

Fallon Community Health Plan, Inc.

COMMUNITY CARE AMENDMENT

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Fallon Community Health Plan, Inc.

AMENDMENT 1

This is part of your Community Care
Member Handbook/Evidence of Coverage
Form # 24-670-018

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 conflict 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. Fallon contract arrangements
2. Leaving Fallon
3. Wellness

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

Wellness

Effective November 27, 2025, the following change applies:

Under **Wellness** in the **Description of Benefits** section remove the following:

Fallon Healthy Health program

The Fallon Healthy Health Plan program is designed to allow members to take an active role in their health care.

The Program is designed to help members achieve or maintain a healthy lifestyle through a health assessment, online self-learning modules, personalized plans and professional health coaching.

For more information about Fallon's health and wellness programs and benefits, visit the Fallon website at www.fallonhealth.org/members/commercial/health-wellness.

Fallon contract arrangements

Effective immediately the following change applies:

Under **Continuation of services with a non-plan provider** in the **Fallon contract arrangements** section, list of comprehensive cancer center, pediatric hospital or pediatric specialty unit has been updated with the following:

Comprehensive Cancer Center

Dana Farber Cancer Institute

Pediatric Hospital

Children's Hospital Boston

Shriners Children's, Boston and Springfield

Pediatric Specialty Unit

Tufts Medical Center

Mass Eye and Ear

Leaving Fallon

Effective immediately the following change applies:

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

Involuntary cancellation rate

For the calendar year 2024, 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 2024, Fallon's voluntary disenrollment rate was 0.15%.

Fallon Community Health Plan, Inc.

AMENDMENT 2

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

1. Infertility/assisted reproductive technology services

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

Infertility/assisted reproductive technology services

Effective immediately the following changes apply:

Under **Infertility/assisted reproductive technology services** in the **Description of benefits** section, replace paragraphs two and three with the following:

Infertility services and assisted reproductive technology (ART) require referral and prior authorization. Fallon's coverage guidelines for all infertility/ART services are available by contacting the Customer Services Department.

Certain fertility medication also requires prior authorization; some may have a quantity limit for each prescription as well. (See **Obtaining specialty care and services** for more information on referral and prior authorization.)

Under **Covered services** replace numbers 4 and 5 with the following:

4. Assisted reproductive technologies (ART) including, but not limited to:
 - a. In vitro fertilization (IVF-ET)
 - b. Gamete intrafallopian transfer (GIFT)
 - c. Zygote intrafallopian transfer (ZIFT)
5. ART-related services, including:
 - a. Intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility or when preimplantation genetic diagnosis (PGD) testing is covered
 - b. PGD when the partners are known carriers for certain genetic disorders
 - c. Sperm, egg, and/or inseminated egg procurement, assisted hatching, cryopreservation, processing and storage/banking for up to 24 months for plan members in active infertility treatment and when a member has a condition or is undergoing medical treatment that may result in infertility, to the extent that such costs are not covered by the donor's insurer

Fallon Community Health Plan, Inc.

AMENDMENT 3

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

1. Obtaining specialty care services
2. Hospital inpatient services
3. Maternity services
4. Preventive care

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

Obtaining specialty care services

Effective immediately the following changes apply:

Under **Obtaining specialty care and services** section, remove the following:

Certain specialty care may not be available within the Community Care facilities, but may be sought at UMass Medical Center, prior authorization is required.

