diabetes outpatient self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider

13. Laboratory tests necessary for the diagnosis or treatment of diabetes, including glycosylated hemoglobin, or HbA1c, tests, and urinary protein/microalbumin and lipid profiles

Medical social services

14. Medical social services provided to assist you in adjustment to your illness or your family member's illness. This includes assessment, counseling, consultation and assistance in accessing community resources.

Voluntary family planning services

15. Consultations, examinations, procedures and medical services related to:
    - genetic counseling
    - elective sterilization
    - termination of pregnancy in an office setting

    (Note: Termination of pregnancy or other procedures provided in a hospital outpatient, day surgery or ambulatory care facility are subject to the outpatient surgery copayment.)

Outpatient (day) surgery

16. Same-day surgery in a hospital outpatient department or ambulatory care facility*

    * Limited to four copayments per calendar year.

Walk In Clinic

17. Visit to a contracted limited service 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)

Related exclusions (please see **General exclusions and limitations** for additional limitations)

1. Services required by a third party or court order. Examples are employment, school, sports, premarital and/or summer camp examinations or tests, and any immunizations required by an employer, related to your job and/or work conditions.
2. Acupuncture or massage (when not performed by a physician or physical therapist as part of your covered physical therapy benefit) therapy
3. Visits to additional providers beyond a second opinion, or a second opinion with a non-plan provider.
4. Emergency laboratory evaluation for a cardiovascular lipoprotein quantitation.

Oral surgery and related services

The plan covers the services listed below. All services must be provided by a plan oral surgeon or plan physician (this does not include a plan general dentist).

You do not need a referral or authorization for extraction of impacted teeth, lingual frenectomy or for emergency care. All other services shown below require referral and authorization. (See **Obtaining specialty care and services** for more information on referrals and authorization.)

Covered services

1. Removal or exposure of impacted teeth, including both hard and soft tissue impactions, or an evaluation for this procedure
2. Surgical treatments of cysts, affecting the teeth or gums, that must be rendered by a plan oral surgeon
3. Treatment of fractures of the jawbone (mandible) or any facial bone
4. Evaluation and surgery for the treatment of temporomandibular joint disorder when a medical condition is diagnosed, or for surgery related to the jaw or any structure connected to the jaw
5. Extraction of teeth in preparation for radiation treatment of the head or neck
6. Surgical treatment related to cancer
7. 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 care. You do not need authorization for emergency care. Go to the closest provider.

Limited services (as a hospital inpatient or at a surgical day care or ambulatory surgical facility)

Benefits are provided for the following procedures only when you have a serious medical condition that makes it essential that you be admitted to a hospital as an inpatient, or to a surgical day care unit or ambulatory surgical facility as an outpatient, in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease. Refer to **Hospital inpatient services** or **Office visits and outpatient services** for more details on your benefits.

- Extraction of seven or more teeth
- Gingivectomies (including osseous surgery) of two or more gum quadrants
- Excision of radicular cysts involving the roots of three or more teeth
- Removal of one or more impacted teeth

Related exclusions (please see **General exclusions and limitations** for additional limitations)

1. Procedures or services related to dental care
2. Dental treatments and appliances for the treatment of temporomandibular joint disorder (TMJ)
3. Services that have not been authorized by the plan and a plan physician, or unauthorized services provided by a non-plan oral surgeon (with the exception of the extraction of impacted teeth or emergency care services as specified above)
4. Dentures and the following procedures, when performed for the preparation of the mouth for dentures: removal of a torus palatinus, alveoplasty, frenectomy and reconstruction of a ridge
5. Osseointegrated implants or insertion of a core-vent implant
6. Covered services that are performed secondary to a noncovered service
7. Inpatient dental care (as a hospital inpatient or at a surgical day care or ambulatory surgical facility), except as shown above under **Limited services**

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 Service number 4 below.

The transplant must be performed at an affiliated transplant facility, subject to your acceptance into the program. The plan will work with the transplant facility to coordinate your care during the evaluation and transplant process and help to arrange your discharge and follow-up care.

