

Fallon Community Health Plan, Inc.

COMMUNITY CARE AMENDMENTS

- **Amendment 3 (eff. 05/01/22)**
- **Amendment 2 (eff. 01/01/22)**
- **Amendment 1**

Fallon Community Health Plan, Inc.

AMENDMENT 3

This is part of your Community Care
Member Handbook/Evidence of Coverage
Form #20-670-011
Effective May 1, 2022

This amendment changes certain sections of your Community Care Member Handbook/Evidence of Coverage. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook, Schedule of Benefits or prior amendments that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TRS 711). Representatives are available Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

Your *Member Handbook/Evidence of Coverage* has been amended to include information on the following:

1. Prescription medication

The following changes apply to your *Member Handbook/Evidence of Coverage*:

Prescription medication

Under **Where you can fill your prescription** in the **Prescription medication** section (Amendment 2), replace the entire section with the following:

You can fill your prescription at a network pharmacy, a network mail-order pharmacy, or a network specialty pharmacy. (Please note that there are some medications that are not available through the mail-order program). Some medications may only be available through the network specialty pharmacy. (See **Dispensing**

Limitations for more information.) We may allow a one-time fill of one specialty drug at a local pharmacy; after this one-time fill, you will receive a letter and a call to set up delivery of your drug through the specialty pharmacy network. All other specialty drugs will be required to be filled within the specialty pharmacy network; there will be no allowance for a retail fill at a local pharmacy. See your *Community Care Provider Network* directory for a list of network pharmacies or visit fallonhealth.org.

Fallon Community Health Plan, Inc.

AMENDMENT 2

This is part of your Community Care
Member Handbook/Evidence of Coverage
Form #20-670-011
Effective January 1, 2022

This amendment changes certain sections of your Community Care Member Handbook/Evidence of Coverage. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook, Schedule of Benefits or prior amendments that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TRS 711). Representatives are available Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

Your *Member Handbook/Evidence of Coverage* has been amended to include information on the following:

1. The claims process
2. Fallon contract arrangements
3. Emergency and urgent care
4. Office visits and outpatient services
5. Prescription medication
6. Telehealth services
7. Other plan benefits and features

The following changes apply to your *Member Handbook/Evidence of Coverage*:

The claims process

Under **Claims for Pharmacy Services** in **The claims process** section, replace the entire section with the following:

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

Write: OptumRx
PO Box 650334
Dallas, TX 75265

Submit through OptumRx Portal: optumrx.com

Fallon contract arrangements

Under **When your provider no longer has a contract with us** in the **Fallon contract arrangements** section, replace the entire section with the following:

We cannot guarantee that any one physician, hospital or other plan provider will be available and/or remain under contract with us. We reserve the right at any time to end our contract with your PCP or with any other plan provider who may be furnishing you with treatment. If this occurs, we will generally no longer pay for services provided to you by that provider, except in the circumstances listed below.

We will continue to pay for services provided by your provider after our contract with the plan provider ends in the following circumstances only:

- If our contract with your PCP ends, you may continue to receive treatment from that provider for 30 days beyond the end of the contract.
- If you are pregnant and are receiving services related to your pregnancy, and our contract with a provider or facility from whom you are receiving that treatment ends, you may continue to receive treatment from that provider or facility through your postpartum period.
- If you are terminally ill and our contract with a provider or facility from whom you are receiving treatment for that illness ends, you may continue to receive treatment from that provider or facility.

- If you are undergoing a course of treatment for a serious and complex condition, and our contract with a provider or facility from whom you are receiving that treatment ends, you may continue to receive that treatment from that provider or facility for 90 days or until the course of treatment ends, whichever comes first.
- If you are undergoing a course of institutional or inpatient care, and our contract with a provider or facility from whom you are receiving that care ends, you may continue to receive that care from that provider or facility for 90 days or until the course of institutional or inpatient care ends, whichever comes first.
- If you are scheduled to undergo a non-elective surgery, including receipt of postoperative care, when our contract with a provider or facility from whom you are scheduled to receive the surgery or postoperative care ends, you may continue to receive such surgery and care from that provider or facility for 90 days or until the surgery or postoperative care is complete, whichever comes first.

