Fallon Health & Life Assurance Co., Inc.

Schedule of Benefits

This *Schedule of Benefits* is part of your
Teamsters Local 170 Health and Welfare Benefit Plan
using the FCHP Select Care network
Member Handbook.
It describes your costs for health care.

This Schedule of Benefits shows your copayments and coinsurance for the covered services outlined in the Teamsters Local 170 Health and Welfare Benefit Plan *Member Handbook*. It also outlines any of your benefits that differ from those shown in the *Member Handbook*. The information in this document replaces any information in your *Member Handbook* that conflicts with it. If you have any questions about your benefits, please call Customer Service at 1-800-868-5200 (TTY users please call TRS Relay 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, 2012 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, 2012. 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 (617) 521-7794 or visiting its website at www.mass.gov/doi.

The following changes apply to your *Member Handbook*:

Copayments

This plan includes two different office visit copayments. The amount of the office visit copayment you pay depends on the provider of the services:

1.) You have a $20 copayment for most office visits with your primary care provider (PCP) and the following specialists:
   - mental health and substance abuse providers
   - chiropractors
   - physical and occupational therapists
   - speech-language pathologists and audiologists
   - early intervention specialists
   - obstetricians and gynecologists
   - podiatrists
   - certified nurse midwives
   - nurse practitioners who bill independently

2.) You have a $35 copayment for office visits with any specialist not listed above.

Out-of-pocket maximum

There is a dollar limit to the amount of coinsurance and copayments you must pay in each calendar year. The out-of-pocket maximum includes your coinsurance and copayments you pay except copayments for prescription drugs and chiropractic, mental and behavioral health services. It does not include your plan premium. **You are responsible for an out-of-pocket maximum of $2,000 per member/$4,000 per family in each calendar year.** 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 family members reaches the out-of-pocket maximum. No individual family member will pay more than the per-member out-of-pocket maximum in a calendar year.

The plan will keep track of the amounts that apply to your out-of-pocket maximum. When you reach the out-of-pocket maximum, we will send you a letter that indicates that you have reached your out-of-pocket maximum and that no further amounts will be required for the remainder of the year.

If you pay any amounts that you are not responsible for, please contact Customer Service, or you may send a letter to Fallon Community Health Plan, Customer Service, 10 Chestnut St., Worcester, MA 01608. Include your name, address, member ID, proof of payment and an address to which the reimbursement should be sent. You must submit a claim for reimbursement within one year of the date of service.

It Fits!™ benefit

Your group contract includes coverage for services provided under the *It Fits!*™ program to a maximum of $150 per member/$300 per family.

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 Teamsters Local 170 Health and Welfare Benefit Plan *Member Handbook*. In summary, your responsibilities are as follows:

Covered services	Benefits
Ambulance services	
1. Ambulance transportation for an emergency	Covered in full
2. Ambulance transportation for non-emergency situations, when medically necessary	Covered in full
Autism services *Prior authorization required*	
1. Habilitative and rehabilitative care including but not limited to applied behavior analysis when *supervised by a board certified behavioral analyst*	$20 copayment per visit
2. Therapeutic care, services including speech, physical and occupational therapy.	$20 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).	30% coinsurance
2. 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 up to $350 per member per calendar year when the prosthesis is determined to be medically necessary by a plan physician and the plan.	30% coinsurance
3. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy	30% coinsurance
4. Prosthetic limbs which replace, in whole or in part, an arm or leg.	20% coinsurance
5. Insulin pump and insulin pump supplies	Covered in full
6. Breast pumps	Covered in full
7. Hearing aids and supplies, when prescribed by a plan provider and obtained from a network provider	Covered in full up to $2,000 in each 36-month period
Emergency and urgent care	
1. Emergency room visits	$150 copayment per visit
2. Emergency room visits when you are admitted to an observation room	Covered in full
3. Emergency room visits when you are admitted as an inpatient	Covered in full
4. Urgent care visits in a doctor's office or at an urgent care facility	$20 copayment per visit
5. Emergency prescription medication provided out of the FCHP Select Care service area as part of an approved emergency treatment	Tier 1: $15 copayment Tier 2: $30 copayment Tier 3: $50 copayment for up to a 14-day supply

