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 Select 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
Ambulance services	
1. Ambulance transportation for an emergency	Covered in full
2. Ambulance transportation for non-emergency situations, when medically necessary	Covered in full
Autism services *Prior authorization required*	
1. Habilitative and rehabilitative care including but not limited to applied behavior analysis when supervised by a board certified behavioral analyst	$20 copayment per visit
2. Therapeutic care, services including speech, physical and occupational therapy.	$20 copayment per visit
Dental benefits *Referral and prior authorization required for most services*	
1. 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).	$10 copayment per visit
2. Minor restorative dental care, such as metal or composite fillings.	Copayments vary. See *Addendum: Discount Dental Services – Fees*.
3. 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.	$20 copayment per visit to a physician's or dentist's office $100 copayment per visit to an emergency room then subject to your deductible
4. Dental services and treatments for minor ailments such as a toothache, or loose filling while out of the Select Care service area. Coverage is provided for up to $50 per incident.	$10 copayment per visit
Durable medical equipment and prosthetic/orthotic devices *Referral and prior authorization required for most services*	
1. The purchase or rental of durable medical equipment and prosthetic/orthotic devices (including the fitting, preparing, repairing and modifying of the appliance).	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.	20% coinsurance after you meet your deductible
5. Insulin pump and insulin pump supplies	Covered in full
6. Breast pumps	Covered in full

Covered services	Benefits
Durable medical equipment and prosthetic/orthotic devices, continued	
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
Emergency and urgent care	
1. Emergency room visits	$100 copayment per visit then subject to your deductible
2. Emergency room visits when you are admitted to an observation room	Covered in full after you meet your deductible
3. Urgent care visits in a doctor's office or at an urgent care facility	$20 copayment per visit
4. Emergency prescription medication provided out of the Select Care service area as part of an approved emergency treatment	Tier 1: $10 copayment Tier 2: $25 copayment Tier 3: $50 copayment for up to a 14-day supply
Enteral formulas and low protein foods *Referral and prior authorization required for enteral formulas*	
1. Enteral formulas, upon a physician's written order, for home use in the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids	Covered in full after you meet your deductible
2. Food products that have been modified to be low in protein for individuals with inherited diseases of amino acids and organic acids. You may be required to purchase these products over the counter and submit claims to the plan for reimbursement.	Covered in full after you meet your deductible
Home health care services	
1. Part-time or intermittent skilled nursing care and physical therapy provided in your home by a home health agency	Covered in full after you meet your deductible
2. Additional services and supplies that are determined to be a medically necessary component of skilled nursing care and physical therapy	Covered in full after you meet your deductible
Hospice care services *Referral and prior authorization required*	Covered in full 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	$500 copayment per admission then subject to your deductible

Covered services	Benefits
Infertility/assisted reproductive technology (art) services* *Referral and prior authorization required (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP)*	
1. Office visits for the consultation, evaluation and diagnosis of fertility	$20 copayment per visit with your PCP and certain other providers $35 copayment per visit with a specialist
2. Diagnostic laboratory and X-ray services	Covered in full after you meet your deductible
3. Artificial insemination, such as intrauterine insemination (IUI)	Covered in full after you meet your deductible
4. Assisted reproductive technologies* except for those services listed below	Covered in full after you meet your deductible
5. Assisted reproductive technologies for: • In vitro fertilization (IVF-ET) • Gamete intrafallopian transfer (GIFT) • Zygote intrafallopian transfer (ZIFT)	$150 copayment per procedure then subject to your deductible
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	Covered in full after you meet your deductible
7. Assisted hatching	Covered in full after you meet your deductible
8. Cryopreservation of eggs	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: $20 copayment (first visit only) Postnatal: $20 copayment per visit
2. Inpatient maternity and newborn child care for a minimum of 48 hours of care following a vaginal delivery, or 96 hours of care following a Caesarean section delivery, 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.	$500 copayment per admission then subject to your deductible

Covered services	Benefits
Mental health and substance abuse services	
Inpatient services	
Prior authorization required	
1. Inpatient hospital care for as many days as your condition requires, including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, individual, family and group therapy, pharmacological therapy, and diagnostic laboratory services.	Covered in full
Intermediate services	
Prior authorization required	
Intermediate services include but are not limited to:	
1. Acute and other residential treatment-Mental health services provided in a 24-hour setting therapeutic environments.	Covered in full
2. Clinically managed detoxification services-24 hour, 7 days a week, clinically managed de-tox services in a licensed non-hospital setting that include 24 hour per day supervision	Covered in full
3. Partial Hospitalization: Short-term day/evening mental health programming available 5 to 7 days per week.	$20 copayment per visit
4. Intensive outpatient programs: Multimodal, inter-disciplinary, structured behavioral health treatment provided 2-3 hours per day, multiple days per week.	$20 copayment per visit
5. Day treatment: Program encompasses some portion of the day or week rather than a weekly visit	$20 copayment per visit
6. Crisis Stabilization: Short-term psychiatric treatment in a structured, community based therapeutic environments.	$20 copayment per visit
7. In-home therapy services	$20 copayment per visit
Outpatient services	
1. Outpatient office visits, including individual, group or family therapy. The actual number of visits authorized beyond the initial eight is based on medical necessity as determined by the plan, and may include individual, group, or family therapy.	$20 copayment per visit
2. Psychopharmacological services, such as visits with a physician to review, monitor and adjust the levels of prescription medication to treat a mental condition	$20 copayment per visit
3. Neuropsychological assessment services when medically necessary	$20 copayment per visit

