The Group Insurance Commission
Group Welfare Benefit Plan

Using the *Fallon Health Direct Care* network

Member Handbook

Administered by
Fallon Health & Life Assurance Company, Inc.

Welcome!

The Group Insurance Commission (GIC) has arranged to provide you with a comprehensive health care plan. The Group Insurance Commission Group Welfare Benefit plan (the plan) is designed to manage quality of care and control health care costs by taking advantage of strong provider contracts and the most current managed care practices.

This *Member Handbook* describes the services covered under this plan including any limitations and exclusions that may affect your rights to covered services, your copayments and claims procedures. Please read this *Member Handbook* carefully and keep it for future reference.

GIC has delegated authority to Fallon Health & Life Assurance Company, Inc. (FHLAC) to administer the plan. FHLAC is a fully-owned subsidiary of Fallon Health. Throughout this document, references to “Fallon,” “Fallon Health,” or “FHLAC” may refer to services provided by either entity.

If you have any questions about your coverage under this plan, please call Customer Service. Representatives are available Monday, Tuesday, Thursday, and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m., at 1-866-344-4GIC (4442) (TRS 711).

✓ 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, 2021 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, 2021. 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 a 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.

Important!

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

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

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

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

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

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

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

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

Khmer/Cambodian:
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងដែជួយ ម្នាសំណួរអ្ពីFallon Health ២, អ្នកម្នាសិ្ធិ្ទ្ធួលជំនួយនិងព័ត៌ម្ន ២ៅ្ន ២ៅ្ន ២ៅ

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

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

Korean:
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Fallon Health에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-800-868-5200로 전화하십시오.

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

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

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

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

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

Notice of nondiscrimination

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

Fallon Health:

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

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

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

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

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

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

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

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

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

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

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Glossary

Adverse determination: A determination by FHLAC or our 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, or level of care or effectiveness.

Allowed charge: The amount that is used to calculate payment of your covered benefits, based on the fee schedule negotiated with that Direct Care network provider.

Anniversary date: July 1 of 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.

Annual 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 July 1. (Also referred to as open enrollment.)

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.

COBRA: The Consolidated Omnibus Reconciliation Act of 1985. Provides for continuation of benefits under certain circumstances when benefits are lost.

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 C ommission, the agency of the Commonwealth of Massachusetts that sponsors your group health plan. Also referred to as “plan sponsor.”

Contract: The agreement that FHLAC 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 Schedule of Benefits. Please note that most of your copayments are determined by plan physician’s 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*.

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 per benefit period before payment is made by the plan for certain covered services under this plan.

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

Direct Care network: A group of plan providers who have contracted with us, either directly or through our agent, to provide services to members covered by this contract.

Direct Care network service area: The geographical area served by Fallon Direct Care. The cities and towns in the service area are included in this *Member Handbook*.

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 GIC, on which your coverage begins.

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

Emergency services: Inpatient and outpatient services, whether inside or outside the Fallon 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 Health'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 Health's Technology Assessment Committee considers experimental or investigational.

If the committee determines that a technology is experimental or investigational, the plan 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: Fallon Health, the parent company of FHLAC.

FHLAC: Fallon Health & Life Assurance Company, Inc. FHLAC is a fully-owned subsidiary of Fallon Health.

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

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

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 member 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.

Medicare: Benefits under Title XVIII of the Social Security Act of 1965, as amended from time to time.

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

Nurse practitioner: A registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under M.G.L. C112, § 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 July 1. (Also referred to as annual enrollment.)

Out-of-pocket maximum: The total amount of deductible, coinsurance and copayments you are responsible for in a benefit period. The out-of-pocket maximum does not include your premium charge or any amounts you pay for services that are not covered by the plan.

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

Peace of Mind Program™: A medical management program, which provides access to certain specialty care services at specified Boston medical centers, in a specific set of circumstances described in this *Member Handbook*.

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

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

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

Plan: The Group Insurance Commission Group Welfare Benefit Plan (also referred to as, “the plan,” “us,” “we,” and “our”). These terms may also refer to FHLAC or its parent company Fallon Health, when acting on behalf of the plan.

Plan Administrator: The person or persons who have the authority to control and manage operation and administration of the plan.

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

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

Plan provider: A licensed physician, plan facility or other health care professional in the Direct Care network, with whom Fallon contracts 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 Direct Care network, with whom we contract 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 physician may not have specialized training.

Plan sponsor: The Group Insurance Commission

Plan year: The 12 month period beginning July 1, 2021 and ending on June 30, 2022.

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; nutrition counseling; and health education. For more information about the services that are part of a health maintenance visit, please see the preventive care guidelines at fallonhealth.org/gic or call Customer Service for a copy.

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

Prior authorization: An assurance by the plan to pay for medically necessary covered benefits provided by a plan physician for an eligible plan member.

Provider: A doctor, hospital, health care professional or 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 or provider 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 prior authorization process.

Reliant Medical Group PCP: A primary care provider (PCP) who is employed by the Reliant Medical Group and who practices within the Reliant Medical Group practice.

Reliant Medical Group specialist: A specialist, including physicians, physician assistants, nurse midwives, and nurse practitioners, who are 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 prior authorization from the plan. See **Obtaining specialty care and services** for information on the services for which you may 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.

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 Fallon 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 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*

This *Member Handbook* is effective July 1, 2021. There are no pre-existing condition limitations under this contract. You may use the services described here beginning on July 1, 2021, or on your effective date, whichever comes later.

This *Member Handbook* details the benefits and services that the plan covers, explains our policies and procedures, and contains other information such as:

- Definitions of important terms
- Important points to remember
- Our customer service capabilities
- The Direct Care service area
- The role of your primary care provider (PCP)
- Referral and prior authorization procedures
- Your rights and responsibilities
- Types of coverage available
- Claims procedures
- Additional contract provisions
- Covered services
- Exclusions

Your Schedule of Benefits lists your costs for covered services. If your group has arranged for additional or different benefits, you can find that information in the Schedule of Benefits as well.

The information contained in a Schedule of Benefits replaces any information in this *Member Handbook* that conflicts with it. If we need to update or change your handbook, we will send to you, or your group representative, an amendment. Please also be advised that this *Member Handbook* and any amendments to it are available at fallonhealth.org.

It is important to keep this booklet and your Schedule of Benefits, along with any amendments, in a place for easy reference. If you have any questions regarding this *Member Handbook*, please call Fallon Customer Service at 1-866-344-4GIC (4442) (TRS 711).

Understanding your health care coverage

This health plan is a health maintenance organization (HMO) plan that provides health care coverage for its members through a network of health care professionals and hospitals. GIC has delegated authority to Fallon Health & Life Assurance Company, Inc. (FHLAC) to help manage the plan. FHLAC is a fully-owned subsidiary of Fallon Health. Our administrative offices are located at Chestnut Place, 10 Chestnut St., Worcester, MA 01608.

This health plan 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 you receive quality care and services.

Important points to remember:

- The Direct Care provider network includes providers in Bristol, Essex, 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
Fallon is committed to giving our members access to a network of high-quality, cost efficient plan doctors and hospitals. Fallon Direct Care plan tiers the following specialists: Allergy/Immunologists, Cardiologists, Dermatologists, Endocrinologists, ENTs/Otolaryngologists, Gastroenterologists, General Surgeons, Hematologists/Oncologists, Nephrologists, Neurologists, Ob/Gyns, Ophthalmologists, Orthopedists, Podiatrists, Pulmonologists, Rheumatologists and Urologists.

Providers are grouped into three tiers:

Tier 1: Plan specialists who meet excellent quality and/or cost efficiency standards. You will pay the lowest copayment when you see a Tier 1 specialist.

Tier 2: Plan specialists who meet good quality and/or cost efficiency standards. You will pay the mid-level copayment when you see a Tier 2 specialist.

Tier 3: Plan specialists contracted through an Academic Medical Center or specialty hospital, exclusively participating in the Peace of Mind program or provide tertiary services. You will pay a higher copayment when you see a Tier 3 specialist.

NT: This designation includes providers that belong to a specialty or subspecialty that is not being tiered by Fallon. These providers are subject to a Tier 2 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.

Your membership card

When you enrolled in this health plan, you were 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.

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, or if you lose or damage your card, contact Customer Service to request a new card.

Notifying us of changes

Contact the GIC to report any changes in your name, address, phone number, primary care providers, number and status of dependents or any other pertinent information. If there is a change to your family status that would require a change to your contract type (for example, you have an individual contract, but you marry or have children), you should notify the GIC within 30 days of the qualifying event, and they will notify FHLAC.

Whenever you change to a new primary care provider, FHLAC recommends that you have your medical records transferred to your new provider. Please note that any costs associated with having your records copied are not covered

Questions? Just ask.

FHLAC is committed to your satisfaction and helping you get the most from your membership in this health plan. FHLAC offers many resources to help you, including a dedicated Customer Service and Member Relations staff. If you have questions, call:

Customer Service
1-866-344-4GIC (4442) (TRS 711)
fallonhealth.org/gic

For answers to general questions or inquiries

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

To change your primary care provider

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

For assistance in finding a provider

- If you need assistance finding a network provider, please call Customer Service at 1-800-868-5200; select menu option 6. For assistance finding a behavioral health provider, call 1-888-421-8861.

With questions about your membership card

- If you do not receive a card
- If the information on your card is not correct

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.
- All subscribers may go to mass.gov/myGICLink to request necessary forms to make changes.

To order materials

- A provider directory, which has a list of plan providers in the network
- Additional copies of this *Member Handbook* and any applicable amendments

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 benefits and features. It's also a convenient and secure way to communicate with us. You can use the site to:

- **Get online access to your claims, benefits and more-at any time of day or night**
  Log into MyFallon, our secure member portal, to see your copayments, track deductibles and out-of-pocket-maximums, change your PCP, check authorizations and more. Visit fallonhealth.org/myfallon to register and log in.
- Search for a doctor in the provider directory
- Use our online health encyclopedia and reference guide for answers to your health questions
- Contact Customer Service

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

Choosing a primary care provider (PCP)

When you join this health plan, you select 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. The 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
- Nurse practitioner
- Physician assistant

The *Direct Care Provider Network* directory contains names of plan providers, their address and admitting hospital(s), who are available as PCPs. 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 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 also can 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.

This health plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the plan network and who is available to accept you or your family members. Until you make this designation, FHLAC 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 Customer Service at 1-866-344-4GIC (4442) or visit 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 FHLAC 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 the plan 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 Customer Service at 1-866-344-4GIC (4442) or visit 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 Direct Care. This means that you must use the health care professionals and facilities in the Fallon Direct 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 specialty physician. You will pay the mid-level copayment when you see a Tier 2 specialty physician. You will pay a higher copayment when you see a Tier 3 specialty physician.

Note: Specialty physician tiering levels will be re-evaluated on a plan year basis. You should always check the appropriate fiscal year provider directory for the tiering level of your specialist. 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 GIC member portal at fallonhealth.org/gic for the most up-to-date provider tier assignment.

Self-referral

In certain instances you can "self-refer" to a plan 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 plan provider.

Services you can self-refer for include:

- Office visits with a plan obstetrician, gynecologist, certified nurse midwife or family practitioner, including annual preventive gynecological health 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. This 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 plan oral surgeon for the extraction of impacted teeth. (Visits to an oral surgeon for any other procedure require prior authorization from the plan.)
- Routine eye exams with a plan ophthalmologist or optometrist
- Outpatient mental health and substance use services with plan providers. For assistance in finding a plan 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 Direct 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 Direct Care network. When selecting a specialist for you, your PCP will consider your clinical needs and any active and long-standing relationships with a Direct Care network provider.

