

Fallon Health and Life Assurance Co., Inc. Schedule of Benefits

This Schedule of Benefits is part of your Minuteman Nashoba Exclusive Provider Organization (EPO) Plan *Member Handbook* using the Fallon Health Direct Care network. It describes your costs for health care.

This Schedule of Benefits shows your copayments and coinsurance for the covered services outlined in the Minuteman Nashoba Exclusive Provider Organization (EPO) Plan *Member Handbook*. It also outlines any of your benefits that differ from those shown in the *Member Handbook*. The information in this document replaces any information in your *Member Handbook* that conflicts with it. If you have any questions about your benefits, please call Customer Service at 1-800-868-5200 (TTY 711).

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

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

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

This health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2014 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2014. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

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

The following apply to your *Member Handbook*:

Deductible

Your deductible is \$250 per member/\$750 per family per benefit period for certain services.

Each member must meet the per-member deductible amount, unless the family deductible applies. The family deductible is considered met when any combination of members in a family reaches the family deductible amount. No individual family member will pay more than the per-member deductible in a benefit period. After you have met your deductible, some services will be covered in full by the plan. For other services, you will be responsible for a copayment or coinsurance when you receive these services. Your costs for covered services are described in this Schedule of Benefits; for detailed information on covered services and any exclusions or limitations that apply, we recommend that you refer to the *Member Handbook*.

Any deductible amounts paid during the last three months of the benefit period may be applied to your deductible for the next benefit period—we call this the “deductible carryover.” In order for a deductible carryover to apply, the member must have had continuous coverage under the plan through the same employer group at the time the charges for the prior benefit period were incurred. After you receive services, we will send you a letter indicating the amount that has been applied to your deductible.

Out-of-pocket maximum

There is a limit to your out-of-pocket costs each benefit period. This is called your out-of-pocket maximum. The out-of-pocket maximum includes your deductible, coinsurance and copayments you pay. It does not include your plan premium. **Your out-of-pocket maximum is \$2,000 per member or \$4,000 per family.** Each member must meet the per-member out-of-pocket maximum, unless the family out-of-pocket maximum applies. The family out-of-pocket maximum is considered met when any combination of members in a family reaches the family out-of-pocket maximum. Please note that once any one member in a family accumulates **\$2,000** in out-of-pocket costs, that family member's out-of-pocket maximum is considered met, and that family member will have no additional out-of-pocket costs for the remainder of the benefit period.

***It Fits!*[™] benefit**

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

Deletion of Healthy Health Plan program

Your contract does not include coverage for services provided under the Healthy Health Plan program.

Covered services

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

Covered services	Benefits
<p>Ambulance services</p> <ol style="list-style-type: none"> Ambulance transportation for an emergency Ambulance transportation for non-emergency situations, when medically necessary 	<p>Covered in full</p> <p>Covered in full</p>
<p>Autism services <i>Prior authorization required</i></p> <ol style="list-style-type: none"> Habilitative and rehabilitative care including but not limited to applied behavior analysis when supervised by a board certified behavioral analyst Therapeutic care, services including speech, physical and occupational therapy. 	<p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p>
<p>Dental benefits <i>Referral and prior authorization required for most services</i></p> <ol style="list-style-type: none"> Preventive dental care, twice annually. Included are an explorer and mouth mirror exam, prophylactic cleaning and necessary scaling, fluoride treatment, pulp vitality tests, diagnostic casts, periapical and bitewing X-rays (one to four films). Minor restorative dental care, such as metal or composite fillings. 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. Dental services and treatments for minor ailments such as a toothache, or loose filling while out of the Direct Care service area. Coverage is provided for up to \$50 per incident. 	<p>\$10 copayment per visit</p> <p>Copayments vary. See <i>Addendum: Discount Dental Services – Fees.</i></p> <p>\$20 copayment per visit to a physician’s or dentist’s office</p> <p>\$100 copayment per visit to an emergency room then subject to your deductible</p> <p>\$10 copayment per visit</p>
<p>Durable medical equipment and prosthetic/orthotic devices <i>Referral and prior authorization required for most services</i></p> <ol style="list-style-type: none"> The purchase or rental of durable medical equipment and prosthetic/orthotic devices (including the fitting, preparing, repairing and modifying of the appliance). Scalp hair prosthesis (wigs) for individuals who have suffered hair loss as a result of the treatment of any form of cancer or leukemia. Coverage is provided for one scalp hair prosthetic (wig) per member per benefit period when the prosthesis is determined to be medically necessary by a plan physician and the plan. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy Prosthetic limbs which replace, in whole or in part, an arm or leg. Insulin pump and insulin pump supplies Breast pumps 	<p>Covered in full after you meet your deductible</p> <p>Covered in full after you meet your deductible</p> <p>Covered in full after you meet your deductible</p> <p>20% coinsurance after you meet your deductible</p> <p>Covered in full</p> <p>Covered in full</p>

