Fallon Community Health Plan, Inc.

Schedule of Benefits

This Schedule of Benefits is part of your
Commonwealth of Massachusetts
Fallon Health Direct Care *Member Handbook.*
It describes your costs for health care.
Effective 7/1/2016

Copayments

This plan includes three different tiers for office specialist visit copayments. The amount of your copayment you pay depends on the tiering level of the plan specialist you visit.

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

Tier 2 (Good):** This tier includes plan specialists practicing at a good level of quality and/or cost-efficiency. You will pay the prevalent (mid-level) copayment when you see a Tier 2 specialist.

Tier 3* (Standard): This tier includes plan specialists practicing at a standard level of quality and cost efficiency. You will pay a higher copayment when you see a Tier 3 specialist.

Note: Fallon Direct Care tiers Cardiologists, Endocrinologists, ENTs/Otolaryngologists, Nephrologists, Neurologists, Ob/Gyns, Pulmonologists and Rheumatologists based on quality and cost-efficiency measures. Quality measures were not used for tiering Allergy/Immunology, Gastroenterology, Hematology/Oncology, Orthopedics, and Podiatry and Urology. Only the cost-efficiency measures were used to score these specialties.

Not Tiered/Insufficient Data (NT/ID): This designation includes plan specialists that did not have sufficient data for tiering and providers that belong to a specialty or subspecialty that is not being tiered by Fallon. If you see a NT/ID physician for prenatal or postnatal care, you pay a $15 copay: for office visits with a specialist, the copay is $60.

- You have a $15 copayment for office visits with your PCP.
- You have a $10 (Tier 1), $15 (Tier 2) or $25 (Tier 3) copayment for prenatal and postnatal visits.
- You have a $30 (Tier 1), $60 (Tier 2) or $90 (Tier 3) copayment for office visits with specialty physicians.

This plan includes a limit to the copayments you pay for inpatient admission copayments and outpatient surgery copayments. You are responsible for a maximum of one inpatient admission copayment per calendar quarter. You are responsible for a maximum of four outpatient surgery copayments per calendar year.

This plan includes a deductible. Your deductible is $300 per member/ $900 per family per benefit period for certain services, (If you are in a two person family contract your deductible is $600). Once you have met your deductible, you may still be responsible for a copayment when you receive certain services. After you receive services, we will send you a letter indicating the amount that has been applied to your deductible.

This plan includes an out-of-pocket maximum. There is a limit to your out-of-pocket costs each benefit period. This is called your out-of-pocket maximum. The out-of-pocket maximum includes your deductible, coinsurance and copayments you pay. It does not include your plan premium. **Your out-of-pocket maximum is $5,000 per member or $10,000 per family.** Each member must meet the per-member out-of-pocket maximum, unless the family out-of-pocket maximum applies. The family out-of-pocket maximum is considered met when any combination of members in a family reaches the family out-of-pocket maximum. Please note that once any one member in a family accumulates **$5,000** in out-of-pocket costs, that family member's out-of-pocket maximum is considered met, and that family member will have no additional out-of-pocket costs for the remainder of the benefit period.

Services that require plan prior authorization

The following covered services require prior authorization from the plan. Prior authorization must be requested by your PCP, or in some cases, your specialist.

- Non-emergency admissions to a hospital or other inpatient facility
- Some same-day surgery (outpatient) and ambulatory procedures
- Services with a non-plan provider
- Organ transplant evaluation and services
- Reconstructive and restorative services
- Infertility/assisted reproductive technology services
- Oral surgery (with the exception of the extraction of impacted teeth)
- Genetic testing
- Neuropsychological testing
- Prosthetics/orthotics and durable medical equipment
- Hospice care
- Non-emergency ambulance
- High tech radiology, including, but not limited to, all outpatient MRI/MRA, CT/CTA, PET and nuclear cardiology imaging studies
- Sleep study and/or sleep therapy
- Oxygen
- Outpatient mental health services (including intermediate care), beyond eight sessions
- Speech therapy
- Habilitative or rehabilitative care, including but not limited to applied behavioral analysis therapy, for the treatment of autism
- Therapeutic care for the treatment of autism
- Injections and injectables that are included on the formulary, that are for covered medical benefits, and that are ordered, supplied and administered by a plan provider
- Enteral formulas and special medical formulas
- Pulmonary rehabilitation services for chronic obstructive pulmonary disease (COPD)
- Intensity modulated radiation therapy (IMRT) of the breast
- Proton beam therapy
- Stereotactic radiosurgery and stereotactic body radiotherapy
- Treatment of cleft lip and cleft palate
- Brand name prescription contraceptive drugs and devices with no genergic equivalent
- Bariatric Weight Loss Surgery
- Gender reassignment, gender identity or gender dysphoria and related health care services