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

- Office visits with a Direct 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 Direct 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 plan 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 plan chiropractor. Your coverage for these services may have a benefit limit. If it does, the Schedule of Benefits for your plan option describes the benefit limit that applies for these services.
- Physical and occupational therapy. Your PCP will give you a written order to take to a plan physical or occupational therapist. 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 prior authorization before you receive services. Prior authorization is an assurance by the plan to pay for medically necessary covered services provided by a plan provider to an eligible plan member.

When a service requires prior authorization, your PCP or specialist will send a request for services to FHLAC. 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 prior authorization from the plan include, but are not limited to:

- Non-emergent 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
- Prosthetics/orthotics and durable medical equipment
- Non-emergency ambulance
- High tech radiology, including, but not limited to, all outpatient MRI/MRA, CT/CTA, PET and nuclear cardiology imaging studies
- Sleep study and/or sleep therapy
- Oxygen
- Habilitative or rehabilitative care, including but not limited to ABA therapy for the treatment of autism
- Therapeutic care for the treatment of autism
- Certain drugs covered under medical benefits, and that are ordered, supplied and administered by a plan provider
- Intensity modulated radiation therapy (IMRT) of the breast
- Proton beam therapy
- Stereotactic radiosurgery and stereotactic body radiotherapy
- Enteral formulas and special medical formulas
- Treatment of cleft lip and cleft palate
- Bariatric weight loss surgery
- Gender-affirmation surgery and related health care services
- Home health care
- Electroconvulsive Therapy (ECT)
- Intermediate services for mental health and substance use treatment
- Psychological and neuropsychological testing

- Transcranial Magnetic Stimulation (TMS)

Please note: prior authorization will not be required for inpatient behavioral health admissions after treatment in an emergency department.

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

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* 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.

Peace of Mind Program™

Fallon's Peace of Mind Program provides access to specialty services at specified Boston area medical centers. You may access Peace of Mind Program providers at your request if you meet the following conditions:

- The specialty service is ordinarily available in the Direct Care network
- Care is for covered services as described in this *Member Handbook*. Tier 3 copayments apply to the respective services accessed through the Peace of Mind program. You have seen a plan specialist for this same condition within the past three months.
- A referral to a specific Peace of Mind Program provider is made by your PCP and notification of the referral is given to us.
- The provider to whom you are referred is on staff at one of the five medical centers listed below:
  - — Beth Israel Deaconess Hospital
  - — Brigham and Women's Hospital
  - — Children's Hospital (Boston)
  - — Dana-Farber Cancer Institute
  - — Massachusetts General Hospital
- If you receive any hospital-based services such as surgery, lab or X-rays, these services must be performed at one of the above hospitals or at another plan facility. If you see a specialist through the Peace of Mind Program, and the specialist recommends or arranges services to be performed at a hospital that is not listed above, these services will not be covered unless the physician has obtained prior authorization from the plan. You must have a copy of the written authorization from the plan; do not rely on assurances by the physician regarding plan coverage.
- As long as you have met the eligibility requirements, you have the right to access your Peace of Mind Program benefit. If you are having difficulty receiving a referral from your PCP, please contact Care Services at 1-800-333-2535, ext. 69138.

Please note: Tufts Medical Center is also now part of the standard Direct Care network. You may change your designated PCP to a Tufts PCP or to a PCP that refers to Tufts Medical Center at any time. (See **Choosing a primary care provider** for details.)

Once we have been notified of the Peace of Mind Program referral to a Peace of Mind specialist, you may see this specialist for a period of one year or until treatment for the presenting condition is complete, whichever comes first. When your course of treatment is complete, or for care for any non-related condition, you should return to your PCP for care.

If your Peace of Mind Program specialist wants you to see another specialist at the same facility for the same condition, your PCP must submit a separate referral before you see the other specialist.

If you want to see a Peace of Mind Program specialist for a different condition, the request must meet the Peace of Mind Program requirements described above for the second condition, your PCP must submit a referral and you must receive prior authorization in order for the services related to the second condition to be covered.

Please note: For the period of time that you are authorized treatment with the Peace of Mind Program provider for a particular condition, the Peace of Mind Program provider may order X-rays, laboratory tests and other tests to evaluate that condition without prior authorization if these services would normally be covered and would require no prior authorization when ordered by a plan provider. All inpatient care or inpatient, outpatient, or office-based surgery requires prior authorization from the plan. For a list of services requiring prior authorization, see **Obtaining specialty care and services**. Note that all high-tech radiology services and genetic testing require prior authorization.

If you need physical therapy or occupational therapy for the same condition for which your Peace of Mind Program specialist is treating you, your Peace of Mind Program specialist may refer you for such physical therapy or occupational therapy up to the benefit maximum without prior authorization at the Peace of Mind Program facility, or you may return to a plan therapist if you want.

You may use the Peace of Mind Program for all specialty care except mental health, substance use, chiropractic services, obstetrics, speech therapy and infertility services. You may not use the Peace of Mind Program for any primary care services, including internal medicine, family practice or pediatrics. If you have not met the conditions listed above, or if you or your physician have not obtained prior authorization for a Peace of Mind Program service, the services will not be covered by the plan and the Peace of Mind Program provider may hold you financially responsible.

Medical management

Utilization management

The objectives of Fallon's 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 programs are staffed by health educators, licensed registered nurse case managers, and physician reviewers 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.

FHLAC 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 1-866-344-4GIC (4442), ext. 69138 (TRS 711).

Fallon 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.

Infusions of certain drugs

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

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 re-credentialing 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 reviews 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. The committee makes use of external research organizations, which perform reviews of available literature regarding a given procedure. When necessary, the committee seeks input from specialists or professionals who have expertise in the proposed technology.

The committee makes recommendations for health plan coverage and develops written coverage 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 annually 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 Direct 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 Direct 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 the network status of an identified health care provider, an estimate for a proposed admission, procedure or service and the estimated amount you will be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit. Estimates will be based on the information available to us at the time you make your request. All costs are estimated, and the actual amount you pay may vary due to unforeseen services that arise out of the proposed admission, procedure or service.

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 556, Randolph, MA 02368. 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 at 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, you are encouraged 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 Member Appeals and Grievances Department.

An adverse determination means a determination by FHLAC or its medical management agent, based upon a review of information, that denies, reduces, modifies, or terminates coverage for health care services because the treatment does not meet the requirements for coverage based on medical necessity, for reasons of 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: 1-866-344-4GIC (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: cs@fallonhealth.org/gic

Write: Fallon Health & Life Assurance Company, Inc.
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, more research may be needed before your request can be completed. In these cases, Customer Service 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 FHLAC.

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

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

- The member’s name
- The FHLAC 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 & Life Assurance Company, Inc.
Member Appeals and Grievances Department
10 Chestnut St.
Worcester, MA 01608

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

E-mail: grievance@fallonhealth.org/gic

Fax: 1-508-755-7393

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

If you 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 FHLAC 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 FHLAC 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. These time limits may be waived or extended if you and FHLAC 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 of allegations of fact or law, in support of your appeal. This may be done in person or in writing. Any new information received during the course of the appeal may be sent to you for review. At any point before or during the appeal process, at no cost to you, 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, we 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, we 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 prior decisions on the issue. The reviewer may consult with a health care professional who is actively practicing in the same or similar specialty that is the subject of your appeal.

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

Our response will describe the specific information we considered as well as an explanation for the decision. If the appeal is about an adverse determination, the written response will include the clinical justification for the decision, consistent with generally accepted principles of professional medical practice; the information on which the decision was based; pertinent information on your condition; alternative covered 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, we would agree in writing to a new time period for review. This would not be longer than 30 days from the date FHLAC agrees to the reconsideration.

Expedited review

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

1. *Inpatient admission:* During your inpatient admission and prior to discharge, a written decision will be provided to you. If the expedited review results in a denial of coverage regarding the continuation of inpatient care, you will have the opportunity to request an expedited external review and the opportunity to request continuation of services through the external review process.
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. If your review involves the termination of ongoing services, you will be notified about the opportunity to request continuation of services.

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

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

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

Expedited review for terminally ill members

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

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

Filing an appeal: external appeal review

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

If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage or treatment. You must file this request by the end of the second business day after receiving the final adverse determination. If the external review agency finds that termination of the 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 have failed 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.

Filing a grievance

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

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

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

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

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

E-mail: grievance@fallonhealth.org/gic

Fax: 1-508-755-7393

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

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

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 FHLAC and are not in our HMO network.

Massachusetts General Laws, Chapter 32A, Section 20: Under Massachusetts state law, a non-plan provider who treats a GIC member cannot charge you any amount in excess of your plan's allowed amount. If you receive treatment from a non-plan provider who is located in Massachusetts, the only amounts you should be charged by the provider are the cost-sharing amounts (copayment, deductibles or coinsurance) you are responsible for under your plan benefits.

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 a non-plan provider located outside of Massachusetts bills you for more than the amount the plan 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 the plan decides it will pay for these services, the plan reserves the right to pay the usual, reasonable and customary charges (less any cost sharing). If a non-plan provider located outside of Massachusetts bills you for more than the amount the plan paid, you are responsible for paying the provider the balance. The plan also reserves the right to pay you directly for these charges. If the plan pays you directly, you will be responsible for submitting payment to the non-plan providers.

Claims from non-plan providers must be submitted 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 claims to:

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

Care in foreign countries

You may submit claims for urgent care or emergency services rendered 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. If claim reimbursement is requested, proof of payment is required. Payment will be made to you, and you must pay the provider.

Recovering money owed

The plan has 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. The plan 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 & Life Assurance Company, Inc.
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, dental or other health care expenses. We will coordinate payment of covered services with other plans under which you are covered. Other plans include personal injury protection insurance, automobile insurance, homeowner's insurance, school insurance and other plans that pay medical expenses. To the extent permitted by law, benefits available under an auto, homeowners or commercial policy shall be primary to this Plan. Medical Payments Coverage under a motor vehicle insurance policy shall always be secondary to and in excess of any Health Benefit Plan or Personal Injury Protection.

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, the plan has the right to reimburse the other plan to the extent necessary to satisfy the intent of COB. If the plan pays benefits in good faith to another plan, we will not have to pay such benefits again. The plan also has the right to recover any overpayment made because of coverage under another plan.

The plan will not duplicate payment for any service. The plan will not make payment for more than the full benefit available under this contract. If the plan provides or arranges services when another carrier is primary, we have the right to recover any overpayment we have made from the primary carrier or other appropriate party. If the plan does 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.

Definition of plan

For the purposes of COB, the term **plan** is defined as any plan that provides medical or dental care coverage. Examples include, but are not limited to, group or blanket coverage; group practice or other group prepayment coverage, including hospital or medical services coverage; labor-management trusteed plans; union welfare plans; employer organization plans; employee benefit organization plans; automobile no-fault coverage; and coverage under a governmental plan, or coverage required or provided by law, including any legally required, no-fault motor vehicle liability insurance. (This does not include a state plan under Medicaid or any plan when, by law, its benefits are in excess of those of any private insurance program or other non-governmental program.)

The term **plan** does not include school-accident type plans or coverage that you purchased on a non-group basis.

Subrogation and reimbursement

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

In addition to our subrogation rights, we have the right to be reimbursed from you or any entity or person that caused your injury or illness and any insurance carrier, including your insurance carrier to the extent permitted by law. If you receive any payment from any party or insurance coverage as a result of an injury, illness or condition, the plan has 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. If you receive any payment from any party or insurance coverage as a result of an injury, illness or condition, FHLAC has 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, the plan 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, the plan may request information from you before processing claims. If the plan does 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.

How your coverage works

Eligibility

You are eligible to enroll in the plan as a subscriber as long as you live in the Fallon Health Direct 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 "annual enrollment" period prior to the anniversary date. Any changes that you make become effective on July 1. If you have any questions about your group's annual enrollment period, please contact the GIC.