Covered services	Benefits
<p><i>Durable medical equipment and prosthetic/orthotic devices, continued</i></p> <p>7. Up to \$2,000 per ear for hearing aid device only, every 36 months (must be 21 years of age or younger)</p> <ul style="list-style-type: none"> • Related services and supplies for hearing aids (not subject to the \$2,000 limit) 	<p>Covered in full after you meet your deductible</p>
<p>Emergency and urgent care</p> <p>1. Emergency room visits</p> <p>2. Emergency room visits when you are admitted to an observation room</p> <p>3. Urgent care visits in a doctor’s office or at an urgent care facility</p> <p>4. Emergency prescription medication provided out of the Direct Care service area as part of an approved emergency treatment</p>	<p>\$100 copayment per visit then subject to your deductible</p> <p>Covered in full after you meet your deductible</p> <p>\$20 copayment per visit</p> <p>Tier 1: \$10 copayment Tier 2: \$25 copayment Tier 3: \$50 copayment for up to a 14-day supply</p>
<p>Enteral formulas and low protein foods</p> <p><i>Referral and prior authorization required for enteral formulas</i></p> <p>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</p> <p>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.</p>	<p>Covered in full after you meet your deductible</p> <p>Covered in full after you meet your deductible</p>
<p>Home health care services</p> <p>1. Part-time or intermittent skilled nursing care and physical therapy provided in your home by a home health agency</p> <p>2. Additional services and supplies that are determined to be a medically necessary component of skilled nursing care and physical therapy</p>	<p>Covered in full after you meet your deductible</p> <p>Covered in full after you meet your deductible</p>
<p>Hospice care services</p> <p><i>Referral and prior authorization required</i></p>	<p>Covered in full after you meet your deductible</p>
<p>Hospital inpatient services</p> <p><i>Referral and prior authorization required</i></p> <p>1. Inpatient hospital services including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient</p>	<p>\$500 copayment per admission then subject to your deductible</p>

Covered services	Benefits
<p>Infertility/assisted reproductive technology (art) services* <i>Referral and prior authorization required (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP)</i></p> <ol style="list-style-type: none"> 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* except for those services listed below 5. Assisted reproductive technologies for: <ul style="list-style-type: none"> • In vitro fertilization (IVF-ET) • Gamete intrafallopian transfer (GIFT) • Zygote intrafallopian transfer (ZIFT) 6. Sperm, egg, and/or inseminated egg procurement, processing and banking when associated with an approved active cycle, to the extent that such costs are not covered by the donor’s insurer 7. Assisted hatching 8. Cryopreservation of eggs <p>* See the Description of benefits section of your <i>Member Handbook</i> for a list of covered infertility/ART services.</p>	<p>\$20 copayment per visit with your PCP and certain other providers</p> <p>\$35 copayment per visit with a specialist</p> <p>Covered in full after you meet your deductible</p> <p>Covered in full after you meet your deductible</p> <p>Covered in full after you meet your deductible</p> <p>\$150 copayment per procedure then subject to your deductible</p> <p>Covered in full after you meet your deductible</p> <p>Covered in full after you meet your deductible</p> <p>Covered in full after you meet your deductible</p>
<p>Maternity services</p> <ol style="list-style-type: none"> 1. Obstetrical services including prenatal, childbirth, postnatal and postpartum care 2. Inpatient maternity and newborn child care for a minimum of 48 hours of care following a vaginal delivery, or 96 hours of care following a Caesarean section delivery, including charges for the following services when provided during an inpatient maternity admission: childbirth, nursery charges, circumcision, routine examination, hearing screening and medically necessary treatments of congenital defects, birth abnormalities or premature birth. The covered length of stay may be reduced if the mother and the attending physician agree upon an earlier discharge. If you or your newborn are discharged earlier, you are covered for home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however that the first home visit shall be conducted by a registered nurse, physician or certified nurse midwife; and provided further, that any subsequent home visit determined to be clinically necessary shall be provided by a licensed health care provider. 	<p>Prenatal: \$20 copayment (first visit only)</p> <p>Postnatal: \$20 copayment per visit</p> <p>\$500 copayment per admission then subject to your deductible</p>