Diagnostic imaging services

You have a $100 copayment for MRIs, CT scans and PET scans, then subject to your deductible. This is limited to one copayment per day for these services.

It Fits! ™ benefit

Your contract includes additional coverage for services provided under the It Fits! ™ program to a maximum of $200 per member/$400 per family.

SmartShopper program

Your contract includes coverage for services provided under the SmartShopper program. Please go to the Fallon Health website at www.fallonhealth.org and visit the member portal for details.

Covered services

The following chart shows your costs for covered services. These costs apply to the services in the **Description of benefits** section of your *Member Handbook*. In summary, your responsibilities are as follows:

Covered services	Benefits
Ambulance services	
1. Ambulance transportation for an emergency	Covered in full after you meet your deductible
2. Ambulance transportation for preauthorized non-emergency transfers	Covered in full after you meet your deductible
Autism services *Prior authorization required*	
1. Habilitative and rehabilitative care	$15 copayment per visit
2. Applied behavior analysis when supervised by a board certified behavioral analyst	Covered in full
3. Therapeutic care, services including speech, physical and occupational therapy.	$15 copayment per visit
Durable medical equipment and prosthetic/orthotic devices *Referral and prior authorization required for most services*	
1. The purchase or rental of durable medical equipment and prosthetic/orthotic devices (including the fitting, preparing, repairing and modifying of the appliance).	20% coinsurance after you meet your deductible
2. Hearing aid(s)	
• Age 22 and older: benefit available once every 24 months	The first $500 of the purchase price is covered in full; you pay 20% of the next $1,500 of the purchase price plus all additional costs. Up to a maximum benefit of $1,700.
• Age 21 and under: Up to $2,000 per ear for hearing aid device only, benefit available once every 36 months • Related services and supplies for hearing aids (not subject to the $2,000 limit)	20% coinsurance after you meet your deductible
3. 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.	20% coinsurance
4. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy	Covered in full after you meet your deductible
5. Oxygen and related equipment	20% coinsurance after you meet your deductible
6. Insulin pump and insulin pump supplies	Covered in full
7. Portable oxygen concentrator	20% coinsurance after you meet your deductible

Covered services	Benefits
Emergency and urgent care	
1. Emergency room visits	$100 copayment per visit then subject to your deductible
2. Emergency room visits when you are admitted to an observation room	Covered in full after you meet your deductible
3. Urgent care visits in a doctor's office or at an urgent care facility	$15 copayment per visit
4. Emergency prescription medication provided out of the Direct Care service area as part of an approved emergency treatment	Tier 1: $10 copayment Tier 2: $30 copayment Tier 3: $65 copayment for up to a 14-day supply
Enteral formulas and low protein foods *Referral and prior authorization required for enteral formulas*	
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	Covered in full after you meet your deductible
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.	Covered in full after you meet your deductible
Home health care services	
1. Part-time or intermittent skilled nursing care and physical therapy provided in your home by a home health agency	Covered in full after you meet your deductible
2. Additional services and supplies that are determined to be a medically necessary component of skilled nursing care and physical therapy	Covered in full after you meet your deductible
Hospice care services *Referral and prior authorization required*	Covered in full
Hospital inpatient services *Referral and prior authorization required*	
1. 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	$275 copayment per admission then subject to your deductible (*you are responsible for up to one copayment per member per calendar quarter)*