You must enroll within 10 days of your date of hire. 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 apply to the GIC to enroll in this plan during annual enrollment or within 60 days of a qualifying event, such as involuntary loss of coverage, marriage, birth or adoption.

Free or low-cost health coverage for children and families

If you are eligible for health coverage from your employer but are unable to afford the premiums, your state may have a premium assistance program to help pay for coverage.

Application for coverage

You must apply to the GIC for enrollment in the Plan. To obtain the appropriate forms, active employees should contact their GIC Coordinator, and retirees should contact the GIC. Subscribers may also obtain the appropriate forms on mass.gov/myGICLink.

You must enroll dependents when they become eligible. Newborns (including grandchildren, if they are eligible dependents of your covered dependents) must be enrolled within 60 days of birth, and adopted children within 60 days of placement in the home. Spouses must be enrolled within 60 days of the marriage.

You must complete an enrollment form to enroll or add dependents. Additional documentation may be required, as follows:

- **Newborns:** copy of hospital announcement letter or the child's certified birth certificate
- **Adopted children:** photocopy of proof of placement letter, court decree of adoption, or amended birth certificate
- **Foster children ages 19-26:** photocopy of proof of placement letter or court order
- **Spouses:** copy of certified marriage certificate

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 limits
- Dependent children who are mentally or physically incapable of earning a living.
- A former spouse, as long as the divorce decree allows for it, and the subscriber has not remarried and added a new spouse to the family contract.

Dependent children include your or your spouse's children by birth or adoption and children who are under your or your spouse's legal guardianship. 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 GIC's eligibility rules. (See **Age limits for dependent children**.)

Adding dependents

The subscriber may always change to family coverage, or add additional dependents to family coverage, during annual enrollment. Changes made during the open enrollment period will be effective on July 1.

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

- The subscriber marries. The subscriber may change to family coverage, or add any additional dependents to family coverage at this time. 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. (See **Changing your coverage**.)
- 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 provided family premiums have been paid. (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 any additional dependents to family coverage at this time. (See **Changing your coverage**.)
- The subscriber is ordered by a court to provide coverage for a spouse, former spouse, or child(ren). See **Divorce** for more information about coverage of former spouses.

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.

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 complete the application and provide supporting documentation to the GIC within 60 days of the event. If the GIC does not receive the request to change within the 60-day period, you may not make a change until the next annual enrollment period.

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're 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 programs. If you or your children aren't eligible for Medicaid or CHIP, you won't 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 aren't 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 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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268

ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext. 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_co nt.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid and CHIP (Hawki)	**NEBRASKA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	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

MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and- services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	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, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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. 6156

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)
)

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 children 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. In order for a dependent to apply for handicapped dependent coverage, he or she must meet one of the following conditions:

- Became mentally or physically incapable of earning his/her own living prior to age 19.
- Became permanently and totally disabled and became so on or after age 19 and is under age 26.

These dependents will only be covered until the last day of the month they turn 26.

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.

Please contact the GIC if you have questions about survivor coverage.

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 **Options for continuing coverage** 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 **https://webapps.dol.gov/elaws/vets/userra/**. 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.

FHLAC contract arrangements

The Plan Administrator has the sole discretionary authority to determine eligibility for benefits and to construe the terms of this plan. The Group Insurance Commission Group Welfare Benefit Plan is responsible for paying the costs of all covered services and charges incurred for services and benefits described in this document. FHLAC is not responsible for any services or charges that are not paid for by the plan.

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.

Notices

When FHLAC sends you a notice, it will be mailed to your most recent address on file. If your name and/or mailing address changes, notify FHLAC and the Plan Administrator. Be sure to provide your old name and address as well as the new information.

FHLAC Contracting arrangements

FHLAC contracts with individual physicians, medical groups, hospitals and ancillary providers to provide care to members. FHLAC 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, coinsurance or deductible amounts shown in this *Member Handbook*, or in any applicable schedules of benefits or addenda.

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

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

If the provider whose contract FHLAC is 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 choose 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.

The plan 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 at 1-866-344-4GIC (4442) (TRS 711) for assistance in choosing a new provider or to request a provider directory. You also can get provider information and choose a new PCP on fallonhealth.org/gic.

Continuation of services with a non-plan provider

Once you become a plan member, the plan will generally only pay for services that you receive from plan providers. However, there are some circumstances in which the plan 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 primary care physician is not a participating provider in any health insurance plan that your plan sponsor offers, the plan 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, the plan 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, the plan 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, the plan 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.

The plan will also pay for services that you receive from a non-plan provider if you meet the criteria below:

1. You are receiving an active course of treatment for a serious disease, and disrupting this treatment would pose an undue hardship.
2. You began this active course of treatment prior to the date you enrolled in a limited or tiered network plan.
3. Your provider is a comprehensive cancer center, pediatric hospital or pediatric specialty unit, as defined by Massachusetts state law. See below for a list of qualifying facilities.
4. The only plans offered to you by your employer are limited or tiered network plans in which your provider is not a plan provider.
5. Your course of treatment is not available from any plan provider.

An active course of treatment is treatment following an inpatient stay or outpatient procedure for your recovery or rehabilitation. Or, it is the continuing care for a serious disease that requires diagnostic tests or the adjustment of medications or treatments at least every six months. Active treatment does not include preventive services or services to monitor your condition after you complete treatment for a serious disease. It also does not include clinical trials, experimental treatments, off-label use for products or products not approved by the Food and Drug Administration in circumstances where these services would not otherwise be covered. A serious disease is one that is life threatening or could lead to a serious or permanent disability if left untreated. Active treatment must be taking place in a comprehensive cancer center, pediatric hospital or pediatric specialty unity listed below.

Comprehensive Cancer Center
Dana Farber Cancer Institute

Pediatric Hospital
Children's Hospital Boston
Shriners Hospitals for Children, Boston and Springfield

Pediatric Specialty Unit
Floating Hospital for Children at Tufts Medical Center
Nashoba Valley Medical Center
Massachusetts Eye and Ear Infirmary

To continue your active course of treatment at a hospital listed above, you must get prior authorization before medical services are received. To request prior authorization, please call 1-866-344-4GIC (4442) (TRS 711) and press the "New Member" prompt, Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m. If you do not request prior authorization before the medical services are received, you may be responsible for the full cost of the services. With prior authorization, services will be covered at the same cost-sharing levels that would apply to a comparable network provider.

If you are a new member and need information on continuing care at other facilities, please call 1-866-344-4GIC (4442) (TRS 711) and press the "New Member" prompt, Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

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 agents of FHLAC or of the Group Insurance Commission Group Welfare Benefit Plan. 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. FHLAC 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 FHLAC, a physician 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*, or that did not receive any necessary prior authorization from the plan, or that are not determined to be medically necessary, are not covered benefits.

Circumstances beyond our control

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

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

Leaving the plan

Ineligibility for you or a dependent

A subscriber's 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 Direct Care service area

A dependent's membership may end because of

- Loss of the subscriber's eligibility
- Age – last day of the month in which he or she attains age 26.
- Divorce
- No longer lives in the Direct Care service area

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 the GIC 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 **Options for continuing coverage**.)

Cancellation by the plan

You do not have to worry that the plan will cancel your contract because you are using services or because you will need more services in the future. The plan may cancel contracts only for the following reasons:

- You or a family member no longer live or work in the Direct Care service area. Notify the GIC within 60 days of the date you move. Adult children age 19-26 may reside outside of the service area but will be subject to the plan's coverage rules.
- You made some misrepresentation or you conspired with another party to defraud FHLAC and/or 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. In any case of misrepresentation, FHLAC and its affiliates may deny enrollment to you in the future.
- Your premium charge is not paid within the grace period appropriate for your 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 agent or another plan member. In such an instance, the plan 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. As allowed by state or federal law or regulation.

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

Duplicate coverage
No person can be covered (1) as both an employee, retiree or surviving spouse, and a dependent, or (2) as a dependent of more than one covered person (employee, retiree, spouse or surviving spouse).

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

Disenrollment by the subscriber

You may end your Membership with the GIC's approval subject to applicable law, including but not limited to Section 125 of the Internal Revenue Service code. To cancel your contract, you must notify your Plan Administrator. The Plan Administrator will submit a transaction request in accordance with the group agreement. If your contract is cancelled, we will not provide benefits for services, supplies or medication received after the cancellation date.

Eligibility for Medicare

If you are a subscriber 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 eligible for GIC group health benefits.
- If you become eligible for Medicare and you leave or retire from state service, you are no longer eligible for coverage under this contract. If you retire from state service, you may be eligible to enroll in a GIC Medicare Plan. Please contact the GIC for information about GIC Medicare Plans or contact Fallon Customer Service.
- If you are eligible for GIC group health benefits but not eligible for Medicare upon reaching age 65, you may continue to be covered under this plan.
- If you leave state service, you may be eligible for enrollment in Fallon Senior Plan™, our Medicare Advantage product, either through your employer 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 Fallon Customer Service for more information.

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 during the GIC's Annual Enrollment period. Changes made during Annual Enrollment will be effective on July 1. You may also do this within 60 days of any of the following:

- The day you move to a place outside the Direct Care service area
- 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.

Options for continuing coverage

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 continuation of health coverage. You will receive a COBRA election 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 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 556, Randolph, MA 02368 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 Qualifying Events:

If you are an employee of the Commonwealth of Massachusetts (the "Commonwealth") 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 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.

Additionally, you or other qualified beneficiaries may qualify for MassHealth (Medicaid), Medicare, or the Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

IMPORTANT INFORMATION REGARDING MEDICARE

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period[1], you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-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 556, Randolph, MA 02368.***

If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617/727-2310, ext. 1 or write to the Public Information Unit at P.O. Box 556, Randolph, MA 02368. 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 and MA Paid Family Medical Leave

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. Under the MA Paid Family Medical Leave , you may be able to take up to 26 weeks of paid 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 apply to the GIC within 60 days and resume coverage when you return to work without waiting for an annual 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.

Direct Care service area

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

The Direct Care service area includes all cities and towns in Bristol, Essex, Middlesex, Norfolk, Plymouth and Suffolk Counties; and all cities and towns in Worcester County with the exception of Athol and Royalston. The service area includes the following towns in Hampden County: Brimfield, Holland, Monson, Palmer and Wales. The service area includes the following town in Hampshire County: Ware.

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* 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 plan year quarter, and four outpatient surgery copayments per member in each plan 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 plan 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 plan 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 for both ears;
  You pay: 20% of the purchase price between $501 and $2,000 plus all additional costs.

Description of benefits

The following section contains a description of your covered services as a member of the plan, 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* 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. Your Schedule of Benefits describes your costs for the benefits that you use.

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:

1. Regular, direct individual contact by a physiatrist or physician of equivalent training and/or experience in rehabilitation who serves as their lead provider;
2. Daily rehabilitation nursing for multiple and/or complex needs;
3. 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
4. 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 services

Emergencies
In an emergency, where a prudent layperson could reasonably believe that a medical condition requires immediate care to prevent serious harm, the plan covers ambulance transportation from the place where a plan member 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 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.

Covered services

1. Ambulance transportation for an emergency
2. Ambulance transportation for nonemergency situations, when medically necessary

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

1. Ambulance, chair van and/or medivan use for patient convenience, or transportation services only, including transportation to and from medical appointments
2. Transfers between hospitals when your medical condition does not require 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 and geographical 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.

