Welcome to Fallon Medicare Plus™

fallonhealth

fallonhealth.org/medicare

H9001_230100_C 22-686-086 Rev. 00 7/22

Fallon Health – a company that cares

Fallon Medicare Plus™ Premier HMO

Our priority—always—is making sure our members get the care they need and deserve. Fallon Medicare Plus Premier HMO is our Medicare Advantage plan for retirees that includes rich benefits like:

Benefit Bank

The Benefit Bank card is preloaded with money that can be used for dental care, eyewear, fitness memberships, and hearing aids. Use the card to pay a portion, or the full cost, of an item. The annual allowance is $250.

Dental

New for 2024! You pay $0 for all preventive dental services like cleanings, exams, and X-rays.

Comprehensive dental care, like root canals, fillings, and crowns are also covered—with a copay. Your Benefit Bank can be used to pay for copays and out-of-network dental services.

Eyewear

$150 toward eyewear, every year. You can also use your Benefit Bank toward additional—or out-of-network—eyewear costs.

Hearing aids

Pay between $695 and $2,645 when you make purchases through Amplifon. Copays vary by hearing aid type and technology. You can use your Benefit Bank toward these copayments or on hearing aids purchased from other providers.

Fitness benefit

A free gym membership, on-demand library of classes, workouts, and instructional videos—all are available through SilverSneakers®. Plus, you can use your Benefit Bank to pay for fitness memberships of your choice.

WW® membership

Free 13-consecutive-week WW (Weight Watchers) membership.

fallonhealth

1-866-231-3669 (TRS 711)

8 a.m.–8 p.m., Monday–Friday (Oct. 1–March 31, seven days a week)

fallonhealth.org/medicare

23-686-144 Rev. 00 8/23 H9001_240151_E

2024 Fallon Medicare Plus™ Premier HMO Enrollment Form

SECTION 1 – All fields on this page are required *(unless marked optional)*.

To enroll, please provide the following information.

Company name:	Group number:
Authorized signature:	Requested effective date:

Last name: First name: Middle initial: *(optional)*

Birth date: (MM/DD/YYYY) _____ / _____ / _____	Sex: M F	Home phone number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Preferred written language: *(optional)*		Preferred spoken language: *(optional)*
Mobile phone number: *(optional)* (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ *I authorize Fallon Health to send me text messages related to my plan benefits and services.*		Email address: *(optional)* _____ *I authorize Fallon Health to send me email messages related to my plan benefits and services.*

Permanent residence street address (P.O. Box is not allowed):

City/town:	State:	ZIP code:	County: *(optional)*

Mailing address if different from above:

Street address: _____

City/town: _____ State: _____ ZIP code: _____

Please provide your Medicare insurance information.

Please take out your red, white and blue Medicare card to complete this section.

Fill out this information as it appears on your Medicare card.

OR

Attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name (as it appears on your Medicare card):

_____

Medicare number: _____

Is entitled to:	Effective date:
Hospital (Part A)	_____
Medical (Part B)	_____

Please read and answer these important questions.

1. **Are you the retiree?** Yes No

   If yes, retirement date (month/date/year): _____

   If no, name of retiree: _____

2. **Are you covering a spouse or dependents under this employer or union plan?** Yes No

   If yes, name of spouse: _____

   Name(s) of dependent(s): _____

Please read and answer these important questions *(continued)*.

3. Do you or your spouse work? Yes No

4. Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits or State pharmaceutical assistance programs.

Will you have other *prescription* drug coverage in addition to Fallon Health? Yes No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

_____

Name of other coverage: _____

ID # for coverage: _____

5. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If "yes" please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street):

_____

6. Please choose a primary care physician (PCP), clinic or health center: *(optional)*

_____

Please check the box below if you would prefer us to send you information in another accessible format:

Braille Audio CD Large print

Please contact Fallon Health at 1-866-231-3669 (TRS 711) if you need information in an accessible format other than what is listed above.

I want to get the following materials via email. Select one or more.