Covered services	Benefits
Infertility/assisted reproductive technology (ART) services* *Referral and prior authorization required (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP)*	
1. Office visits for the consultation, evaluation and diagnosis of fertility	$15 copayment per visit with your PCP and certain other providers Specialist: Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $90 copayment per visit
2. Diagnostic laboratory and X-ray services	Covered in full after you meet your deductible
3. Artificial insemination, such as intrauterine insemination (IUI)	Covered in full after you meet your deductible
4. Assisted reproductive technologies*except for those services listed below	Covered in full after you meet your deductible
5. Assisted reproductive technologies for: • In vitro fertilization (IVF-ET) • Gamete intrafallopian transfer (GIFT) • Zygote intrafallopian transfer (ZIFT)	$250 copayment per procedure after you meet your deductible
6. 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	Covered in full after you meet your deductible
* See the **Description of benefits** section of your *Member Handbook* for a list of covered infertility/ART services.	
Maternity services 1. Obstetrical services including prenatal, childbirth, postnatal and postpartum care	Prenatal (first visit only): Tier 1: $10 copayment Tier 2: $15 copayment Tier 3: $25 copayment Postnatal (per visit): Tier 1: $10 copayment Tier 2: $15 copayment Tier 3: $25 copayment
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, including 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.	$275 copayment per admission then subject to your deductible *(you are responsible for up to one copayment per member per calendar quarter)*

Covered services	Benefits
Mental health and substance abuse services Note: Effective for plan years beginning on or after October 1, 2015, Massachusetts state law (Chapter 258 of the Acts of 2014) restricts the circumstances in which insurers may require prior authorization for substance abuse services. We will not require prior authorization for substance abuse services in any circumstances where this is not allowed by Chapter 258. Please see the Fallon Handbook or call Fallon for more information.	
Inpatient services *Prior authorization required for the services below, except:* • *The first 14 days of acute treatment services or clinical stabilization services for substance abuse or addiction; the admitting facility must notify Fallon of admission.* • *Substance abuse services where the services are provided by a Massachusetts Department of Public Health licensed provider.* *Please contact Fallon with any questions about prior authorization requirements.*	
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.	Covered in full
2. Professional services provided by physicians or other health care professionals for the treatment of mental conditions while you are an inpatient.	Covered in full
Intermediate services *Prior authorization required for the services below, except:* • *The first 14 days of acute treatment services or clinical stabilization services for substance abuse or addiction; the admitting facility must notify Fallon of admission.* • *Substance abuse services where the services are provided by a Massachusetts Department of Public Health licensed provider.* *Please contact Fallon with any questions about prior authorization requirements.* *Intermediate services include but are not limited to:*	
1. Acute and other residential treatment-Mental health services provided in a 24-hour setting therapeutic environments.	Covered in full
2. Clinically managed detoxification services-24 hour, 7 days a week, clinically managed de-tox services in a licensed non-hospital setting that include 24 hour per day supervision	Covered in full
3. Partial Hospitalization-Short-term day/evening mental health programming available 5 to 7 days per week.	$15 copayment per visit
4. Intensive outpatient programs-Multimodal, inter-disciplinary, structured behavioral health treatment provided 2-3 hours per day, multiple days per week.	$15 copayment per visit
5. Day treatment-program encompasses some portion of the day or week rather than a weekly visit	$15 copayment per visit
6. Crisis Stabilization-Short-term psychiatric treatment in a structured, community based therapeutic environments.	$15 copayment per visit
7. In-home therapy services	$15 copayment per visit

Covered services	Benefits
Mental health and substance abuse services, continued	
Outpatient services	
1. Outpatient office visits, including individual, group or family therapy. The actual number of visits authorized beyond the initial eight is based on medical necessity as determined by the plan, and may include individual, group, or family therapy.(Prior authorization required beyond eight visits, except for substance abuse treatment by a Massachusetts Department of Public Health licensed or certified provider. Please contact Fallon with any questions about prior authorization requirements.)	$15 copayment per visit
2. Psychopharmacological services, such as visits with a physician to review, monitor and adjust the levels of prescription medication to treat a mental condition	$15 copayment per visit
3. Neuropsychological assessment services when medically necessary	$15 copayment per visit