Covered 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 analyst. Services require plan authorization.
2. Therapeutic care, services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers. Therapeutic care requires plan authorization.
3. Pharmacy care, medications prescribed by a licensed physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the contract for other medical conditions.
4. Psychiatric care, direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
5. Psychological care, direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

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

The following terms shall have the following meaning:

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

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

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

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

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

1. Equine therapy
2. Aqua therapy

Clinical trials

The Plan covers patient care services provided as part of a **qualified clinical trial** studying potential treatment(s) for cancer. Patient care services include items and services provided when you are enrolled in a qualified clinical trial consistent with your diagnosis and the study protocol. Coverage is subject to all pertinent provisions of the Plan, including medical necessity review, use of participating providers, preapproval reviews, and provider payment methods.

The Plan covers patient care services provided within the trial only if it is a **qualified clinical trial**, according to state law:

1. The clinical trial is to study potential treatments for cancer.
2. The clinical trial has been peer reviewed and approved by one of the following:
   - The United States National Institutes of Health (NIH)
   - A cooperative group or center of the NIH
   - A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants
   - The United States Food and Drug Administration (FDA) pursuant to an investigational new drug exemption
   - The United States Departments of Defense or Veterans Affairs
   - With respect to Phase II, III and IV clinical trials only, a qualified institutional review board
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that experience.
4. With respect to Phase I clinical trials, the facility must be an academic medical center (or an affiliated facility) at which the clinicians conducting the trial have staff privileges.
5. The member meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.
6. The member has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.
7. The available clinical or pre-clinical data provide a reasonable expectation that the member's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.
8. The clinical trial does not unjustifiably duplicate existing studies.
9. The clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the member.

The following services for cancer treatment are covered under this benefit:

- All services that are medically necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan.
- The allowed cost, as determined by the Plan, of an investigational drug or device that has been approved for use in the clinical trial studying potential treatments for cancer to the extent it is not paid for by its manufacturer, distributor or provider, regardless of whether the FDA has approved the drug or device for use in treating your particular condition.

Related exclusions

1. There is no coverage for any clinical research trial other than a qualified clinical trial studying potential treatments for cancer.
2. Patient care services do not include any of the following:
   - An investigational drug or device, except as noted above
   - Non-health care services that you may be required to receive as a result of participation in the clinical trial
   - Costs associated with managing the research of the clinical trial
   - Costs that would not be covered for non-investigational treatments
   - Any item, service, or cost that is reimbursed or furnished by the sponsor of the clinical trial
   - The costs of services that are inconsistent with widely accepted and established national or regional standards of care
   - The costs of services that are provided primarily to meet the needs of the trial including, but not limited to, covered tests, measurements, and other services that are being provided at a greater frequency, intensity, or duration.
   - Services or costs that are not covered under the Plan

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 and leg braces with rigid supports, including orthopedic shoes that are part of braces
- Splints
- Medically necessary habilitative devices

Covered services

- The purchase or rental of durable medical equipment and prosthetic/orthotic devices (including the fitting, preparing, repairing and modifying of the appliance).
- Scalp hair prosthesis (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.
- Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy.
- Oxygen and related equipment
- Prosthetic limbs which replace, in whole or in part, an arm or leg.
- Insulin pump and insulin pump supplies
- 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 price; 80% of the next $1,500 of the purchase price, up to a maximum benefit of $1,700 for both ears combined. (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 24 months. Deductible and coinsurance apply. (See your Schedule of Benefits.)
        - Related services and supplies for hearing aids (not subject to the $2,000 limit)
- Medical and surgical supplies

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
    - Alcohol and alcohol wipes
    - Air conditioners, air cleaners or purifiers, dehumidifiers, humidifiers, HEPA filters and other filters, and portable nebulizers
    - 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 (unless specifically covered in your Schedule of Benefits)
    - 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 medical 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 harnesses, 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 Direct Care service area.
4. Services that are not determined to be medically necessary. This applies even if the benefit period limits have not been reached.
5. Charges for hearing aids in excess of $1,700 for both ears combined, 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 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.

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 immediate medical attention to result in:

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

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

Emergency services do not require prior authorization. You should notify your PCP so that arrangements can be made to coordinate any needed follow-up care. 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.

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 Direct 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 to you to the most appropriate facility.

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

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

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

1. Non-emergency care provided in an emergency room
2. Out-of-area care or services that could have been anticipated before leaving the Direct 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 includes follow-up care in an emergency room setting.
4. Care from a non-plan or out-of-area provider once you are medically able to return to the Direct Care service area

Enteral formulas and low protein foods

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

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

Covered services

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 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 plan providers requires prior authorization by the plan. Durable medical equipment 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
3. Home dialysis services and non-durable medical supplies (such as dialysis membrane and solution, tubing, and drugs that are needed during dialysis); the cost to install the dialysis equipment in your home; and the cost to maintain or to fix the dialysis equipment.

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 aides, 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. (See **Obtaining specialty care and services** for more information.)

Covered service

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

Covered services

1. Room and board in a semiprivate room or a private room when medically necessary. (Limited to one copayment per plan 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 a FHLAC 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 or blood donation or storage for use during surgery or other medical procedure
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

The plan covers the services shown below for diagnosis and treatment of infertility. 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 6 months if the female is over age 35. If a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one year or six month period as applicable.

The plan covers fertility preservation services for plan members prior to treatment for cancer or another life-threatening disease or condition that is expected to render them permanently infertile, for example, chemotherapy or radiation therapy. For plan members diagnosed with persistent *Gender dysphoria*, the plan covers fertility preservation services prior to gender-confirming hormone therapy or surgery that is expected to render the plan member permanently infertile. Coverage for fertility preservation is limited to one in vitro fertilization (IVF) cycle, cryopreservation and short-term (up to 90 days) storage.

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

Infertility services require referral and prior authorization unless provided by a Reliant Medical Group specialist (if you have a Reliant Medical Group PCP). See **Obtaining specialty care and services** for more information on referral and prior 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.
6. Fertility preservation services:
   a. One cycle of IVF with egg or embryo cryopreservation and short-term (up to 90 days) storage.
   b. Sperm collection, cryopreservation and short-term (up to 90 days) storage
   c. Frozen embryo transfer when the embryo is transferred back to the member (not to a gestational carrier).

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

1. Charges for the storage of donor sperm, eggs or embryo that remain in storage after the completion of an approved series of infertility cycles.
2. Clinical or laboratory research
3. Donation or sale of gametes or embryos

4. Donor sperm in the absence of documented male factor infertility, as evidenced by abnormal semen analysis or in men with genetic sperm defects
5. Chromosome studies of a donor (sperm or egg).
6. Preimplantation genetic diagnosis (PGD) for aneuploidy screening or other indications not listed under **Covered services.**
7. Gender selection in the absence of a documented X-linked disorder.
8. Infertility medication for donors
9. Medications for ART cycles/attempts without prior authorization
10. Treatments requested solely for the convenience, lifestyle, personal or religious preference of the member in the absence of medical necessity.
11. Transportation costs to and from the medical facility
12. Infertility services that are necessary as a result of a prior voluntary sterilization or unsuccessful sterilization reversal procedure.
13. 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).
14. Services related to achieving pregnancy as a surrogate or gestational carrier.
15. Services that are considered experimental or investigational.
16. Services for a member who is not medically infertile.
17. Services for a partner who is not a member.
18. Services for women who are menopausal, except those women who are experiencing premature menopause.
19. 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.
20. Supplies that may be purchased without a physician's written order, such as ovulation test kits.
21. Treatments to reverse voluntary sterilization.

Maternity services

The plan covers maternity and obstetrical care in accordance with the General Laws of Massachusetts. Routine obstetrical and maternity care does not require a referral or prior 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.)

Covered services

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. For a listing of certified lactation counselors visit zipmilk.org. Eligible members will receive a breast pump. Please contact Customer Service at 1-866-344-4GIC (4442) (TRS 711), or visit the Fallon website fallonhealth.org/gic for more information.

Well Newborn Care

The plan provides coverage for well newborn care furnished during the enrolled mother's inpatient maternity stay: This coverage includes:

- Pediatric care furnished by a plan provider (who is a pediatrician) or network nurse practitioner or physician assistant for a well newborn.
- Routine circumcision furnished by a plan physician.
- Newborn hearing screening tests performed by a plan provider before the newborn child (an infant under three months of age) is discharged from the hospital to the care of the parent or guardian or as provided by regulations of the Massachusetts Department of Public Health.

Note: See **Adding dependents** in **How your coverage works** section for coverage when an enrolled newborn child requires medically necessary inpatient care.

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. Charges for a home birth
4. Services for a well newborn who has not been enrolled as a member, other than nursery charges for routine services provided to a well newborn.

Mental health and substance use services

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

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

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

Please see below for further explanation of when prior authorization is necessary and which services may be used without prior authorization. Prior authorization is not required for behavioral health inpatient admissions after treatment in an emergency department.

Inpatient services

The plan covers mental health services in an inpatient setting when authorized by the plan. To access services and obtain prior authorization, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660). Except as noted below, inpatient admissions generally require prior authorization. Prior authorization will not be required for behavioral health inpatient admissions after treatment in an emergency department. As required by Massachusetts law, prior authorization generally is not required for inpatient substance use services, or required for acute treatment services and clinical services for up to 14 consecutive stabilization days. If the services are provided in Massachusetts, prior authorization is not needed so long as the provider is an in-network provider. Out-of-state and out-of-network inpatient services for substance use, however, generally require prior authorization.

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

Covered service

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

Intermediate services
Members may receive mental health and substance use treatment in an alternative setting in lieu of inpatient hospitalization. Intermediate services may occur in 24-hour, non-24-hour and community based settings. Intermediate services generally require prior authorization. To access services and obtain prior authorization, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660). As required by Massachusetts law, prior authorization generally is not required for substance use inpatient services. If the services are being provided in Massachusetts, prior authorization is not needed so long as the provider is in-network. Out-of-state and out-of-network inpatient services for substance use, however, generally require prior authorization

Covered intermediate services

1. Acute and other residential treatment: Mental health services provided in a 24-hour setting therapeutic environments.
2. Clinically managed detoxification services: 24-hour, 7 days-a-week, clinically managed detox services in a licensed non-hospital setting that include 24-hour per day supervision.
3. Partial hospitalization: Short-term day/evening mental health programming available 5 to 7 days per week.
4. Intensive outpatient programs: Multimodal, inter-disciplinary, structured behavioral health treatment provided 2-3 hours per day, multiple days per week.
5. Day treatment: Program encompasses some portion of the day or week rather than a weekly visit.
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 use clinic licensed by the department of public health, a public community mental health center, or a professional office. Members may self-refer for outpatient mental health and substance use services. For assistance in finding a plan provider, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660).

The following outpatient behavioral health services require prior authorization:

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

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

Covered outpatient services

1. Outpatient office visits, including individual, group or family therapy.
2. Psychopharmacological services, such as visits with a physician to review, monitor and adjust the levels of prescription medication to treat a mental condition
3. Neuropsychological assessment services when medically necessary

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

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

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. Residential halfway house services
5. Acupuncture, biofeedback and biofeedback devices for home use, or any other alternative treatment for the treatment of a mental health or substance use condition.
6. Services or programs that are not medically necessary for the treatment of a mental health or substance use condition. Some examples of services or programs that are not covered include (but are not limited to) at high-risk youth expeditions, outward bound-type programs, and wilderness programs.
7. Services or programs that are provided in an educational, vocational or recreational setting.
8. Services or programs that provide primarily custodial care.

Office visits and outpatient services

The plan provides coverage for the covered 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 prior authorization. See **Obtaining specialty care and services** for more information on referral and prior authorization.