Evidence of Coverage Formulary Email address: _____

Please read the important information on the following page and then sign below.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request by Fallon Health or by Medicare.

X _____ _____

Your signature/authorized representative Today's date

If you are the authorized representative, you must sign above and provide the following information:

_____ _____

Name (printed) Relationship to enrollee

_____

Address

Phone number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

SECTION 2 – All fields in this section are optional.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? *Select all that apply.*

- No, not of Hispanic, Latino/a, or Spanish origin
- Yes, Puerto Rican
- Yes, another Hispanic, Latino/a, or Spanish origin
- Yes, Mexican, Mexican American, Chicano/a
- Yes, Cuban
- **I choose not to answer.**

What's your race? *Select all that apply.*

- American Indian or Alaska Native

Asian:

- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian

- Black or African American

Native Hawaiian and Pacific Islander:

- Guamanian or Chamorro
- Native Hawaiian
- Samoan
- Other Pacific Islander

- White
- **I choose not to answer.**

SECTION 3 – Read this important information.

By completing this enrollment application, I agree to the following:

Fallon Health is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in Fallon Health depends on contract renewal. I will need to keep my Medicare Parts A and B. (This means I must continue to pay my Medicare Part B premium.) I can only be in one Medicare Advantage Plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15–December 7 of every year), or under certain special circumstances.

Fallon Medicare Plus Premier HMO serves a specific service area. If I move out of the area that Fallon Medicare Plus Premier HMO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Fallon Medicare Plus Premier HMO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Fallon Medicare Plus Premier HMO when I get it to know which rules I must follow to receive coverage with this Medicare Advantage Plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Fallon Medicare Plus Premier HMO coverage begins, I must get all of my health care from Fallon Medicare Plus Premier HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Fallon Medicare Plus Premier HMO and other services contained in my plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FALLON MEDICARE PLUS PREMIER HMO WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Fallon Health, they may be paid based on my enrollment in Fallon Medicare Plus Premier HMO.

Release of information:
By joining this Medicare health plan, I acknowledge that Fallon Medicare Plus Premier HMO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Fallon Medicare Plus Premier HMO will release my information including my prescription drug event data (if applicable) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

1-866-231-3669 (TRS 711)

8 a.m.–8 p.m., seven days a week
(Apr.–Sept., 8 a.m.–8 p.m., Mon.–Fri.)

FALLON HEALTH USE ONLY New enrollment l Group to group
OEV required: _____ Sales staff initials: _____ OEV complete: _____
Name of staff member (if assisted in enrollment): _____
EGWP: _____ ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not eligible: _____
Staff verification: _____ Effective date of coverage: _____
County code: _____ Previous insurance: _____
Broker name: _____ Broker ID: _____

Fallon Medicare Plus™ Premier HMO Summary of Benefits

January 1, 2024–December 31, 2024

H9001_240123_E
23-686-129 Rev. 00 8/23
RWv0 H9001_PBP_803

Fallon Medicare Plus Premier HMO

2024 Summary of Plan Benefits

This is a summary of drug and health services covered by Fallon Medicare Plus Premier HMO for January 1, 2024–December 31, 2024.

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 does not 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 or by calling the phone number at the end of this book.

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 plans 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 10.

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

Plan Costs	Monthly plan premium *You must continue to pay your Part B premium.*	Medical deductible *This is the amount you must pay before your health plan pays for part of the cost of medical care and services.*	Maximum out-of-pocket *This is the yearly limit that you will pay out-of-pocket for covered medical services. This amount does not include your monthly premium or any prescription drug costs.*
Fallon Medicare Plus Premier HMO	Because you pay a premium to your employer group, please contact your benefits administrator for 2024 premium information.	$0	$3,400

