Fallon Companion Care

Schedule of Benefits

January 1, 2013 through December 31, 2013

fallon health & life
assurance company, inc.

12-670-923

RCeO

Fallon Companion Care
Schedule of Benefits
January 1, 2013 through December 31, 2013

This Schedule of Benefits describes the benefits and services available with Fallon Companion Care and your costs for health care. This policy provides coverage secondary to Medicare, as well as coverage for some additional services not covered by Medicare, for members enrolled through employer groups. Covered services under this policy generally fall into two categories: services for which the policy provides coverage secondary to Medicare, and non-Medicare services mandated by Massachusetts state law.

This health plan alone does not meet Minimum Creditable Coverage standards and will not satisfy the individual mandate that you have health insurance. Enrollment in Original Medicare (Part A and Part B) satisfies Minimum Creditable Coverage standards, however. Since enrollment in Original Medicare is an eligibility requirement for this plan, any insured enrolled in this health plan should satisfy Minimum Creditable Coverage standards.

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 plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the insured's other health plans.

If you have questions about this notice, you may contact the Division of Insurance by calling 1-617-521-7794 or visiting its website at www.mass.gov/doi.

The benefits described here are available to all insureds provided that the criteria below are met. Covered services under this policy generally fall into two categories: services for which the policy provides coverage secondary to Medicare, and non-Medicare services mandated by Massachusetts state law.

For Medicare-covered services:

- The services are received from a provider or facility that is eligible to receive payments from Medicare.
- The services are covered by Medicare Part A or Part B.
- The charges for the services do not exceed the Medicare allowed amount.

For other services:

- The services are received from a properly licensed provider or facility.
- The services are described as a covered service in the *Member Handbook*, and are not limited or excluded elsewhere in the *Member Handbook*, in the Schedule of Benefits, or in an amendment to the *Member Handbook*.
- The services are medically necessary, or meet any other criteria described in the *Member Handbook*.
- The charges for the services do not exceed the reasonable and customary amount.

For Medicare-covered services, this policy provides secondary coverage for any service covered by Medicare Part A or B, including but not limited to the services listed in this Schedule of Benefits. Unless otherwise noted, coverage for services in this category is provided only if the services are covered by Medicare Part A or Part B, and only for the deductible, copayment and coinsurance amounts which are not paid by Medicare. Coverage is provided for 100% of the deductible, copayment and coinsurance, up to the Medicare-allowed amount, unless stated otherwise in this Schedule of Benefits, *Member Handbook* or in an amendment to the handbook. Note that Medicare coverage of certain services may be limited, or may be restricted to services which meet certain criteria. In some cases, providers who do not accept Medicare "assignment" may be able to bill you for charged amounts that exceed the Medicare-approved deductible or coinsurance amount. In such cases, this amount is the responsibility of the insured, and will not be covered by either Medicare or Fallon Companion Care. Fallon Companion Care will not provide coverage for any service not covered by Medicare unless specifically indicated otherwise in this Schedule of Benefits, *Member Handbook* or in an amendment to the handbook.

Those services mandated by Massachusetts state law listed in your *Member Handbook* are covered by Fallon Companion Care even if Medicare does not cover them or if they are received from providers who are not eligible to receive payment from Medicare. To the extent that Medicare does provide coverage for them, however, Fallon Companion Care's coverage will be secondary to Medicare. All Fallon Companion Care coverage will be less any payments made by Medicare. Coverage is provided for 100% of the reasonable or customary amount, unless stated otherwise in this Schedule of Benefits, *Member Handbook* or in an amendment to the handbook.

We recommend that you do not rely solely on this Schedule of Benefits for information about the plan. Be sure to read all parts of the *Member Handbook*.

The chart on the following pages shows Medicare coverage for various services. Medicare coverage information is shown for purposes of illustration only and is not guaranteed by Fallon Companion Care. Medicare coverage guidelines may change from time to time, and the Medicare program makes the ultimate determination as to which services it will cover and in what manner.