If you want a second opinion the plan will identify another suitable transplant facility. Additional opinions beyond a second opinion are not covered. Transplant services require a referral from your PCP and plan authorization. (See **Obtaining specialty care and services** for more information.)

Covered services

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

* Your copayment for inpatient admissions will apply to each inpatient admission, including admissions for services related to organ transplants. Limited to four inpatient copayments per calendar year. However, if you are re-admitted within a 30-day period, we will waive the second copayment.

Related exclusions (please see **General exclusions and limitations** for additional limitations)

1. Investigational, experimental or unproven procedures, including but not limited to:
   a. the transplant of partial pancreatic tissue or islet cells
   b. 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 the organ donor that are covered by another insurer
5. Services for an organ donor if the recipient is not a member of the plan
6. Transportation or housing costs for the recipient or donor
7. House cleaning costs incurred in preparation for a transplant recipient’s discharge

Prescription medication

The plan covers medically necessary prescription drugs according to the requirements and guidelines discussed below.

Who can write your prescription

A plan provider or a provider you have seen through an authorized referral can write your prescription.

Where you can fill your prescription

You can fill your prescription at a plan pharmacy or through a plan pharmacy mail-order program. (Please note that there are some medications that cannot be mailed and are not available through the mail-order program.) See your Select Care Provider Network directory for a list of plan pharmacies.

The Fallon Health formulary

The Fallon formulary is a list of medications that shows the applicable cost-sharing tier and prior authorization requirements for each medication. We have selected the tiers and determined the criteria for prior authorization based on efficacy and cost-effectiveness.

The Fallon prescription drug formulary has a multi-tiered cost-sharing structure. We have selected the tiers based on efficacy and cost-effectiveness. There is a different cost-sharing for each tier.

Coverage of certain drugs is based on medical necessity. For these drugs, you will need prior authorization from the plan. They are noted on the formulary as “PA.” Your doctor should request authorization from Fallon, and give us the clinical information that we need to make our decision, before he or she writes the prescription. We will review the authorization request according to our criteria for medical necessity.

The prescription drug formulary is available at our website at fallonhealth.org/gic. If you do not have access to our website or if you have any questions about the formulary please call Customer Service.

The Fallon formulary may include drugs used for the formulary treatment of cancer or HIV/AIDS, in accordance with state law.

Dispensing limitations

Prescription drugs are generally dispensed for up to a 30-day supply. The corresponding cost-sharing, as noted in your Schedule of Benefits, will be charged for up to a 30-day supply. In some instances, the plan has established dispensing limitations, which may include a quantity limit on certain medications. For maintenance medication you may obtain up to a 90-day supply. We follow FDA, state and federal dispensing guidelines. You generally cannot obtain a refill until most or all of the previous supply has been used.

***Please note*:** Your doctor may prescribe medication in a dose that is not available through the purchase of a single prescription. In these cases, you may need to fill more than one prescription—and pay the corresponding cost-sharing, as noted in your Schedule of Benefits, each—to achieve the desired dose.

Generic and brand-name drugs

A generic drug is a drug product that meets the approval of the U.S. Food and Drug Administration and is equivalent to a brand-name product in terms of quality and performance. It may differ in certain other characteristics (e.g., shape, flavor or preservatives). By law, generic drug products must contain identical amounts of the same active drug ingredient as the brand-name product.

A generic preferred program is now in place. This means if you fill a prescription with a brand-name drug when a generic is available, you will be responsible for the drug copayment plus the cost difference between the two drugs.

You will generally receive a generic drug from plan pharmacies anytime one is available, unless your doctor has directed the pharmacist to only dispense a specific brand-name drug. However, some brand-name drugs do not have a generic equivalent. In both of these cases, you will receive the brand-name drug and will be responsible for the appropriate cost-sharing for that drug, as noted in your Schedule of Benefits.

Mail-order prescriptions

You may also get your prescription medication refill(s) through a plan pharmacy mail-order program. You may have your prescription mailed directly to you at home or at any other location if you are traveling within the country. Most medications can be mailed; however, there are some that may not. (Medications cannot be mailed to other countries.)

