

# Fallon Medicare Plus<sup>TM</sup> Premier HMO Summary of Benefits

Jan. 1, 2027–Dec. 31, 2027



# Fallon Medicare Plus Premier HMO

## 2027 Summary of Plan Benefits

This is a summary of drug and health services covered by Fallon Medicare Plus Premier HMO for Jan. 1, 2027–Dec. 31, 2027.

Fallon Health is an HMO plan with a Medicare contract. Enrollment in Fallon Health depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please see the Evidence of Coverage, which is available online at [fallonhealth.org/medicare](https://fallonhealth.org/medicare) or by calling the phone number at the end of this booklet.

To join Fallon Medicare Plus Premier HMO, you and/or your spouse must be a member of an employer/union group and you and/or your spouse must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. The service area, for the plan listed in this Summary of Benefits, includes the following counties in Massachusetts: Barnstable, Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester. Our service area also includes some cities and towns—outside of Massachusetts—that border the previously named counties. For a listing of cities and towns in our service area outside of Massachusetts, please see page 8.

Fallon Medicare Plus Premier HMO has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that aren't in our network, the plan won't pay for these services except in certain circumstances.

| Fallon Medicare Plus Premier HMO costs                                                                                                                                                                          |                                                                                                                        |                                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| Monthly plan premium                                                                                                                                                                                            | Medical deductible                                                                                                     | Maximum out-of-pocket                                                                                                                         |
| <i>You must continue to pay your Part B premium.</i>                                                                                                                                                            | <i>This is the amount you must pay before your health plan pays for part of the cost of medical care and services.</i> | <i>This is the yearly limit that you'll pay out-of-pocket for covered medical services. This amount doesn't include your monthly premium.</i> |
| If you pay a premium to your employer group, please contact your benefits administrator for 2027 premium information.<br>If you pay a premium to Fallon Health, please contact us for 2027 premium information. | \$0                                                                                                                    | \$3,400                                                                                                                                       |

| Fallon Medicare Plus Premier HMO medical benefits                                                                                                                                                                                              | You pay                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inpatient hospital care</b><br>Includes medical, surgical, detoxification, and rehabilitation services.<br><i>Requires prior authorization and PCP referral.</i>                                                                            | \$250 per admission                                                                                                                  |
| <b>Outpatient hospital care</b><br>Includes: <ul style="list-style-type: none"> <li>• Outpatient surgery in a hospital outpatient facility or ambulatory surgical center<br/> <i>Requires prior authorization and PCP referral.</i></li> </ul> | \$125                                                                                                                                |
| <ul style="list-style-type: none"> <li>• Observation services</li> </ul>                                                                                                                                                                       | \$0                                                                                                                                  |
| <b>Doctor visits</b><br>Includes: <ul style="list-style-type: none"> <li>• Primary care provider (PCP)</li> </ul>                                                                                                                              | \$15                                                                                                                                 |
| <ul style="list-style-type: none"> <li>• Annual supplemental physical exam with PCP</li> </ul>                                                                                                                                                 | \$0                                                                                                                                  |
| <ul style="list-style-type: none"> <li>• Annual wellness visit with PCP</li> </ul>                                                                                                                                                             | \$0                                                                                                                                  |
| <ul style="list-style-type: none"> <li>• Specialists<br/> <i>May require prior authorization and PCP referral.</i></li> </ul>                                                                                                                  | \$25                                                                                                                                 |
| <ul style="list-style-type: none"> <li>• Telehealth services<br/> <i>May require PCP referral.</i></li> </ul>                                                                                                                                  | \$0 PCP<br>\$0 outpatient mental health<br>\$0 outpatient substance use disorder<br>\$25 specialists<br><i>except as noted above</i> |
| <ul style="list-style-type: none"> <li>• 24/7 access to doctors by phone or video—with Teladoc®—for non-emergency conditions</li> </ul>                                                                                                        | \$0 primary care services                                                                                                            |