The plan covers the costs for services furnished to members enrolled in certain qualified 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 and the clinical trial must be one that is intended to treat cancer. Coverage for services 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 plan 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. Certain drugs covered under the medical benefits, and that are ordered, supplied and administered by a plan provider (requires prior authorization).
4. Allergy injections
5. Radiation therapy and Chemotherapy. Benefits include chemotherapy furnished by a covered provider including but not limited to a physician; or a nurse practitioner; or a free-standing radiation therapy and chemotherapy facility; or a hospital; or a covered provider who has recognized expertise in a specialty pediatrics. This coverage includes;
   - Radiation therapy using isotopes, radium, radon, and other ionizing radiation.
   - X-ray therapy for cancer or when it is used in place of surgery
   - Drug therapy for cancer (chemotherapy)
6. Respiratory therapy
7. Hormone replacement services in the doctor’s office for perimenopausal or 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 office visit

Chiropractic services

10. Chiropractic services for acute musculoskeletal conditions. The condition must be new or an acute exacerbation of a previous condition. This coverage includes: diagnostic lab tests such as blood tests); diagnostic X-rays other than magnetic resonance imaging (MRI), computerized axial tomography (CT scans), and other imaging tests; and outpatient medical care services, including spinal manipulation. Your coverage for these services may have a benefit limit. If it does, the Schedule of Benefits for your plan option describes the benefit limit that applies for these services.

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 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 (abortion) 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 plan 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)

Podiatry Care

18. Podiatry Care covers non-routine (foot) care when it is furnished for you by a covered provider. This may include (but is not limited to): a physician; or a podiatrist. This coverage includes; diagnostic lab tests; diagnostic X-rays; surgery and necessary postoperative care; and other medically necessary foot care such as treatment for hammertoe and osteoarthritis.

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. Emergency laboratory evaluation for a cardiovascular lipoprotein quantitation.
4. Routine foot care services:
    - Trimming of corns, trimming of nails, and other hygienic care, except when the care is medically necessary because you have systemic circulatory disease (such as diabetes)

- Certain non-routine foot care services and supplies such as foot orthotics, arch supports, shoe (foot) inserts, orthopedic and corrective shoes that are not part of a leg brace (except as described in this *Member Handbook* for **Durable medical equipment and prosthetic/orthotic devices**)
- Fittings, castings, and other services related to devices for the feet.

Oral surgery

The plan covers the oral surgery 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 plan referral or prior authorization for extraction of impacted teeth or lingual frenectomy. All other oral surgery services require plan referral and prior authorization. See **Obtaining specialty care and services** for more information on plan referrals and prior 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. Outpatient services that are furnished to you by a covered provider to diagnose and/or treat temporomandibular joint (TMJ) disorders that are caused by or result in specific medical conditions (such as degenerative arthritis and jaw fractures or dislocations). The medical condition must be proven to exist by means of diagnostic X-ray tests or other generally accepted diagnostic procedures. This coverage includes:
    - Diagnostic X-rays
    - Surgical repair or intervention
    - Non-dental medical care services to diagnose and treat a TMJ disorder
    - Splint therapy (This includes measuring, fabricating, and adjusting the splint.)
    - Physical therapy (See **Rehabilitation and Habilitation services**)
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 traumatic and/or accidental injury to sound natural teeth or tissues, when provided as soon as medically possible after the injury in the office of a physician, dentist or in a hospital emergency room. This does not include restorative or other dental services. No referral or authorization is required. 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. Covered services that are performed secondary to a non-covered service
2. TMJ disorders that are not proven to be caused by or to result in a specific medical condition; appliances, other than a mandibular orthopedic repositioning appliance (MORA); and services, supplies, or procedures to change the height of teeth or otherwise restore occlusion (such as bridges, crowns, or braces).
3. 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
4. Osseointegrated implants or insertion of a core-vent implant
5. Procedures or services related to dental care.
6. Services that have not been authorized by the plan, 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)
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. For example, this includes but may not be limited to 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 the preparation, 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 a contracted transplant facility, subject to your acceptance into the program. FHLAC 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, FHLAC will identify another suitable transplant facility. Additional opinions beyond a second opinion are not covered. Transplant services require a referral from your PCP and prior 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 (or private room if it is required based on medical necessity) 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 histocompatability 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 one inpatient copayments per plan quarter. 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. Bioartificial transplantation, such as the transplant of a total artificial heart
2. Experimental/investigational or unproven 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
3. House cleaning costs incurred in preparation for a transplant recipient's discharge
4. Xenotransplantation, such as the transplant of animal tissues or organs into a human
5. Services for the organ donor that are covered by another insurer
6. Services for an organ donor if the recipient is not a member of the plan
7. Transportation or housing costs for the recipient or donor

GIC's Pharmacy Benefit

GIC's prescription drug benefits are administered through Express Scripts.

For questions about any of the information in this section, please contact Express Scripts at 855-283-7679.

Express Scripts is the pharmacy benefit manager for your prescription drug benefit plan. The Express Scripts pharmacy network includes major chain pharmacies nationwide, many independent pharmacies, a mail order pharmacy and a specialty drug pharmacy.

If you have any questions about your prescription drug benefits, contact Express Scripts Member Services toll free at 855-283-7679.

About Your Plan

Prescription medications are covered by the plan only if they have been approved by the U.S. Food and Drug Administration (FDA). In addition, with the exception of the over-the-counter versions of preventive drugs, medications are covered only if a prescription is required for their dispensing. Diabetes supplies and insulin are also covered by the plan.

The plan categorizes medications into seven major categories:

Generic Drugs

Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand-name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements help to assure that generic drugs are as safe and effective as brand-name drugs.

Maintenance Drug

A maintenance drug is a medication taken on a regular basis for chronic conditions such as asthma, diabetes, high blood pressure or high cholesterol.

Non-Preferred Brand-Name Drug

A non-preferred drug is a medication that usually has an alternative, therapeutically equivalent drug available on the formulary.

Preferred Brand-Name Drug

A preferred brand-name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost effectiveness.

Preventive Drugs

Preventive drugs consist primarily of drugs recommended for coverage by the U.S. Preventive Services Task Force, and as specified by the federal Patient Protection and Affordable Care Act.
See "Preventive Drugs" listed below for more information.

Specialty Drugs

Specialty drugs are usually injectable and non- injectable biotech or biological drugs with one or more of several key characteristics, including:

- Potential for frequent dosing adjustments and intensive clinical monitoring
- Need for intensive patient training and compliance for effective treatment
- Limited or exclusive product distribution
- Specialized product handling and/or administration requirements

Over-the-Counter (OTC) Drugs
Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of preventive drugs (all of which are covered only if dispensed with a written prescription).

Copayments and Deductible
One of the ways your plan maintains coverage of quality, cost-effective medications is a multi-tier copayment pharmacy benefit: Tier 1 (generic drugs), Tier 2 (preferred brand-name drugs), Tier 3 (non-preferred brand-name drugs), or drugs which require no copayments. The following shows your deductible and copayment based on the type of prescription you fill and where you get it filled.

Deductible for Prescription Drugs
Deductible (fiscal year July through June)

- For an individual: **$100 for one person**
- For a family: **$200 for the entire family**

  No more than $100 per person will be applied to the family deductible. Multiple family members can satisfy the family deductible.

Copayments for Prescription Drugs
Participating Retail pharmacy up to 30-day supply and Mail Order or CVS Pharmacy up to a 90-day supply:

Tier 1 – Generic Drugs
30-day supply: $10
90-day supply: $25

Tier 2 – Preferred Brand-Name Drugs
30-day supply: $30
90-day supply: $75

Tier 3 – Non-Preferred Drugs
30-day supply: $65
90-day supply: $165

Other:
$0 member cost (deductible does not apply)

- Orally-administered anti-cancer drugs
- Generic drugs to treat opioid use disorder (generic buprenorphine-naloxone, naloxone, and naltrexone products)
- Preventive drugs: Refer to the “Preventive Drugs” section below for detailed information

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Specialty Drugs: Specialty drugs must be filled only through Accredo, a specialty pharmacy.

Specialty Drugs: Tier 1
$10 per 30-day supply

Specialty Drugs: Tier 2
$30 per 30-day supply

Specialty Drugs: Tier 3
$65 per 30-day supply

Orally-administered anti-cancer specialty drugs
$0 per 30-day supply
Specialty medications may be dispensed up to a 30-day supply, some exceptions may apply.

Copayments for ADHD Medications
May be filled through mail order or any network pharmacy. Limited to a 60-day supply per state statute:

Tier 1: 60-day supply: $20

Tier 2: 60-day supply: $60

Tier 3: 60-day supply: $130

Out-of-Pocket Limit

This plan has an out-of-pocket limit that is combined with your medical and behavioral health out-of-pocket limit. Deductibles and copayments you pay for prescription drugs during the year count toward this limit. Once you reach the limit, your prescription drugs are covered at 100%. Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket limit.

Individual	$5,000
Family	$10,000

How to Use the Plan
After you first enroll in the plan, Express Scripts will send you a welcome packet and Express Scripts Prescription Card(s). Your Prescription Card(s) will be mailed to you with ID cards for you and your dependents (if any) along with a mail order form.

Show your new Prescription Card to your pharmacy so they can correctly process your prescription drug benefits.

Register at express-scripts.com. As a registered user, you can check drug costs, order mail order refills, and review your prescription drug history. You can access this site 24 hours a day.

Filling Your Prescription
You may fill your prescriptions for non-specialty drugs at any participating retail pharmacy, or through mail order from the Express Scripts Pharmacy℠.

Prescriptions for specialty drugs must be filled as described in the “Accredo, an Express Scripts Specialty Pharmacy” subsection.

To obtain benefits at a retail pharmacy, you must fill your prescription at a participating pharmacy using your Express Scripts Prescription Card, with the exception of the limited circumstances detailed in the “Claim Forms” subsection.

Filling Your Prescriptions at a Participating Retail Pharmacy
The retail pharmacy is your most convenient option when you are filling a prescription for a short-term prescription that you need immediately (for example, antibiotics for strep throat or painkillers for an injury). Simply present your Express Scripts Prescription Card to your pharmacist, along with your written prescription, and pay the required copayment.

Prescriptions filled at a non-participating retail pharmacy are not covered.

You can locate the nearest participating retail pharmacy anytime online after registering at express-scripts.com or by calling toll free at 855-283-7679.

If you do not have your Prescription Card the pharmacist can also verify eligibility by contacting the Express Scripts Pharmacy Help Desk at 800-922-1557; TDD: 800-922-1557.

Maintenance Medications – Up to 30 Days

After you fill two 30-day supplies of a maintenance medication at a retail pharmacy, you will receive a letter from Express Scripts explaining how you may convert your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy. You will receive coverage for additional fills of that medication only if you convert your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy, or if you inform Express Scripts that you instead prefer to continue to receive 30-day supplies at a participating retail pharmacy. Exceptions for this policy do apply to ADHD medications. Per state statute, prescriptions are limited to a 60-day supply.

Express Scripts will assist you in transitioning your maintenance prescription to either mail order or a CVS Pharmacy location.

Maintenance Medications – Up to 90 Days

Filling 90-day Prescriptions Through the Express Scripts Pharmacy or CVS Pharmacy

You have the choice and convenience of filling maintenance prescriptions for up to a 90-day supply at the mail order copayment, either through the Express Scripts Pharmacy or at a CVS Pharmacy.

The Express Scripts Pharmacy is a convenient option for prescription drugs that you take on a regular basis for conditions such as asthma, diabetes, high blood pressure and high cholesterol. Your prescriptions are filled and conveniently sent to you in a plain, weather- resistant pouch for privacy and protection. They are delivered directly to your home or to another location that you prefer.

CVS Pharmacy is another option for getting your 90- day maintenance medications for the same copayment amount as mail order. Prescriptions can be filled at a CVS Pharmacy location across the country.

Convenient for You

You get up to a 90-day supply of your maintenance medications – which means fewer refills and fewer visits to your pharmacy, as well as lower copayments. Once you begin using mail order, you can order refills online or by phone, or you can use your local CVS Pharmacy.