Covered services	Benefits
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
2. Additional services and supplies that are determined to be a medically necessary component of skilled nursing care and physical therapy	Covered in full
Hospice care services *Referral and prior authorization required*	Covered in full
Hospital inpatient services *Referral and prior authorization required*	
1. Room and board in a semiprivate room or a private room when medically necessary	$500 copayment per admission
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	Covered in full
3. Physician and surgeon services	Covered in full
4. General nursing services	Covered in full
5. Intensive and/or coronary care	Covered in full
6. Dialysis services	Covered in full
7. Medical, surgical or psychiatric services	Covered in full
8. Nursing services provided by a certified registered nurse anesthetist	Covered in full
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	$20 copayment per visit with your PCP and certain other providers $35 copayment per visit with a specialist
2. Diagnostic laboratory and X-ray services	Covered in full
3. Artificial insemination, such as intrauterine insemination (IUI)	Covered in full
4. Assisted reproductive technologies*	Covered in full
5. Sperm, egg, and/or inseminated egg procurement, processing and banking when associated with an approved active cycle, to the extent that such costs are not covered by the donor's insurer	Covered in full
* See the **Description of benefits** section of your *Member Handbook* for a list of covered infertility/ART services.	

Covered services	Benefits
Maternity services	
1. Obstetrical services including prenatal, childbirth, postnatal and postpartum care	Prenatal: $20 copayment first visit only Postnatal: $20 copayment per visit
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.	$500 copayment per admission
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	Covered in full
Mental health and substance abuse services **Inpatient services** *Prior authorization required*	
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

Covered services	Benefits
Mental health and substance abuse services, continued **Intermediate services** *Prior authorization required* *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.	$20 copayment per visit
4. Intensive outpatient programs-Multimodal, inter-disciplinary, structured behavioral health treatment provided 2-3 hours per day, multiple days per week.	$20 copayment per visit
5. Day treatment-program encompasses some portion of the day or week rather than a weekly visit	$20 copayment per visit
6. Crisis Stabilization-Short-term psychiatric treatment in a structured, community based therapeutic environments.	$20 copayment per visit
7. In-home therapy services	$20 copayment per visit
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.	$20 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	$20 copayment per visit
3. Neuropsychological assessment services when medically necessary	$20 copayment per visit

Covered services	Benefits
Office visits and outpatient services	
1. Office visits, to diagnose or treat an illness or an injury	$20 copayment per visit with your PCP and certain other providers $35 copayment per visit with a specialist
2. A second opinion, upon your request, with another plan provider	$20 copayment per visit with your PCP and certain other providers $35 copayment per visit with a specialist
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
4. Allergy injections	Covered in full
5. Radiation therapy	Covered in full
6. Respiratory therapy	Covered in full
7. Hormone replacement services in the doctor's office for perimenopausal or postmenopausal women	$20 copayment per visit
8. Diagnostic lab and X-ray services ordered by a plan provider, in relation to a covered office visit	Covered in full
9. High-tech imaging services, including but not limited to, MRI/MRA, CT/CTA, PET scans and nuclear cardiology imaging. *(Prior authorization required.)*	Covered in full
10. Chiropractic services for acute musculoskeletal conditions. The condition must be new or an acute exacerbation of a previous condition. Coverage is provided for up to 20 office visits in each calendar year. The actual number of visits provided is based on medical necessity as determined by your plan provider and the plan.	$20 copayment per visit
11. Outpatient renal dialysis at a plan-designated center or continuous ambulatory peritoneal dialysis	Covered in full
12. Diabetes outpatient self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider	$20 copayment per visit
13. 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
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.	$20 copayment per visit