Covered services	Benefits
Office visits and outpatient services	
1. Office visits, to diagnose or treat an illness or an injury	$20 copayment per visit with your PCP and certain other providers $35 copayment per visit with a specialist
2. A second opinion, upon your request, with another plan provider	$20 copayment per visit with your PCP and certain other providers $35 copayment per visit with a specialist
3. Injections and injectables drugs that are included on the formulary, that are for covered medical benefits, and that are ordered, supplied and administered by a plan provider	Covered in full after you meet your deductible
4. Allergy injections	Covered in full
5. Radiation therapy	Covered in full after you meet your deductible
6. Respiratory therapy	Covered in full after you meet your deductible
7. Hormone replacement services in the doctor's office for perimenopausal or postmenopausal women	$20 copayment per visit
8. Diagnostic lab and X-ray services ordered by a plan provider, in relation to a covered office visit	Covered in full after you meet your deductible
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. *(Prior authorization required.)*	$100 copayment per MRI, CT, PET scan or nuclear cardiology image then subject to your deductible
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.	$20 copayment per visit
11. Outpatient renal dialysis at a plan-designated center or continuous ambulatory peritoneal dialysis	Covered in full after you meet your deductible
12. Diabetes outpatient self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider	$20 copayment per visit
13. Laboratory tests necessary for the diagnosis or treatment of diabetes, including glycosylated hemoglobin, or HbAlc, tests, and urinary/protein/ microalbumin and lipid profiles	Covered in full after you meet your deductible
14. Medical social services provided to assist you in adjustment to your or your family member's illness. This includes assessment, counseling, consultation and assistance in accessing community resources.	$20 copayment per visit

Covered services	Benefits
Office visits and outpatient services, continued	
15. Outpatient surgery, anesthesia and the medically necessary preoperative and postoperative care related to the surgery	$150 copayment per surgery then subject to your deductible when provided in a hospital outpatient, day surgery or ambulatory care facility
16. Visit to a contracted limited service clinic. Services are provided for a variety of common illnesses, including, but not limited to: • strep throat • ear, eyes, sinus, bladder and bronchial infections • minor skin conditions (e.g. sunburn, cold sores)	$20 copayment per visit
Oral surgery and related services *Referral and prior authorization required (except for extraction of impacted teeth)*	
1. Removal or exposure of impacted teeth, including both hard and soft tissue impactions, or an evaluation for this procedure	$35 copayment per visit
2. Surgical treatments of cysts, affecting the teeth or gums, that must be rendered by a plan oral surgeon	$35 copayment per visit
3. Treatment of fractures of the jaw bone (mandible) or any facial bone	$35 copayment per visit
4. Evaluation and surgery for the treatment of temporomandibular joint disorder when a medical condition is diagnosed, or for surgery related to the jaw or any structure connected to the jaw	$35 copayment per visit
5. Lingual frenectomy	$35 copayment per visit
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.	
Organ transplants *Referral and plan authorization required*	
1. Office visits related to the transplant	$20 copayment per visit with your PCP and certain other providers $35 copayment per visit with a specialist
2. Inpatient hospital services, including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient	$500 copayment per admission then subject to 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

Covered services	Benefits
Prescription drugs	
Covered prescription items: • Prescription medication • Prescription contraceptive drugs and devices* • Hormone replacement therapy for per- and post-menopausal women • Injectable agents (self-administered**) • Insulin • Syringes (including insulin syringes) or needles when medically necessary • Supplies for the treatment of diabetes, as required by state law, including: – blood glucose monitoring strips – urine glucose strips – lancets – ketone strips • 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: $25 copayment Tier 3: $50 copayment for up to a 30-day supply Mail-order pharmacy: Tier 1: $20 copayment Tier 2: $50 copayment Tier 3: $110 copayment for up to a 90-day supply
Orally administered anticancer medications used to kill or slow the growth of cancerous cells	Covered in full
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:	Covered in full

Covered services	Benefits
Preventive care, continued • physical examination • history • measurements • sensory screening • neuropsychiatric evaluation • development screening and assessment	
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. Voluntary family planning	Covered in full
10. Consultations, examinations, procedures and medical services related to the use of all contraceptive methods	Covered in full
11. Contraceptive devices that are supplied by a plan provider during an office visit*	Covered in full
* Prescription contraceptive devices are covered under the prescription drug benefit.	
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	$500 copayment per admission then subject to 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.	$20 copayment per visit
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)	$20 copayment per visit
3. Cardiac rehabilitation services to treat cardiovascular disease in accordance with state law and Department of Public Health regulations	$20 copayment per visit
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

Covered services	Benefits
Rehabilitation and habilitation services, continued	
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)	Covered in full after you meet your deductible
Skilled nursing facility services *Referral and prior authorization required*	
1. Inpatient hospital services, for up to 100 days per benefit period provided criteria is met, including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient	$500 copayment per admission then subject to your deductible