In all of the above cases, we will notify you that our contract with the provider is ending. The provider must agree to accept reimbursement for services at the rates in effect when our contract with the provider ended, and to adhere to our quality assurance standards, and other policies and procedures such as referrals and prior authorization. You will be eligible for benefits as if the provider had remained under contract with us. The above terms do not apply in any situation where we are ending the provider's contract for reasons involving fraud, patient safety or quality of care.

If the plan provider whose contract we are ending is your PCP, we will notify you in writing at least 30 days prior to the date of the end of his or her contract, except where the

contract has been ended for reasons involving fraud, patient safety or quality of care. If your PCP ends his or her contract with us, we will notify you of the change either 30 days prior to the date the contract ends, or as soon as we are notified of the termination, whichever is later. If our contract with your PCP ends, you will be required to choose a new PCP.

If your provider is no longer under contract with us, call Customer Service at 1-800-868-5200 (TRS 711) for assistance in choosing a new plan provider or to request a provider directory. You also can get plan provider information and choose a new PCP on our website, fallonhealth.org

Under **Continuation of services with a non-plan provider**, remove the following bullets:

- If you are receiving an ongoing course of treatment from a provider who is not a participating provider in any health insurance plan that your plan sponsor offers, we will pay for services from that provider for 30 days from your effective date.
- If you are in the second or third trimester of pregnancy and you are receiving services related to your pregnancy from a provider who is not a participating provider in any health insurance plan that your plan sponsor offers, we will pay for services from that provider through your postpartum period.
- If you are terminally ill, and you are receiving ongoing treatment from a provider who is not a participating provider in any health insurance plan that your plan sponsor offers, we will pay for your services from that provider until your death.

Add the following bullets:

- If you are pregnant and are receiving services related to your pregnancy from a provider or facility who is not a participating provider in this plan, we will pay for services from that provider through your postpartum period.
- If you are terminally ill, and you are receiving ongoing treatment from a provider or facility who is not a participating provider in this plan, we will pay for your services from that provider until your death.
- If you are undergoing a course of treatment for a serious and complex condition from a provider or facility who is not a participating provider in this plan, we will pay for services from that provider or facility for 90 days or until the course of treatment ends, whichever comes first.
- If you are undergoing a course of institutional or inpatient care from a provider or facility who is not a participating provider in this plan, we will pay for services from that provider or facility for 90 days or until the course of institutional or inpatient care ends, whichever comes first.
- If you are scheduled to undergo non-elective surgery, including receipt of postoperative care, from a provider of facility who is not a participating provider in this plan, we will continue to pay for services from that provider for 90 days or until the surgery or postoperative care is complete, whichever comes first.
- If you are receiving an ongoing course of treatment from a provider who is not a participating provider in any health insurance plan that your plan sponsor offers, we will pay for services from that provider for 30 days from your effective date.

Emergency and urgent care

Under **Emergency and urgent care** in the **Description of benefits** section, under **Covered services** remove the following:

6. Fallon Health will cover telemedicine visits with physicians through an agreement exclusively with Teladoc. Visits are performed by phone, video, or mobile app. These visits are used to diagnose, treat and prescribe medications (if necessary) for common health issues such as sinus problems, bronchitis, allergies, cold and flu symptoms, respiratory infection, or ear infection.

Teladoc does not replace your primary care physician; it is a convenient option for care. Please visit the Fallon Health website for URL link and additional information on Teladoc. See your Schedule of Benefits for cost-sharing information.