When you fill your prescription through our mail-order program you may order up to a 90-day supply of most medications. The Tier-1 and Tier-2 mail-order copayment amount is equal to the cost of two retail pharmacy copayments (that is, the amount you would pay for a 60-day supply at a retail pharmacy). The Tier-3 mail-order copayment amount is equal to the cost of two-and-one-quarter retail pharmacy copayments.

New members

If you are a new member and need to have an existing prescription refilled, we encourage you to see your PCP to review your prescriptions. If you are currently taking a drug for that requires prior authorization by Fallon, your doctor will need to submit a request for prior authorization. We will determine coverage of that drug based on our criteria for medical necessity. If the drug you are currently taking is a Tier-3 drug, you may want to discuss alternatives with your doctor.

Covered items: (some of these medications and covered items may require prior authorization)

- Prescription medication
- Contraceptive drugs and devices
- Hormone replacement therapy
- Injectable agents (self-administered*)
- Insulin
- Syringes or needles (including insulin syringes) when medically necessary
- Orally administered anticancer medications used to kill or slow the growth of cancerous cells
- Supplies for the treatment of diabetes, as required by state law, including:
  - —blood glucose monitoring strips
  - —urine glucose strips
  - —ketone strips
  - —lancets
  - —insulin pens, for the treatment of diabetes
- Prescribed oral medications that influence blood sugar levels, for the treatment of diabetes, as required by state law
- Certain injectable medications administered in the home setting, when approved by Fallon and received through a plan-approved pharmacy vendor

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

Over-the-Counter Medications
Fallon 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 Fallon Claims Department for reimbursement.

Fallon 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 Fallon Claims Department for reimbursement.

Special Medical Formulas
Fallon covers special medical formulas to treat certain metabolic disorders as required by state law. Metabolic disorders covered under state law include: phenylketonuria; tyrosinemia; homocystinuria; maple syrup urine disease; propionic acidemia; and methylmalonic acidemia in a dependent child, including when medically necessary to protect unborn fetuses of pregnant women with phenylketonuria. Prior authorization required.

Related exclusions (please see **General exclusions and limitations** for additional limitations)

1. Drugs that you can buy without a prescription, unless included on the Fallonformulary specifically described as covered in the above Over-the-Counter Medications section.
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 are not used in accordance with FDA-approved labeling, including, but not limited to: unapproved doses, unapproved duration of therapy and unapproved indications
4. Drugs that require prior authorization if prior authorization is not 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 noncovered conditions. This also includes drugs that do not meet medical criteria.
6. Prescriptions obtained within the Select Care service area at a non-network pharmacy
7. Non-emergency prescriptions filled outside the Select Care service area.
8. Vitamins and minerals, whether or not a prescription is required, are excluded from coverage, unless listed in the Fallon drug formulary.
9. Over-the-counter birth control preparations or devices, unless specifically described as covered in the above Over-the-Counter Medications section.
10. Drugs that are prescribed for anything other than the U.S. Food and Drug Administration's approved usage. (This does not include the off-label uses of covered prescription drugs used in the treatment of HIV/AIDS or cancer when used in accordance with state law. This also does not include bone marrow transplants for breast cancer as required by state law.)
11. Products used for any dental condition that is not covered under your Fallon dental benefit
12. Medications used for preference or convenience
13. Medications that are new to the market that have not been reviewed by Fallon for safety and adverse events. These medications are not covered by Fallon until they have been reviewed and guidelines for their use have been developed. This could take up to 180 days after they are on the market.
14. Replacement of more than one lost/mishandled medication per prescription per benefit period
15. 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