Using Mail Order from the Express Scripts Pharmacy

To begin using mail order for your prescriptions, just follow these three simple steps:

1. Ask your physician to write a prescription for up to a 90-day supply of your maintenance medication plus refills for up to one year, if appropriate. (Remember also to ask for a second prescription for an initial 30-day supply and take it to your local participating retail pharmacy.)
2. Complete a mail order form (contained in your Welcome Kit or found online after registering at express-scripts.com). Or call Express Scripts Member Services toll free at 855-283-7679 to request the form.
3. Put your prescription and completed order form into the return envelope (provided with the order form) and mail it to the Express Scripts Pharmacy.

Please allow 7-10 business days for delivery from the time your order is mailed. A pharmacist is available 24 hours a day to answer your questions about your medication.

If the Express Scripts Pharmacy is unable to fill a prescription because of a shortage of the medication, you will be notified of the delay in filling the prescription. You may then fill the prescription at a retail pharmacy, but the retail pharmacy copayment will apply.

Accredo, an Express Scripts Specialty Pharmacy
Accredo is a full-service specialty pharmacy that provides personalized care to each patient and serves a wide range of patient populations, including those with hemophilia, hepatitis, cancer, multiple sclerosis and rheumatoid arthritis.

You will be required to fill your specialty medications at Accredo. This means that your prescriptions can be sent to your home or your doctor's office.

Specialty medications may be filled only at a maximum of a 30-day supply; some exceptions may apply. Many specialty medications are subject to a clinical review by Express Scripts to ensure the medications are being prescribed appropriately.

Accredo offers a complete range of services and specialty drugs. Your specialty drugs are quickly delivered to any approved location, at no additional charge. We ship to all 50 states using one of our preferred expedited carriers. We can also ship to a variety of alternate addresses, including physician's offices or to another family member's address. We do not ship to P.O. Boxes.

You have toll-free access to expert clinical staff who are available to answer all of your specialty drug questions. Accredo will provide you with ongoing refill reminders before you run out of your medications.

To begin receiving your specialty drugs through Accredo, call toll free at 855-667-8678.

Accredo Pharmacy Services

- **Patient Counseling** – Convenient access to pharmacists and nurses who are specialty medication experts
- **Patient Education** – Educational materials
- **Convenient Delivery** – Coordinated delivery to your home, your doctor's office, or other approved location
- **Refill Reminders** – Ongoing refill reminders from Accredo
- **Language Assistance** – Language-interpreting services are provided for non-English speaking patients

Claim Forms
Retail purchases out of the country, or purchases at a participating retail pharmacy without the use of your Express Scripts Prescription Card, are covered as follows:

Claims Reimbursement
Type of Claim

- Claims for purchases at a participating (in-network) pharmacy without an Express Scripts Prescription Card.

Claims incurred within 30 days of the member's eligibility effective date will be covered at full cost, less the applicable copayment.

-or-

Claims incurred more than 30 days after the member's eligibility effective date will be reimbursed at a discounted cost, less the applicable copayment.

Claim forms are available to registered users on express-scripts.com or by calling 855-283-7679.

Other Plan Provisions

Preventive Drugs
Coverage will be provided for the following drugs:[2]

Aspirin
Generic OTC aspirin ≤ 325mg when prescribed for adults less than 70 years of age for the prevention of heart attack or stroke and to help prevent illness and death from preeclampsia for females who are at high risk for the condition.

Bowel preparation medications
Generic and brand (Rx and OTC) products for adults ages 50 to 75 years old. Limited to 2 prescriptions at $0 copay each year.

Contraceptives
Generic and brand versions of contraceptive drugs and devices, and OTC contraceptive products, when prescribed for women less than 50 years old.

Folic acid supplements
Generic OTC and Rx versions (0.4mg – 0.8mg strengths only) when prescribed for women under the age of 51.

HIV Pre-Exposure Prophylaxis (PrEP)
Generic only (Brand Truvada covered only until generic becomes available). No age restriction. No copayment.

Immunization vaccines
Generic or brand versions prescribed for children or adults.

Oral fluoride supplements
Generic and brand supplements prescribed for children 6 months through five years of age for the prevention of dental caries.

Breast cancer
Generic prescriptions for raloxifene or tamoxifen are covered for the primary prevention of breast cancer for females who are at increased risk, age 35 years and older.

Tobacco cessation
All FDA-approved smoking cessation products prescribed for adults, age 18 and older.

Statins
Generic-only, single-entity, low-to-moderate dose statin agents for adults 40 to 75 years old.

Call Express Scripts at 855-283-7679 for additional coverage information on specific preventive drugs.

Brand-Name Drugs with Exact Generic Equivalents
The plan encourages the use of generic drugs. There are many brand-name drugs, such as Lipitor®, Ambien® and Fosamax®, for which exact generic equivalents are available. If you fill a prescription for a brand-name medication for which there is an exact generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand-name drug and the generic drug, plus the generic copayment. This amount does not count towards the out-of-pocket limit. Exceptions to this provision may apply to certain brand-name preventive drugs; contact Express Scripts for additional information.

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[2] This list is subject to change during the year. Call Express Scripts toll free at 855-283-7679 to check if your drugs are included in the program.

Prescription Drugs with Over-the-Counter (OTC) Equivalents
Some prescription drugs have over-the-counter (OTC) equivalent products available. These OTC products have strengths, active chemical ingredients, routes of administration and dosage forms identical to the prescription drug products. Your plan does not provide benefits for prescription drugs with OTC equivalents. This provision is not applicable to preventive drugs.

Some prescription drugs also have OTC product alternatives available. These OTC products, though not identical, are very similar to the prescription drugs.

Your plan does not provide benefits for prescription drugs when OTC equivalents are available. This provision is not applicable to preventive drugs.

Prior Authorization
Some drugs in your plan require prior authorization. Prior authorization ensures that you are receiving the appropriate drug for the treatment of a specific condition, in quantities approved by the FDA. For select drugs, prior authorization also includes a medical necessity review that ensures the use of less expensive first-line formulary prescription drugs before the plan will pay for more expensive prescription drugs. First-line formulary prescription drugs are safe and effective medications used for the treatment of medical conditions or diseases.

If a drug that you take requires prior authorization, your physician will need to contact Express Scripts to see if the prescription meets the plan's conditions for coverage. If you are prescribed a drug that requires prior authorization, your physician should call Express Scripts at 800-417-1764.

Current Examples of Drugs Requiring Prior Authorization for Specific Conditions[3]

Topical Tazarotene Products
Tazorac® cream, gel Fabior® foam

Topical tretinoin products
Retin-A®, Retin-A Micro®; Avita®; Tretin·X™; Atralin™ gel; other generic topical tretinoin products - various manufacturers and Clindamycin Phosphate 1.2% and Tretinoin 0.025% gel, (Ziana®; Veltin®)

Testosterone – Topical
Androderm, AndroGel, Axiron, Fortesta, Striant, Testim

Testosterone - Injectable
Aveed®, Depo®-Testosterone [testosterone cypionate injection, generics], Xyosted® [testosterone enanthate injection, generics], Testopel® [testosterone pellet]

Glaucoma: Ophthalmic Prostaglandin
Lumigan®, Rescula, Xalatan® [generics], Travatan Z®, Zioptan®

Compounded -Select medications
A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available.

Diabetes GLP-1 agonists
Adlyxin, Byetta®, Bydureon®/ BCISE, Ozempic, Rybelsus, Tanzeum Trulicity®, Victoza®, Incretin Mimetics

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[3] This list is not all-inclusive and is subject to change during the year. Call Express Scripts toll free at 855-283-7679 to check if your drugs are included in the program.

Rosacea
Mirvaso®, Rhofade™ cream

Nutritional Supplements
Nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

Pain
Fentanyl Transmucosal Drugs (Abstral®, Actiq®, Fentora®, Lazanda®, Subsys®) Lidoderm®, Ztlido

Weight Management
Adipex®/ -P [phentermine], Bontril®/ PDM [phendimetrazine], Contrave® [bupropion; naltrexone], Didrex® [benzphetamine], Regimex, Sanorex® [mazindol], Suprenza™ [phentermine], Tenuate® [diethylpropion], Xenical® [orlistat], Belviq®/ XR, Qsymia®, Saxenda®, Xenical 120mg

Dry Eyes
Cequa, Restasis®,Xildra®

Current Examples of Top Drug Classes that May require Prior Authorization for Medical Necessity

Dermatological Agents
Insulins
Diabetic Supplies
Nasal Steroids
Epinephrine Auto-Injector Systems
Ophthalmic Agents
Erectile Dysfunction Oral Agents
Opioid Analgesics
Erythropoiesis-Stimulating Agents
Opioid Dependence Agents
Glaucoma
Osteoarthritis - Hyaluronic Acid Derivatives
Growth Hormones
Osteoporosis Therapy
Hepatitis C Agents
Proton Pump Inhibitors

Select drugs within these classes require prior authorization for medical necessity to ensure formulary alternative(s) within the class have been tried. If you are a registered user on express-scripts.com, refer to the National Preferred Formulary or call Express Scripts toll free at 855-283-7679 for additional information.

Quantity Dispensing Limits
To promote member safety and appropriate and cost- effective use of medications, your prescription plan includes a drug quantity management program. This means that for certain prescription drugs, there are limits on the quantity of the drug that you may receive at one time.
Quantity per dispensing limits are based on the following:

- FDA-approved product labeling
- Common usage for episodic or intermittent treatment

- Nationally accepted clinical practice guidelines
- Peer-reviewed medical literature
- As otherwise determined by the plan Examples of drugs with quantity limits currently include Cialis®, Imitrex®, and lidocaine ointment.[1]

Drug Utilization Review Program
Each prescription drug purchased through this plan is subject to utilization review. This process evaluates the prescribed drug to determine if any of the following conditions exist:

- Adverse drug-to-drug interaction with another drug purchased through the plan;
- Duplicate prescriptions;
- Inappropriate dosage and quantity; or
- Too-early refill of a prescription.

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be filled.

Exclusions
Benefits exclude:[4]

- Dental preparations (e.g., topical fluoride, Arestin®), with the exception of oral fluoride
- Over-the-counter drugs, vitamins or minerals (with the exception of diabetic supplies and preventive drugs)
- Homeopathic drugs
- Prescription products for cosmetic purposes such as photo-aged skin products and skin depigmentation products
- Medications in unit dose packaging
- Impotence medications for members under the age of 18
- Injectable allergens
- Hair growth agents
- Special medical formulas and medical food products, except as required by state law
- Compounded medications-some exclusions apply-examples include: bulk powders, bulk chemicals, and proprietary bases used in compounded medications
- Drugs administered intrathecally, by or under the direction of health care professionals and recommended to be administered under sedation

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Definitions
Brand-Name Drug – The brand name is the trade name under which the product is advertised and sold, and during a period of patent protection it can only be produced by one manufacturer. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

Compounded Medication – A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available. At least one of the ingredients must be a medication that can only be dispensed with a written prescription.

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[4] This list is subject to change during the year. Call Express Scripts toll free at 855-283-7679 to check if your drugs are included in the program.

Copayment – A copayment is the amount that members pay for covered prescriptions. If the plan's contracted cost for a medication is less than the applicable copayment, the member pays only the lesser amount.

Deductible – A deductible is the dollar amount you must pay during a plan year before the copayments for covered prescriptions apply.

Diabetes Supplies – Diabetic supplies include needles, syringes, test strips, lancets and blood glucose monitors.

FDA – The U.S. Food and Drug Administration.

Formulary – A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The Express Scripts National Preferred Formulary contains a wide range of generic and preferred brand-name products that have been approved by the FDA. The formulary applies to medications that are dispensed in either the retail pharmacy or mail-order settings. The formulary is developed and maintained by Express Scripts.