| Fallon Medicare Plus Premier HMO medical benefits                                                                                                                                                                                                                                                                                         | You pay |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|
| <b>Preventive care</b><br>Includes Welcome to Medicare preventive visit, certain screenings, and immunizations, such as those for pneumonia and influenza, as well as other preventive care services.<br><i>May require prior authorization.</i>                                                                                          | \$0     |
| <b>Emergency care</b><br>Copays are per visit at in- or out-of-network facilities. Coverage is worldwide. You won't pay the emergency copay if you're admitted to the hospital within 72 hours for the same condition.                                                                                                                    | \$75    |
| <b>Urgently needed services</b> <ul style="list-style-type: none"> <li>• In the United States and its territories</li> </ul>                                                                                                                                                                                                              | \$15    |
| <ul style="list-style-type: none"> <li>• Outside of the United States and its territories</li> </ul>                                                                                                                                                                                                                                      | \$75    |
| <b>Outpatient diagnostic tests and therapeutic services and supplies</b><br>Includes Medicare-covered lab services, diagnostic procedures and tests, X-rays and therapeutic radiology services, as well as INR testing (anti-coagulant visit).<br><i>Some services, tests, and supplies require prior authorization and PCP referral.</i> | \$0     |
| <b>Outpatient diagnostic imaging</b><br>Includes Medicare-covered diagnostic radiology services such as CT scans, PET scans, MRIs, and nuclear studies.<br><i>Requires prior authorization and PCP referral.</i>                                                                                                                          | \$0     |

| Fallon Medicare Plus Premier HMO medical benefits                                                                                                                                                                                                                         | You pay                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|
| <b>Hearing services</b><br>Includes: <ul style="list-style-type: none"> <li>• One (1) supplemental routine exam per year</li> </ul>                                                                                                                                       | \$0                                |
| <ul style="list-style-type: none"> <li>• Hearing aid copays apply to purchases made through Amplifon, with a prescription, and vary by model and manufacturer. For coverage, purchases must be made through Amplifon.<br/><i>Limit 2 per member, per year.</i></li> </ul> | Copays range from \$695 to \$1,795 |
| <ul style="list-style-type: none"> <li>• Diagnostic exams<br/><i>May require PCP referral.</i></li> </ul>                                                                                                                                                                 | \$25                               |
| <ul style="list-style-type: none"> <li>• Prescription hearing aids covered as part of the Benefit Bank</li> </ul>                                                                                                                                                         | See Benefit Bank                   |
| <b>Dental services</b><br>Includes: <ul style="list-style-type: none"> <li>• Preventive care like exams and cleanings through DentaQuest</li> </ul>                                                                                                                       | \$0                                |
| <ul style="list-style-type: none"> <li>• Comprehensive non-orthodontic care like root canals, fillings, and crowns<br/><i>Requires prior authorization.</i></li> </ul>                                                                                                    | Copays vary from \$0 to \$990      |
| <ul style="list-style-type: none"> <li>• Dental services covered as part of the Benefit Bank</li> </ul>                                                                                                                                                                   | See Benefit Bank                   |
| <b>Vision care</b><br>Includes: <ul style="list-style-type: none"> <li>• Medicare-covered glaucoma tests</li> </ul>                                                                                                                                                       | \$0                                |
| <ul style="list-style-type: none"> <li>• One (1) pair of Medicare-covered eyeglasses or contact lenses after cataract surgery, when obtained from an EyeMed provider</li> </ul>                                                                                           | \$0                                |
| <ul style="list-style-type: none"> <li>• One (1) supplemental routine exam per year</li> </ul>                                                                                                                                                                            | \$25                               |
| <ul style="list-style-type: none"> <li>• Medicare-covered exams to treat diseases and conditions of the eye</li> </ul>                                                                                                                                                    | \$25                               |
| <ul style="list-style-type: none"> <li>• \$150 coverage for 1 pair of non-Medicare-covered eyeglasses or contacts, every year, in-network only. Excludes the 1 pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.</li> </ul>                   | Costs above \$150                  |
| <ul style="list-style-type: none"> <li>• Prescription eyewear covered as part of the Benefit Bank</li> </ul>                                                                                                                                                              | See Benefit Bank                   |