Fallon Medicare Plus Premier HMO Medical Benefits	You pay
Inpatient Hospital Care Includes medical, surgical, and rehabilitation services *Requires prior authorization*	$125 per admission
Outpatient Hospital Care Includes: • Outpatient surgery provided in a hospital outpatient facility and ambulatory surgical center *Requires prior authorization*	$100
• Observation services	$0
Doctor Visits Includes: • Primary Care Provider (PCP)	$15
• Annual Supplemental Physical Exam with PCP	$0
• Annual Wellness Visit with PCP	$0
• Specialists *May require referral*	$25
• Telehealth services *May require referral*	$0 PCP $0 Outpatient mental health $0 Outpatient substance abuse $25 Specialists *except as noted above*
• 24/7 phone, video, or mobile access to board-certified doctors	$0 primary care services

Fallon Medicare Plus Premier HMO Medical Benefits	You pay
Preventive Care Includes Welcome to Medicare preventive visit, certain screenings, and immunizations such as those for pneumonia and influenza, as well as other preventive care services *May require prior authorization*	$0
Emergency Care Copays are per visit at in- or out-of-network facilities. Coverage is worldwide. You will not pay the emergency copay if you are admitted to the hospital within 72 hours for the same condition.	$65
Urgently Needed Services • In the United States and its territories	$15
• Outside of the United States and its territories	$65
Outpatient Diagnostic Tests and Therapeutic Services and Supplies Includes Medicare-covered lab services, diagnostic procedures and tests, X-rays, and therapeutic radiology services, as well as INR testing (anti-coagulant visit). *Some services, tests, and supplies require prior authorization.*	$0
Outpatient Diagnostic Imaging Includes Medicare-covered diagnostic radiology services such as CT scans, PET scans, MRIs, and nuclear studies *Requires prior authorization.*	$0
Hearing Services • One supplemental routine exam per year	$0
• Diagnostic exams	$25
• Hearing aid copays apply to purchases made through Amplifon and vary by model and manufacturer. For coverage, purchases must be made through Amplifon. *Limit 2 per member per year.*	Copays vary from $695 to $2,645
• Hearing aids covered as part of the Benefit Bank	See Benefit Bank
Dental Services Includes: • Preventive care, like exams and cleanings, through DentaQuest	$0
• Comprehensive non-orthodontic care, like root canals, fillings, and crowns *May require prior authorization*	Copays vary from $0 to $990
• Dental services covered as part of the Benefit Bank	See Benefit Bank
Vision Care Includes: • One pair of Medicare-covered standard eyeglasses with standard frames or contact lenses after cataract surgery, when obtained from an EyeMed provider • Medicare-covered glaucoma tests	$0
• One supplemental routine exam per year • Medicare-covered exams to treat diseases and conditions of the eye	$25

Fallon Medicare Plus Premier HMO Medical Benefits	You pay
Vision Care, *continued* • $150 coverage for one pair of non-Medicare-covered eyeglasses or contact lenses, every year, in-network only. Excludes the one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.	Costs above $150
• Eyewear covered as part of the Benefit Bank	See Benefit Bank
Mental Health Care • Inpatient: *Requires prior authorization*	$125 per admission
• Outpatient: Individual and group therapy visits *Prior authorization is required for:* *Transcranial Magnetic Stimulation (TMS) Therapy* *Electroconvulsive Therapy (ECT)* *Neuropsychological Testing* *Intensive Outpatient (IOP) Therapy*	In-office without a psychiatrist: $15 In-office with a psychiatrist: $25 Telehealth visit, with or without a psychiatrist: $0
Skilled Nursing Facility (SNF) Care *Requires prior authorization* • Per-day cost, for days 1–6 per admission	$20
• Per-day cost, for days 7–100 per benefit period	$0
Outpatient Rehabilitation Services *Physical and occupational therapy visits beyond 60 visits each require prior authorization. Speech language therapy visits beyond 35 visits require prior authorization.*	$15
Ambulance Copays are for one-way Medicare-covered transports. Ambulance services are covered worldwide. *Non-emergency ambulance services require prior authorization.*	$0
Transportation One-way, non-emergent chair van transport from hospital to skilled nursing facility	$35
Medicare Part B Prescription Drugs Drugs that usually aren't self-administered and are injected or infused while at a doctor's office, hospital, or ambulatory/outpatient facility. *Certain drugs require prior authorization and/or step therapy.*	$10–$50
Medicare Part B insulin	Up to $35 per month supply
Podiatry Includes medically necessary foot care services *Requires referral*	$15
Durable Medical Equipment and Related Supplies *Requires prior authorization*	$0
Acupuncture for chronic low back pain Includes up to 12 visits in 90 days *Requires referral*	$15