Covered services	Benefits
Office visits and outpatient services	
1. Office visits, to diagnose or treat an illness or an injury	$15 copayment per visit with your PCP and certain other providers Specialist: Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $90 copayment per visit
2. A second opinion, upon your request, with another plan provider	$15 copayment per visit with your PCP and certain other providers Specialist: Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $90 copayment per visit
3. Injections and injectables that are included on the formulary, that are for covered medical benefits, and that are ordered, supplied and administered by a plan provider	Covered in full after you meet your deductible
4. Allergy injections	Covered in full
5. Radiation therapy	Covered in full after you meet your deductible
6. Respiratory therapy	Covered in full after you meet your deductible
7. Hormone replacement services in the doctor's office for perimenopausal or postmenopausal women	$15 copayment per visit
8. Audiological examination for the purpose of prescribing a hearing aid. Coverage is limited to one exam every two years.	$15 copayment per visit
9. Diagnostic lab and X-ray services ordered by a plan provider, in relation to a covered office visit	Covered in full after you meet your deductible
10. High-tech imaging services, including but not limited to, MRI/MRA, CT/CTA, PET scans and nuclear cardiology imaging. Limited to one copayment per day when performed at the same facility for the same diagnosis. (Prior authorization required.)	$100 copayment per MRI, CT scan, PET scan or nuclear cardiology imaging then subject to your deductible
11. Electrocardiogram (EKG)	Covered in full
12. Chiropractic services for acute musculoskeletal conditions. The condition must be new or an acute exacerbation of a previous condition. Coverage is provided for up to 12 office visits in each benefit period. The actual number of visits provided is based on medical necessity as determined by your plan provider and the plan.	$15 copayment per office visit
13. Outpatient renal dialysis at a plan-designated center or continuous ambulatory peritoneal dialysis	Covered in full after you meet your deductible
14. Diabetes outpatient self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider	$15 copayment per visit

Covered services	Benefits
Office visits and outpatient services, continued	
15. Laboratory tests necessary for the diagnosis or treatment of diabetes, including glycosylated hemoglobin, or HbAlc, tests, and urinary/protein/ microalbumin and lipid profiles	Covered in full after you meet your deductible
16. 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.	$15 copayment per visit
17. Consultations, examinations, procedures and medical services related to: • genetic counseling; • elective sterilization • termination of pregnancy in an office setting (Note: Termination of pregnancy or other procedures provided in a hospital outpatient, day surgery or ambulatory care facility are subject to the outpatient surgery copayment.)	$15 copayment per visit
18. Outpatient surgery, anesthesia and the medically necessary preoperative and postoperative care related to the surgery	$250 copayment per surgery then subject to your deductible, when provided in a hospital outpatient, day surgery or ambulatory care facility (*you are responsible for up to four copayments per member per calendar year)*
19. 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)	$15 copayment per visit

Covered services	Benefits
Oral surgery and related services	
Referral and prior authorization required (except for extraction of impacted teeth or lingual frenectomy)	
1. Removal or exposure of impacted teeth, including both hard and soft tissue impactions, or an evaluation for this procedure	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $90 copayment per visit
2. Surgical treatments of cysts, affecting the teeth or gums, that must be rendered by a plan oral surgeon	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $90 copayment per visit
3. Treatment of fractures of the jaw bone (mandible) or any facial bone	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $90 copayment per visit
4. Evaluation and surgery for the treatment of temporomandibular joint disorder when a medical condition is diagnosed, or for surgery related to the jaw or any structure connected to the jaw	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $90 copayment per visit
5. Extraction of teeth in preparation for radiation treatment of the head or neck	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $90 copayment per visit
6. Surgical treatment related to cancer	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $90 copayment per visit
7. Emergency medical care, such as, to relieve pain and stop bleeding as a result of accidental injury to sound natural teeth or tissues, when provided as soon as medically possible after the injury. This does not include restorative or other dental services. No referral or authorization is required. Go to the closest provider. Note: Benefits are provided for the dental services listed below only when the Member has a serious medical condition that makes it essential that he or she be admitted to a general 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.	$15 copayment per visit in a physician's or dentist's office. $100 copayment per visit in an emergency room then subject to your deductible
8. Removal of 7 or more permanent teeth	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $90 copayment per visit
9. Gingivectomies (including osseous surgery) of two or more gum quadrants	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $90 copayment per visit
10. Excision of radical cysts, affecting the roots of 3 or more teeth or gums, that must be rendered by a plan oral surgeon	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $90 copayment per visit
11. Removal of one or more impacted teeth	Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $90 copayment per visit
Note: See **Office visits and outpatient services** for diagnostic lab and X-ray services.	