16. The following proton pump inhibitors: Prevacid, Iansoprazole, Protonix, Pantoprazole, Zegerid, omeprazole, Prilosec
17. Bio-identical hormone replacement therapy
18. Vimovo
19. The following non-sedating antihistamines: Allegra, Allegra ODT, cetirizine HCI, Clarinex, Claritin, Claritin Reditabs, fexofenadine HCI, Xyzal and Zyrtec.
20. Medical marijuana
21. Duexis (ibuprofen/famotidine)
22. Omeclamox (amoxicillin/clarithromycin/omeprazole) Therapy Pack
23. Vascepta (icosapent ethyl)
24. Liptruzet (atorvastatin/ezetimibe)
25. Diclegis (doxylamine/pyriodoxine)
26. Acticlate (doxycycline Hyclate)
27. Jublia (efinaconazole soln)
28. Durlaza (aspirin 162.5mg)
29. Cuprimine (penicillamine) capsules
30. Glumetza (metformin) tablets

Preventive care

The plan covers preventive 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 fallonhealth.org/gic or more information on these guidelines.

Service

1. Periodic physical exams with your PCP for the prevention and detection of disease.
2. Immunizations that are included on the Fallon formulary, that are for covered medical benefits and that are ordered, supplied and administered by a plan physician. If administered by a plan specialist, you will generally need to obtain a referral to see the specialist
3. A baseline mammogram for women age 35 to 40, and a yearly mammogram for women age 40 and older
4. Routine gynecological care services, including an annual Pap smear (cytological screening) and pelvic exam
5. Routine eye exams, once in each 24-month period
6. Hearing and vision screening performed during a physical exam
7. Well-child care and pediatric services, at least six times during the child's first year after birth, at least three times during the next year, then at least annually until the child's 19th birthday. This includes the following services, as recommended by the physician and in accordance with state law:
   - physical examination
   - history
   - measurements
   - sensory screening
   - neuropsychiatric evaluation
   - development screening and assessment
   - appropriate immunizations
   - hereditary and metabolic screening at birth
   - newborn hearing screening test performed before the newborn infant is discharged from the hospital or birthing center
   - tuberculin tests, hematocrit, hemoglobin, and other appropriate blood tests and urinalysis
   - lead screening
8. Consultations, examinations, procedures and medical services related to the use of all contraceptive methods (Note: generic contraceptives are covered in full)
9. Contraceptive devices that are supplied by a plan provider during an office visit

Related exclusions (please see **General exclusions and limitations** for additional limitations)

1. More than one routine eye examination in each 24-month period
2. Fittings for contact lenses
3. Eyeglasses or contact lenses
4. Vision therapy or services (also referred to as orthoptics)

5. Services required by a third party or court order. Examples are employment, school, sports, premarital and/or summer camp examinations or tests, and any immunizations required by an employer that are related to your job and/or work conditions.
6. Routine eye exams provided by an optometrist or ophthalmologist not contracted with EyeMed. See the Fallon “Find a doctor” tool at fallonhealth.org/gic for details.

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 & 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.

You may self-refer to a Reliant Medical Group specialist if you have a Reliant Medical Group PCP. Services with a non-Reliant Medical Group specialist require referral and authorization. Your surgeon must obtain prior authorization from Fallon for all procedures. (See **Obtaining specialty care and services** for more information on referrals and authorization.)

Reconstructive and **restorative** surgery are subject to inpatient and outpatient copayments and exclusions.

Services

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.

Related exclusions (please see **General exclusions and limitations** for additional limitations)

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 clip 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.

Rehabilitation and Habilitation services

The plan covers outpatient rehabilitation services as indicated below. Short-term rehabilitation services such as physical and occupational therapy, are limited to a 90-day period per acute episode, beginning with the first office visit. Medical necessity determines the actual number of visits covered.

The plan covers habilitation services. Examples include therapy for a child who isn't walking or talking at the expected age. Habilitation services help a person keep, learn or improve skill and functioning for daily living. 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.

Services require referral and authorization. (See **Obtaining specialty care and services** for more information on referrals and authorization.)