Benefit Category	Original Medicare	Fallon Companion Care	Your Responsibility
IMPORTANT INFORMATION			
1 – Premium and Other Important Information	In 2013 the monthly Part B Premium is $104.90 and may change for 2014 and the annual Part B deductible amount is $147 and may change for 2014. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	
2 – Doctor and Hospital Choice (For more information, see Emergency – #15 and Urgently Needed Care – #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	You may go to any doctor, specialist or hospital that accepts Medicare.	

Benefit Category	Original Medicare	Fallon Companion Care	Your Responsibility
INPATIENT CARE			
3 - Inpatient Hospital Care **(includes Substance Abuse and Rehabilitation Services)**	In 2013 the amounts for each benefit period are: Days 1-60: $1,184 deductible Days 61-90: $296 per day Days 91-150: $592 per lifetime reserve day These amounts may change for 2014. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	100% coverage of any Medicare-allowed amount which was applied to a deductible or copayment. If you have exhausted your Medicare lifetime reserve days, 100% coverage of the reasonable and customary amount for up to 365 additional inpatient hospital days per lifetime (the 365-day limit applies to services received in both a general hospital and a mental or psychiatric hospital).	$0 for inpatient hospital care.*
4 - Inpatient Mental Health Care	In 2013 the amounts for each benefit period are: Days 1-60: $1,184 deductible Days 61-90: $296 per day Days 91-150: $592 per lifetime reserve day These amounts may change for 2014. You get up to 190 days of inpatient	100% coverage of any Medicare allowed amount which was applied to a deductible or copayment. If you have exhausted your Medicare lifetime reserve days or reached your 190-day Medicare lifetime limit on care in a psychiatric hospital, 100% coverage of the reasonable and customary	$0 for inpatient mental health care.*

* For any services charged at the Medicare allowed amount.

Benefit Category	Original Medicare	Fallon Companion Care	Your Responsibility
4 - Inpatient Mental Health Care, *continued*	psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	amount for up to 365 additional inpatient hospital days per lifetime (the 365-day limit applies to services received in both a general hospital and a psychiatric hospital).	
5 - Skilled Nursing Facility (SNF) **(in a Medicare-certified skilled nursing facility)**	In 2013 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1–20: $0 per day Days 21–100: $148.00 per day These amounts may change for 2014. 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	100% coverage of any Medicare allowed amount which was applied to a deductible or copayment for days 21-100.	$0 for days 1-100 each benefit period for a skilled nursing facility stay.* 100% of the costs for days 101-365 for a skilled nursing facility stay.
6 - Home Health Care **(includes medically-necessary intermittent skilled nursing care, home health aide services, rehabilitation services, etc.)**	$0 copay.	100% coverage of any Medicare allowed amount which would normally be your responsibility.	$0 for home health care.*

* For any services charged at the Medicare allowed amount.

Benefit Category	Original Medicare	Fallon Companion Care	Your Responsibility
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	100% coverage of any Medicare allowed amount which would normally be your responsibility.	$0 for hospice.*
OUTPATIENT CARE			
8 - Doctor Office Visits	20% coinsurance	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for doctor office visits.*
9 - Chiropractic Services	Supplemental routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for chiropractic care.* 100% of the cost for routine chiropractic care not covered by Medicare.
10 - Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for podiatry services.* 100% of the cost for routine podiatry care not covered by Medicare.

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Benefit Category	Original Medicare	Fallon Companion Care	Your Responsibility
11 - Outpatient Mental Health Care	40% coinsurance for most outpatient mental health services. Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 40% of the Medicare allowed amount that Medicare does not pay.	$0 for outpatient mental health care.*
12 - Outpatient Substance Abuse Care	20% coinsurance	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for outpatient substance abuse care.*
13 – Outpatient Services/Surgery	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services. Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for outpatient services/surgery.*

* For any services charged at the Medicare allowed amount.