Under **Prior authorization**, replace the ninth bullet item with the following:

- Home health care, including but not limited to home visiting services

Hospital inpatient services

Effective immediately the following change applies:

Under **Hospital inpatient services** in the **Description of benefits** section, add the following under **Covered services**:

10. Pasteurized donor human milk and donor human milk-derived products when medically necessary for infants under the age of six months undergoing treatment in an inpatient setting. (For more information, go to our website at fallonhealth.org/maternity)

Maternity services

Effective immediately the following change applies:

Under **Maternity services** in the **Description of benefits** section, under **Covered services** add the following:

5. Postpartum home care visit for postpartum members and caregivers with newborns within 8 weeks postpartum, including, but not limited to screenings for unmet health needs including reproductive health services; maternal and infant nutritional needs; and emotional health supports, including postpartum depression supports. Additional visits beyond the initial postpartum visit are covered if medically necessary. (For more information, go to our website at fallonhealth.org/maternity)

Preventive care

Effective immediately the following change applies:

Under **Preventive care** in the **Description of benefits** section, under **Covered services** add the following:

13. Screenings for postpartum depression and major depressive disorders for a member who:

- is within 12 months of giving birth;
- is a biological parent or an adoptive or foster parent that is within 12 months from assuming custodial care of a child; or
- has lost a pregnancy due to a still birth, miscarriage or a medical termination within the previous 12 months

(For more information, go to our website at fallonhealth.org/maternity)

Fallon Community Health Plan, Inc.

AMENDMENT 4

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

1. Gender affirming services
2. Reconstructive and restorative services
3. General exclusions and limitations
4. Cosmetic services

The following changes are effective immediately to your *Member Handbook/Evidence of Coverage*:

Gender affirming services (new section)

In the **Description of benefits** section add the following new section:

Gender Affirming Services

The plan covers gender affirming services when medically necessary to treat gender dysphoria including office visits, gender affirming surgery, hair removal, and hormone therapy. Most services require referral and prior

authorization. (See **Obtaining specialty care and services** for more information on referral and prior authorization). Per Fallon Health policy, if a covered service that is medically necessary is not available to you within the Community Care network, we will cover the out-of-network service, and you will not be responsible to pay upfront. You will only be responsible for the appropriate in network cost-sharing amount, as noted in your *Schedule of Benefits*.

If you need assistance finding a network provider or have additional questions, please call Customer Service at 1-800-868-5200.

Covered services

1. Office visits related to gender affirming services
2. Gender affirming surgery, including chest/breast surgeries, genital surgeries, and facial feminization/masculinization. Prior authorization is required.
3. Hair removal (electrolysis or laser) when services are provided by a physician or qualified midlevel/nonphysician practitioners such as a nurse practitioner, clinical nurse specialist or physician assistant. Prior authorization is required.
4. Hormone therapy

Related exclusions

1. Reversal of any gender-affirming surgery
2. Revision of any gender affirming surgery other than for impaired of function
3. Hair removal, except when medically necessary as part of gender affirming services.
4. Cosmetic procedures include, but are not limited to, otoplasty, abdominoplasty, buttock lift, implants (calf, gluteal, pectoral), hair transplantation, lip reduction or enhancement.

5. Electrolysis performed and billed directly by electrologists.

Reconstructive and restorative services

Under **Reconstructive and restorative services** in the **Description of benefits** section in the **Related exclusions** replace number 1 with the following:

1. Cosmetic surgery, cosmetic treatments, cosmetic procedures, cosmetic medications and cosmetic supplies, including, but not limited to: otoplasty for protruding ears; ear piercing; abdominoplasty; chemical peel (dermal and epidermal); microdermabrasion; and hair removal except when medically necessary as part of gender affirming services.

General exclusions and limitations

In **General exclusions and limitations** section delete exclusion number 28.

Cosmetic services

Under **Cosmetic services** in the **Index** section, replace second bullet with the following:

- Breast implants (unless medically necessary as part of breast reconstruction/mastectomy)

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AMENDMENT 5

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

1. Mental health and substance use disorder services
2. Prescription medication

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

Mental health and substance use disorder

Effective January 1, 2026, the following change applies:

Under **Mental health and substance use disorder services** in the **Description of benefits** section, under **Outpatient services** add the following under **covered services**:

3. Substance use recovery coaches licensed or authorized to practice under MGL Chapter 111J

Prescription medication

Effective July 1, 2025, the following changes apply:

Under **Prescription medication** in the **Description of benefits** section, under **The Fallon Health formulary**, replace the third paragraph with the following:

Only medications on our formulary are covered. Medications not on the formulary are considered non-formulary and are not covered. There is a non-formulary exception process if your provider feels that the medications on our formulary are not appropriate for your condition. This request must be approved by Fallon before we will pay for the drug. (See **Non-Covered Items**.)

