Teamsters Local 170
Health and Welfare Benefit Plan

Using the Fallon Health Direct Care network

Member Handbook

Administered by
Fallon Health & Life Assurance Company, Inc.

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 ម្នាសំណួរអ្ំពី Fallon Health បេ,
អ្នកម្នាសិេធិេេួលជំនួយនិងព័ែ៌ម្នាន ជៅកនុងភាសា ររស់អ្នក
ជោយមិនអ្ស់ប្ាក់ ។ បែើមបីនិយាយជាមួយអ្នករកដប្រ សូម 1-800-868-5200 ។

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

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

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

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

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

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

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

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

Notice of nondiscrimination

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

Fallon Health:

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

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

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

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

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

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

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

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

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

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

Welcome!

Teamsters Local 170 Health and Welfare Fund has arranged to provide you with a comprehensive health care plan in conjunction with Fallon Health & Life Assurance Company, Inc. (FHLAC). The Teamsters Local 170 Health and 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.

Teamsters Local 170 Health and Welfare Fund administers the plan, and has the right to make rules about eligibility for benefits and the level of benefits available. Teamsters Local 170 Health and Welfare Fund may amend the rules and benefits at any time. Teamsters Local 170 Health and Welfare Fund has the right to interpret the terms of this document and will interpret and apply its terms in situations not expressly addressed in this document. Teamsters Local 170 Health and Welfare Fund 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. Throughout this document, references to “Fallon”, “Fallon Health” or “FHLAC” may refer to services provided by 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 1-800-868-5200 (TRS 711).

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Glossary

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

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

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

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

Copayment: The amount you are responsible to pay for covered services. The copayment amounts for services are listed in the accompanying *Schedule of Benefits*.

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.

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

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

Deductible carryover: Any deductible amount that is incurred by the member for services rendered during the last three months of the coverage period. This may be applied toward the deductible for the next coverage period. Deductible amounts are incurred as of the date of the service.

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 Fallon, 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 the Fallon Direct Care. The counties 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, as shown on our records, on which your coverage begins under this contract or under an amendment to it. Your effective date is determined by your employer group in accordance with the group agreement for waiting periods, open enrollment periods and special qualifying events.

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.

ERISA: The Employee Retirement Income Security Act of 1974, and regulations thereunder, as may be amended from time to time.

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. There is a physician bill and the hospital also bills 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 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.

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

Group: Any partnership, association or corporation that has an agreement to pay the plan or its agent the premium charge for a group of subscribers.

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 have a 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").

Network pharmacy: A licensed pharmacy in the Direct Care network, with whom we contract to provide covered prescription drugs to members.

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 the group anniversary date.

Out-of-pocket maximum: The total amount of deductible, coinsurance and copayments you are responsible for in a coverage 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 Teamsters Local 170 Health and 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 Fallon contracts 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 Fallon contracts 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: Teamsters Local 170 Health and Welfare Fund Board of Trustees

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 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 is employed by the Reliant Medical Group and who practices within the Reliant Medical Group practice.

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

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

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

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

Subscriber: The person who is responsible for the premium charge. On group plans, the subscriber is typically a member of Teamsters Local 170 Health and Welfare Fund.

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.

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.

About this *Member Handbook*

This *Member Handbook* is effective January 1, 2021. There are no waiting periods or pre-existing condition limitations under this contract. You may use the services described here beginning on January 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 network 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 FHLAC needs 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.

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. Teamsters Local 170 Health and Welfare Fund 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 network is a Limited Provider Network. The Direct Care network provides access to a network that is smaller than the Select Care network. In this plan, members have access to network benefits only from the providers in the Direct Care network. Please consult the Direct Care provider directory – a paper copy can be requested by calling the Customer Service Department at 1-800-868-5200 (TRS 711) – or visit the provider search tool at fallonhealth.org to determine which providers are included in Direct Care.
- The Direct Care network service area includes all cities and towns in the following counties: Bristol, Essex, Middlesex, Norfolk, Plymouth and Suffolk. The service area includes all cities and towns in Worcester County with the exception of Athol and Royalston. The service area includes the following town in Hampshire County: Ware. The service area includes the following towns in Hampden County: Brimfield, Holland, Monson, Palmer and Wales.
- When you join this health plan, you choose a primary care provider (PCP) who coordinates your health care. You will not require a referral 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 prior authorization from the health plan.
- This health plan maintains a formulary, or a list of medications, approved for coverage.
- This health plan requires prior authorization for certain services and the site of where those services will be provided.

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 Fallon or 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 the necessary prior authorization are not covered services. Services that are not medically necessary are not covered services. Services and supplies you receive from providers who are not in the Direct Care network are not covered services, unless you received prior authorization to go to that provider. Unauthorized services will be the financial responsibility of the member.

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, or you may be asked for your card when you fill a prescription at a network pharmacy.

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

Notifying us of changes

Contact Customer Service to report any changes in your name, address, phone number, 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 your Plan Administrator 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 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
1-800-868-5200 (TRS 711)
fallonhealth.org

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 you lose or damage your card

To notify us of changes

- 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

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

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

- **Register and log into myFallon** – a secure area to view your specific benefit information, view your claims, change your PCP, print a temporary ID card and more
- Search for a doctor in the provider directories
- 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 to obtain names of plan providers in your area.

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 1-800-868-5200 or visit fallonhealth.org 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 1-800-868-5200 or visit fallonhealth.org.

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.

For some services, your PCP is authorized to give you a referral to see a plan specialist (see **PCP referral**). If you receive services from any doctor, hospital or other health care provider outside of the Direct Care network without getting a prior authorization from FHLAC, you will have to pay for these services yourself.

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.)
- 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 specialist 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 plan specialist.
- Podiatric care. Your PCP will give you a prescription 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.

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 one business day. If the service is authorized, we will send you and your PCP an authorization letter within one business day after the determination has been made. When you get the letter, you can call a plan specialist to make an appointment. The authorization letter will state the services the plan has approved for coverage. Make sure that you have this prior authorization letter before any services requiring prior authorization are furnished to you.

If the specialist feels you need services beyond those authorized, the specialist will ask for prior authorization directly from FHLAC. If the request for additional services is approved, we will send both you and your PCP an authorization letter.

If a service is not authorized, we will send you and your PCP a denial letter within one business day of the decision. The denial letter will explain the reasons for our decision and your right to file an appeal. For information on filing an appeal, see **Inquiries, appeals and grievances**.

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
- 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
- Intermediate community-based mental health services for children and adolescents under the age of 19
- Speech therapy
- Habilitative or rehabilitative care, including but not limited to ABA therapy for the treatment of autism

- Therapeutic care for the treatment of autism
- Certain drugs covered under medical benefits, and that are ordered, supplied and administered by a plan provider.
- Intensity modulation radiation therapy (IMRT) of the breast
- Proton beam therapy
- Stereotactic radiosurgery and stereotactic body radiotherapy
- Second opinion and access to specialty care from Dana Farber Cancer Institute
- Enteral formulas and special medical formulas
- Brand name prescription contraceptive drugs and devices with no generic equivalent
- Bariatric weight loss surgery
- Treatment of cleft lip and cleft palate
- Gender reassignment, gender identity or gender dysphoria 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)

* Prior authorization will not be required for inpatient behavioral health admissions after treatment in an emergency department.