Formulary designations may change as new clinical information becomes available.

Generic Drugs – Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand-name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand-name drugs.

Maintenance Drug – A maintenance drug is a medication taken on a regular basis for conditions such as asthma, diabetes, high blood pressure or high cholesterol.

Non-Preferred Drug – A non-preferred drug is a medication that has been reviewed by Express Scripts, which determined that an alternative drug that is clinically equivalent and more cost-effective may be available.

Out-of-Pocket Limit – The out-of-pocket limit is the most you could pay in copayments during the year for prescription drugs that are covered by Express Scripts. Once you reach this limit, you will have no more copayments for covered drugs. Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket limit.

Over-the-Counter (OTC) Drugs – Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of preventive drugs (all of which are covered only if dispensed with a written prescription).

Participating Pharmacy – A participating pharmacy is a pharmacy in the Express Scripts nationwide network. All major pharmacy chains and most independently owned pharmacies participate.

Preferred Brand-Name Drug – A preferred brand- name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost effectiveness.

Prescription Drug – A prescription drug means any and all drugs which, under federal law, are required, prior to being dispensed or delivered, to be labeled with the statement "Caution: Federal Law prohibits dispensing without prescription," or a drug which is required by any applicable federal or state law or regulation to be dispensed pursuant only to a prescription drug order.

Preventive Drugs – Preventive drugs consist primarily of drugs recommended for coverage by the U.S. Preventive Services Task Force, and as specified by the federal Patient Protection and Affordable Care Act.

Prior Authorization – Prior authorization means determination that a drug is appropriate for treatment of a specific condition. It may also mean determination of medical necessity. It is required before prescriptions for certain drugs will be paid for by the plan.

Special Medical Formulas or Food Products – Special medical formulas or food products means nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. These products require prior authorization to determine medical necessity.

To access the benefit for special medical formulas or food products, call the Group Insurance Commission at 617-727-2310, extension 1.

Specialty Drugs – Specialty drugs are usually injectable and non-injectable biotech or biological drugs with one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring
- Need for intensive patient training and compliance for effective treatment
- Limited or exclusive product distribution
- Specialized product handling and/or administration requirements

Member Appeals

Express Scripts has processes to address:

- Inquiries concerning your drug coverage
- Appeals:
  - Internal Member Appeals
  - Expedited Appeals
  - External Review Appeals

All appeals should be sent to Express Scripts at the following address:

Complete the form and fax it to 877.328.9660 or mail to:

Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St Louis, MO 63166-6587

All calls should be directed to Express Scripts Member Services at 855-283-7679

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling the Member Services phone number on the back of the prescription card.

Internal Inquiry

Call Express Scripts Member Services to discuss concerns you may have regarding your prescription drug coverage. Every effort will be made to resolve your concerns. If your concerns cannot be resolved or if you tell a Member Services representative you are not satisfied with the response you have received, Member Services will notify you of any options you may have, including the right to have your inquiry processed as an appeal. Member Services will also provide you with the steps you and your doctor must follow to submit an appeal.

Internal Member Appeals

Requests for coverage that were denied as specifically excluded in this member handbook or for coverage that was denied based on medical necessity determinations are reviewed as appeals through the Express Scripts Internal Appeals Process. You may file an appeal request yourself or you may designate someone to act on your behalf in writing. You have 180 days from the date you were notified of the denial of benefit coverage or prescription drug claim payment to file your appeal. To request an initial administrative coverage review, the member or his or her representative must submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling the Customer Service phone number on the back of the prescription card.

1. You must submit a written appeal to the address listed above. Your letter should include:
   - Your complete name and address;
   - Your Express Scripts ID number;
   - Your date of birth;
   - A detailed description of your concern, including the drug name(s) being requested; and
   - Copies of any supporting documentation, records or other information relating to the request for appeal
2. The Express Scripts Appeals Department will review appeals concerning specific prescription drug benefit provisions, plan rules, and exclusions and make determinations. If you are not satisfied with an Appeals Department denial related to a plan rule or exclusion (i.e., non-medical necessity appeal), you may have the right to request an independent External Review of the decision (refer to the “External Review Appeals” section for details on this process). For denials related to a medical necessity determination, you have the right to an additional review by Express Scripts. Express Scripts will request this review from an independent practitioner in the same or in a similar specialty that typically manages the medical condition for which the prescription drug has been prescribed. If the second review is an adverse determination, you have the right to request an External Review of this decision (refer to the “External Review Appeals” section for details on this process).
3. For an appeal on a prescription drug that has not been dispensed, an Appeals Analyst will notify you in writing of the decision within no more than fifteen calendar days of the receipt of an appeal. For an appeal on a prescription drug already dispensed, an Appeals Analyst will notify you in writing of the decision within no more than thirty calendar days of the receipt of an appeal.

   A copy of the decision letter will be sent to you and your physician. A determination of denial will set forth:
   - ❑ Express Scripts understanding of the request;
   - ❑ The reason(s) for the denial;
   - ❑ Reference to the contract provisions on which the denial is based; and
   - ❑ A clinical rationale for the denial, if the appeal involves a medical necessity determination.

Express Scripts maintains records of each inquiry made by a member or by that member’s designated representative.

Express Scripts recognizes that there are circumstances that require a quicker turnaround than allotted for the standard Appeals Process. Express Scripts will expedite an appeal when a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. If your request does not meet the guidelines for an expedited appeal, Express Scripts will explain your right to use the standard appeals process.

If your request meets the guidelines for an expedited appeal, it will be reviewed by a practitioner in the same or in a similar specialty that typically manages the medical condition for which the prescription drug has been prescribed. Express Scripts will notify you of its decision by telephone no later than 72 hours after Express Scripts' receipt of the request.

If the patient or provider believes the patient's situation is urgent, the provider must request the expedited review by phone at 800-753-2851.

External Review Appeals

In most cases, if you do not agree with the Appeals decision, you or your authorized representative have the right to request an independent, external review of the decision. Should you choose to do so, send your request within four months of your receipt of the written notice of the denial of your appeal to:

To submit an external review, the request must be mailed or faxed to MCMC, LLC, an independent third- party utilization management company, at:

MCMC LLC
Attn: Express Scripts Appeal Program
300 Crown Colony Drive, Suite 203
Quincy, MA 02169-0929
617-375-7700, ext. 28253
617-375-7683

In some cases, members may have the right to an expedited external review. An expedited external review may be appropriate in urgent situations. Generally, an urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. The request must be received within 4 months of the date of the final internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day. For urgent external appeals urgent external review, the IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

If you request an external review, an independent organization will review the decision and provide you with a written determination. If this organization decides to overturn the Appeals decision, the service or supply will be covered under the plan.

If you have questions or need help submitting an appeal, please call Customer Care for assistance at 855-283-7679.

Health and Prescription Information

GIC authorizes health and prescription information about members be used by Express Scripts to administer benefits. As part of the administration, Express Scripts may report health and prescription information to the administrator or sponsor of the benefit plan. Express Scripts also uses that information and prescription data gathered from claims nationwide for reporting and analysis without identifying individual members.

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 of 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 for more information on these guidelines.

Covered services

1. Routine physical exams for the prevention and detection of disease
2. Immunizations that are included on the GIC's 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
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 sixth 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
8. Pediatric services including:
   - 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
9. Consultations, examinations, procedures and medical services related to the use of all contraceptive methods
10. Contraceptive devices that are supplied by a plan provider during an office visit
11. Tobacco counseling sessions with your primary physician or other provider designed to create a plan to stop smoking.

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 not provided by an optometrist or ophthalmologist 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 lymphadema.

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 prior authorization. Your surgeon must obtain prior authorization from FHLAC for all procedures. See **Obtaining specialty care and services** for more information on referrals and prior authorization.

Reconstructive and **restorative** surgery are subject to inpatient and outpatient cost sharing amounts and exclusions.

Covered 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. The treatment of cleft lip and cleft palate for children under the age of 18. The coverage shall include benefits for medical, dental, oral and facial surgery, surgical management and follow-up care by oral and plastic surgeons, orthodontic treatment and management, preventative and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy, speech therapy, audiology, and nutrition services. Payment for dental or orthodontic treatment not related to the management of the congenital conditions of cleft lip and cleft palate will not be covered. Prior authorization is required.
5. Medical or drug treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome including, but not limited to, reconstructive surgery, such as assisted lipectomy, other restorative procedures and dermal injections or fillers for reversal of facial lipoathrophy.

Gender-affirming surgery

The Plan covers gender-affirming surgery for the treatment of *Gender dysphoria*. Coverage for gender-affirming surgical procedures will be determined on an individual case-by-case basis, when all of the following criteria are met:

1. The member is 18 years of age or older.
2. The member has a definitive diagnosis of persistent Gender dysphoria that has been made and documented by a qualified licensed mental health professional such as a licensed psychiatrist, psychologist or other licensed physician experienced in the field. The Plan reserves the right to request the credentials of this mental health professional.
3. The member has received continuous hormone therapy for 12 months or more under the supervision of a physician with documentation of the member's compliance and the type, frequency, and route of administration.
4. The member has lived as their chosen or reassigned gender full-time for 12 months or more; (3 and 4 may occur concurrently).
5. The member's medical and mental health providers document that there are no contraindications to the planned surgery and agree with the plan.

Coverage for gender-affirming surgery is limited to once, per covered procedure, per lifetime. Coverage is not available for repeat or revision procedures, other than for the treatment of complications resulting from the initial surgery or to correct functional impairment resulting from initial surgery. Coverage is not available for reversal of gender-affirming surgery. Coverage is not available for gender-affirming surgery for any condition other than *Gender dysphoria*.

Fallon Health covers injections and injectables administered by a plan provider. For coverage of prescription medications and self-administered injections and injectables refer to the **Prescription medication** section.

Prior authorization is required for all gender-affirming surgical procedures and must meet Medical Policy requirements outlined above.

Covered Services

1. Female-to-male gender-affirming surgical procedures: mastectomy, hysterectomy, salpingo-oopherectomy, vulvectomy, vaginectomy, urethroplasty, metoidoplasty (micropenis) or phalloplasty, and scrotoplasty with insertion of testicular prosthesis.
2. Male-to-female gender-affirming surgical procedures: augmentation mammoplasty with implantation of breast prostheses, penectomy, clitoroplasty, colovaginoplasty, vulvoplasty, labiaplasty, and orchiectomy.
3. Electrolysis or laser hair removal performed by a licensed provider for the removal of hair on a skin being used for a genital gender-affirming surgical procedure.
4. Facial feminization or masculinization surgeries: tracheoplasty, forehead contouring, brow lift, blepharoplasty (in conjunction with other facial feminization procedures), brow lift, cheek augmentation, rhinoplasty, genioplasty, and rhytidectomy (forehead and cheek, excluding neck) or suction-assisted lipectomy, as needed, in conjunction with a covered facial feminization or masculinization procedures.