Covered services

1. Physical therapy to restore function after medical illness, accident or injury. Coverage is provided for as many visits as are medically necessary per acute episode within a 90-day period, beginning with the first office visit. Visits after 90 days require prior authorization.
2. Occupational therapy to restore function after medical illness, accident or injury. Coverage is provided for as many visits as are medically necessary per acute episode within a 90-day period, beginning with the first office visit. Visits after 90 days require prior authorization.
3. Medically necessary services for the diagnosis and treatment of speech, hearing and language disorders when services are provided aplan provider who is a speech-language pathologist or audiologist and at a plan facility or plan provider's office.
4. Cardiac rehabilitation services to treat cardiovascular disease, in accordance with state law and Department of Public Health regulations
5. Medically necessary early intervention services delivered by a certified early intervention specialist, according to operational standards developed by the 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.
6. 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.

Related exclusions (please see **General exclusions and limitations** for additional limitations)

1. Long-term rehabilitation services
2. Maintenance treatment or services
3. Services for non-acute 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 or illness causing the original pain.
4. Services that are not determined to be medically necessary. This applies to physical therapy, speech therapy, occupational therapy and chiropractic care, even if the plan limits have not yet been reached.
5. Massage therapy, including myotherapy, unless provided by a Select Care physician or physical therapist with one-to-one patient contact
6. Acupuncture

7. Early intervention services for patients over age 3
8. Pulmonary rehabilitation services for chronic obstructive pulmonary disease beyond 36 lifetime sessions.
9. Pulmonary maintenance

Skilled nursing facility

The plan covers inpatient services in a plan skilled nursing facility for up to 100 days in each benefit period, provided criteria are met.

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 do not require the specialized care of an acute care hospital.

Services require referral and authorization. (See **Obtaining specialty care and services** for more information on referral and authorization.) The level of services, number of covered days that you are admitted and where you are admitted will be based upon the medical necessity of your condition as determined by your plan physician and the plan.

Service (see **Inpatient services** for more details)

1. Room and board in a semiprivate room (or private room if medically necessary), for up to 100 days in each benefit period, provided criteria are met
2. The services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, nursing services, physical, speech and occupational therapy, medical supplies and equipment.
3. Physician services

Related exclusions (please see **Inpatient services** and **General exclusions and limitations** for more details.)

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

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.

It Fits

- It Fits! reimburses eligible Fallon Health members for participating in a variety of healthy 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.

Other plan benefits and features

Out-of-area student coverage

Students attending school outside the Select Care service area may not have easy access to the plan provider network. They are covered for a limited number of services while out-of-area, if authorized in advance by the plan. You must work with your PCP to get plan authorization. These services include:

- Nonroutine medical office visits
- Diagnostic lab and X-ray connected with a nonroutine office visit
- Nonelective inpatient services
- Outpatient services to diagnose and/or treat mental conditions
- Short-term rehabilitation services, including physical, occupational and speech therapy. Coverage for physical and occupational therapy is provided for as many visits as are medically necessary per acute episode, within a 90-day period beginning with the first office visit (combined with any in-area visits). Coverage for speech therapy is provided for as many visits as are medically necessary.

Aside from emergency care, the services listed above are the only services that are covered for students on an out-of-network basis. To be covered, all other plan services must be obtained when they return to the Select Care service area.

Every day health

In addition to providing health care coverage for our members, Fallon offers a variety of resources and wellness features for members who want to take an active role in their health care.

- Disease care services support members who have chronic conditions like asthma, congestive heart failure, coronary artery disease and diabetes.
- Eyewear discounts from contracted vendors
- It Fits! reimburses eligible Fallon members for participating in a variety of healthy 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.
- Naturally Well program 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!
- Quit to Win program helps members develop a stop-smoking plan and gives them the tools they need to succeed. The program offers counseling for tobacco dependence/smoking cessation up to and including a maximum of 300 minutes. The counseling can be telephonic or face-to-face and may be completed in either individual or group sessions.
- 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 1-866-344-4GIC (4442) (TRS 711) 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 1-866-344-4GIC (4442) (TRS) 711 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 1-866-344-4GIC (4442) (TRS 711), or visit the Fallon website fallonhealth.org/gic, for more information on these and other programs that are part of *Every Day Health*.