For substance use services, prior authorization rules will follow Massachusetts state law as established by Chapter 258 of the Acts of 2014. We will not require prior authorization for substance use services in any circumstances where this is not allowed by Chapter 258.

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*. The same copayments and benefit limits apply.
- 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 FHLAC.
- The provider to whom you are referred is on staff at one of the six medical centers listed below:
  - — Beth Israel Deaconess Hospital
  - — Brigham and Women's Hospital
  - — Children's Hospital (Boston)
  - — Dana-Farber Cancer Institute
  - — Massachusetts General Hospital
  - — Tufts Medical Center
- 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 that Tufts Medical Center is 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 FHLAC has 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 services 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 1-800-868-5200, 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 provided by Fallon preferred home infusion providers. For outpatient hospital administration, the first doses may be given at 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.

Confidentiality of member information

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

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

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

This notice is provided to all new subscribers upon enrollment and is available on fallonhealth.org (keyword: "privacy policies"), or for a printed copy call our Customer Service Department at 1-800-868-5200 (TRS 711).

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 the 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. This includes, but is not limited to, cases where the treatment does not meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care or effectiveness. A rescission of coverage may also be appealed.

Making an inquiry

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

Call: 1-800-868-5200 (TRS 711)
Monday, Tuesday, Thursday, and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

E-mail: cs@fallonhealth.org

Write: Fallon Health & Life Assurance Company, 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.

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. A rescission of coverage may also be appealed.

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

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 and 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, 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.

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

Expedited external review

You may request an expedited (fast) external review. You may request an expedited external review under the following circumstances:

- Your appeal involves a medical condition for which the timeframes for completion of a standard appeal would seriously jeopardize your life, health, or ability to regain maximum function
- Your appeal involves an admission, availability of care, continued stay, or health care item or service for which you have received emergency services, but have not been discharged from the hospital

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

Filing a grievance

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

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

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

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

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

E-mail: grievance@fallonhealth.org

Fax: 1-508-755-7393

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 from the time the issue arose.

ERISA

As a participant or a beneficiary of an employee welfare benefit plan under ERISA (Employee Retirement Income Security Act of 1974), you may have a right to bring a civil action under ERISA section 502(a) following an adverse benefit determination. Please see your Summary Plan Description provided by Teamsters Local 170 Health and Welfare Fund for a complete statement of your rights.

The claims process

Claims, reimbursements and refunds

When you obtain a covered service, the only payment that a plan 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. 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 coverage information on the back of the claim and return it to the provider's office with a request to bill FHLAC 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.

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

Adjustments or refunds will be approved in accordance with our underwriting guidelines. The plan 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.

Claims for Pharmacy Services

Pharmacy reimbursement requests must be submitted within 1 year of date of service. Send claims to:

Write: CVS/Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Submit through CVS/Caremark Portal: http://www.caremark.com/wps/portal

Submit through Mobile Application: CVSCaremark app

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.

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 the benefits we provide to you 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 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 cooperating includes providing us with all necessary documentation and information and the assignments 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

You are eligible to enroll in the plan as long as you live or work in the Direct Care service area and you meet underwriting guidelines.

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

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. Adopted children are included from the date of placement in the home or, in the case of a foster child, from the date of the filing of the petition to adopt. If your dependent child has a child, that child is included as a family member as long as your dependent child remains enrolled. (See **Age limits for dependent children**.)

Adding dependents

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

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

- The subscriber marries. The subscriber may change to family coverage, or add any additional dependents to family coverage at this time. (See **Changing your coverage**.)
- Birth or adoption of a child. The subscriber may change to family coverage, or add any additional dependents to family coverage at this time. The effective date of coverage for a newborn child will be the date of birth. The subscriber must formally notify the plan within 30 days of the date of birth. (A claim for the enrolled mother's maternity admission may be considered a notice when the subscriber's membership under this plan contract is a family plan.) The plan provides coverage for newly born infants for injury and sickness. This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and premature birth. Coverage for these services is subject to all of the provisions described in your contract. (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. If the previous coverage was not through FHLAC, FHLAC will require notification from the prior insurance company. (See **Changing your coverage.**)
- A spouse and/or child(ren) who formerly lived outside the Direct Care service area move into the service area. (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 notify your Plan Administrator of the change within 30 days of the event. If you do not request the change within the 30-day period, you may not make a change until your next anniversary date.

Qualified medical child support order (QMCSO)

The plan will provide coverage for a child under the terms of a Qualified Medical Child Support Order (QMCSO) even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restriction which may exist for dependent coverage. If the plan receives a QMCSO and you do not enroll the dependent child, the plan will allow the custodial parent or state agency to enroll the child.

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.

Age limits for dependents

Coverage for the dependent 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. (See **Options for continuing coverage** for more information.) Whenever a dependent child's coverage under the family coverage ends, the coverage for any offspring of that dependent child also ends.

Disabled dependents

A dependent child who is mentally or physically disabled when he or she reaches the age limit for dependents, and is not capable of earning his or her own living, can remain on the family or adult child(ren) contract. The subscriber must apply within 30 days of the last day of the month in which he or she reaches age 26. The plan determines eligibility for handicapped children. The subscriber must supply us with any medical or other information that may be needed to determine if the child is eligible to continue coverage under the family coverage.

The plan determines eligibility for disabled children. The subscriber must give us any medical or other information that we may need to determine if the child is eligible to continue coverage.

Continuing coverage for former dependents

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

Surviving dependents

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

Divorce

In the event of divorce, the subscriber's former spouse may remain covered under the family coverage. Coverage may continue, with no additional premium due, unless: (1) the divorce decree does not require (or no longer requires) the subscriber to maintain health insurance coverage for the former spouse, or (2) either the subscriber or the former spouse remarry.

If the subscriber remarries and wishes to add his or her new spouse to the family coverage, the former spouse remains eligible for coverage under the subscriber's group. However, the former spouse must move from family coverage to individual coverage, subject to provisions of COBRA, and additional premium will be required; the former spouse only remains eligible under the group if the divorce decree provides for such coverage. If the former spouse remarries, the former spouse's eligibility ends.

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

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 Teamsters Local 170 Health and 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

All enrollment changes or any additions or changes to coverage type are allowed only when they conform to underwriting guidelines. The Plan Administrator reserves the right to change, alter, amend or terminate the plan, including the benefits available to you under this plan at any time, for any reason.

FHLAC will notify your Plan Administrator of any changes to your benefits under this plan. The notice will include the effective date of the change. The plan will be changed whether or not you receive the notice.

If the plan is terminated, any eligible claims incurred before the date of termination will be paid to the extent assets held by Teamsters Local 170 Health and Welfare Fund are available (or according to the insurance contract for coverage), if submitted to FHLAC within a reasonable period of time, as established by the Plan Administrator. Any claims incurred after the date of termination will not be considered for payment.

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.

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 later.

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.

- 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 1-800-868-5200 (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.

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.

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 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 unit 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 1-800-868-5200 (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 1-800-868-5200 (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 Teamsters Local 170 Health and Welfare Benefit Plan. FHLAC is 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 laid off
- Leaves a job
- Loses coverage due to a reduction in work hours
- No longer lives or works 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
- The subscriber's death

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 Plan Administrator 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 no longer live or work in the Direct Care service area
- 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.
- 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 plan is no longer offered by Teamsters Local 170 Health and Welfare Fund. If you would like to remain a Fallon Health member, you can join a consumer plan. (See **Options for continuing coverage** for more information.)
- 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.