Under **Pain Management Alternatives to Opiate Products** replace section with the following:

If you are interested in pain management alternatives to opioid products, speak to your provider. Many non-opioid medications and treatments are available. These include, but are not limited to, those listed below.

Non-opiate medication treatment options:

- Ibuprofen
- Topical Lidocaine (Note: some lidocaine products require prior authorization)

See earlier in this section for further information about our prescription drug formulary

Non-medication, non-surgical treatment modalities:

- Chiropractic care. Your PCP will give you a prescription to a Community Care network chiropractor. Your coverage for these services may have a benefit limit. If it does, the *Schedule of Benefits* for your plan option describes the benefit

limit that applies for these services. (See **Office visits and outpatient services** section for details.)

- Physical therapy services. (See **Rehabilitation and Habilitation services** section for details.)
- Behavioral health providers with pain management-related specialties, such as cognitive behavioral therapy, pain management and treatment of chronic pain. (See **Mental health and substance use disorder services** section for details.) For assistance in finding a plan provider, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660).

Additional medications and treatments are available which may also serve as pain management alternatives to opioid products. These include other medications, certain other types of therapies, treatment by certain types of non-behavioral health specialists, certain types of surgery and certain types of injections. Some of these additional medication services may require prior authorization or may be subject to benefit limitations; see our prescription drug formulary or your Member Handbook/Evidence of Coverage and Schedule of Benefits for further information about how your plan covers these services.

Under **Covered items** replace section with the following:

Covered items (Some of these medications and covered items may require prior authorization.) This list includes formulary medications only, unless otherwise stated or excluded below.

- Prescription medication
- Prescription contraceptive drugs and devices
- Hormone replacement therapy
- Injectable agents (self-administered*)

- Insulin, insulin pens, and oral/injectable medications to treat diabetes (including GLP-1 agonists for diabetes)
- Syringes (including insulin syringes) or needles when medically necessary
- Opioid antagonist reversal agents
- Orally administered anticancer medications used to kill or slow the growth of cancerous cells
- Certain orally administered medications used to prevent breast cancer
- Supplies for the treatment of diabetes, as required by Massachusetts state law, including, but not limited to:
 - Blood glucose monitors and strips
 - Urine glucose strips
 - Lancets
 - Ketone strips
- Prior authorization is required for therapeutic continuous glucose monitors (such as FreeStyle Libre and Dexcom) and monitoring supplies, including transmitters and sensors.
- Prior authorization is required for blood glucose monitors and supplies that are non-preferred brands, or that require adaptive features.

Members with a demonstrated need, including having a severe visual impairment or impaired manual dexterity, may require a blood glucose monitor with adaptive features, such as an integrated voice synthesizer or integrated lancing device. Prior authorization is required.

*Injectables administered in the doctor's office or under other professional supervision are covered as a medical benefit.

Note: Compound medications (a drug that is specifically mixed and prepared for you, based on a prescription from your doctor) will incur a copay associated with your highest brand tier (typically, the non-preferred brand tier).

After **ACA Prevention Medications at \$0** section add the following:

Medications for Chronic Conditions

Certain medications to treat chronic conditions are covered with no or limited cost-sharing. Fallon annually selects at least one generic drug (if available), and one brand name drug used to treat each of the four conditions:

- diabetes (insulin);
- asthma; and
- the two most prevalent heart conditions among members

Please refer to the Fallon formulary at <https://fallonhealth.org> and your Schedule of Benefits for the list of medications and applicable cost-sharing specific to your Plan.

