Fallon Health and Life Assurance Co., Inc.

Schedule of Benefits

Fallon Health Direct Care QHD HSA $2,000

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 (TRS 711).

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

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

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

This health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2021 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2021. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

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

The following apply to your *Member Handbook*:

Deductible

Before the plan will begin to provide benefits for most covered services you must first meet a benefit period deductible. Each member must meet the per-member deductible unless the family deductible applies. The family deductible is considered met when any combination of members in a family reaches the family deductible amount.

The deductible does not apply to preventive care, including immunizations; health maintenance visits for adults and children, as well as those mammograms, cytological exams and tests associated with health maintenance visits; prenatal care; well child care, including vision and auditory screening; voluntary family planning; or nutrition counseling and health education.

A deductible carryover provision does not apply to this plan.

Your costs for covered services

Your deductible is **$2,000** if you elected individual coverage. Your deductible is **$4,000** if you elected family coverage. If you elect individual coverage, you must meet the individual coverage deductible amount. If you elect family coverage, you and your family must meet the family coverage deductible amount. The family coverage deductible is considered met when any combination of members in a family reaches the family deductible amount. The deductible does not apply to preventive care. A deductible carryover provision does not apply to this plan.

Out-of-pocket maximum

There is a limit to what you will have to pay for the covered health care services you receive during the benefit period. This is called your out-of-pocket maximum. Your out-of-pocket maximum includes your deductible plus any coinsurance and copayments you pay. Your out-of-pocket maximum does not include your premium charge or any costs you incur for health care services not covered by the plan. **Your out-of-pocket maximum is $6,550 if you elected individual coverage. Your out-of-pocket maximum is $13,100 if you elected family coverage.** The family out-of-pocket maximum is considered met when any combination of members in a family reaches the family out-of-pocket maximum amount.

Deletion of domestic partner coverage

You **do not** have coverage for domestic partners under this plan. A domestic partner is defined as a partner of the same or opposite sex whom you would have registered with your employer for eligibility for benefits, and would have included under your family coverage for health insurance.

It Fits! ™ benefit

Your contract includes coverage for services provided under the It Fits! ™ program to a maximum of $250 per member/$500 per family.

Healthy Health Plan program

Your contract includes coverage for services provided under the Healthy Health Plan program. See your *Member Handbook* for details.

Covered services

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

Covered services	Benefits
Ambulance services	
1. Ambulance transportation for an emergency	Covered in full after you meet your deductible
2. Ambulance transportation for non-emergency situations, when medically necessary	Covered in full after you meet your deductible
Autism services *Prior authorization required*	
1. Habilitative and rehabilitative care	Covered in full after you meet your deductible
2. Applied behavior analysis when supervised by a board certified behavioral analyst	Covered in full after you meet your deductible
3. Therapeutic care, services including speech, physical and occupational therapy	Covered in full after you meet your deductible
Durable medical equipment and prosthetic/orthotic devices *Referral and prior authorization required for most services*	
1. The purchase or rental of durable medical equipment and prosthetic/orthotic devices (including the fitting, preparing, repairing and modifying of the appliance)	Covered in full after you meet your deductible
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 benefit period when the prosthesis is determined to be medically necessary by a plan physician and the plan.	Covered in full after you meet your deductible
3. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy	Covered in full after you meet your deductible
4. Prosthetic limbs which replace, in whole or in part, an arm or leg	Covered in full after you meet your deductible
5. Insulin pump and insulin pump supplies	Covered in full after you meet your deductible
6. Breast pumps	Covered in full
7. Up to $2,000 per ear for hearing aid device only, every 36 months (must be 21 years of age or younger) • Related services and supplies for hearing aids (not subject to the $2,000 limit)	Covered in full after you meet your deductible
8. Medical and surgical supplies	Covered in full after you meet your deductible
Emergency and urgent care	
1. Emergency room visits	Covered in full after you meet your deductible
2. Emergency room visits when you are admitted to an observation room	Covered in full after you meet your deductible
3. Urgent care visits in a doctor's office or at an urgent care facility	Covered in full after you meet your deductible