Disenrollment by the subscriber

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 the subscriber or Teamsters Local 170 Health and Welfare Fund cancels the contract, we will not provide benefits for services, supplies or medication received after the cancellation date.

Eligibility for Medicare

If you are a 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 member of Teamsters Local 170 Health and Welfare Fund eligible for group benefits.
- If you become eligible for Medicare and you are no longer employed, you are no longer eligible for coverage under this contract. You may be eligible for enrollment in Fallon Senior Plan, our Medicare Advantage product, either through Teamsters Local 170 Health and Welfare Fund 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 Customer Service for more information.
- If you are not eligible for Medicare upon reaching age 65, you may continue to be covered under this plan.

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

Changing to other health insurance

As long as Teamsters Local 170 Health and Welfare Fund agrees, you may change your coverage to any other health benefits plan offered where you work. You may do this within 30 days of any of the following:

- The anniversary date of your group. There will generally be an open enrollment period preceding Teamsters Local 170 Health and Welfare Fund's anniversary date, during which you can arrange for changes that will be effective on the anniversary date. There also may be a special enrollment period determined by FHLAC and Teamsters Local 170 Health and Welfare Fund.
- The day you move to a place outside the Direct Care service area
- The date you become eligible to enroll in another federally qualified health maintenance organization within the Direct Care service area for which you were not formerly eligible because of where you live
- The date this plan is no longer a part of the health benefits plan offered by Teamsters Local 170 Health and Welfare Fund.
- 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

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

You are receiving this notice because you are covered under the Teamsters Local 170 Health and Welfare Benefit Plan (the plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It also can become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, you should review the plan's summary plan description or contact the Plan Administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Who is eligible for COBRA coverage?

If you are a member of Teamsters Local 170 Health and Welfare Fund, you will become a qualified beneficiary if you lose your coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a member of Teamsters Local 170 Health and Welfare Fund, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

- The parent-member dies.
- The parent-member's hours of employment are reduced.
- The parent-member's employment ends for any reason other than his or her gross misconduct.
- The parent-member becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated.
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA coverage available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Teamsters Local 170 Health and Welfare Fund member, or the member's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You must give notice of some qualifying events

For the other qualifying events (divorce or legal separation of the Teamsters Local 170 Health and Welfare Fund member and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator.

How is COBRA coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered members may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Teamsters Local 170 Health and Welfare Fund member, the member's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of membership or reduction of the Teamsters Local 170 Health and Welfare Fund member's hours of employment, and the member became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the member lasts until 36 months after the date of Medicare entitlement. For example, if a covered member becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the end of membership or reduction of the member's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the member or former member dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

If you have questions
Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under COBRA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Keep your plan informed of address changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
If you have questions about the plan or about COBRA continuation coverage, contact the Plan Administrator at the following address:

Teamsters Local 170 Health and Welfare Fund
330 Southwest Cutoff
P.O. Box 1046
Worcester, MA 01613
1-508-791-3416

Family and medical leave act

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

Your coverage under the FMLA will cease if Teamsters Local 170 Health and Welfare Fund is notified or otherwise determines that you have ended your employment, exhausted your 12-week FMLA leave entitlement or do not intend to return from leave. Your coverage also will cease if either you or your employer fails to maintain coverage on your behalf by making the required contribution/premium.

Once Teamsters Local 170 Health and Welfare Fund determines that you are ending your employment following a period of FMLA leave, you may elect to continue your coverage under the COBRA continuation health coverage rules, as described in the previous section. The qualifying event entitling you to COBRA continuation health coverage is the last day of your FMLA leave.

Uniformed services employment and re-employment rights act of 1994 (USERRA)
USERRA requires that the plan provide you the right to elect continuous health coverage for you and your dependents for up to 24 months, beginning on the date your absence begins from employment due to military service, including Reserve and National Guard Duty, as described below.

If you are absent from employment by reason of service in the uniformed services, you can elect to continue coverage for yourself and your eligible dependent(s) under the provisions of USERRA. The period of coverage for you and your eligible dependent(s) ends on the earlier of:

1. The end of the 24-month period on the date on which your absence begins; or
2. The day after the date on which you are required but fail to apply for return to a position of employment for which coverage under this plan would be extended (for example, for periods of military service over 181 days, generally you must re-apply for employment with 90 days of discharge).

You may be required to pay a portion of the cost of your benefits. The cost that you must pay to continue benefits will be determined with the provisions of the USERRA.

You must notify your employer or FHLAC that you will be absent from employment due to military service unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. You must notify FHLAC that you wish to elect continuation coverage for yourself or your eligible dependents under the provisions of USERRA.

Changing to a consumer plan

If your eligibility for health insurance coverage through Teamsters Local 170 Health and Welfare Fund ends, you may be eligible to join a consumer plan. In order to be eligible to enroll in a consumer plan you must first be an eligible individual. An eligible individual is defined as a resident of the state in which you reside. If you are an eligible individual who does not meet the standards for immediate enrollment into a consumer plan due to a qualifying event, you may only enroll during the state mandated open enrollment period. For more information, please go to www.HealthCare.gov or contact Fallon Health at 1-888-797-3247 to find out more about the options available to you.

Direct Care service area

Fallon Health Direct Care is a Limited Provider Network plan. This plan provides access to a network that is smaller than Fallon Health Select Care. In this plan, members have access to network benefits only from the providers in Direct Care. Please consult the Direct Care provider directory or visit the provider search tool at fallonhealth.org to determine which providers are included in Direct Care.

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

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

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 coverage period. The practitioners who comprise the interdisciplinary team have special training and experience in evaluating, diagnosing, and treating persons with limited function as a consequence of diseases, injuries, impairments, or disabilities. Further, acute inpatient rehabilitation care is provided to patients who are at high risk of potential medical instability, have a potential for needing skilled nursing care of a high medical acuity, and require a coordination of services, level of intensity and setting as follows:

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

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

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

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

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

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

The type of ambulance used (air ambulance, land ambulance, etc.) must be appropriate to medical and geographic conditions. Emergency ambulance services do not require prior authorization.

Nonemergency situations
Ambulance service for medical treatments and procedures may be provided for certain nonemergency situations, when medically necessary. Any such services require prior authorization.

This may include ambulance transportation to return to the closest available medical facility capable of providing those services, as determined by FHLAC. It may include ambulance transportation to the contiguous United States (not necessarily the Direct Care service area) following an emergency inpatient admission which occurs outside of the country.

FHLAC will determine whether you need to be transported to the nearest point in the contiguous United States or all the way to the Direct Care service area based upon your medical condition and upon the adequacy of the care available to you while you are away from the service area.

Transportation by any other means must be contraindicated by your medical condition in order to be considered.