After **Step Therapy Exception Request and Continuity of Care** section add the following:

Continuity of Care

Fallon has a medication continuity of care (or transition) policy. This is for drugs requiring Prior Authorization (PA) or Step Therapy. Fallon allows a 30-day supply of medication for newly enrolled members who have already been prescribed the medication and on which the member is stable, upon documentation by the member's prescriber. Fallon does not apply any greater deductible, coinsurance,

copayments or out-of-pocket limits than would otherwise apply to other drugs covered by the plan.

This ensures that the member does not experience any delay in accessing the drug prescribed by their health care provider while the PA or Step Therapy request is being reviewed. After this transition period, if a PA or Step Therapy is not granted, the appropriate requirements need to be met.

Under **Non-Covered items** replace section with the following:

Exclusions:

Medications/conditions listed below under “**Related Exclusions**” are not a covered benefit.

Non-Formulary:

Medications not on the formulary are considered non-formulary 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 non-formulary 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 non-formulary 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 prior authorization request to Fallon per the normal prior authorization 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 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.

Under **Related exclusions** replace the entire section with the following:

Please note numbers 8 and 9 are effective January 1, 2026.

1. Drugs that you can buy without a prescription, unless included on the Fallon formulary or specifically described as covered above.
2. Drugs not on our formulary unless non-formulary prior authorization/exception has been granted.

3. Drugs/conditions that are specifically excluded from the formulary
4. Drugs that are investigational or that have not been approved for general sale and distribution by the U.S. Food and Drug Administration.
5. Drugs that are not used or prescribed in accordance with FDA-approved labeling (unless compendia supported), including, but not limited to: unapproved doses, unapproved duration of therapy and unapproved indications. (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.)
6. Drugs that require prior authorization if prior authorization is not received.
7. Drugs used for cosmetic purposes or to enhance athletic performance, or for other non-covered conditions, unless otherwise included in the formulary for that condition.
8. Drugs used for weight loss (including appetite suppression, obesity, and overweight) whether FDA-approved for weight loss or as off-label use for weight loss.
9. Drugs used for weight loss (including appetite suppression, obesity, overweight) and associated comorbidities (example: Wegovy)
10. Drugs that do not meet Fallon medical criteria
11. Non-emergency prescriptions obtained at a non-network pharmacy.
12. Vitamins and minerals, whether or not a prescription is required, are excluded from

coverage, unless listed in the Fallon drug formulary or under the Oh Baby! Program.

13. Over-the-counter birth control preparations or devices, unless listed in the formulary or specifically described as covered in the above.
14. Medications used for preference or convenience.
15. Medications that are new to the market that have not been reviewed by Fallon for safety and adverse events. These medications are not covered by Fallon until they have been reviewed and guidelines for their use have been developed. This could take up to 180 days post-marketing.
16. Replacement of more than one lost/mishandled medication per benefit period.
17. Prescription drugs that are a combination of a covered prescription item and an item that is specifically excluded, such as vitamins, minerals, or medical food/formulas.
18. Bio-identical hormone replacement therapy.
19. The following Prescription Proton Pump Inhibitors: Prevacid (brand name capsules), Protonix (brand name), Zegerid, Prilosec (brand name) and others not on the Fallon formulary.
20. Tier cost-sharing exceptions.
21. The following are not covered benefits:
 - Topical emollients,
 - Medical wound dressings for maintenance or long term care of a condition, or
 - Work-required vaccines.
22. The following non-sedating antihistamines: Allegra, Allegra ODT, cetirizine HCl, Clarinex, Claritin, Claritin Reditabs, fexofenadine HCl, Xyzal and Zyrtec.

23. Vimovo.
24. Medical marijuana.
25. Duexis (ibuprofen/famotidine).
26. Omeclamox (amoxicillin/clarithromycin/omeprazole) Therapy Pack.
27. Vascepa (icosapent ethyl).
28. Liptruzet (atorvastatin/ezetimibe).
29. Acticlate (doxycycline Hyclate).
30. Jublia (efinaconazole soln).
31. Durlaza (aspirin 162.5mg).
32. Cuprimine (penicillamine) capsules.
33. Glumetza (metformin) tablets.
34. Fortamet (metformin SR 24h osmotic) tablets.
35. Sernivo (betamethasone dipropionate spray emulsion) 1.5% Spray.
36. Bonjesta (doxylamine/pyridoxine).
37. Yosprala (aspirin/omeprazole).
38. Ybuphen (ibuprofen 600mg & acetaminophen 500mg).