Covered services	Benefits
<p>Mental health and substance abuse services</p> <p>Inpatient services <i>Prior authorization required</i></p> <ol style="list-style-type: none"> 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. <p>Intermediate services <i>Prior authorization required</i> <i>Intermediate services include but are not limited to:</i></p> <ol style="list-style-type: none"> Acute and other residential treatment-Mental health services provided in a 24-hour setting therapeutic environments. Clinically managed detoxification services-24 hour, 7 days a week, clinically managed de-tox services in a licensed non-hospital setting that include 24 hour per day supervision Partial Hospitalization: Short-term day/evening mental health programming available 5 to 7 days per week. Intensive outpatient programs: Multimodal, inter-disciplinary, structured behavioral health treatment provided 2-3 hours per day, multiple days per week. Day treatment: Program encompasses some portion of the day or week rather than a weekly visit Crisis Stabilization: Short-term psychiatric treatment in a structured, community based therapeutic environments. In-home therapy services <p>Outpatient services</p> <ol style="list-style-type: none"> Outpatient office visits, including individual, group or family therapy. The actual number of visits authorized beyond the initial eight is based on medical necessity as determined by the plan, and may include individual, group, or family therapy. Psychopharmacological services, such as visits with a physician to review, monitor and adjust the levels of prescription medication to treat a mental condition Neuropsychological assessment services when medically necessary 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p>

Covered services	Benefits
<p>Office visits and outpatient services</p> <ol style="list-style-type: none"> 1. Office visits, to diagnose or treat an illness or an injury 2. A second opinion, upon your request, with another plan provider 3. Injections and injectables drugs that are included on the formulary, that are for covered medical benefits, and that are ordered, supplied and administered by a plan provider 4. Allergy injections 5. Radiation therapy 6. Respiratory therapy 7. Hormone replacement services in the doctor’s office for perimenopausal or postmenopausal women 8. Diagnostic lab and X-ray services ordered by a plan provider, in relation to a covered office visit 9. High-tech imaging services, including but not limited to, MRI/MRA, CT/CTA, PET scans and nuclear cardiology imaging. Limited to one copayment per day when performed at the same facility for the same diagnosis. <i>(Prior authorization required.)</i> 10. Chiropractic services for acute musculoskeletal conditions. The condition must be new or an acute exacerbation of a previous condition. Coverage is provided for up to 12 office visits in each benefit period. The actual number of visits provided is based on medical necessity as determined by your plan provider and the plan. 11. Outpatient renal dialysis at a plan-designated center or continuous ambulatory peritoneal dialysis 12. Diabetes outpatient self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider 13. Laboratory tests necessary for the diagnosis or treatment of diabetes, including glycosylated hemoglobin, or HbA1c, tests, and urinary/protein/ microalbumin and lipid profiles 14. Medical social services provided to assist you in adjustment to your or your family member’s illness. This includes assessment, counseling, consultation and assistance in accessing community resources. 	<p>\$20 copayment per visit with your PCP and certain other providers</p> <p>\$35 copayment per visit with a specialist</p> <p>\$20 copayment per visit with your PCP and certain other providers</p> <p>\$35 copayment per visit with a specialist</p> <p>Covered in full after you meet your deductible</p> <p>Covered in full</p> <p>Covered in full after you meet your deductible</p> <p>Covered in full after you meet your deductible</p> <p>\$20 copayment per visit</p> <p>Covered in full after you meet your deductible</p> <p>\$100 copayment per MRI, CT, PET scan or nuclear cardiology image then subject to your deductible</p> <p>\$20 copayment per visit</p> <p>Covered in full after you meet your deductible</p> <p>\$20 copayment per visit</p> <p>Covered in full after you meet your deductible</p> <p>\$20 copayment per visit</p>

Covered services	Benefits
<p><i>Office visits and outpatient services, continued</i></p> <p>15. Outpatient surgery, anesthesia and the medically necessary preoperative and postoperative care related to the surgery</p> <p>16. Visit to a contracted limited service clinic. Services are provided for a variety of common illnesses, including, but not limited to:</p> <ul style="list-style-type: none"> • strep throat • ear, eyes, sinus, bladder and bronchial infections • minor skin conditions (e.g. sunburn, cold sores) 	<p>\$150 copayment per surgery then subject to your deductible when provided in a hospital outpatient, day surgery or ambulatory care facility</p> <p>\$20 copayment per visit</p>
<p>Oral surgery and related services</p> <p><i>Referral and prior authorization required (except for extraction of impacted teeth)</i></p> <p>1. Removal or exposure of impacted teeth, including both hard and soft tissue impactions, or an evaluation for this procedure</p> <p>2. Surgical treatments of cysts, affecting the teeth or gums, that must be rendered by a plan oral surgeon</p> <p>3. Treatment of fractures of the jaw bone (mandible) or any facial bone</p> <p>4. Evaluation and surgery for the treatment of temporomandibular joint disorder when a medical condition is diagnosed, or for surgery related to the jaw or any structure connected to the jaw</p> <p>5. Lingual frenectomy</p> <p>Note: These benefits are for oral surgery services in an office setting. Oral surgery services in a hospital outpatient, day surgery or ambulatory care facility, or as an inpatient are covered in full after you meet your deductible.</p> <p>See Office visits and outpatient services for diagnostic lab and X-ray services.</p>	<p>\$35 copayment per visit</p> <p>\$35 copayment per visit</p> <p>\$35 copayment per visit</p> <p>\$35 copayment per visit</p> <p>\$35 copayment per visit</p>
<p>Organ transplants</p> <p><i>Referral and plan authorization required</i></p> <p>1. Office visits related to the transplant</p> <p>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</p> <p>3. Human leukocyte antigen (HLA) or histocompatibility locus antigen testing for A, B or DR antigens, or any combination thereof, necessary to establish bone marrow transplant donor suitability of a member</p>	<p>\$20 copayment per visit with your PCP and certain other providers</p> <p>\$35 copayment per visit with a specialist</p> <p>\$500 copayment per admission then subject to your deductible</p> <p>Covered in full after you meet your deductible</p>