Benefit Category	Original Medicare	Fallon Companion Care	Your Responsibility
14 - Ambulance Services **(medically necessary ambulance services)**	20% coinsurance	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay. Supplemental coverage for emergency-related transportation services received outside the United States is limited to road ambulance transportation to the nearest appropriate hospital.	$0 for worldwide ambulance services.* 100% of the cost for ambulance services that are not covered by Medicare or Fallon Companion Care.
15 - Emergency Care **(You may go to any emergency room if you reasonably believe you need emergency care.)**	20% coinsurance for the doctor's services. Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay. Supplemental coverage for services received outside the United States excludes services that would not be covered by Medicare or Fallon Companion Care if they were received in the United States, services that are routine or preventive in nature, or services that could have been received or scheduled before leaving the United States.	$0 for worldwide emergency care.* 100% of the costs for emergency services that are not covered by Medicare or Fallon Companion Care.
16 - Urgently Needed Care **(This is NOT emergency care)**	20% coinsurance, or a set copay Not covered outside the U.S. except under limited circumstances.	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for urgently needed services received in the United States.* 100% of the costs for urgently needed services received outside the United States (there are some limited exceptions).

* For any services charged at the Medicare allowed amount.

Benefit Category	Original Medicare	Fallon Companion Care	Your Responsibility
17 - Outpatient Rehabilitation Services **(Occupational Therapy, Physical Therapy, Speech and Language Therapy)**	20% coinsurance	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for outpatient rehabilitation services.*
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
18 - Durable Medical Equipment **(includes wheelchairs, oxygen, etc.)**	20% coinsurance	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for durable medical equipment.*
19 - Prosthetic Devices **(includes braces, artificial limbs and eyes, etc.)**	20% coinsurance	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for prosthetic devices.*
20 - Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for diabetes self-management training and supplies.*

* For any services charged at the Medicare allowed amount.

Benefit Category	Original Medicare	Fallon Companion Care	Your Responsibility
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and X-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol. 20% coinsurance for digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50.	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for diagnostic tests, X-rays, and lab services.*
22 – Cardiac and Pulmonary Rehabilitation Services	20% coinsurance for Cardiac Rehabilitation services 20% coinsurance for Pulmonary Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for cardiac and pulmonary rehabilitation services.*

* For any services charged at the Medicare allowed amount.

Benefit Category	Original Medicare	Fallon Companion Care	Your Responsibility
PREVENTIVE SERVICES			
23 - Preventive Services and Wellness/Education Programs	No coinsurance, copayment or deductible for the following: - Abdominal Aortic Aneurysm Screening - Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. - Cardiovascular Screening - Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine for people with Medicare who are at risk - HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. - Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every	100% coverage of any Medicare allowed amount which would normally be your responsibility.	$0 for preventive services and some wellness education services.* Smoking Cessation classes and the first week of nicotine replacement therapy (NRT) are free. After the free NRT the following costs apply: one week's supply of patches (7 patches) is $15; supplemental gum (14 pieces) is $5; and one box of gum (100 pieces) is $25.

* For any services charged at the Medicare allowed amount.

Benefit Category	Original Medicare	Fallon Companion Care	Your Responsibility
23 - Preventive Services and Wellness/Education Programs, *continued*	12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. - Medical Nutrition Therapy Services. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease - Personalized Prevention Plan Services (Annual Wellness Visits) - Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. - Prostate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. - Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. - Welcome to Medicare Physical Exam (initial preventive physical exam) when you join Medicare Part B, then you are eligible as follows: During the first 12 months of your new Part B coverage,		

Benefit Category	Original Medicare	Fallon Companion Care	Your Responsibility
23 - Preventive Services and Wellness/Education Programs, *continued*	you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.		
24 - Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for renal dialysis and kidney disease education.*
25 – Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	For Part B prescription drugs: 100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay. For non-Part B covered prescription drugs: Full coverage of medically-necessary prescription drugs. Members are responsible for copayments.	$0 for Part B prescription drugs.* Your employer group has elected a non-Part B prescription drug benefit through Fallon Companion Care for medically-necessary, covered medications. Your copayments under this benefit are shown below. *Retail pharmacy:* Tier 1: $10 Copayment for up to a 30-day supply Tier 2: $30 Copayment for up to a 30-day supply Tier 3: $50 Copayment for up to a 30-day supply *Mail-order pharmacy:* Tier 1: $20

* For any services charged at the Medicare allowed amount.