Covered services	Benefits
Emergency and urgent care, continued	
4. Emergency prescription medication provided out of the Direct Care service area as part of an approved emergency treatment	Tier 1: $10 copayment Tier 2: $30 copayment Tier 3: $65 copayment for up to a 14-day supply after you meet your deductible
Enteral formulas and low protein foods *Referral and prior authorization required for enteral formulas*	
1. Enteral formulas, upon a physician's written order, for home use in the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids	Covered in full after you meet your deductible
2. Food products that have been modified to be low in protein for individuals with inherited diseases of amino acids and organic acids. You may be required to purchase these products over the counter and submit claims to the plan for reimbursement.	Covered in full after you meet your deductible
Home health care services *Prior authorization required*	
1. Part-time or intermittent skilled nursing care and physical therapy provided in your home by a home health agency	Covered in full after you meet your deductible
2. Additional services and supplies that are determined to be a medically necessary component of skilled nursing care and physical therapy	Covered in full after you meet your deductible
3. Home dialysis services and non-durable medical supplies	Covered in full after you meet your deductible
Hospice care services *Referral and prior authorization required*	Covered in full after you meet your deductible
Hospital inpatient services *Referral and prior authorization required*	
1. Inpatient hospital services including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient	Covered in full after you meet your deductible
Infertility/assisted reproductive technology (art) services* *Referral and prior authorization required (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP)*	
1. Office visits for the consultation, evaluation and diagnosis of fertility	Covered in full after you meet your deductible
2. Diagnostic laboratory services	Covered in full after you meet your deductible
3. Diagnostic X-ray services	Covered in full after you meet your deductible
4. Artificial insemination, such as intrauterine insemination (IUI)	Covered in full after you meet your deductible
5. Assisted reproductive technologies*	Covered in full after you meet your deductible

Covered services	Benefits
Infertility/assisted reproductive technology (art) services, continued*	
6. Sperm, egg, and/or inseminated egg procurement, assisted hatching, cryopreservation, processing and banking for plan members in active infertility treatment, to the extent that such costs are not covered by the donor's insurer	Covered in full after you meet your deductible
* See the **Description of benefits** section of your *Member Handbook* for a list of covered infertility/ART services.	
Maternity services 1. Obstetrical services including prenatal, childbirth, postnatal and postpartum care	Prenatal: Covered in full (first visit only) Postnatal: Covered in full after you meet your deductible
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.	Covered in full after you meet your deductible
(Fallon Health members are eligible for childbirth classes (refresher class or siblings class))	Covered in full through member reimbursement

Covered services	Benefits
Mental health and substance use services *Inpatient services* *Prior authorization required*	
1. Inpatient hospital care for as many days as your condition requires, including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, individual, family and group therapy, pharmacological therapy, and diagnostic laboratory services. **Note:** Prior authorization will not be required for behavioral health inpatient admission immediately following an emergency room visit.	Covered in full after you meet your deductible
Intermediate services *Prior authorization required* *Intermediate services include but are not limited to:*	
1. Acute and other residential treatment-Mental health services provided in a 24-hour setting therapeutic environments	Covered in full after you meet your deductible
2. Clinically managed detoxification services-24 hour, 7 days a week, clinically managed de-tox services in a licensed non-hospital setting that include 24 hour per day supervision	Covered in full after you meet your deductible
3. Partial Hospitalization: Short-term day/evening mental health programming available 5 to 7 days per week	Covered in full after you meet your deductible
4. Intensive outpatient programs: Multimodal, inter-disciplinary, structured behavioral health treatment provided 2-3 hours per day, multiple days per week	Covered in full after you meet your deductible
5. Day treatment: Program encompasses some portion of the day or week rather than a weekly visit	Covered in full after you meet your deductible
6. Crisis Stabilization: Short-term psychiatric treatment in a structured, community based therapeutic environments.	Covered in full after you meet your deductible
7. In-home therapy services	Covered in full after you meet your deductible
Outpatient services	
1. Outpatient office visits, including individual, group or family therapy.	Covered in full after you meet your deductible
2. Psychopharmacological services, such as visits with a physician to review, monitor and adjust the levels of prescription medication to treat a mental condition	Covered in full after you meet your deductible
3. Neuropsychological assessment services when medically necessary	Covered in full after you meet your deductible
Note: Effective for plan years beginning on or after October 1, 2015, Massachusetts state law (Chapter 258 of the Acts of 2014) restricts the circumstances in which insurers may require prior authorization for substance use services. We will not require prior authorization for substance use services in any circumstances where this is not allowed by Chapter 258.	