Add the following:

6. Fallon Health will cover telemedicine visits with physicians through an approved telehealth vendor. Visits are performed by phone, video, or mobile app. These visits are used to diagnose, treat and prescribe medications (if necessary) for common health issues such as sinus problems, bronchitis, allergies, cold and flu symptoms, respiratory infection, or ear infection. Please visit the Fallon Health website for information on the approved telehealth vendor, including a URL to access services from the vendor. See your Schedule of Benefits for cost-sharing information.

Visits with the approved telehealth vendor do not replace your primary care physician; they are a convenient option for urgent care. Your primary care physician may also offer telehealth services.

See the **Telehealth services** section of this *Member Handbook/Evidence of Coverage*, and the Telehealth section of your Schedule of Benefits, for benefit and cost-sharing information.

Office visits and outpatient services

Under **Office visits and outpatient services** in the **Description of benefits** section, under **Covered services** add the following:

8. In accordance with Massachusetts state law, Fallon will cover medically necessary treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS) including, but not limited to, the use of intravenous immunoglobulin therapy.

Prescription medication

Under **Where you can fill your prescription** in the **Prescription medication** section, replace the entire section with the following:

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

Under **Opioid Management Program**, replace the entire section with the following:

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

Inappropriate Drug Therapy Combinations

The pharmacy may need to contact your prescriber to resolve these issues:

- Opioids & Medication Assisted Treatment (MAT): reject for an opioid claim secondary to a MAT drug (includes only buprenorphine-combination products)
- Opioids & Benzodiazepine: reject for an opioid drug if the member has an existing claim for a benzodiazepine and vice versa
- Opioids & Prenatal Vitamin: reject for an opioid drug if the member has an existing claim for a prenatal vitamin claim and vice versa

Inappropriate opioid quantities or dosing

The pharmacy may need to contact your prescriber to resolve these issues:

- Members already on opioids: reject for a cumulative Short Acting Opioid/Long Acting Opioid dose check for >90 MME*/day
- Members new to opioids: reject for a cumulative Short Acting Opioid/Long Acting Opioid dose check for >50 MME*/day
- Members new to opioids: reject for Short Acting Opioid prescriptions for >7- day supply

- Members new to opioids: reject for a Long Acting Opioid with no paid claim for a Short Acting Opioid

The following requires prior authorization from your prescriber:

- Members already on opioids: Prior Authorization required for a cumulative Short Acting Opioid/Long Acting Opioid dose check for >180 MME*/day

Therapeutic Dose Limit

The pharmacy may need to contact your prescriber to resolve this issue:

- Cumulative acetaminophen dose check (with opioid-containing drugs) >4 grams/day (reject)

Refill Threshold

- This edit narrows the refill window for Schedule II-V controlled drugs to a 90% threshold at retail pharmacy and 80% at mail order

Opioid Management Edits

The following require prior authorization from your prescriber if exceeding the limit:

- Members new to opioids: Short Acting Opioids maximum 50 MME*/day
- Members new to opioids: Short Acting Opioids 7-day supply limit
- Members already on opioids: Short Acting Opioids maximum 90 MME*/day
- All members: use of Short Acting Opioids required before Long Acting Opioids
- All members: Quantity Limits on all Long Acting Opioids based on FDA maximum dosing frequency (i.e. once daily)
- All members: Maximum 2 opioid fills within a 60-day time period

Pediatric (≤19 years of age) Edits

The following require prior authorization from your prescriber if exceeding the limit:

- All pediatric members: PA required for all opioid containing cough and cold medications
- Pediatric members new to opioids: 3-day supply limit

*Morphine Milligram Equivalents are a way to compare different opioid medications based on their strength as compared to morphine.