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 lip and cleft palate). Similarly, medical or surgical procedures in preparation for a dental procedure are also not covered (for example, a bone graft to prepare for a dental implant).
4. Surgery, treatments, procedures, medications, and supplies to prevent snoring.
5. Removal of intact breast implants for suspected autoimmune or connective tissue disease or for breast cancer prevention because these indications are considered experimental/investigational.
6. Removal of an intact breast implant that has shifted. Implant shifting in the absence of refractory infection or Stage IV capsular contracture is not medically necessary.
7. Liposuction, also known as suction lipectomy or suction assisted lipectomy, is the surgical excision of subcutaneous fatty tissue. Liposuction (CPT codes 15876-15879) is not covered. However, liposuction is an integral part of certain covered services, such as the surgical removal of excessive skin (CPT codes 15830-15839), but is not separately reimbursed.
8. Treatments for acne scarring including, but not limited to subcutaneous injections to raise acne scars, chemical exfoliation (CPT 17360), and dermabrasion.
9. The following treatments for active acne are not covered: acne surgery (CPT code 10040), cryotherapy for acne (CPT code 17340), chemical exfoliation for acne (CPT code 17360), and laser and light-based therapies, including but not limited, to blue light therapy, pulsed light, and diode laser treatment.
10. Reconstructive/cosmetic surgery or other services following gender-affirming surgery to reverse natural signs of aging or if the member is not satisfied with the surgical result.
11. Breast lift, neck lift, collagen injections, dermabrasion, chemical peels, hair transplantation, lip reduction or enhancement, panniculectomy or abdominoplasty, vocal cord surgery, voice modification surgery, pectoral, calf, or gluteal implants, clavicle shortening or isolated blepharoplasty for the treatment of Gender dysphoria.

Rehabilitation and habilitation services

The plan covers outpatient rehabilitation services. Rehabilitation services must be medically necessary, ordered by a plan physician and provided by a plan provider.

The plan covers habilitation services. Habilitation services help a person keep, learn or improve skill and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient 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 by a plan provider who is a speech-language pathologist or audiologist; and at a provider facility or plan provider's office with a PCP referral. After 30 speech therapy visits, prior authorization based on medical necessity is required for additional visits.
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 certified early intervention specialists, 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 this *Member Handbook* 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 even if the plan limits have not yet been reached.
5. Massage therapy, including myotherapy, unless provided by a Direct 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 does not require the specialized care of an acute care hospital.

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

Covered services (see **Hospital 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 **Hospital 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

Telehealth Services

The Plan provides coverage for clinically appropriate, medically necessary health care services delivered via telehealth by plan providers, when:

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

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

Covered services

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

1. Office visits your primary care provider (PCP)
2. Office visits with a specialist
3. Office visits for the evaluation, diagnosis, treatment or management of a mental health, developmental or substance abuse disorder.
4. Chronic disease management, i.e., care and services for the management of chronic conditions, including but not limited to diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, cancer and coronary artery disease.
5. Remote patient monitoring, also known as remote physiologic monitoring, or RPM. RPM involves the collection and analysis of physiologic data that are used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition.

In addition to covering services delivered via telehealth by plan providers, the Plan covers telehealth visits through an agreement with Teladoc. Refer to the **Emergency and urgent care** section of this Member Handbook for more information on Teladoc.

Exclusions

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

Wellness

Fitness and Weight Loss Essential Health Benefits (EHBs)

- One WW (Weight Watchers® reimagined) Monthly Pass reimbursement per subscriber for 5 months. Subscriber must be a Fallon member for 3 months or longer.
- One YMCA or YWCA fitness membership reimbursement per subscriber for 3 months. Subscriber must be a Fallon member for 3 months or longer.

It Fits

- 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, WW programs, and local town and school sports programs for all ages when they include an aerobic and instructional component. Aerobic activities for the whole family include: baseball, softball, soccer, football, dance classes, ski lessons, golf lessons, swimming lessons, tennis, and sports camps.

Fallon Healthy Health Plan program

The Fallon Healthy Health Plan program is designed to allow members to take an active role in their health care. The Program is designed to help members achieve or maintain a healthy lifestyle through a health assessment, online self-learning modules, personalized plans and professional health coaching. Members are not eligible for incentive payments. However, if you are age 18 or over, you may continue to work towards achieving or maintaining a healthy lifestyle by participating in the Healthy Health Plan program by completing the health assessment and taking part in online self-learning modules and personalized programs.

Other plan benefits and features

Out-of-area student coverage

Students attending school outside the Direct 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 Direct 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, WW 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 save money by choosing a lower cost provider for certain health care services. 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.*
  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.

Employee Assistance Program (EAP)

If you have a question about Employee Assistance Program (EAP) benefits, please contact Optum at (844) 263-1982, or their website at www.liveandworkwell.com (*Website Access Code: Mass4You*). The website gives you access to your Employee Assistance Program (EAP) benefits and the status of (or a question about) an EAP claim.

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*
2. Any service or supply related to or furnished along with 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 a non-plan provider, unless approved by a plan provider and Fallon in accordance with Fallon policies and rules. The plan 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, and aquatic (when not provided by a Direct Care provider as a part of your covered physical therapy benefit), art, herbal, massage (when not provided by a Direct Care physician or physical therapist as part of your covered physical therapy benefit), music
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 FHLAC determines 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 FHLAC determines is custodial. Custodial care is defined as a level of care which: (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: keratoconus; aphakia; or following a cornea transplant, for up to one year, if medically necessary. A lens applied as a bandage lens following an eye injury or to treat a diseased cornea is covered. Multifocal, astigmatism-correcting and presbyopia-correcting intraocular lenses are not covered.

18. Cosmetic or beautifying surgeries, procedures, drugs, services, or appliances
19. Dermatoscopy for detection of melanoma
20. 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
21. 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.
22. Early intervention services for patients over age 3
23. Educational services or testing, except services covered under the benefit for early intervention services described in **Rehabilitation services**
24. Elective long-term psychotherapy
25. Elective treatment or surgery not required by your medical condition, according to the judgment of the plan
26. 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.
27. 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**.)
28. Extracorporeal Shock Wave Therapy (ESWT) for chronic plantar fasciitis
29. Eyeglasses
30. Fittings for contact lenses
31. Holistic treatments
32. 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
33. Laser vision corrective surgery
34. Long-term rehabilitation services
35. Mediation or intervention services

36. Medical care that Fallon determines is experimental, investigational, or not generally accepted in the medical community. Experimental means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that are considered to be unsafe, experimental, or investigational. This is determined by, among other sources, formal or informal studies, opinions and references to or by the American Medical Association, the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies, experts in the field, and any other association or federal program or agency that has the authority to approve medical testing or treatment.
37. Medical expenses incurred in any government hospital or facility or for services of a government doctor or other government health professional
38. Non-emergency care provided in an emergency room
39. Nutritional supplements, medical foods and formulas unless described in this *Member Handbook* as covered
40. Orthodontics
41. 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 Direct Care service area.
42. Procedures or services related to dental care.
43. Provider charges for shipping or copying medical records, or for failing to keep an appointment. You must pay for these charges.
44. Psychological testing or neuropsychological assessments unless determined to be medically necessary
45. Removal of nonimpacted wisdom teeth
46. Replacement of lost or stolen WW coupons
47. Rest care or long-term care
48. Routine foot care. This includes, but is not limited to:
    a. Cutting or removal of corns, calluses and plantar keratoses
    b. Trimming, cutting and clipping of nails
    c. Treatment of weak, strained, flat, unstable or unbalanced feet
    d. Other hygienic and preventive maintenance care considered self-care (i.e., cleaning and soaking the feet, and the use of skin creams to maintain skin tone)
    e. Any service performed in the absence of localized illness, injury or symptoms involving the foot
49. Routine maternity care when you are traveling outside the plan service area. This includes prenatal, delivery and admission, and postpartum care.
50. Sclerotherapy, joint and ligamentous injections (prolotherapy) for non-symptomatic varicose veins
51. Sensory integration therapy
52. Services and supplies received for reasons of preference or convenience, including a preference to have services provided by a non-plan provider due to personal preference
53. 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 use care, crystal healing therapy, Rolfing®, regressive therapy, EST, and herbal therapy.

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

    Members who believe that their child may be handicapped (physical disability, mental disability, 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.
55. 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
56. Services for an organ donor if the recipient is not a member of the plan
57. Services for cosmetic reasons
58. Services for the organ donor that are covered by another insurer
59. Services furnished to someone other than the member
60. Services in a residential halfway house
61. 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
62. 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
63. Services or supplies that are not described as covered in this *Member Handbook*
64. 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 provider and the plan. Some examples include (but are not limited to): autopsies, ear plugs to prevent fluid from entering the ear canal during water activities, and nutritional supplements or formulas for adults or children unless described as covered in this *Member Handbook*. Services or supplies that do not meet the plan's medical criteria are not considered to be medically necessary.
65. 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**.
66. 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
67. Services received after the date that coverage ends
68. 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.
69. Services that are considered experimental or which have not been approved by a plan medical director

70. Services that are covered by another insurer
71. Services that have not been authorized by the plan, including nonemergency services received out of the Direct Care service area, or services beyond the plan benefit limits
72. Services to reverse a voluntary sterilization
73. Special duty or private duty nursing and attendant services
74. Specialty clothing appropriate to specific medical conditions
75. Tinnitus masker
76. Total body photography
77. 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
78. Transportation between hospitals when your medical condition does not warrant that you be transported to another facility
79. Treatment for personal growth, or other treatment that is not medically necessary, or not in keeping with national standards of practice
80. Vocational rehabilitation, including job retraining, or vocational and driving evaluations focused on job adaptability, or therapy to restore function for a specific occupation
81. White noise machines
82. Auditory integration therapy, such as Berard auditory integration therapy
83. Home video EEG monitoring
84. Any clinical research trial other than a qualified clinical trial for the treatment of cancer
85. Interspinous process decompression (or the X-Stop interspinous process decompression device)
86. Naturopath services (uses natural or alternative treatments)

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
- Cosmetic or beautifying surgeries, procedures, drugs, services, or appliances
- Dermabrasion for removal of acne scars
- Earlobe repair to close a stretched or torn ear pierce 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.

Facts about this plan

If you have questions regarding any aspect of the plan, you should contact the Plan Administrator named below who will help you understand fully your rights and obligations.

1. **Name of plan:**
   Group Insurance Commission Group Welfare Benefit Plan

2. **Name and address of plan sponsor:**
   The Group Insurance Commission
   19 Staniford Street
   Boston, MA 02114
   1-617-727-2310

3. **Federal Identification Number:**
   046002284

4. **Plan number:**
   501

5. **Type of plan:**
   The plan is a self-funded employee welfare plan that provides health benefits for eligible employees and their dependents.

6. **Type of administration:**
   The Plan Administrator is responsible for administering the plan. Certain administrative functions in connection with the plan, including claims processing, utilization review and the provision of a network of providers are to be performed by Fallon Health & Life Assurance Company, Inc. (FHLAC), as agreed to by GIC and FHLAC.

   Fallon Health & Life Assurance Company, Inc.
   10 Chestnut St.
   Worcester, MA 01608
   1-508-799-2100

7. **Person(s) eligible:**
   All persons who meet the eligibility requirements as defined in this *Member Handbook* of the Group Insurance Commission Group Welfare Benefit Plan.

8. **Plan benefits:**
   The plan provides group health benefits. Your *Member Handbook* contains a detailed description of benefits. If you lose or misplace your *Member Handbook*, you may obtain a new copy, without charge, from the Plan Administrator.

   For the member welfare benefit plan(s) described herein: GIC reserves the right to modify, suspend or terminate the plan or any benefit option or service therein, including the plan of benefits offered by the plan as described in this *Member Handbook*, for benefits payable there under, in whole or in part at any time and from time to time for any reason by written notification.

   In some situations, federal law may provide a right to continue benefits beyond the date upon which they otherwise would have terminated. Please refer to the COBRA section contained herein, which describes a federal law under which you and/or your dependents may have a right to continue coverage beyond the date it otherwise would terminate. See the Plan Administrator if you have any questions regarding this law or if you have any questions regarding other arrangements if any, may be made to continue your coverage beyond the date your employment terminates or you cease to be eligible.

9. **Effective date:**
   The plan, as described in this *Member Handbook*, became effective July 1, 2021.

10. Agent for service of legal process:

The Plan Administrator at the above address.

11. Plan records:

The financial records of the plan are maintained on the basis of a benefit period beginning on July 1, 2021 and ending on June 30, 2022.

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