Covered services	Benefits
<p>Prescription drugs Covered prescription items:</p> <ul style="list-style-type: none"> • Prescription medication • Prescription contraceptive drugs and devices* • Hormone replacement therapy for per- and post-menopausal women • Injectable agents (self-administered**) • Insulin • Syringes (including insulin syringes) or needles when medically necessary • Supplies for the treatment of diabetes, as required by state law, including: <ul style="list-style-type: none"> – blood glucose monitoring strips – urine glucose strips – lancets – ketone strips • Special medical formulas to treat certain metabolic disorders as required by state law (prior authorization required). <p>*Generic prescription contraceptive drugs and devices are covered in full. Brand name prescription contraceptive drugs and devices with no generic equivalent are covered in full (prior authorization required).</p> <p>**Injectables administered in the doctor’s office or under other professional supervision are covered as a medical benefit.</p> <p>Orally administered anticancer medications used to kill or slow the growth of cancerous cells</p>	<p>Network pharmacy: Tier 1: \$10 copayment Tier 2: \$25 copayment Tier 3: \$50 copayment for up to a 30-day supply</p> <p>Mail-order pharmacy: Tier 1: \$20 copayment Tier 2: \$50 copayment Tier 3: \$110 copayment for up to a 90-day supply</p> <p>Covered in full</p>
<p>Preventive care</p> <ol style="list-style-type: none"> 1. Routine physical exams for the prevention and detection of disease 2. Immunizations that are included on the formulary, that are for covered medical benefits and that are ordered, supplied and administered by a plan physician. If administered by a plan specialist, you will generally need to obtain a referral to see the specialist. 3. A baseline mammogram for women age 35 to 40, and a yearly mammogram for women age 40 and older 4. Routine gynecological care services, including an annual Pap smear (cytological screening) and pelvic exam 5. Routine eye exams, once in each 12-month period 6. Hearing and vision screening 7. Well-child care and pediatric services, at least six times during the child’s first year after birth, at least three times during the next year, then at least annually until the child’s sixth birthday. This includes the following services, as recommended by the physician and in accordance with state law: 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>

Covered services	Benefits
<p><i>Preventive care, continued</i></p> <ul style="list-style-type: none"> • physical examination • history • measurements • sensory screening • neuropsychiatric evaluation • development screening and assessment <p>8. Pediatric services including:</p> <ul style="list-style-type: none"> • 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 <p>9. Voluntary family planning</p> <p>10. Consultations, examinations, procedures and medical services related to the use of all contraceptive methods</p> <p>11. Contraceptive devices that are supplied by a plan provider during an office visit*</p> <p>* Prescription contraceptive devices are covered under the prescription drug benefit.</p>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>
<p>Reconstructive surgery</p> <p><i>Referral and prior authorization required (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP)</i></p> <p>1. Inpatient hospital services including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient, including Massachusetts mandated services for cleft lip and cleft palate</p>	<p>\$500 copayment per admission then subject to your deductible</p>
<p>Rehabilitation and habilitation services</p> <p><i>Referral required</i></p> <p>1. Physical and occupational therapy services are covered for up to 60 visits combined per benefit period when medically necessary.</p> <p>2. 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 (Prior authorization required)</p> <p>3. Cardiac rehabilitation services to treat cardiovascular disease in accordance with state law and Department of Public Health regulations</p> <p>4. Medically necessary early intervention services delivered by a certified early intervention specialist, according to operational standards developed by the Department of Public Health, for children from birth to their third birthday.</p>	<p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>Covered in full</p>

Covered services	Benefits
<p><i>Rehabilitation and habilitation services, continued</i></p> <p>5. Pulmonary rehabilitation services for chronic obstructive pulmonary disease (COPD) are covered for up to two one-hour sessions per day, for up to 36 lifetime sessions (Prior authorization required)</p>	<p>Covered in full after you meet your deductible</p>
<p>Skilled nursing facility services</p> <p><i>Referral and prior authorization required</i></p> <p>1. Inpatient hospital services, for up to 100 days per benefit period provided criteria is met, including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient</p>	<p>\$500 copayment per admission then subject to your deductible</p>