Chair van or medivan transportation may be authorized in lieu of ambulance transportation. FHLAC reserves 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. Air ambulance, when not appropriate to medical and geographical conditions
4. Commercial airline transportation
5. Taxi services

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

Durable medical equipment and prosthetic/orthotic devices

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

Most services require referral and prior 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
- Visual magnifying aids and voice synthesizers for blood glucose monitors, for use by diabetics who are legally blind
- Therapeutic molded shoes and shoe inserts for the treatment of severe diabetic foot disease

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 prosthesis
- Electric speech aids

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

1. The purchase or rental of durable medical equipment and prosthetic/orthotic devices (including the fitting, preparing, repairing and modifying of the appliance).
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 one scalp hair prosthetic (wig) per member per coverage period when the prosthesis is determined to be medically necessary by a plan physician and the plan.
3. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy.
4. Insulin pump and insulin pump supplies
5. Breast pumps
6. Hearing aids and supplies for individuals age 22 and older, when prescribed by a plan physician and obtained from a network provider up to $5,000 in each 36 month period.
7. Hearing aids for individuals age 21 or younger for the cost of one (1) hearing aid per hearing impaired ear up to $3,000 for each hearing aid device only, every 36 months.
   - Related services and supplies for hearing aids (not subject to the $3,000 limit)
8. 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 coverage 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
   - Exercise or sports equipment or similar devices
   - 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 coverage period limits have not been reached.

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 individual (or unborn child)
- Serious impairment to bodily functions or
- Serious dysfunction of any bodily organ or part

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

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 doctor's office or at an urgent care facility
5. Emergency prescription medication provided out of the Direct Care service area as part of an approved emergency treatment

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. Non-emergency prescription medication outside the Direct Care service area such as medication for a chronic condition or a maintenance supply. You may use the prescription medication mail-order program to fill medication refills. (See **Prescription medication**.)
5. Care from a non-plan or out-of-area provider once you are medically able to return to the Direct Care service area

Enteral formulas and low protein foods

The plan covers the 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. DME provided in conjunction with home health care requires prior authorization. (See **Obtaining specialty care and services** and **Durable medical equipment** for more information.) Members receiving skilled services must meet the homebound criteria.

Covered services

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

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

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

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

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

Maternity services

The plan covers 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 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.
3. 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.
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 1-800-868-5200 (TRS 711), or visit the Fallon website fallonehealth.org, 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 the three months 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 abuse counselor, marriage and family therapist or other provider as authorized by the plan.

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.

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). Inpatient admissions generally require prior authorization. Prior authorization will not be required for behavioral health inpatient admissions after treatment in an emergency department, however. Prior authorization also will not be required for inpatient substance abuse services in any circumstances where this is not allowed by Massachusetts state law, including acute treatment services and clinical stabilization services for up to 14 consecutive days.

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).

Covered 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

Intermediate services for children and adolescents under the age of 19. Benefits are only available to members who are residents of Massachusetts or whose principal place of employment is in Massachusetts.

1. Community-based acute treatment (CBAT): provided in a staff-secure setting on a 24-hour basis to provide intensive therapeutic services including, but not limited to daily medication monitoring; psychiatric assessment; nursing availability; specialing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed.
2. Intensive community-based treatment (ICBAT): providing the same services as CBAT but for higher intensity-including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery.
3. Intensive Care Coordination (ICC): a collaborative service that provides targeted case management services to children and adolescents with a serious emotional disturbance, including individuals with co-occurring conditions, in order to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality, cost-effective outcomes. This service includes an assessment, the development of an individualized care plan, referrals to appropriate levels of care, monitoring of goals, and coordinating with other services and social supports and with state agencies, as indicated. The service shall be based upon a system of care philosophy and the individualized care plan shall be tailored to meet the needs of the individual. The service shall include both face-to-face and telephonic meetings, as indicated and as clinically appropriate. ICC is delivered in office, home or other settings, as clinically appropriate.
4. Family Stabilization Team (FST): FST (also referred to as In-Home Therapy), is an intensive family therapy model focused on youth who are most at risk for out-of-home placement due to behaviors in the home. Youth and family engage in intensive family therapy, as well as some individual skill building to improve functioning. This service is implemented by a two-person team; a master's-level clinician creates the treatment plan and provides the clinical interventions while a paraprofessional conducts skill building activities with individuals, dyads, or groups within the family system.
5. In-home Behavioral Services (IHBS): a combination of medically necessary behavior management therapy and behavior management monitoring; provided, however, that such services shall be available, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. In-home behavioral services include:
    - Behavior management monitoring - monitoring of a child's behavior, the implementation of a behavior plan and reinforcing implementation of a behavior plan by the child's parent or other caregiver.

- Behavior management therapy - therapy that addresses challenging behaviors that interfere with a child's successful functioning; provided, however, that "behavior management therapy" shall include a functional behavioral assessment and observation of the youth in the home and/or community setting, development of a behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy; and provided further, that "behavior management therapy" may include short-term counseling and assistance.

6. Mobile Crisis Intervention (MCI): a short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, 7 days a week to a child experiencing a behavioral health crisis. Mobile crisis intervention is used to identify, assess, treat and stabilize a situation, to reduce the immediate risk of danger to the child or others, and to make referrals and linkages to all medically necessary behavioral health services and supports and the appropriate level of care. The intervention shall be consistent with the child's risk management or safety plan, if any. Mobile crisis intervention includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan. Prior authorization not required for MCI.
7. Family support and training: medically necessary services provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to ameliorate or resolve the child's emotional or behavioral needs; provided, however, that such service shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Family support and training addressed one or more goals on the youth's behavioral health treatment plan and may include educating parents/caregivers about the youth's behavioral health needs and resiliency factors, teaching parents/caregivers how to navigate services on behalf of the child and how to identify formal and informal services and supports in the communities, including parent support and self-help groups.
8. Therapeutic mentoring services: medically necessary services provided to a child, designed to support age-appropriate social functioning or to ameliorate deficits in the child's age-appropriate social functioning resulting from a DSM diagnosis; provided, however, that such services may include supporting, coaching, and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution, and relating appropriately to other children and adolescents and to adults. Such services shall be provided, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service addressing one or more goals on the youth's behavioral health treatment plan. It may also be delivered in the community, to allow the youth to practice desired skills in appropriate setting.

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 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

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

1. Mediation (dispute resolution) or intervention services
2. Vocational evaluation, vocational counseling, vocational rehabilitation, and or vocational training
3. Faith-based counseling (e.g., Christian counseling) or vocational counseling
4. Services that do not include face-to-face participation by the member, such as “phone therapy”
5. Residential halfway house services
6. Acupuncture, biofeedback and biofeedback devices for home use, or any other alternative treatment for the treatment of a mental health or substance use condition.
7. 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.
8. Services or programs that are provided in an educational, vocational or recreational setting.
9. Services or programs that provide primarily custodial care.

Office visits and outpatient services

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

Covered services

Office visits and related services

1. Office visits, to diagnose or treat an illness or an injury
   - Telehealth visits done via a secure, real time Telemedicine platform which is inclusive of both an audio and visual component.
2. A second opinion, upon your request, with another plan provider
3. Certain drugs covered under medical benefits, and that are ordered, supplied and administered by a plan provider.
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 a recognized expertise in specialty pediatrics. This coverage includes:
   - Radiation therapy using isotopes, radium, radon, and other ionizing radiation.
   - X-ray therapy for cancer or when it is used in place of surgery
   - Drug therapy for cancer (chemotherapy)
6. Respiratory therapy
7. Hormone replacement services in the doctor’s office for peri-menopausal or postmenopausal women

Diagnostic lab and X-ray services

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

Chiropractic services

9. 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 Schedules of Benefits for your plan option describes the benefit limit that applies for these services.