Fallon Medicare Plus Premier HMO Medical Benefits	You pay
Meals 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
Benefit Bank Pay for dental care, eyewear, fitness memberships, and hearing aids with your Benefit Bank card. We put money on the card, and you choose how to use it. Pay for a portion, or the full cost, of an item.	Costs above $250
Health and Wellness Programs	
Fitness membership/classes • SilverSneakers® – Includes access to online classes and instructional videos, an at-home fitness kit, and/or a gym membership	$0
• Fitness memberships and online fitness program services covered as part of the Benefit Bank	See Benefit Bank
WW® (Weight Watchers) • One 13-consecutive-week membership each year	$0
• WW online memberships covered as part of the Benefit Bank	See Benefit Bank
Care Connect 24/7 phone access to registered nurses who will recommend where you should receive care or will connect you to your doctor	$0

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 four "drug payment stages" for Part D prescription drug coverage: deductible stage, initial coverage stage, coverage gap stage and catastrophic coverage stage.

Our plan covers most Part D vaccines at no cost to you in all coverage stages. You will pay no more than $35 for a 30-day supply of covered insulin drugs, regardless of the drug coverage stage.

Deductible Stage

Because there is no deductible for Fallon Medicare Plus Premier HMO, this stage does not apply to your Part D prescription drug coverage.

Initial Coverage Stage

You pay the following amounts until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $8,000.

Fallon Medicare Plus Premier HMO						
	Retail			Mail order		
	30-day supply	60-day supply	Tier 1: 100-day supply Tiers 2-4: 90-day supply	30-day supply	60-day supply	Tier 1: 100-day supply Tiers 2-4: 90-day supply
Tier 1: Preferred generic drugs	$0	$0	$0	$0	$0	$0
Tier 2: Generic drugs	$10	$20	$30	$10	$20	$20
Tier 3: Preferred brand drugs	$25	$50	$75	$25	$50	$50
Tier 4: Non-preferred drugs	$50	$100	$150	$50	$100	$100
Tier 5: Specialty drugs	$50	Not available for this tier	Not available for this tier	$50	Not available for this tier	Not available for this tier
Tier 6: 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.

Coverage Gap Stage

You do not have a coverage gap.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs reach $8,000, 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.

Notice of inclusion resources

At Fallon Health, we believe everyone deserves access to **health care without discrimination.** We work every day to help people of any age, income level, race, color, ethnicity, national origin, disability, religion, sexual orientation, sex, gender identity, and health status achieve their health goals.

To make sure you have access to all the resources and information necessary to understand and access your health plan benefits, we:

- Provide **free aids and services—**such as qualified sign language interpreters and written information in other formats, including large print, braille, accessible electronic formats, and other formats.
- Provide **free language services—**such as qualified interpreters and information written in other languages—to people whose primary language is not English.
- Have **dedicated resources, individuals, and teams** that specialize in reviewing our policies to ensure inclusion of the unique needs of our transgender and gender diverse members.

If you need access to or wish to discuss any of this information or resources, **please call us** at the phone number on the back of your member ID card. Or you can email us at cs@fallonhealth.org.