Covered services	Benefits
Organ transplants *Referral and prior authorization required* 1. Office visits related to the transplant	$15 copayment per visit with your PCP and certain other providers Specialist: Tier 1: $30 copayment per visit Tier 2: $60 copayment per visit Tier 3: $90 copayment per visit
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	$275 copayment per admission then subject to your deductible *(you are responsible for up to one copayment per member per calendar quarter)*
3. Human leukocyte antigen (HLA) or histocompatibility locus antigen testing for A, B or DR antigens, or any combination thereof, necessary to establish bone marrow transplant donor suitability of a member	Covered in full after you meet your deductible
Limited to one inpatient copayment per calendar quarter. If you are re-admitted within a 30-day period in the same calendar year, we will waive the second copayment.	
Prescription drugs *Covered prescription items:* • Prescription medication • Contraceptive drugs and devices (Note: generic contraceptive drugs and devices are covered in full.) • Hormone replacement therapy • Injectable agents (self-administered*) • Insulin • Syringes or needles (including insulin syringes) when medically necessary • Insulin pens • Supplies for the treatment of diabetes, as required by state law, including: – blood glucose monitoring strips – urine glucose strips – lancets – ketone strips • Special medical formulas to treat certain metabolic disorders as required by state law (prior authorization required). • Certain injectable medications administered in the home setting, when approved by Fallon and received through a plan-approved pharmacy vendor	*Network pharmacy:* Tier 1: $10 copayment Tier 2: $30 copayment Tier 3: $65 copayment for up to a 30-day supply *Mail-order pharmacy:* Tier 1: $25 copayment Tier 2: $75 copayment Tier 3: $165 copayment for up to a 90-day supply
* Injectables administered in the doctor's office or under other professional supervision are generally covered as a medical benefit.	
Orally administered anticancer medications used to kill or slow the growth of cancerous cells	Covered in full
A generic preferred program is now in place. This means that if you fill a prescription with a brand-name drug when a generic is available, you will be responsible for the generic drug copayment plus the cost difference between the two drugs.	

Covered services	Benefits
Preventive care	
1. Routine physical exams for the prevention and detection of disease	Covered in full
2. Immunizations that are included on the 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.	Covered in full
3. A baseline mammogram for women age 35 to 40, and a yearly mammogram for women age 40 and older	Covered in full
4. Routine gynecological care services, including an annual Pap smear (cytological screening) and pelvic exam	Covered in full
5. Routine eye exams, once in each 24-month period	$15 copayment per visit
6. Hearing and vision screening	Covered in full
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	Covered in full
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	Covered in full
9. Female consultations, examinations, procedures, contraceptive devices, and medical services related to the use of all contraceptive methods* * Prescription contraceptive devices are covered under the prescription drug benefit.	Covered in full
Reconstructive surgery *Referral and prior authorization required (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP)* 1. 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, including Massachusetts mandated services for cleft lip and cleft palate	$275 copayment per admission then subject to your deductible *(you are responsible for up to one copayment per member per calendar quarter)*

Covered services	Benefits
Rehabilitation and habilitation services *Referral required*	
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 per injury or illness, beginning with the first office visit. Visits after 90 days require prior authorization.	$15 copayment per visit
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 per injury or illness, beginning with the first office visit. Visits after 90 days require prior authorization.	$15 copayment per visit
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 plan facility or plan provider's office (Prior authorization required)	$15 copayment per visit
4. Cardiac rehabilitation services to treat cardiovascular disease in accordance with state law and Department of Public Health regulations	Covered in full after you meet your deductible
5. Medically necessary early intervention services delivered by a certified early intervention specialist, according to operational standards developed by the Department of Public Health, for children from birth to their third birthday. Early intervention services include applied behavior analysis (ABA) therapy. See the **Autism services** section of your Evidence of Coverage for details. Benefits are only available to members who are residents of Massachusetts or whose principal place of employment is in Massachusetts. Services require prior authorization.	Covered in full
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. (Prior authorization required)	Covered in full after you meet your deductible
Skilled nursing facility services *Referral and prior authorization required*	
1. Inpatient hospital services, for up to 100 days per benefit period provided criteria is met, 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	Covered in full after you meet your deductible