Renal dialysis

10. 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

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

13. 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.

Outpatient (day) surgery

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

Walk In clinic

15. 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

16. 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 ad 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. Alternative therapies (also known as complementary and alternative medicine) including but not limited to acupuncture, biofeedback, massage therapy, craniosacral therapy, hippotherapy, etc.
3. Laboratory tests to evaluate cardiovascular disease risk, such as Lipoprotein, The PLAC Test, and NMR Lipoprofile.
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.

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. Surgical removal of benign or malignant lesions (includes cysts) affecting the intraoral cavity. Reconstruction of a ridge is covered when performed as a result of and at the same time as the surgical removal of a tumor.
4. Treatment of fractures of the jawbone (mandible) or any facial bone
5. 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 condition (such as degenerative arthritis and jaw fractures or dislocations). The medical condition must be proven to exist by means of diagnostic X-ray tests or other generally accepted diagnostic procedures. This coverage includes:
   a. Diagnostic X-rays
   b. Surgical repair or intervention
   c. Non-dental medical care services to diagnose and treat a TMJ disorder
   d. Splint therapy (This includes measuring, fabricating, and adjusting the splint.)
   e. Physical therapy (See Rehabilitation and Habilitation services)
6. Extraction of teeth in preparation for radiation treatment of the head or neck
7. Surgical treatment related to cancer
8. 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.

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

1. Procedures or services related to dental care.
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. Services that have not been authorized by the plan, or unauthorized services provided by a non-plan oral surgeon
4. Dentures and the following procedures, when performed for the preparation of the mouth for dentures: removal of a torus palatinus, alveoplasty, frenectomy and reconstruction of a ridge
5. Osseointegrated implants or insertion of a core-vent implant

6. Covered services that are performed secondary to a noncovered service
7. Insertion of a core-vent implant (a titanium prosthetic inserted for implantation into the maxillary ridges to provide suitable abutments for the replacement of missing teeth) to support dentures.
8. Extractions due to decay or periodontal disease or extractions in preparation for dentures.
9. Removal of nonimpacted wisdom teeth.

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.

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

* If your group has a copayment for inpatient admissions, the copayment will apply to each inpatient admission, including admissions for services related to organ transplants.

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

1. 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
2. Bioartificial transplantation, such as the transplant of a total artificial heart
3. Xenotransplantation, such as the transplant of animal tissues or organs into a human
4. Services for the organ donor that are covered by another insurer
5. Services for an organ donor if the recipient is not a member of the plan
6. Transportation or housing costs for the recipient or donor
7. House cleaning costs incurred in preparation for a transplant recipient’s discharge

Prescription medication

The plan covers medically necessary prescription drugs that are prescribed by a licensed health care provider, according to the requirements and guidelines discussed below. All drugs and supplies must be approved for sale by the U.S. Food and Drug Administration and used for the purposes indicated.

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

Where you can fill your prescription
You can fill your prescription at a network pharmacy, a network mail-order pharmacy, or a network specialty pharmacy. (Please note that there are some medications that are not available through the mail-order program). Some medications may only be available through the network specialty pharmacy, and will only be available up to a one-month supply at a time. We may allow a one-time fill of a specialty drug at a local pharmacy; after the one-time fill, you will receive a letter and a call to set up delivery of your drug through the specialty pharmacy network. See your *Direct Care Provider Network* directory for a list of network pharmacies or visit fallonhealth.org.

The Fallon Health formulary
The Fallon formulary is a list of medications covered by the health plan that shows the applicable cost-sharing tier, prior authorization requirements, and any other limitation for each medication. We have selected the formulary, tiers, and determined the criteria for prior authorization based on the medication's efficacy and cost-effectiveness. The prescription drug formulary is available online at fallonhealth.org. If you do not have access to our website or if you have any questions about the formulary, call Customer Service. A committee of doctors and pharmacists reviews and updates the formulary regularly.

The Fallon prescription drug formulary has a multi-tiered cost-sharing structure. There is a different cost-sharing for each tier. A tier exception is not allowed. The Fallon formulary may include drugs used for the off-label treatment of cancer or HIV/AIDS, in accordance with Massachusetts state law.

Only medications on our formulary are covered. Medications not on the formulary are considered non-formulary and are excluded and are not covered. There is a Non-formulary exception process if your provider feels that the medications on our formulary are not appropriate for your condition. This request must be approved by Fallon before we will pay for the drug. (See **Non-Covered Items**.)

Utilization Management
Utilization management includes Prior Authorization, Quantity Limits, and Step Therapy as described below.

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

Opioid Management Program
Opioid painkillers provide needed relief to those with acute or chronic pain. But given their potential for harm, and the very real – and pervasive – problem of misuse and abuse, ensuring appropriate use is more critical now than ever before. Our standard opioid management program will be aligned with the "Guideline for Prescribing Opioids for Chronic Pain" issued by the Centers of Disease and Prevention (CDC) in March 2016 and will:

- **Limit days' supply**
  The length of the first fill (when appropriate) will be limited to three days for members 19 and under or 7 days for members over 19 years of age for immediate release, new acute prescriptions for plan members who do not have a history of prior opioid use, based on their prescription claims. A physician can submit a prior authorization request if it is important to exceed the seven-day limit.

- **Limit quantity of opioids**
  The quantity of opioid products prescribed (including those that are combined with acetaminophen, ibuprofen or aspirin) will be limited up to 90 Morphine Milligram Equivalent (MME) per day (based on a 30-day supply). Prescribers who believe their patient should exceed CDC Guideline recommendations can submit a PA request for up to 200 MME per day. Quantities over 200 MME per day will require an appeal. Opioid products containing acetaminophen, aspirin, or ibuprofen will be limited to 4 grams of acetaminophen or aspirin, and 3.2 grams of ibuprofen per day.

- **Require step therapy**
  Use of an immediate-release (IR) formulation will be required before moving to an extended-release (ER) formulation, unless the member has a previous claim for an IR or ER product, or the prescriber submits a PA.

Pain Management Alternatives to Opiate Products
If you are interested in pain management alternatives to opioid products, speak to your provider. Many non-opioid medications and treatments are available. These include, but are not limited to, those listed below.

Non-opiate medication treatment options:

- Ibuprofen
- Topical Lidocaine (Note: some lidocaine products require prior authorization)

See earlier in this section for further information about our prescription drug formulary and prior authorization requirements.

Non-medication treatment modalities:

- Chiropractic care. Your PCP will give you a prescription to a Direct Care network 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. (See **Office visits and outpatient services** section for details.)
- Physical therapy services. (See **Rehabilitation and Habilitation services** section for details.)
- Behavioral health providers with pain management-related specialties, such as cognitive behavioral therapy, pain management and treatment of chronic pain. (See **Mental health and substance use services** section for details.) For assistance in finding a plan provider, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660).

Additional medications and treatments are available which may also serve as pain management alternatives to opioid products. These include other medications, certain other types of therapies, treatment by certain types of non-behavioral health specialists, certain types of surgery, and certain types of injections.