| Fallon Medicare Plus Premier HMO medical benefits                                                                                                                                                                                                                   | You pay                                                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| <b>Mental health care</b><br>• Inpatient<br><i>Requires prior authorization.</i>                                                                                                                                                                                    | \$250 per admission                                                                                                                    |
| • Outpatient:<br>Individual and group therapy visits<br><i>Certain services require prior authorization.</i>                                                                                                                                                        | In-office without a psychiatrist: \$15<br>In-office with a psychiatrist: \$25<br>Telehealth visit, with or without a psychiatrist: \$0 |
| <b>Skilled Nursing Facility (SNF) care</b><br><i>Requires prior authorization and PCP referral.</i><br>• Per-day cost, for days 1–10 per admission                                                                                                                  | \$20                                                                                                                                   |
| • Per-day cost, for days 11-100 per benefit period                                                                                                                                                                                                                  | \$0                                                                                                                                    |
| <b>Outpatient rehabilitation services</b><br>Physical and occupational therapy visits beyond 60 visits each <i>require prior authorization and PCP referral.</i><br>Speech language therapy visits beyond 35 visits <i>require prior authorization.</i>             | \$15                                                                                                                                   |
| <b>Ambulance</b><br>Copays are for one-way Medicare-covered transports. Coverage is worldwide. Non-emergency ambulance services <i>require prior authorization.</i>                                                                                                 | \$0                                                                                                                                    |
| <b>Transportation</b><br>One-way, non-emergency chair van transport from hospital to skilled nursing facility.                                                                                                                                                      | \$35                                                                                                                                   |
| <b>Medicare Part B prescription drugs</b><br>Drugs that usually aren't self-administered and are injected or infused while at a doctor's office, hospital, or ambulatory/outpatient facility. <i>Certain drugs require prior authorization and/or step therapy.</i> | \$10 to \$65                                                                                                                           |
| <b>Medicare Part B insulin</b>                                                                                                                                                                                                                                      | Up to \$35 per month supply                                                                                                            |

| Fallon Medicare Plus Premier HMO medical benefits                                                                                                                                                                                                                                                                                 | You pay           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| <b>Podiatry</b><br>Includes medically necessary foot care services<br><i>Requires PCP referral.</i>                                                                                                                                                                                                                               | \$15              |
| <b>Durable medical equipment and related supplies</b><br><i>Requires prior authorization.</i>                                                                                                                                                                                                                                     | \$0               |
| <b>Acupuncture for chronic low back pain</b><br>Includes up to 12 visits in 90 days<br><i>Requires PCP referral.</i>                                                                                                                                                                                                              | \$15              |
| <b>Meals</b><br>Up to 14 fully prepared, home-delivered meals (2 meals/day for 7 days) upon discharge from an observation stay or inpatient admission at a hospital or skilled nursing facility.                                                                                                                                  | \$0               |
| <b>Benefit Bank</b><br>Pay for dental care, prescription eyewear, prescription hearing aids, and fitness/gym memberships with your Benefit Bank card. We preload money onto the card, and you choose how to use it. Pay for a portion, or the full cost, of an item.<br><i>Funds will expire at the end of the calendar year.</i> | Costs above \$250 |
| <b>Care Connect</b><br>24/7 phone access to registered nurses who will recommend where you should receive care or connect you to your doctor                                                                                                                                                                                      | \$0               |
| <b>Health and wellness programs</b> <ul style="list-style-type: none"> <li>• Fitness memberships and online fitness program services covered as part of the Benefit Bank</li> </ul>                                                                                                                                               | See Benefit Bank  |
| <ul style="list-style-type: none"> <li>• WW® (Weight Watchers) online memberships covered as part of the Benefit Bank</li> </ul>                                                                                                                                                                                                  | See Benefit Bank  |

# Part D prescription drug benefits

These medications are ones that you need a prescription to receive, and that you typically get at a retail pharmacy or through mail order. There are 3 “drug payment stages” for Part D prescription drug coverage: deductible stage, initial coverage stage, and catastrophic coverage stage. Our plan covers most Part D vaccines at no cost to you, regardless of coverage stage.

**Deductible stage:** Because there’s no deductible for Fallon Medicare Plus Premier HMO, this stage doesn’t apply to your Part D prescription drug coverage.