If you believe Fallon or a provider has **discriminated against you or didn't provide these resources,** please tell us. You can write, call, or email us at:

Compliance Director Fallon Health	Phone: 1-508-368-9988 (TRS 711) Email: compliance@fallonhealth.org	10 Chestnut St. Worcester, MA 01608

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, D.C., 20201
Phone: 1-800-368-1019 (TDD: 1-800-537-7697)

Form Approved
OMB# 0938-1421

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-325-5669. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-325-5669. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-325-5669。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-325-5669。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-325-5669. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-325-5669. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-325-5669 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-325-5669. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-325-5669 번으로 문의해 주십시오.한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-325-5669. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، بمساعدتك. هذه خدمة مجانية ليس عليك سوى الاتصال بنا على 1-800-325-5669. سيقوم شخص ما يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-325-5669 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-325-5669. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-325-5669. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-325-5669. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-325-5669. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通 訳サービスがありますございます。通訳をご用命になるには、1-800-325-5669 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Khmer: យើងមានសេវាកម្មអ្នកបកប្រែផ្ទាល់មាត់ឥតគិតថ្លៃដើម្បីឆ្លើយសំណួរណាមួយ ដែលអ្នកអាចមានអំពីគម្រោងសុខភាព ឬគម្រោងឱសថរបស់អ្នក។ ដើម្បីទទួលបានអ្នកបកប្រែផ្ទាល់មាត់ម្នាក់ សូមទូរស័ព្ទមកយើងតាមលេខ 1-800-325-5669។ អ្នកណាម្នាក់ដែលនិយាយភាសាអង់គ្លេស/ភាសា អាចជួយអ្នកបាន។ នេះគឺជាសេវាកម្មមិនគិតថ្លៃ។

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

CONNECTICUT, cont.

East Woodstock	06244
Eastford	06242
Fabyan	06256
Killingly	06233 06239 06241 06243 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
Cheshire County*	
Fitzwilliam	03447
Rindge	03461
Hillsborough County*	
Brookline	03033
Greenville	03048
Hollis	03049
Hudson	03051
Jaffrey	03452
Mason	03048

NEW HAMPSHIRE, cont.

Nashua	03060 03061 03062 03063 03064
New Ipswich	03071
Pelham	03076
Rockingham County*	
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
Columbia County*	
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
Old Chatham	12136
West Lebanon	12195

NEW YORK, cont.

Rensselaer County*	
Berlin	12022
Stephentown	12168 12169

RHODE ISLAND

Town	ZIP
Bristol County*	
Bristol	02809
Warren	02885
Newport County*	
Little Compton	02837
Tiverton	02878
Providence County*	
Burrillville	02826 02830 02839 02858
Cumberland	02864
Glendale	02826
Harrisville	02830
Mapleville	02839
North Smithfield	02824 02876 02896
Oakland	02858
Pawtucket	02860 02861 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 webpages or call us using the information listed below.

Fallon Medicare Plus	Current members:	**1-800-325-5669 (TRS 711)**
	Prospective members:	**1-866-231-3669 (TRS 711)**
	Website:	**fallonhealth.org/medicare**
	Hours:	Monday–Friday, 8 a.m.–8 p.m. From Oct. 1–March 31, we're available seven days a week.
Provider Directory	fallonhealth.org/findphysician	
Pharmacy Directory	fallonhealth.org/pharmacyfinder	
Prescription Drug Formulary	fallonhealth.org/medicare-formulary	
Original Medicare More information about coverage and costs	"Medicare & You" handbook • View online: • Get a copy:	 http://www.medicare.gov Call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

fallonhealth

Fallon Medicare Plus™ Premier Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Fallon Health representative at 1-866-231-3669 (TRS 711), 8 a.m.–8 p.m., Monday–Friday (Oct. 1–March 31, seven days a week).

Understanding the benefits

The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit fallonhealth.org/medicare or call 1-866-231-3669 (TRS 711) to view or request a copy of the EOC.

Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Review the Formulary to make sure your drugs are covered.

Understanding important rules

Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2025.

In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider Directory).

Effect on current coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

IMPORTANT INFORMATION:

2024 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Fallon Health - H9001

For 2024, Fallon Health - H9001 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★★☆
Health Services Rating:	★★★★☆
Drug Services Rating:	★★★★☆

fallon health

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at medicare.gov/plan-compare.

Questions about this plan?

Contact Fallon Health 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at 888-377-1980 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time. Current members please call 800-325-5669 (toll-free) or 711 (TTY).