Dispensing limitations
Prescription drugs are generally dispensed for up to a 30-day supply. The corresponding cost-sharing, as noted in your Schedule of Benefits, will be charged for up to a 30-day supply. In some instances, the plan has established dispensing limitations (They are noted on the formulary as "QL."), which may include a quantity limit on certain medications. Occasionally, for safety reasons or as directed by your provider, the length of therapy may be less than 30 days. If your doctor prescribes an amount of medication that is less than a 30-day supply (or for other prescription items, such as inhalers, that are dispensed as single units), you must still pay the corresponding cost-sharing for each prescription. For maintenance medication, you may obtain up to a 90-day supply unless the medication must be obtained from the specialty vendor (noted as "SP" on the on-line formulary) or for certain narcotic medications per Massachusetts law. Per Massachusetts state law, certain contraceptives may be available for up to a 12 month supply. We follow FDA, state and federal dispensing guidelines. You cannot obtain a refill until most or all of the previous supply has been used.

Certain medications cannot be limited to a 30-day supply due to manufacturer packaging, for example, a prefilled syringe. In these cases, you will be charged the applicable copay/coinsurance based on the actual day supply.

If you fill a prescription for an opioid (a covered drug that is a narcotic substance contained in U.S. Drug Enforcement Administration Schedule II), you may choose to obtain a fill in a lesser quantity than the full amount prescribed. If you do, you may then choose to later obtain the remainder of the prescribed fill. You will not be responsible for any copayment amount beyond the amount that would normally apply if you obtained the entire fill at once.

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

Step-therapy
There are certain medications for which you will be required to have previously used or be unable to take certain other formulary medications. This is called step-therapy. They are noted on the formulary as "ST".

Step-therapy is a strategy where drugs for a given condition are dispensed using a logical sequence beginning with Step 1 drugs (most cost-effective) moving to Step 2 drugs (less cost-effective), based on accepted medical guidelines and standards.

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

Generic drugs cost less than their brand name counterpart. You should discuss generic drug alternatives with your physician or pharmacist. You will receive a generic drug from network pharmacies anytime one is available, unless your doctor has directed the pharmacist to only dispense a specific brand-name drug. However, some brand-name drugs do not have a generic equivalent. In both these cases, you will receive the brand-name drug if on the Fallon formulary or if approved through the non-formulary exception process, and you will be responsible for the appropriate cost-sharing for that drug, as noted in your Schedule of Benefits.

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

When you fill your prescription through our mail-order program, you may order up to a 90-day supply of most medications. Certain narcotic medications cannot be filled for a 90-day supply per Massachusetts law. Per Massachusetts state law, certain contraceptives may be available for up to a 12 month supply. You will be responsible for the appropriate cost-sharing amount, as noted in your Schedule of Benefits. Medications required to be obtained from the network specialty pharmacy (noted as “SP” on the on-line formulary) can only be obtained up to a one-month supply at a time.

New members
If you are a new member and need to have an existing prescription refilled, we encourage you to see your provider to review your prescriptions. If you are currently taking a drug that requires prior authorization or other utilization management by Fallon, your doctor will need to submit a request for prior authorization. We will determine coverage of that drug based on our criteria for medical necessity. If the drug you are currently taking is a higher-tier medication or a brand medication, you may want to discuss lower-tier or generic alternatives with your doctor.

Prior Authorization Process
Prior authorization (PA) is required for any medication exceeding the cost threshold and any medication noted with a “PA”, “QL”, or “ST” on the Fallon Health formulary. A PA is also required for a drug that exceeds our Opioid Management Strategy limits and for formulary exception requests. Before we will pay for these medications, your provider must fill out a Fallon Health prescription prior authorization form.

This form will be reviewed by clinical pharmacists and compared to our clinical criteria. Routine requests are processed within 2 business days from the date of receipt of a complete request. Urgent/emergency requests are processed within one business day of the date or receipt of a complete request. Both the provider and member will receive written confirmation of approval or denial of the request. If the request is approved, you may fill your prescription at a network pharmacy. If the request is denied, you and your provider will receive detailed denial information that includes your rights to appeal our decision.

Covered items (some of these medications and covered items may require prior authorization.) This list includes formulary medications only, unless otherwise stated or excluded below.

- Prescription medication
- Prescription contraceptive drugs and devices
- Hormone replacement therapy
- Injectable agents (self-administered*)
- Insulin, insulin pens, and oral medications to treat diabetes
- Syringes (including insulin syringes) or needles when medically necessary
- Orally administered anticancer medications used to kill or slow the growth of cancerous cells
- Certain orally administered medications used to prevent breast cancer

- Supplies for the treatment of diabetes, as required by Massachusetts state law, including, but not limited to:
  - Blood glucose monitoring strips
  - Urine glucose strips
  - Lancets
  - Ketone strips
- Long-term antibiotic therapy for a patient with Lyme disease when determined to be medically necessary and ordered by a licensed physician after making a thorough evaluation of the patient's symptoms, diagnostic test results or response to treatment. An experimental drug shall be covered as a long-term antibiotic therapy if it is approved for an indication by the United States Food and Drug Administration.
- *Prior authorization is required for blood glucose meters and supplies that are non-preferred brands, continuous or require adaptive features.*

  Blood glucose meters are limited to OneTouch® glucose meters and test strips manufactured by LifeScan. Plan members can obtain a OneTouch® glucose meter at network pharmacies, by calling LifeScan at 1-877-356-8480 (TTY: 711), order code number 160FCH002 or by going to the LifeScan website, www.onetouch.orderpoints.com and input order code 160FCH002. Continuous blood glucose monitors are limited to the Freestyle Libre System. Members may obtain Freestyle Libre at network durable medical equipment suppliers or pharmacies.

  Members with a demonstrated need, including having a severe visual impairment or impaired manual dexterity, may require a blood glucose meter with adaptive features, such as an integrated voice synthesizer or integrated lancing device. Prior authorization is required.

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

Preventive medications

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

ACA Preventive Medications at $0

- Fallon will cover preventive medications as required by the Patient Protection and Affordable Care Act. This includes over-the-counter medications. Over-the-counter medications must be prescribed by a health care provider. Covered over-the counter medications include:
  - aspirin
  - iron supplementation
  - folic acid
  - Calcium with Vitamin D
  - some vitamin D formulations
  - gum/lozenges/patches for nicotine replacement therapy
  - bowel preps

  Note: you may need to submit your prescription and your receipt to Fallon for reimbursement.
- FDA-approved tobacco cessation medications, no prior authorization required:
  - Nicotine patch
  - Nicotine oral or nasal spray

  - Nicotine inhaler
  - Bupropion
  - Varenicline
- Certain bowel preps
- Certain oral contraceptives*, emergency contraceptives, and contraceptive devices
  - Fallon will also cover over-the-counter women's contraceptive methods such as sponges and spermicides that are FDA–approved and prescribed by a health care provider. You may need to submit your prescription and your receipt to Fallon for reimbursement
- Certain low to moderate dose statins used for the prevention of cardiovascular disease
- Certain pediatric multivitamins containing fluoride and fluoride supplements for children six months to sixteen years of age
- Certain medications for pre-exposure prophylaxis (PrEP) to prevent HIV infection

Note: Compound medications (a drug that is specifically mixed and prepared for you, based on a prescription from your doctor) will incur a copay associated with your highest brand tier (typically, the non-preferred brand tier).