Benefit Category	Original Medicare	Fallon Companion Care	Your Responsibility
25 – Outpatient Prescription Drugs, *continued*			Copayment for up to a 90-day supply Tier 2: $60 Copayment for up to a 90-day supply Tier 3: $100 Copayment for up to a 90-day supply See the Prescription Medication section at the end of this document for more information on this benefit.
26 - Dental Services	Preventive dental services (such as cleaning) not covered.	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for oral surgery and dental services.* 100% of the cost for preventive dental services and other dental services not covered by Medicare.
27 - Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for diagnostic hearing exams.* In general, supplemental routine hearing exams and hearing aids are not covered.
28 - Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	100% coverage of any Medicare allowed amount which was applied to a deductible or coinsurance. This means we will pay your annual deductible and the remaining 20% of the Medicare allowed amount that Medicare does not pay.	$0 for vision services.*

* For any services charged at the Medicare allowed amount.

Benefit Category	Original Medicare	Fallon Companion Care	Your Responsibility
Over-the-Counter Items	Not covered.	This plan does not cover Over-the-Counter items.	This plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	This plan does not cover supplemental routine transportation.	This plan does not cover supplemental routine transportation.
Acupuncture	Not covered.	This plan does not cover Acupuncture.	This plan does not cover Acupuncture.
ADDITIONAL COVERAGE BEYOND MEDICARE			
Wellness Program	You pay 100%.	You may access FCHP's It Fits! benefit which entitles you to $200 to use toward gym memberships, new home cardiovascular equipment, Pilates and yoga classes, weight loss programs, and a variety of other healthy activities. Please contact the plan for more details. The plan also covers the following supplemental education/wellness programs: - Written health education materials, including newsletters - Additional Smoking Cessation (copayments may apply) - 24-hr/day Nursing Hotline	You pay 100% of the cost above the $200 per year It Fits! reimbursement for gym memberships, new home cardiovascular equipment, weight loss programs, fitness classes and various other healthy activities.

STATE-MANDATED SERVICES

The services mandated by Massachusetts state law listed in your *Member Handbook* are covered as follows:

To the extent that services are covered by Medicare, 100% coverage of any Medicare allowed amount which was applied to a deductible, copayment or coinsurance.

To the extent that services listed are not covered by Medicare, 100% coverage of the reasonable and customary amount for the service.

- Autism services
- Bone-marrow transplants for breast cancer patients
- Contraceptive services and hormone replacement therapy
- Home health care
- Hospice care
- Hypodermic needles and syringes
- Mammograms and Pap smears
- Mastectomy-related services
- Mental health and substance abuse services
- Scalp hair prosthesis
- Special formulas
- Speech hearing and language services

PRESCRIPTION MEDICATION

Fallon Companion Care covers medically necessary prescription drugs according to the requirements and guidelines discussed below, subject to the copayments on pages 14 and 15. This plan's prescription coverage is considered creditable prescription drug coverage.

Who can write your prescription
Prescriptions must be written by a licensed physician and approved by the U.S. Food and Drug administration for the purposes prescribed.

Where you can fill your prescription
You must fill your prescription at a pharmacy, a pharmacy mail-order program, or a specialty pharmacy affiliated with Fallon Health & Life Assurance Company. (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 as a one-month supply at a time. For a list of affiliated pharmacies, contact Customer Service at 1-800-868-5200 (TTY users, please call TRS Relay 711) or visit www.fchp.org. The pharmacy will process your prescription at the point of service in accordance with the requirements and guidelines discussed in this section. You will pay your copayment to the pharmacy.

The formulary
The Fallon Companion Care formulary is a list of covered medications that shows the copayment tier, prior authorization requirements, and any other limitation for each medication. We have selected the tiers and determined the criteria for prior authorization based on the medication's efficacy and cost-effectiveness.