Covered services	Benefits
Office visits and outpatient 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.	Covered in full after you meet your deductible
2. A second opinion, upon your request, with another plan provider	Covered in full after you meet your deductible
3. Certain drugs covered under medical benefits, and that are ordered, supplied and administered by a plan provider	Covered in full after you meet your deductible
4. Allergy injections	Covered in full after you meet your deductible
5. Radiation therapy and Chemotherapy	Covered in full after you meet your deductible
6. Respiratory therapy	Covered in full after you meet your deductible
7. Hormone replacement services in the doctor's office for perimenopausal or postmenopausal women	Covered in full after you meet your deductible
8. Diagnostic lab services ordered by a plan provider, in relation to a covered office visit	Covered in full after you meet your deductible
9. Diagnostic X-ray services ordered by a plan provider, in relation to a covered office visit	Covered in full after you meet your deductible
10. Other diagnostic services including but not limited to, EKG, endoscopy, colonoscopy and ultrasound	Covered in full after you meet your deductible
11. High-tech imaging services, including but not limited to, MRI/MRA, CT/CTA, PET scans and nuclear cardiology imaging. (Prior authorization required.)	Covered in full after you meet your deductible
12. Chiropractic services for acute musculoskeletal conditions. The condition must be new or an acute exacerbation of a previous condition. Coverage is provided for up to 12 office visits in each benefit period. The actual number of visits provided is based on medical necessity as determined by your plan provider and the plan. • Outpatient lab tests and x-rays	Covered in full after you meet your deductible See Diagnostic lab, x-ray and high-tech imaging services
13. Outpatient renal dialysis at a plan-designated center or continuous ambulatory peritoneal dialysis	Covered in full after you meet your deductible
14. Diabetes outpatient self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider	Covered in full after you meet your deductible
15. Laboratory tests necessary for the diagnosis or treatment of diabetes, including glycosylated hemoglobin, or HbAlc, tests, and urinary/protein/ microalbumin and lipid profiles	Covered in full after you meet your deductible
16. Medical social services provided to assist you in adjustment to your or your family member's illness. This includes assessment, counseling, consultation and assistance in accessing community resources.	Covered in full after you meet your deductible

Covered services	Benefits
Office visits and outpatient services, continued	
17. Outpatient surgery, anesthesia and the medically necessary preoperative and postoperative care related to the surgery	Covered in full after you meet your deductible when provided in a hospital outpatient, day surgery or ambulatory care facility
18. 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)	Covered in full after you meet your deductible
19. Podiatry care	
• Outpatient lab tests and x-rays	See Diagnostic lab, x-ray and imaging services
• Outpatient surgical services	See Outpatient surgery
• Outpatient medical care	See Office visits
Oral surgery and related services *Referral and prior authorization required (except for extraction of impacted teeth or lingual frenectomy)*	
1. Removal or exposure of impacted teeth, including both hard and soft tissue impactions, or an evaluation for this procedure	Covered in full after you meet your deductible
2. Surgical treatments of cysts, affecting the teeth or gums, that must be rendered by a plan oral surgeon	Covered in full after you meet your deductible
3. Treatment of fractures of the jaw bone (mandible) or any facial bone	Covered in full after you meet your deductible
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	Covered in full after you meet your deductible
5. Extraction of teeth in preparation for radiation treatment of the head or neck	Covered in full after you meet your deductible
6. Surgical treatment related to cancer	Covered in full after you meet your deductible
7. Emergency medical care, such as, to relieve pain and stop bleeding as a result of accidental injury to sound natural teeth or tissues, when provided as soon as medically possible after the injury. This does not include restorative or other dental services. No referral or authorization is required. Go to the closest provider.	Covered in full after you meet your deductible per visit to a physician's or dentist's office Covered in full after you meet your deductible per visit to an emergency room
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.	
See **Office visits and outpatient services** for diagnostic lab and X-ray services.	

Covered services	Benefits
Organ transplants *Referral and prior authorization required* 1. Office visits related to the transplant	Covered in full after you meet your deductible
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*	Covered in full after you meet your deductible
3. Human leukocyte antigen (HLA) or histocompatability locus antigen testing for A, B or DR antigens, or any combination thereof, necessary to establish bone marrow transplant donor suitability of a member	Covered in full after you meet your deductible
Prescription drugs Covered prescription items: • Prescription medication • Prescription contraceptive drugs and devices* • Hormone replacement therapy for peri- and post-menopausal women • Injectable agents (self-administered**) • Insulin • Syringes (including insulin syringes) or needles when medically necessary • Supplies for the treatment of diabetes, as required by state law, including: – blood glucose monitoring strips – urine glucose strips – lancets – ketone strips • Special medical formulas to treat certain metabolic disorders as required by state law (prior authorization required). *Generic prescription contraceptive drugs and devices are covered in full. Brand name prescription contraceptive drugs and devices with no generic equivalent are covered in full (prior authorization required). **Injectables administered in the doctor's office or under other professional supervision are covered as a medical benefit.	Network pharmacy: Tier 1: $10 copayment Tier 2: $30 copayment Tier 3: $65 copayment for up to a 30-day supply after you meet your deductible Mail-order pharmacy: Tier 1: $25 copayment Tier 2: $75 copayment Tier 3: $165 copayment for up to a 90-day supply after you meet your deductible
Orally administered anticancer medications used to kill or slow the growth of cancerous cells	Covered in full after you meet your deductible
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. **Note:** Medical and surgical supplies obtained through a pharmacy may have a drug prescription benefit cost-sharing applied.	
Preventive drugs	See Addendum: Preventive Drugs That Do Not Apply To Your Deductible