General exclusions and limitations

You are not covered for the following services. These are in addition to the individual exclusions listed in the **Description of benefits** section of this handbook; however, this is not an exhaustive list. If you have any questions about your benefits, please contact Customer Service at 1-866-344-4GIC (4442) (TRS 711).

1. Services or supplies that are not described as covered in this *Member Handbook/Evidence of Coverage*
2. Any service or supply related to a non-covered service or condition.
3. 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.)
4. ALCAT test for food sensitivity
5. All medical, hospital, or other health care services or supplies provided by an non-plan provider, unless approved by a plan provider and Fallon in accordance with Fallon policies and rules. Fallon will cover services or supplies rendered by non-plan providers in cases of an emergency medical condition. (See **Emergency and urgent care.**)
6. Alternative therapies such as acupuncture, biofeedback and biofeedback devices for home use, neurofeedback, aquatic (when not provided by a Select Care provider as apart of your covered physical therapy benefit), art, herbal, massage (when not provided by a Select Care physician or physical therapist as part of your covered physical therapy benefit), music or telephone therapy
7. Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment or vocational counseling and training, or educational therapy for learning disabilities
8. 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.)
9. Any services furnished by any provider not having a license or approval, under applicable state law, to furnish that type of service
10. Any services provided by the Veterans Administration for service-connected disabilities to which members are legally entitled and for which facilities are reasonably available
11. 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
12. Arch supports, foot orthotic devices, and corrective shoes, except as required by law
13. Auditory integration therapy, such as Berard auditory integration therapy
14. 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.
15. Charges after the date on which your membership ends
16. 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
17. 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.
18. Cosmetic or beautifying surgeries, procedures, drugs, services, or appliances

19. Dental treatments and appliances for the treatment of temporomandibular joint (TMJ) disorder or other conditions. Dental treatment of TMJ is defined as conservative, nonsurgical intervention. This may include, but is not limited to: therapeutic splints, oral appliances and corrective dental treatments (for example, crowns, bridges, braces and/or prosthetic appliances).
20. Dermatoscopy for detection of melanoma
21. Diagnostic tests analyzed in functional medicine laboratories including but not limited to:
    - Genova Diagnostics
    - Commonwealth Laboratories
    - Dunwoody Laboratories
    - Diagnos-Techs Inc
    - Red Path Integrated Pathology
22. Dietary supplements, specialized infant formulas (such as Nutramigen, Elecare and Neocate); vitamins and/or minerals taken orally to replace intolerable foods, supplement a deficient diet, or provide alternative nutrition for conditions such as hypoglycemia, allergies, obesity and gastrointestinal disorders. These products are not covered even if they are required to maintain weight or strength.
23. Early intervention services for patients over age 3
24. Educational services or testing, except services covered under the benefit for early intervention services described in **Rehabilitation services**
25. Elective long-term psychotherapy
26. Elective treatment or surgery not required by your medical condition, according to the judgment of the plan
27. Exams or treatment required by a third party unless medically necessary as determined by a plan physician and the plan. Examples are employment or school physicals, premarital medical tests, court-ordered treatment or immunizations required due to your job or work conditions.
28. 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**.)
29. Extracorporeal Shock Wave Therapy (ESWT) for chronic plantar fasciitis
30. Eyeglasses
31. Fittings for contact lenses
32. Holistic treatments
33. 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
34. Laser vision correction surgery
35. Long-term rehabilitation services
36. Mediation or intervention services