**Initial coverage stage:** You pay the following amounts until your yearly out-of-pocket drug costs (your payments or those paid on your behalf) total \$2,400.

|                                           | Retail        |                             |                                                          | Mail order    |                             |                                                          |
|-------------------------------------------|---------------|-----------------------------|----------------------------------------------------------|---------------|-----------------------------|----------------------------------------------------------|
|                                           | 30-day supply | 60-day supply               | Tier 1:<br>100-day supply<br>Tiers 2-4:<br>90-day supply | 30-day supply | 60-day supply               | Tier 1:<br>100-day supply<br>Tiers 2-4:<br>90-day supply |
| <b>Tier 1:</b><br>Preferred generic drugs | \$0           | \$0                         | \$0                                                      | \$0           | \$0                         | \$0                                                      |
| <b>Tier 2:</b><br>Generic drugs           | \$10          | \$20                        | \$30                                                     | \$10          | \$20                        | \$20                                                     |
| <b>Tier 3:</b><br>Preferred brand drugs   | \$30          | \$60                        | \$90                                                     | \$30          | \$60                        | \$60                                                     |
| <b>Tier 4:</b><br>Non-preferred drugs     | \$65          | \$130                       | \$195                                                    | \$65          | \$130                       | \$162.50                                                 |
| <b>Tier 5:</b><br>Specialty drugs         | \$65          | Not available for this tier | Not available for this tier                              | \$65          | Not available for this tier | Not available for this tier                              |
| <b>Tier 6:</b><br>Select care drugs       | \$0           | Not available for this tier | Not available for this tier                              | \$0           | Not available for this tier | Not available for this tier                              |

Certain drugs are not available in an extended-day supply. These drugs may be included within Tiers 1-6. Your copays for insulin drugs are no more than: \$35 for a 30-day supply purchased at retail or through mail order, \$105 for a 90-day supply purchased at retail, and \$70 for a 90-day supply purchased through mail order.

**Catastrophic coverage stage:** After your yearly out-of-pocket drug costs reach \$2,400, you pay \$0 for all covered prescription drugs.

For more information about cost-sharing specific to the different phases of the benefit, please use the contact information included on the back page to call us.

# Fallon Medicare Plus Premier HMO service area

(ZIP codes listed represent the service area outside of Massachusetts)

| MASSACHUSETTS       |                   |                    |                    |
|---------------------|-------------------|--------------------|--------------------|
| Barnstable County** | Essex County**    | Hampshire County** | Plymouth County**  |
| Berkshire County**  | Franklin County** | Middlesex County** | Suffolk County**   |
| Bristol County**    | Hampden County**  | Norfolk County**   | Worcester County** |

| CONNECTICUT             |                         |
|-------------------------|-------------------------|
| Town                    | ZIP                     |
| <b>Hartford County*</b> |                         |
| East Granby             | 06026                   |
| East Windsor            | 06088                   |
| East Windsor Hill       | 06028                   |
| Enfield                 | 06082<br>06083          |
| Granby                  | 06035<br>06090          |
| Hazardville             | 06082                   |
| North Granby            | 06060                   |
| N. Thompsonville        | 06082                   |
| Scitico                 | 06082                   |
| Suffield                | 06078<br>06080<br>06093 |
| Thompsonville           | 06082                   |
| West Granby             | 06090                   |
| West Suffield           | 06093                   |
| Windsor Locks           | 06096                   |
| <b>Tolland County*</b>  |                         |
| Ellington               | 06029                   |
| Somers                  | 06071                   |
| Stafford                | 06075                   |
| Stafford Springs        | 06076                   |
| Union                   | 06076                   |
| Willington              | 06279                   |
| <b>Windham County*</b>  |                         |
| Ashford                 | 06278                   |
| Ballouville             | 06233                   |
| Danielson               | 06239                   |
| Dayville                | 06241                   |
| East Killingly          | 06243                   |

| CONNECTICUT, cont.          |                                           |
|-----------------------------|-------------------------------------------|
| East Woodstock              | 06244                                     |
| Eastford                    | 06242                                     |
| Fabyan                      | 06256                                     |
| Killingly                   | 06233<br>06239<br>06241<br>06243<br>06263 |
| Mechanicsville              | 06277                                     |
| North Grosvenordale         | 06255                                     |
| North Windham               | 06256                                     |
| Pomfret                     | 06258                                     |
| Pomfret Center              | 06259                                     |
| Putnam                      | 06260                                     |
| Rogers                      | 06263                                     |
| South Woodstock             | 06267                                     |
| Thompson                    | 06277                                     |
| Woodstock                   | 06281                                     |
| Woodstock Valley            | 06282                                     |
| NEW HAMPSHIRE               |                                           |
| Town                        | ZIP                                       |
| <b>Cheshire County*</b>     |                                           |
| Fitzwilliam                 | 03447                                     |
| Rindge                      | 03461                                     |
| <b>Hillsborough County*</b> |                                           |
| Brookline                   | 03033                                     |
| Greenville                  | 03048                                     |
| Hollis                      | 03049                                     |
| Hudson                      | 03051                                     |
| Jaffrey                     | 03452                                     |
| Mason                       | 03048                                     |