Covered services	Benefits
Preventive care	
1. Routine physical exams for the prevention and detection of disease	Covered in full
2. Immunizations that are included on the formulary, that are for covered medical benefits and that are ordered, supplied and administered by a plan physician. If administered by a plan specialist, you will generally need to obtain a referral to see the specialist.	Covered in full
3. A baseline mammogram for women age 35 to 40, and a yearly mammogram for women age 40 and older	Covered in full
4. Routine gynecological care services, including an annual Pap smear (cytological screening) and pelvic exam	Covered in full
5. Routine eye exams, once in each 12-month period	Covered in full
6. Hearing and vision screening	Covered in full
7. Well-child care and pediatric services, at least six times during the child's first year after birth, at least three times during the next year, then at least annually until the child's sixth birthday. This includes the following services, as recommended by the physician and in accordance with state law: • physical examination • history • measurements • sensory screening • neuropsychiatric evaluation • development screening and assessment	Covered in full
8. Pediatric services including: • appropriate immunizations • hereditary and metabolic screening at birth • newborn hearing screening test performed before the newborn infant is discharged from the hospital or birthing center • tuberculin tests, hematocrit, hemoglobin, and other appropriate blood tests and urinalysis • lead screening	Covered in full
9. Female consultations, examinations, procedures, contraceptive devices, and medical services related to the use of all contraceptive methods*	Covered in full
10. Tobacco counseling sessions with your primary physician or other provider designed to create a plan to stop smoking.	Covered in full
* Prescription contraceptive devices are covered under the prescription drug benefit.	

Covered services	Benefits
Reconstructive surgery *Referral and prior authorization required (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP)* 1. Inpatient hospital services including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient, including Massachusetts mandated services for cleft lip and cleft palate	Covered in full after you meet your deductible
Rehabilitation and habilitation services *Referral required* 1. Physical and occupational therapy services are covered for up to 60 visits combined per benefit period when medically necessary with a PCP referral. After 60 combined physical and occupational therapy visits, prior authorization based on medical necessity is required for additional visits.	Covered in full after you meet your deductible
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 with a PCP referral. After 30 speech therapy visits, prior authorization based on medical necessity is required for additional visits.	Covered in full after you meet your deductible
3. Cardiac rehabilitation services to treat cardiovascular disease in accordance with state law and Department of Public Health regulations	Covered in full after you meet your deductible
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.	Covered in full after you meet your deductible
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.	Covered in full after you meet your deductible
Skilled nursing facility services *Referral and prior authorization required* 1. Inpatient hospital services, for up to 100 days in each benefit period provided criteria is met, including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient	Covered in full after you meet your deductible

Addendum
Preventive Drugs That Do Not Apply to Your Deductible

For members of self-funded QHD plans administered through Fallon Health, the prescription drugs listed below are not subject to the plan deductible when filled at an in-network pharmacy. If applicable, you may be responsible for a copayment.

Your prescription drug coverage features a preventive therapy drug benefit, including medications to help prevent chronic conditions and illnesses. Generic drugs are in lower case; brand name drugs are in UPPER CASE.

RESPIRATORY AGENTS FOR ASTHMA/COPD

ADVAIR DISKUS
ADVAIR HFA
albuterol sulfate
ATROVENT HFA
budesonide
BREO ELLIPTA
COMBIVENT RESPIMAT
cortisone acetate (oral)
cromolyn sodium
DALIRESP
dexamethasone (oral)
FLOVENT DISKUS
FLOVENT HFA
hydrocortisone (oral)
ipratropium/albuterol
levalbuterol
metaproterenol
methylprednisolone (oral)
montelukast
prednisone (oral)
PROAIR HFA
QVAR
SEREVENT DISKUS
terbutaline
theophylline
TUDORZA PRESSAIR
XOPENEX HFA
Zafirlukast

BLOOD CLOTS AND STROKE PREVENTION

anagrelide
BRILINTA
cilostazol
clopidogrel
dipyridamole
EFFIENT
ELIQUIS
enoxaparin
fondaparinux
ticlopidine
warfarin
XARELTO