37. Medical care that Fallon determines is experimental, investigational, or not generally accepted in the medical community, including cancer clinics. 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.
38. Medical expenses incurred in any government hospital or facility or for services of a government doctor or other government health professional
39. Non-emergency care provided in an emergency room
40. Nutritional supplements or formulas for adults or children, unless they are described in this *Member Handbook/Evidence of Coverage* as covered
41. Orthodontics
42. Oxygen and related equipment, when received from a non-plan provider. This includes oxygen and related equipment that you are supplied with while you are out of the Select Care service area.
43. Procedures or services related to dental care.
44. Provider charges for shipping or copying medical records, or for failing to keep an appointment
45. Psychological testing or neuropsychological assessments unless determined to be medically necessary
46. Removal of nonimpacted wisdom teeth
47. Replacement of lost or stolen Weight Watchers® coupons
48. Rest care or long-term care
49. Routine foot care. This includes, but is not limited to:
    - Cutting or removal of corns, calluses and plantar keratoses
    - Trimming, cutting and clipping of nails
    - Treatment of weak, strained, flat, unstable or unbalanced feet
    - 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)
    - Any service performed in the absence of localized illness, injury or symptoms involving the foot
50. Routine maternity care when you are traveling outside the plan service area. This includes prenatal, delivery and admission, and postpartum care.
51. Sclerotherapy, joint and ligamentous injections (prolotherapy) for non-symptomatic varicose veins
52. Sensory integration therapy
53. Services and supplies received for reasons of preference or convenience, including services provided by a non-plan provider due to personal preference
54. 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.

55. Services authorized to be provided under MGL Chapter 71B in Massachusetts (referred to as "Chapter 766"). These services include, for example:
    - Adaptive physical education
    - Physical and occupational therapy
    - Psychological counseling
    - Speech and language therapy
    - Transportation

    Members who believe that their child may be handicapped (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.
56. 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
57. Services for an organ donor if the recipient is not a member of the plan
58. Services for cosmetic reasons
59. 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.
60. Services for the organ donor that are covered by another insurer
61. Services furnished to someone other than the member
62. Services in a residential halfway house
63. Services or supplies associated with care for military service connected disabilities for which you are legally entitled to services and for which facilities are reasonably available, or care for conditions that state and local law require be treated at a public facility
64. 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
65. Services or supplies that are not described as covered in this *Member Handbook/Evidence of Coverage*
66. 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, routine circumcision performed after an infant's discharge from a maternity admission, 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.
67. Services or supplies that are not provided by or authorized by a plan provider or the plan, except in the emergency situations described in **Emergency and urgent care**
68. 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
69. Services received after the date that coverage ends

70. 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.
71. Services that are considered experimental or which have not been approved by a plan medical director
72. Services that are covered by another insurer
73. Services that have not been authorized by the plan, including non-emergency services received out of the Select Care service area, or services beyond the plan benefit limits
74. Services to reverse a voluntary sterilization
75. Special duty or private duty nursing and attendant services
76. Specialty clothing appropriate to specific medical conditions
77. Supplies that may be purchased without a physician's written order
78. Tinnitus masker
79. Total body photography
80. 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
81. Treatment by telephone
82. Transportation between hospitals when your medical condition does not warrant that you be transported to another facility
83. Treatment for personal growth, or other treatment that is not medically necessary, or not in keeping with national standards of practice
84. Unauthorized in-area urgent care visits
85. Vision therapy or services (also referred to as orthoptics)
86. Vitamins and minerals, whether or not a prescription is required, are excluded from coverage, unless listed in the Fallon drug formulary.
87. Vocational rehabilitation, including job retraining, or vocational and driving evaluations focused on job adaptability, or therapy to restore function for a specific occupation
88. Any service or supply related to a non-covered service or condition
89. White noise machines
90. Auditory integration therapy, such as Berard auditory integration therapy
91. Total body photography
92. Home video EEG monitoring
93. Services provided by a lactation consultant
94. Any clinical research trial other than a qualified clinical trial for the treatment of cancer
95. Interspinous process decompression (or the X-Stop interspinous process decompression device)

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 pierced ear hole
- Electrolysis for hirsutism
- Excision of excessive skin on thigh, leg, hip, buttock, arm, forearm or hand, submental fat pad, or other areas, unless there is documentation of a permanent weight loss of 50 or more pounds, and documentation of recurrent skin rashes or other functional impairment that does not respond to more conservative treatment
- Excision or repair of keloid
- Grafts, fat
- Otoplasty
- Reduction of labia minora
- Removal of spider angiomata
- Rhytidectomy (face lift)
- Salabrasion
- Scar revision
- Suction-assisted lipectomy

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

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16-672-002 Rev. 00 6/16