| NEW HAMPSHIRE, cont.      |                                           |
|---------------------------|-------------------------------------------|
| Nashua                    | 03060<br>03061<br>03062<br>03063<br>03064 |
| New Ipswich               | 03071                                     |
| Pelham                    | 03076                                     |
| <b>Rockingham County*</b> |                                           |
| Atkinson                  | 03811                                     |
| East Kingston             | 03827                                     |
| Hampstead                 | 03841                                     |
| Hampton                   | 03842                                     |
| Hampton Beach             | 03843                                     |
| Hampton Falls             | 03844                                     |
| Plaistow                  | 03865                                     |
| Salem                     | 03079                                     |
| Seabrook                  | 03874                                     |
| South Hampton             | 03827                                     |
| Windham                   | 03087                                     |
| NEW YORK                  |                                           |
| Town                      | ZIP                                       |
| <b>Columbia County*</b>   |                                           |
| Austerlitz                | 12017                                     |
| Canaan                    | 12029                                     |
| Chatham                   | 12037                                     |
| Chatham Center            | 12184                                     |
| Copake                    | 12516                                     |
| Copake Falls              | 12517                                     |
| Craryville                | 12521                                     |
| East Chatham              | 12060                                     |
| Hillsdale                 | 12529                                     |
| Malden Bridge             | 12115                                     |
| New Lebanon               | 12125                                     |

| NEW YORK, cont.           |                                  |
|---------------------------|----------------------------------|
| Old Chatham               | 12136                            |
| West Lebanon              | 12195                            |
| <b>Rensselaer County*</b> |                                  |
| Berlin                    | 12022                            |
| Stephentown               | 12168<br>12169                   |
| RHODE ISLAND              |                                  |
| Town                      | ZIP                              |
| <b>Bristol County*</b>    |                                  |
| Bristol                   | 02809                            |
| Warren                    | 02885                            |
| <b>Newport County*</b>    |                                  |
| Little Compton            | 02837                            |
| Tiverton                  | 02878                            |
| <b>Providence County*</b> |                                  |
| Burrillville              | 02826<br>02830<br>02839<br>02858 |
| Cumberland                | 02864                            |
| Glendale                  | 02826                            |
| Harrisville               | 02830                            |
| Mapleville                | 02839                            |
| North Smithfield          | 02824<br>02876<br>02896          |
| Oakland                   | 02858                            |
| Pawtucket                 | 02860<br>02861<br>02862          |
| Slatersville              | 02876                            |
| Smithfield                | 02917                            |
| Valley Falls              | 02864                            |
| Woonsocket                | 02895                            |

\* Partial county

\*\* Full county

# More information

To learn more about Fallon Medicare Plus Premier HMO or to view plan documents, visit our website, or call us using the information listed below.

|                                                                       |                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Fallon Medicare Plus Premier HMO</b>                               | Current members: <b>1-800-325-5669 (TTY 711)</b><br>Prospective members: <b>1-866-231-3669 (TTY 711)</b><br>Website: <b>fallonhealth.org/medicare</b><br>Hours: 8 a.m.–8 p.m., Monday–Friday<br>(7 days a week, Oct. 1–March 31) |
| <b>Provider Directory</b>                                             | fallonhealth.org/findphysician                                                                                                                                                                                                   |
| <b>Pharmacy Directory</b>                                             | fallonhealth.org/pharmacyfinder                                                                                                                                                                                                  |
| <b>Prescription Drug Formulary</b>                                    | fallonhealth.org/medicare-formulary                                                                                                                                                                                              |
| <b>Original Medicare</b><br>More information about coverage and costs | “Medicare & You” handbook<br>• View online: medicare.gov<br>• Get a copy: Call 1-800-MEDICARE (1-800-633-4227)<br>TTY users can call 1-877-486-2048<br>24 hours a day, 7 days a week                                             |

This document is available in other formats such as braille, large print, audio CD, or data CD.



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