Covered services	Benefits
Office visits and outpatient services, continued 15. Outpatient surgery, anesthesia and the medically necessary preoperative and postoperative care related to the surgery	$300 copayment per surgery when provided in a hospital outpatient, day surgery or ambulatory care facility $20 copayment per visit when provided in an office
16. 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)	$20 copayment per visit
Oral surgery and related services *Referral and prior authorization required (except for extraction of impacted teeth)* 1. Removal or exposure of impacted teeth, including both hard and soft tissue impactions, or an evaluation for this procedure	$35 copayment per visit
2. Surgical treatments of cysts, affecting the teeth or gums, that must be rendered by a plan oral surgeon	$35 copayment per visit
3. Treatment of fractures of the jaw bone (mandible) or any facial bone	$35 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	$35 copayment per visit
5. Lingual frenectomy	$35 copayment per visit
6. 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.	$20 copayment per visit to a physician's or dentist's office $150 copayment per visit to an emergency room
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	 $20 copayment per visit with your PCP and certain other providers $35 copayment per visit with a specialist
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	$500 copayment per admission
3. Professional services provided to you while you are an inpatient, including, but not limited to medical, surgical and psychiatric services	Covered in full
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	Covered in full
Prescription drugs *Covered prescription items:* • Prescription medication • Prescription contraceptive drugs and devices* • Hormone replacement therapy for per- and post-menopausal women • Injectable agents (self-administered**) • Insulin • Syringes (including insulin syringes) or needles when medically necessary • Supplies for the treatment of diabetes, as required by state law, including: – blood glucose monitoring strips – urine glucose strips – lancets – ketone strips * Generic prescription contraceptive drugs and devices are covered in full. Brand name prescription contraceptive drugs and devices with no generic equivalent are covered in full (prior authorization required). ** Injectables administered in the doctor's office or under other professional supervision are covered as a medical benefit.	*Network pharmacy:* Tier 1: $15 copayment Tier 2: $30 copayment Tier 3: $50 copayment for up to a 30-day supply *Mail-order pharmacy:* Tier 1: $30 copayment Tier 2: $60 copayment Tier 3: $100 copayment for up to a 90-day supply

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 FCHP 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. Hearing and vision screening	Covered in full
6. 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
7. 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
8. Voluntary family planning	Covered in full
9. Consultations, examinations, procedures and medical services related to the use of all contraceptive methods	Covered in full
10. Contraceptive devices that are supplied by an FCHP Select Care network provider during an office visit*	Covered in full
* Prescription contraceptive devices are covered under the prescription drug benefit.	

Covered services	Benefits
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 inpatient	$500 copayment per admission
Rehabilitation services *Referral and prior authorization required*	
1. Physical therapy to restore function after medical illness, accident or injury. Coverage is provided for up to 60 non-consecutive office visits per illness or injury in each calendar year when medically necessary.	$20 copayment per visit
2. Occupational therapy to restore function after medical illness, accident or injury. Coverage is provided for up to 60 non-consecutive office visits per illness or injury in each calendar year when medically necessary.	$20 copayment per visit
3. Respiratory therapy to restore function after medical illness, accident or injury	$20 copayment per visit
4. Treatment for acute episodes of an illness related to a chronic condition when the benefit limit has not been exceeded	$20 copayment per visit
5. Medically necessary services for the diagnosis and treatment of speech, hearing and language disorders when services are provided by an FCHP Select Care provider who is a speech-language pathologist or audiologist; and at an FCHP Select Care provider facility or FCHP Select Care provider's office. Coverage is provided for up to 60 non-consecutive office visits per illness or injury in each calendar year when medically necessary	$20 copayment per visit
6. Cardiac rehabilitation services to treat cardiovascular disease in accordance with state law and Department of Public Health regulations	Covered in full
7. 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. Benefits are limited to a maximum of $5,200 per calendar year per child and an aggregate benefit of $15,600 over the term of the child's plan membership.	Covered in full

Covered services	Benefits
Skilled nursing facility services *Referral and prior authorization required*	
1. Room and board in a semiprivate room (or private room if medically necessary), for up to 100 days in each calendar year, provided criteria is met	$500 copayment per admission
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	Covered in full
3. Physician services	Covered in full
Special formulas *Referral and prior authorization required*	
1. Special medical formulas to treat certain metabolic disorders as required by state law. Metabolic disorders covered under state law include: phenylketonuria, tyrosinemia; homocystinuria; maple syrup urine disease; propionic academia; and methylmalonic academia in a dependent child, including when medically necessary to protect unborn fetuses of pregnant women with phenylketonuria.	Covered in full
2. 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
3. Food products that have been modified to be low in protein for individuals with inherited diseases of amino acids and organic acids. Coverage is provided for up to $2,500 per member in each calendar year. You may be required to purchase these products over the counter and submit claims to the plan for reimbursement.	Covered in full

As stated in the *Member Handbook,* Fallon Community Health Plan is a federally qualified health plan, and its arrangements with plan sponsors generally are designed in light of applicable laws and regulations. However, this arrangement, entered into at the request of your plan sponsor, may or may not meet all of the specific legal requirements for federal qualification and should not be considered a federally qualified line of business.