Under **Mail-order prescriptions**, replace the second paragraph with the following:

When you fill your prescription through our mail-order program, you may order up to a 90-day supply of most medications. Certain opioid medications are limited to a 30-day supply at mail-order. Certain narcotic medications cannot be filled for a 90-day supply per Massachusetts law. Per Massachusetts state law, certain contraceptives may be available for up to a 12 month supply. You will be responsible for the appropriate cost-sharing amount, as noted in your Schedule of Benefits. Medications required to be obtained from the network specialty pharmacy (noted as “SP” on the on-line formulary) can only be obtained up to a one-month supply at a time. (See **Dispensing Limitations** for more information.)

Under **Prior Authorization Process**, replace the first paragraph with the following:

Prior authorization (PA) is required for any medication (including compounds) exceeding the cost threshold and any medication noted with a “PA”, “QL”, or “ST” on the Fallon Health formulary. A PA may also be required for a drug that exceeds our Opioid Management Strategy limits (See **Opioid Management Program** for more information) and for formulary exception requests. Before we will pay

for these medications, your provider must fill out a Fallon Health prescription prior authorization form. This form will be reviewed by clinical pharmacists and compared to our clinical criteria. Requests are processed within 2 business days from the date of receipt of a complete request. Both the provider and member will receive written confirmation of approval or denial of the request. If the request is approved, you may fill your prescription at a network pharmacy. If the request is denied, you and your provider will receive detailed denial information that includes your rights to appeal our decision.

Under **Exception Request for Contraceptives**, replace the entire paragraph with the following:

Generic contraceptives are covered in full. Brand name contraceptives generally require cost sharing such as a copayment. However, if your attending provider indicates you must use an FDA-approved brand contraceptive due to medical necessity you may make an exception request to have the brand name contraceptive covered with no cost sharing. Your attending provider should submit a PA to Fallon per the normal PA process and request an exception request for contraceptive cost sharing due to medical necessity. Examples of medical necessity include severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to appropriate use of the item or service.

Under **Non-Covered Items**, replace the entire section with the following:

Non-Formulary:

Medications not on the formulary are considered non-formulary and are not covered.

Exclusions:

Medications listed below under “**Related Exclusions**” are considered excluded and are not covered.

If your provider feels that the medications on our formulary are not appropriate for your condition there is an exception request process available. Your prescriber must support the request by providing a statement that provides justification for supporting the need for the excluded drug to treat your condition, including a statement that all covered formulary drugs on any tier will be or have been ineffective, would not be as effective as the excluded drug, or would have adverse effects. This request must be approved by Fallon Health before we will pay for the drug. Your attending provider should submit a PA to Fallon per the normal PA process and request an exception request. You or your prescribing physician may make an expedited exception request if exigent circumstances exist. Exigent circumstances exist when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug. You will be notified within 72 hours of receipt of information sufficient to begin our review for a standard request, or 24 hours of receipt of information sufficient to begin our review for an expedited request. If you disagree with the decision on your standard or expedited exception request above, you may file an external exception request. To file a standard or expedited external exception request please contact Fallon Health at 1-800-333-2535 or email us at grievance@fallonhealth.org. We will forward your external exception request to an independent review organization for a review and determination. The same standards and time

frames outlined above will apply to standard and expedited external review requests.

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

Telehealth services

After **Skilled nursing facility** in the **Description of benefits** section, add the following:

Telehealth Services

The plan provides coverage for clinically appropriate, medically necessary health care services delivered via telehealth by plan providers, when:

1. The health care services are covered when provided in-person, and
2. The health care services may be appropriately provided through the use of telehealth.

Telehealth is defined as the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including, but not limited to interactive audio video technology; remote patient monitoring devices; audio-only telephone and online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring a plan member's physical health, oral health, mental health or substance use disorder condition. Most specialist visits require a PCP referral and some specialty services require prior authorization. See **Obtaining specialty care and services** for additional information.

Note: Not all providers offer a telehealth option. Please contact the providers' office to find out if they offer telehealth services.