***Exception Request for Contraceptives**
Generic contraceptives are covered in full. Brand name contraceptives generally require cost sharing such as a copayment. However, if your attending provider indicates you must use an FDA-approved brand contraceptive due to medical necessity you may make an exception request to have the brand name contraceptive covered with no cost sharing. Your attending provider should contact CVS Caremark by telephone at 1-866-772-9538 or Fax 1-888-836-0730 and request an exception request for contraceptive cost sharing due to medical necessity. Examples of medical necessity include severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to appropriate use of the item or service.

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

Non-Covered Items
Non-Formulary:
Medications not on the formulary are considered non-formulary and are not covered.

> If your provider feels that the medications on our formulary are not appropriate for your condition, there is a formulary exception request process available. Your prescriber must support the request by providing clinical information and a statement that provides justification for supporting the need for the non-formulary drug to treat your condition, including a statement that all covered formulary drugs on any tier will be or have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects. This request must be approved by Fallon Health before we will pay for the drug.

If approved, a non-formulary drug will incur a copay associated with your highest generic (if the drug is a generic) or brand (if the drug is a brand) copay tier.

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

1. Drugs that you can buy without a prescription, unless included on the Fallon formulary or specifically described as covered above.
2. Drugs not on our formulary, unless non-formulary prior authorization has been granted.
3. Drugs that are specifically excluded from the formulary, unless an exception has been granted.
4. Drugs that are investigational or that have not been approved for general sale and distribution by the U.S. Food and Drug Administration
5. Drugs that are not used or prescribed in accordance with FDA-approved labeling (unless compendia supported), including, but not limited to: unapproved doses, unapproved duration of therapy and unapproved indications. (This does not include the off-label uses of covered prescription drugs used in the treatment of HIV/AIDS or cancer when used in accordance with state law. This also does not include bone marrow transplants for breast cancer as required by state law.)
6. Drugs that require prior authorization, if prior authorization is not received
7. Drugs prescribed for purposes that are not medically necessary. This includes, but is not limited to, drugs for cosmetic purposes, to enhance athletic performance, for appetite suppression, or for other non-covered conditions. This also includes drugs that do not meet medical criteria. Cosmetic includes, but is not limited to, melasma, vitiligo, and alopecia.
8. Non-emergency prescriptions obtained at a non-network pharmacy
9. Vitamins and minerals, whether or not a prescription is required, are excluded from coverage, unless listed in the Fallon drug formulary or under the Oh Baby! program
10. Over-the-counter birth control preparations or devices, unless specifically described as covered in the above
11. Medications used for preference or convenience
12. Medications that are new to the market that have not been reviewed by Fallon for safety and adverse events. These medications are not covered by Fallon until they have been reviewed and guidelines for their use have been developed. This could take up to 180 days post-marketing.
13. Replacement of more than one lost/mishandled medication per benefit period
14. Prescription drugs that are a combination of a covered prescription item and an item that is specifically excluded, such as vitamins, minerals, or medical foods/formulas.
15. Bio-identical hormone replacement therapy.
16. The following Prescription Proton Pump Inhibitors: Prevacid (brand name capsules), Protonix (brand name), Zegerid, Prilosec (brand name) and others not on the Fallon formulary
17. Tier cost-sharing exceptions.
18. The following are not covered benefits:
    a. Topical emollients
    b. Medical wound dressings for maintenance or long term care of a condition
    c. Work-required vaccines

19. The following non-sedating antihistamines: Allegra, Allegra ODT, cetirizine HCl, Clarinex, Claritin, Claritin Reditabs, fexofenadine HCl, Xyzal and Zyrtec.
20. Vimovo
21. Medical marijuana
22. Duexis (ibuprofen/famotidine)
23. Omeclamox (amoxicillin/clarithromycin/omeprazole) Therapy Pack
24. Vascepa (icosapent ethyl)
25. Liptruzet (atorvastatin/ezetimibe)
26. Diclegis (doxylamine/pyriodoxine)
27. Acticlate (doxycycline Hyclate)
28. Jublia (efinaconazole soln)
29. Durlaza (aspirin 162.5mg)
30. Cuprimine (penicillamine) capsules
31. Glumetza (metformin) tablets
32. Fortamet (metformin SR 24h osmotic) tablets
33. Sernivo (betamethasone dipropionte spray emulsion) 1.5% Spray
34. Bonjesta (doxylamine/pyridoxine)
35. Yosprala (aspirin/omeprazole)
36. Ybuphen (ibuprofen 600mg & acetaminophen 500mg)

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 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 Fallon formulary, that are for covered medical benefits and that are ordered, supplied and administered by a plan physician. If administered by a plan specialist, you will generally need to obtain a referral to see the specialist (requires prior authorization)
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. Hearing and vision screening
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
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
8. Voluntary family planning
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. Routine eye examinations
2. Fittings for contact lenses
3. Eyeglasses or contact lenses
4. Laser vision correction surgery
5. Vision therapy or services (also referred to as orthoptics)
6. 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.

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.

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. Services for the treatment of snoring.
5. Removal of breast implant except when determined to be medically necessary by FHLAC. Even when removal of a breast is covered, reinsertion of a replacement breast implant is considered cosmetic and is not covered (except for plan members who elected reconstruction following mastectomy).
6. 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.
7. Treatments for acne scarring including, but not limited to subcutaneous injections to raise acne scars, chemical exfoliation (CPT 17360), and dermabrasion.
8. 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.
9. Custom breast prosthesis.

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 may include physical and occupational therapy and speech-language pathology and other services for people with disabilities in a variety of inpatient or outpatient settings. Medical necessity determines the actual number of visits covered.

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

Covered services

1. Physical therapy to restore function after medical illness, accident or injury. Coverage is provided when medically necessary.
2. Occupational therapy to restore function after medical illness, accident or injury. Coverage is provided when medically necessary.
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 a plan provider's office. Speech therapy requires prior authorization.
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 behavioral analysis (ABA) therapy. See the **Autism services** section of your *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 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. Services that are not medically necessary, including but not limited to, acupuncture, biofeedback, hippotherapy, and massage therapy.
6. Educational services or testing, except services covered under the benefit for early intervention services as described above.

7. Pulmonary rehabilitation services for chronic obstructive pulmonary disease beyond 36 lifetime sessions.
8. Pulmonary maintenance.

Skilled nursing facility

The plan covers inpatient services in a plan skilled nursing facility for up to 100 days in each coverage 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 **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 coverage period, provided criteria are met
2. The services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, nursing services, physical, speech and occupational therapy, medical supplies and equipment.
3. Physician services

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

1. Services beyond 100 days in each coverage period
2. Services that are not determined to be medically necessary, even if the plan limit of 100 days per coverage period has not yet been reached
3. Rest care or long-term care

Wellness

Fitness and Weight Loss Essential Health Benefits (EHBs)

- One Weight Watchers Monthly Pass reimbursement per subscriber for 5 months. Subscriber must be a Teamsters Local 170 Health & Welfare Benefit Plan member for 3 months or longer.
- One YMCA or YWCA fitness membership reimbursement per subscriber for 3 months. Subscriber must be a Teamsters Local 170 Health & Welfare Benefit Plan member for 3 months or longer.