Fallon Community Health Plan, Inc.

AMENDMENT 6

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

1. Rehabilitation and Habilitation services

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

Rehabilitation and Habilitation services

Under **Rehabilitation and Habilitation services** in the **Description of benefits** section under **Covered services**, add the following:

6. Speech therapy, occupational therapy, physical therapy and applied behavior analysis services when medically necessary for the treatment of Down Syndrome. Services require prior authorization.

Fallon Community Health Plan, Inc.

AMENDMENT 7

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

1. Obtaining specialty care and services
2. Acute inpatient rehabilitation services
3. Wellness
4. Other plan benefits and features

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

Obtaining specialty care and services

Effective immediately the following change applies:

Under **Obtaining specialty care and services** in the **Prior authorization** section add the following:

For services requested upon transfer from an inpatient facility to a post-acute care facility or agency, we will issue a prior authorization decision by the next business day following receipt of all necessary information.

Acute inpatient rehabilitation services

Effective immediately the following change applies:

Under **Acute inpatient rehabilitation services** in the **Description of benefits** section add the following:

Services require referral and prior authorization. (See **Obtaining specialty care and services** for more information on referrals and prior authorization.) The level of services, number of covered days that you are admitted and where you are admitted will be based upon the medical necessity of your condition as determined by your plan physician and the plan.

Wellness

Effective January 1, 2026, the following changes apply:

Under **Wellness** in the **Description of benefits** section replace **Fitness and Weight Loss Essential Health Benefits (EHBs)** section with the following:

- Reimbursement for 3 months of membership for certain weight loss programs per plan year for a covered subscriber. Subscriber must be a Fallon Health member for 3 months or longer. For more information about qualifying weight loss programs, visit the Fallon Health website at www.fallonhealth.org/members/commercial/health-wellness

Replace **It Fits!** with the following:

- **It Fits!** reimburses eligible Fallon Health members for participating in a variety of healthy activities: membership at local fitness centers, home fitness equipment, aerobics, Pilates and yoga classes when taught by a certified instructor, qualifying weight loss programs, and local town and school sports programs for all ages when they include an aerobic and instructional component. Aerobic activities for the whole family include: baseball, softball, soccer,

football, dance classes, ski lessons, golf lessons, swimming lessons, tennis and sports camps.

Other plan benefits and features

Effective immediately the following change applies:

Under **Other plan benefits and features** in the **Description of benefits** under **Other plan features** section replace the third bullet with the following:

- Discounts on acupuncture, massage therapy and chiropractic care.

Fallon Community Health Plan, Inc.

AMENDMENT 8

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

1. Inquiries, appeals and grievances
2. Office visits and outpatient services
3. Preventive care

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

Inquiries, appeals and grievances

Effective immediately the following changes apply:

Under **Inquiries, appeals and grievances** section replace the first paragraph with the following:

Whenever you have a question or need help using plan providers and services, Fallon encourages you to contact Customer Service. If you have a question or concern regarding an adverse determination or if you would like to file an appeal or grievance, contact Customer Service.

Under **Making an inquiry** section, replace the fourth paragraph with the following:

In most cases, our Customer Service Representatives will be able to answer your question or handle your request the first time you call. In some cases, however, we may need to do more research before we complete your request. In these cases, we will make every effort to provide you with a response within three business days. If we have not been able to provide a satisfactory response to your inquiry within this time period, we will send you a letter explaining your right to continue with the inquiry process or to have your request handled as a grievance. If you tell us that you want to have your issue handled as a grievance, we will proceed to the grievance procedure. (See **Filing a grievance**.) The 30 day timeframe for resolving the grievance will begin either three business days after the date we receive your inquiry or on the day you notify us that you are dissatisfied with the outcome of your inquiry – whichever occurs first.