Covered services

The following services may be delivered via telehealth by plan providers:

1. Office visits with your primary care provider (PCP)
2. Office visits with a specialist
3. Office visits for the evaluation, diagnosis, treatment or management of a mental health, developmental or substance use disorder
4. Chronic disease management services, i.e., establishment, implementation, revision, or monitoring of a comprehensive care plan for members with multiple (two or more) chronic conditions, including but not limited to diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, cancer and coronary artery disease
5. Remote patient monitoring, also known as remote physiologic monitoring, or RPM. RPM involves the collection and analysis of physiologic data that are used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition.

In addition to covering services delivered via telehealth by plan providers, the plan covers telehealth visits through an approved telehealth vendor. Refer to the **Emergency and urgent care section** of this *Member Handbook/Evidence of Coverage* for more information on telehealth services delivered by an approved telehealth vendor.

Exclusions

1. Health care services delivered via telehealth by non-plan providers without prior authorization from the plan

Other plan and benefits features

Under **Other plan features** in the **Other plan and benefits features** section, replace bullet 7 with the following:

- With Care Connect, you get free access, by phone to experienced registered nurses 24 hours a day, 7 days a week to answer your health questions.

Remove the following bullet:

- Caremark ExtraCare Health Care® discount, eligible members receive a CVS Caremark ExtraCare Health Card which allows them to receive a 20% discount on certain items at any CVS/pharmacy® store or online at www.cvs.com

Fallon Community Health Plan, Inc.

AMENDMENT 1

This is part of your Community Care
Member Handbook/Evidence of Coverage
Form #20-670-011

This amendment changes certain sections of your Community Care Member Handbook/Evidence of Coverage. Please read it carefully and keep it with your handbook. The information in this amendment replaces any information in your handbook, Schedule of Benefits or prior amendments that conflicts with it. If you have questions about this amendment, please contact the Customer Service Department at 1-800-868-5200 (TRS 711). Representatives are available Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

Your *Member Handbook/Evidence of Coverage* has been amended to include information on the following:

1. Our website
2. Medical management
3. Disenrollment rates
4. General exclusions and limitations

The following changes apply to your *Member Handbook/Evidence of Coverage*:

Questions? Just ask.

Effective immediately the following change applies:

Under **Our website** in the **Questions? Just ask.** section, replace the first bullet with the following:

- **Get online access to your claims, benefits and more-at any time of day or night**
Log into MyFallon, our secure member portal, to see your copayments, track deductibles and out-of-

pocket-maximums, change your PCP, check authorizations and more. Visit fallonhealth.org/myfallon to register and log in.

Medical management

Effective immediately the following change applies:

Under **Services** in the **Medical management** section, replace the third paragraph with the following:

You may contact our toll free number 1-800-868-5200 or visit our website at www.fallonhealth.org to obtain the network status of an identified health care provider, an estimate for a proposed admission, procedure or service and the estimated amount you will be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit. Estimates will be based on the information available to us at the time you make your request. All costs are estimated, and the actual amount you pay may vary due to unforeseen services that arise out of the proposed admission, procedure or service.

2020 Disenrollment rates

Effective immediately the following change applies:

Under **Involuntary cancellation rate** in the **Leaving Fallon** section, replace entire paragraph with the following:

For the calendar year 2020, Fallon's involuntary cancellation or disenrollment rate was 0.00%. The involuntary disenrollment rate includes any members disenrolled by the plan due to misrepresentation or fraud on the part of the member or commission of acts of verbal or physical abuse. For calendar year 2020, Fallon's voluntary disenrollment rate was 0.03%.

General exclusions and limitations

Effective July 1, 2021 the following change applies:

Under **General exclusions and limitations** section, replace bullet 13 with the following:

13. Contact lenses are covered only for: keratoconus; aphakia; or following a cornea transplant, for up to one year, if medically necessary. A lens applied as a bandage lens following an eye injury or to treat a diseased cornea is covered. Multifocal, astigmatism-correcting and presbyopia-correcting intraocular lenses are not covered.