DEPRESSION

amitriptyline
amitriptyline/perphenazine
amoxapine
APLENZIN
citalopram
clomipramine
desipramine
duloxetine DR
escitalopram
fluoxetine
fluvoxamine
imipramine
maprotiline
mirtazapine
nefazodone
nortriptyline
paroxetine
paroxetine ER
PRISTIQ
sertraline
tranylcypromine
trazodone
venlafaxine ER
venlafaxine

DIABETES

acarbose
diabetic supplies
glimepiride
glipizide
glipizide ER
glipizide/metformin
glyburide
glyburide/metformin
glyburide, micronized
HUMALOG
HUMULIN
INVOKANA
INVOKAMET
JANUMET
JANUMET XR
JANUVIA
JENTADUETO
LANTUS
metformin
metformin ER
nateglinide
pioglitazone
pioglitazone/glimepiride
pioglitazone/metformin
repaglinide
repaglinide/metformin
TANZEUM
TOUJEO
TRADJENTA
TRULICITY
VICTOZA

HEART FAILURE

flecainide
mexiletine
propafenone ER
propafenone

HIGH BLOOD PRESSURE

acebutolol
acetazolamide
amiloride
amiloride/hctz
amiodarone
amlodipine/atorvastatin
amlodipine/benazepril
atenolol
atenolol/chlorthalidone
benazepril
benazepril/hctz
BENICAR
BENICAR HCT
betaxolol
bisoprolol fumarate
bisoprolol fumarate/hctz
bumetanide
candesartan
candesartan/hctz
captopril
carvedilol
chlorothiazide
chlorthalidone
clonidine
digoxin
diltiazem
diltiazem ER
disopyramide
doxazosin

Preventive Drugs That Do Not Apply to Your Deductible, continued

High Blood Pressure, continued

enalapril
eplerenone
eprosartan
felodipine ER
fosinopril
fosinopril/hctz
furosemide
guanfacine
hydralazine
hydrochlorothiazide (hctz)
indapamide
irbesartan
irbesartan/hctz
isosorbide dinitrate ER
isosorbide mononitrate ER
isradipine
labetalol
levatol
lisinopril
lisinopril/hctz
losartan
losartan/hctz
methazolamide
methyldopa
metolazone
metoprolol succinate er
metoprolol tartrate
metoprolol/hctz
midodrine
moexipril
moexipril/hctz
nadolol
nicardipine hcl
nifedipine
nifedipine ER
nimodipine
nisoldipine ER
NITRO-DUR
nitroglycerin
NITROGLYCERIN LINGUAL
nitroglycerin spray
NITROSTAT
NYMALIZE
perindopril
pindolol
prazosin
propranolol
propranolol ER
quinapril
quinapril/hctz
ramipril
sotalol
sotalol AF
spironolactone
spironolactone/hctz
telmisartan
telmisartan/hctz
terazosin
timolol maleate
torsemide
trandolapril/verapamil ER
triamterene/hctz
valsartan/hctz
verapamil
verapamil ER

MALARIA

atovaquone/proguanil
chloroquine phosphate
DARAPRIM
hydroxychloroquine
mefloquine
quinine sulfate capsule

OSTEOPOROSIS

alendronate
calcitonin-salmon nasal spray
estradiol transdermal
ESTROPIPATE
FORTEO
fortical
ibandronate
MENEST
MENOSTAR
PREMARIN (ORAL)
PREMPHASE
PREMPRO

This is not an all-inclusive list. Limitations and restrictions may apply.

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.

16-735-009 Rev. 01 4/17

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 ឬនរណាម្ននក់ដែលអ្នកកំពុងដែជួយ ម្ននសំណួរអ្ំពី Fallon Health បេ,
អ្នកម្ននសិេធិេេួលជំនួយនិងព័ែ៌ម្នន ជៅកនុងភាសា ររស់អ្នក ជោយមិនអ្ស់ប្ាក់ ។
បែើមបីនិយាយជាមួយអ្នកែកដប្រ 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 રહ્ાાાં તેમ ાાંથી કોઇને Fallon Health વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ મ ાાં પ્ર મ કરી શક ર્ છે. ્ ભ વષર્ો િ ત કરિ મ ટે,આ 1-800-868-5200 પર કોલ કરો.

Laotian:
้าท่าน, ท ูือค้นห ่ท่านกำลังช่วยเท ูือ, ม ค ำถ ามก ่ยวกับ Fallon Health, ท่านม สิดห ่จะได้ร ับการช่วยเท ูือฟร ีและข้ ้มูลข่าวสารน ห ่เป ็นภาษาของท่านบ ่ม ค่าใช้จ่าย. การโอ้ ้อมกับนายพาสา, โท้ โทหา 1-800-868-5200.

16-735-008a Rev. 00 5/16