Under **Filing an appeal: internal appeal review** section, replace the **Call** information with the following:

Call: 1-800-868-5200 (TRS 711)
Monday, Tuesday, Thursday, and Friday from
8:00 a.m. to 6:00 p.m. and Wednesday from
10:00 a.m. to 6:00 p.m.

Replace the fourth paragraph with the following:

We will complete our review and send you a written response within 30 calendar days from the date that we receive your request. These time limits may be waived or extended if you and the plan both agree in writing to the change. This agreement must note the length of the extension, which can be up to 30 days from the date of the agreement.

Remove **Opportunity for reconsideration** section.

Under **Filing a grievance** section, replace the **Call** information with the following:

Call: 1-800-868-5200 (TRS 711)
Monday, Tuesday, Thursday, and Friday from
8:00 a.m. to 6:00 p.m. and Wednesday from
10:00 a.m. to 6:00 p.m.

Office visits and outpatient services

For policies issued or renewed coincident with or following January 1, 2026, the following change applies:

Under **Office visits and outpatient services** in the **Description of benefits** section under Covered services replace **Diagnostic lab and X-ray services** section with the following:

Diagnostic lab, X-ray, and other imaging services

9. Diagnostic lab, X-ray and other imaging services ordered by a plan provider, in relation to a covered office visit. This includes a diagnostic examination for breast cancer, by mammogram, digital breast tomosynthesis, breast magnetic resonance imaging (MRI), or breast ultrasound. Note: Prior authorization required for high-tech radiology, including breast MRI.

Preventive care

Effective immediately the following change applies:

Under **Preventive care** in the **Description of benefits** section replace the first paragraph with the following:

The plan covers preventive services under the United States Preventive Services Task Force (USPSTF), Health Resources and Services Administration (HRSA) and the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention (ACIP) as

required by the Patient Protection and Affordable Care Act of 2010. For immunizations, the plan covers all vaccines and the cost to administer vaccines for members who meet the recommended guidelines established by the Massachusetts Department of Public Health for the provision of immunizations in Massachusetts. In addition to the services listed in this section, you may visit our website at fallonhealth.org for more information on these guidelines.

For policies issued or renewed coincident with or following January 1, 2026, the following change applies:

Under **Covered services** section, replace number 3 with the following:

3. A baseline screening examination for breast cancer for women age 35 to 40, and a yearly screening examination for breast cancer for women age 40 and older, by mammogram, digital breast tomosynthesis, breast magnetic resonance imaging (MRI), or breast ultrasound. Note: Prior authorization required for high-tech radiology, including breast MRI.

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AMENDMENT 9

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Member Handbook/Evidence of Coverage
Form # 24-670-018

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 conflict 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. Wellness

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

Wellness

Effective October 15, 2025, through December 31, 2025, the following change applies:

Under **Wellness** in the **Description of Benefits** section add the following:

In-Home Health Visit

Members who complete an in-home health assessment between 10/15/25 and 12/31/25 with Fallon Health's vendor Fusion Advantage receive a \$50 Target gift card. Members who participate will meet with a licensed clinician

who reviews their medications and medical history. The clinician will also check vital signs, look for safety risks and answer health questions. While the in-home visit does not replace a regular doctor visit, members are able to receive current information about their health in the convenience of their home. There is no cost to members for the health assessment. Members who complete an assessment will receive their Target gift card in the mail, which can be used for purchasing items pertaining to health and wellness. Members will receive an introductory letter explaining the benefits of the home visit as well as a phone call to schedule their appointment. Members also have the option to call Fusion Advantage to request a visit. More information can be found on Fallon Health's website at <https://fallonhealth.org/members/commercial/health-wellness/inhomevisit>. There is a limit of one gift card per member.