The Fallon Companion Care prescription drug formulary has a multi-tiered copayment structure. We have selected the tiers based on efficacy and cost-effectiveness. There is a different copayment for each tier. A tier exception is not allowed.

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.

The Fallon Companion Care formulary may include drugs used for the off-label treatment of cancer or HIV/AIDS, in accordance with state law.

Dispensing limitations
Prescription drugs are generally dispensed for up to a 30-day supply. A one-month copayment will be charged for up to a 30-day supply. In some instances, the plan has established dispensing limitations, which may include a quantity limit on certain medications. For maintenance medication, you may obtain up to a 90-day supply unless the medication must be obtained from the specialty vendor. We follow FDA, state and federal dispensing guidelines. You cannot obtain a refill until most or all of the previous supply has been used.

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 a copayment for each to achieve the desired dose.

Step therapy
There are certain medications for which you will be required to have previously used certain other formulary medications. This is called step-therapy.

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
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.

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 and will be responsible for the appropriate tiered copayment for that drug.

Mail-order prescriptions
You may also get your prescription medication refill(s) through a pharmacy mail-order program affiliated with Fallon Health & Life Assurance Company. 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. You will be responsible for the appropriate copayment amount.

Medications required to be obtained from the network specialty pharmacy can only be obtained as 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 PCP to review your prescriptions. If you are currently taking a drug that requires prior authorization, 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.

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

- Prescription medication
- Prescription contraceptive drugs and devices
- Hormone replacement therapy for pre- and post-menopausal women
- Injectable agents (self-administered*)
- Insulin
- Syringes (including insulin syringes) or needles when medically necessary
- Supplies for the treatment of diabetes including:
  - Blood glucose monitoring strips
  - Urine glucose strips
  - Lancets
  - Ketone strips

* Injectables administered in the doctor's office or under other professional supervision are not covered as a prescription benefit, but may be covered as a medical benefit if they are covered by Medicare Part A or Part B, or are otherwise covered under the benefits described in your *Member Handbook*.

Exclusions (the following items are not covered)

1. Drugs that you can buy without a prescription, including prescription medications that are available as over-the-counter products unless included on the Fallon Companion Care formulary
2. Drugs that are investigational or that have not been approved for general sale and distribution by the U.S. Food and Drug Administration
3. Drugs that are not used in accordance with FDA-approved labeling, including, but not limited to: unapproved doses, unapproved duration of therapy and unapproved indications
4. Drugs that require prior authorization, if prior authorization is not received
5. 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, melisma, vitiligo, and alopecia.
6. Prescriptions obtained at a non-plan pharmacy.
7. Vitamins and minerals, whether or not a prescription is required, are excluded from coverage, unless listed in the FCHP drug formulary
8. Over-the-counter birth control preparations or devices
9. Drugs that are prescribed for anything other than the U.S. Food and Drug Administration's approved usage. (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.)
10. Medications used for preference or convenience
11. Medications that are new to the market that have not been reviewed by Fallon Health & Life Assurance Company for safety and adverse events. These medications are not covered by Fallon Companion Care until they have been reviewed and guidelines for their use have been developed. This could take up to 180 days post-marketing.
12. Replacement of more than one lost/mishandled medication per prescription per calendar year
13. 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
14. Bio-identical hormone replacement therapy
15. The following Proton Pump Inhibitors: Prevacid, lansoprazole, Protonix, pantoprazole, Zegerid, omeprazole, Prilosec and others not on the Fallon Companion Care formulary
16. Drugs that are specifically excluded from the formulary.
17. Copayment tier exceptions.

18. The following are not covered benefits;
    - Topical acne combination products
    - Topical emollients
    - Medical wound dressings for maintenance or long term care of a condition
    - 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. Products used for any dental condition that is not covered by Fallon Companion Care

fallon health & life
assurance company, inc.

10 Chestnut St.
Worcester, MA 01608
1-800-868-5200
(TTY users, please call TRS Relay 711)
www.fchp.org