It Fits!™

- It Fits! reimburses eligible members for participating in a variety of healthy activities: membership at local fitness centers, home fitness equipment, aerobics, Pilates and yoga classes when taught by a certified instructor, Weight Watchers® programs, and local town and school sports programs for all ages when they include an aerobic and instructional component. Aerobic activities for the whole family include: baseball, softball, soccer, football, dance classes, ski lessons, golf lessons, swimming lessons, tennis, and sports camps.

Other plan benefits and features

Out-of-area student coverage
Students attending school outside the 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 prior authorization. These services include:

- Non-routine medical office visits
- Diagnostic lab and X-ray connected with a non-routine office visits
- Non-elective inpatient services
- Outpatient services to diagnose and/or treat mental conditions
- Speech therapy
- Short-term rehabilitation services, including physical and occupational therapy are covered when medically necessary, up to the benefit maximum (combined with any in-area visits).

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 services must be obtained when they return to the Direct Care service area.

Health resources

- Disease care services support members who have chronic conditions like asthma, congestive heart failure, coronary artery disease and diabetes.
- Eyewear discounts from contracted vendors
- Naturally Well 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!
- Tobacco Treatment Program helps members develop a stop-smoking plan and gives them the tools they need to succeed.
- With Nurse Connect, you get free access, by phone, to experienced registered nurses 24 hours a day, 7 days a week to answer your health questions.
- Caremark ExtraCare Health Card® discount, eligible members receive a CVS Caremark ExtraCare Health Card which allows them to receive a 20% discount on certain items at any CVS/pharmacy® store or online at www.cvs.com.
- Family Fun program, free or discounted admission at local family fun spots.

Call Customer Service at 1-800-868-5200 (TRS 711), or visit fallonhealth.org, for more information on these and other programs.

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 1-800-868-5200 (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 an 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. Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment or vocational counseling and training, or educational therapy for learning disabilities
7. 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.)
8. Any services furnished by any provider not having a license or approval, under applicable state law, to furnish that type of service
9. Any services provided by the Veterans Administration for service-connected disabilities to which members are legally entitled and for which facilities are reasonably available
10. 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
11. Auditory integration therapy, such as Berard auditory integration therapy
12. 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.
13. Charges after the date on which your membership ends
14. 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 and presbyopia-correcting lenses are not covered.
15. Dermatoscopy for detection of melanoma
16. 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

17. Elective long-term psychotherapy
18. Elective treatment or surgery not required by your medical condition, according to the judgment of the plan
19. Extracorporeal Shock Wave Therapy (ESWT) for chronic plantar fasciitis
20. Holistic treatments
21. Home video EEG monitoring
22. Interspinous process decompression (or the X-Stop® interspinous process decompression device).
23. Maintenance treatment or services
24. 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.
25. Medical expenses incurred in any government hospital or facility or for services of a government doctor or other government health professional
26. Procedures or services related to dental care.
27. Provider charges for shipping or copying medical records, or for failing to keep an appointment. You must pay for these charges.
28. Psychological testing or neuropsychological assessments unless determined to be medically necessary
29. Replacement of lost or stolen Weight Watchers® coupons
30. 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
31. Sclerotherapy, joint and ligamentous injections (prolotherapy) for non-symptomatic varicose veins
32. Sensory integration therapy
33. 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

34. 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.
35. 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 retardation, learning problem, or behavioral problem) should seek a Chapter 766 evaluation. Members must make appropriate and reasonable efforts to obtain benefits available under state law.
36. 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
37. Services for cosmetic reasons
38. 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 of illness causing the original pain.
39. Services furnished to someone other than the member
40. 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
41. 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
42. 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.
43. 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**.
44. 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
45. Services received after the date that coverage ends

46. 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.
47. Services that are considered experimental or which have not been approved by a plan medical director
48. Services that are covered by another insurer
49. 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
50. Services to reverse a voluntary sterilization
51. Special duty or private duty nursing and attendant services
52. Specialty clothing appropriate to specific medical conditions
53. Tinnitus masker
54. Total body photography
55. 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
56. Transportation between hospitals when your medical condition does not warrant that you be transported to another facility
57. Treatment for personal growth, or other treatment that is not medically necessary, or not in keeping with national standards of practice
58. Vocational rehabilitation, including job retraining, or vocational and driving evaluations focused on job adaptability, or therapy to restore function for a specific occupation
59. White noise machines
60. 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
- 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
- Excision or repair of keloid
- Grafts, fat
- Otoplasty
- Reduction of labia minora
- Removal of spider angiomata
- Rhytidectomy
- Salabrasion
- Scar revision
- Suction-assisted lipectomy

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

Facts about this plan

The Employee Retirement Income Security Act of 1974 (ERISA) requires that Teamsters Local 170 Health and Welfare Fund furnish you with certain information regarding this plan, which is a benefit option provided to you as a member of Teamsters Local 170 Health and Welfare Fund. 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:**
   Teamsters Local 170 Health and Welfare Benefit Plan

2. **Name and address of plan sponsor:**
   Teamsters Local 170 Health and Welfare Fund
   Board of Trustees
   P.O. Box 1046
   Worcester, MA 01613
   1-508-791-3416

3. **Federal Identification Number:**
   04-2219623

4. **Plan number:**
   501

5. **Type of plan:**
   The plan is a self-funded health and welfare plan that provides health benefits for eligible Teamsters Local 170 members 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 Teamsters Local 170 Health and Welfare Fund and FHLAC.

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

7. **Name and address of Plan Administrator:**
   Teamsters Local 170 Health and Welfare Fund
   P.O. Box 1046
   Worcester, MA 01613
   1-508-791-3416

8. **Person(s) eligible:**
   All persons who meet the eligibility requirements as defined in this *Member Handbook* of the Teamsters Local 170 Health and Welfare Benefit Plan.

9. **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: Teamsters Local 170 Health and Welfare Fund 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.

10. Funding of the plan:

Collective Bargaining Agreement(s): The plan is (partially) maintained as a result of a Collective Bargaining Agreement (CBA) between Teamsters Local 170 and participating employers, with various dates and as subsequently amended. You may obtain a copy of the applicable CBA upon written request to the Plan Administrator. A reasonable charge will be made for copies of the agreement. You may also examine the applicable CBA, without charge, during regular business hours at the Fund Office.

Upon request, the Fund Office will provide you with information as to whether a particular employer is contributing to the Plan on behalf of participants working under a Collective Bargaining Agreement.

11. Effective date:

The plan, as described in this *Member Handbook*, became effective January 1, 2021.

12. Agent for service of legal process:

The Plan Administrator at the above address.

13. Plan records:

The financial records of the plan are maintained on the basis of a coverage period beginning on January 1 and ending on the following December 31.

Statement of ERISA rights

A. As a participant in the Teamsters Local 170 Health and Welfare Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

   i) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

   ii) Obtain copies of all plan documents and other plan information governing the operations of the plan upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

   iii) Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

   iv) Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of qualifying event. You or your dependents may need to pay for such coverage. Review this *Member Handbook* and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

B. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants.

C. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

D. If your claim for a plan benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Please refer to claim procedures described herein for further information about your right to seek review of a claim denial.

E. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within thirty days, you may file a suit in federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

F. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these court costs and fees, for example, if it finds your claim frivolous.

G. If you have any questions about your plan, you should contact the Plan Administrator.

H. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave. NW, Washington DC 20210.

Effective date: This *Member Handbook* reflects the status of the plan as of January 1, 2021.

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