

# Community Care Connector High Silver

## Benefit Summary—Benefits effective January 1, 2026

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### The Fallon Health difference

With Community Care High Silver, you get:

- **A fitness reimbursement** of up to \$150 that can be used for gym memberships at the gym of your choice with no limitations, streaming fitness programs, Peloton subscriptions, school and town sports fees, home fitness equipment, exercise classes, ski lift tickets, and more!
- **\$0 copayments for routine physical exams** and other preventive services, including mammograms, cholesterol screenings and immunizations.
- **\$0 copayments for routine annual eye exams.**
- **Pedi-Dental:** dental benefits for members under age 19 included.
- **Pedi-Glasses:** One designated set, once per calendar year.
- **Telehealth:** This plan covers certain services delivered via telehealth by plan providers. Members also get 24/7 access to a national network of U.S. board-certified doctors from an approved telehealth vendor to discuss non-emergency conditions by phone, mobile device or online.

### How to receive care:

Members have access to network benefits only from the providers in Community Care. Please consult the Fallon Health Community Care provider directory; a paper copy can be requested by calling Customer Service at 1-800-868-5200, or visit the provider search tool at [fallonhealth.org](https://fallonhealth.org) to determine which providers are included in Community Care.

### Choosing a primary care provider (PCP)

Your relationship with your PCP is very important because he or she will work with Fallon to provide or arrange most of your care. As a member of Community Care Connector High Silver you must select a PCP. To do this, just complete the section on your Fallon Health membership enrollment form. If you need help choosing a PCP, please visit the “Find a Doctor” tool on [fallonhealth.org](https://fallonhealth.org) or call Customer Service.

### Obtaining specialty care

When you want to visit a specialist, talk with your PCP first. He or she will help arrange specialty care for you. The following services do not require a referral when you see a provider in the Community Care network: routine obstetrics/gynecology care, screening eye exams and behavioral health services. For more information on referral procedures for specialty services, consult your Community Care Member Handbook/Evidence of Coverage.

### Emergency medical care

Emergency services do not require referral or authorization. When you have an emergency medical condition, you should go to the nearest emergency department or call your local emergency communications system (police, fire department or 911). For more information on emergency benefits and plan procedures for emergency services, consult your Community Care Member Handbook/Evidence of Coverage.

## Plan specifics

### Benefit period

The benefit period, sometimes referred to as a “benefit year,” is the 12-month span of plan coverage, and the time during which the deductible, out-of-pocket maximum and specific benefit maximums accumulate.

Varies by account

### Deductible

A deductible is the amount of allowed charges you pay per benefit period before payment is made by the plan for certain covered services. The amount that is put toward your deductible is calculated based on the allowed charge or the provider’s actual charge— whichever is less.

\$2,000 individual  
\$4,000 family

### Embedded deductible

Please note that once any one member in a family accumulates \$2,000 of services that are subject to the family deductible, that individual member’s deductible is considered met, and that family member will receive benefits for covered services less any applicable copayments.

\$2,000

### Deductible carryover

Any deductible amount that is incurred by the member for services rendered during the last three months of the benefit period will be applied toward the deductible for the next benefit period. Deductible amounts are incurred as of the date of the service.

Included

### Out-of-pocket maximum

The out-of-pocket maximum is the total amount of deductible, coinsurance and copayments you are responsible for in a benefit period. The out-of-pocket maximum does not include your premium charge or any amounts you pay for services that are not covered by the plan.

\$10,150 individual  
\$20,300 family

## Benefits

## Your cost

### Office

Routine physical exams (according to MHQP\* preventive guidelines)

\$0

Primary care visits to treat an injury or illness (in-person or by telehealth)  
*(If you choose to get these services by telehealth, you must use a plan provider who offers the service by telehealth.)*

\$25 per visit

Specialist visits (in-person or by telehealth)  
*(If you choose to get these services by telehealth, you must use a plan provider who offers the service by telehealth.)*

\$60 per visit

Urgent care

\$60 per visit

Routine eye exams (adult routine eye exams, once in each 12-month period;  
pediatric routine eye exams, once per calendar year)

\$0

Telehealth visits for non-emergency conditions by an approved telehealth vendor  
*(For more information on covered telehealth services, consult your Community Care Member Handbook/Evidence of Coverage)*

\$25 copayment

Short-term rehabilitative services (physical and occupational therapy, limited to 60 visits combined per benefit period)

\$60 copayment

Prenatal care

\$0

| <b>Benefits</b>                                                                                                                                                                                                                   |  | <b>Your cost</b>                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|
| <b>Office</b>                                                                                                                                                                                                                     |  |                                                                         |
| Preventive services<br>Tests, immunizations and services to help screen for diseases and improve early detection when symptoms or diagnosis are not present                                                                       |  | \$0                                                                     |
| Diagnostic lab services<br>Tests and services that are intended to diagnose or check the status of a disease or condition                                                                                                         |  | \$30 copayment after deductible                                         |
| Diagnostic x-ray services<br>Tests and services that are intended to diagnose, check the status of, or treat a disease or condition                                                                                               |  | \$60 copayment after deductible                                         |
| Diagnostic other (EKG, ultrasound, colonoscopy, etc.)<br>Tests and services that are intended to diagnose, check the status of, or treat a disease or condition                                                                   |  | Covered in full after deductible                                        |
| Diagnostic breast exam by mammogram, digital breast tomosynthesis, breast magnetic resonance imaging or breast ultrasound (prior authorization required for breast MRI)                                                           |  | \$0                                                                     |
| Imaging (CAT, PET, MRI, Nuclear Cardiology)                                                                                                                                                                                       |  | \$350 copayment after deductible                                        |
| Chiropractic care                                                                                                                                                                                                                 |  | \$25 per visit                                                          |
| <b>Prescriptions</b>                                                                                                                                                                                                              |  |                                                                         |
| <i>Please note: Specialty medication that falls under the medical benefit will apply toward your deductible. For more information, please contact Fallon Health's Customer Service Department at 1-800-868-5200.</i>              |  | <b>Tier 1/Tier 2/Tier 3</b>                                             |
| Prescription drugs, insulin and insulin syringes<br>( <b>Note:</b> Standard plan members have access to at least one insulin vial and one insulin pen injector dose for each major type of insulin at the Tier 1 copayment level) |  | \$30/\$55/\$75 after deductible (30-day supply)                         |
| Generic contraceptives and contraceptive devices                                                                                                                                                                                  |  | \$0 (30-day supply)                                                     |
| Brand contraceptives with no generic equivalent (prior authorization required)                                                                                                                                                    |  | With prior authorization: \$0 (30-day supply)                           |
| Brand contraceptives with a generic equivalent (prior authorization required)                                                                                                                                                     |  | With prior authorization: Tier 3: \$75 after deductible (30-day supply) |
| Prescription medication refills obtained through the mail order program                                                                                                                                                           |  | \$60/\$110/\$225 after deductible (90-day supply)                       |
| <b>Inpatient hospital services</b>                                                                                                                                                                                                |  |                                                                         |
| Room and board in a semiprivate room (private when medically necessary)                                                                                                                                                           |  | \$1,000 copayment after deductible                                      |
| Inpatient hospital care including, but not limited to, physician and surgeon services, physical and respiratory therapy, and intensive care services.                                                                             |  | Covered in full after deductible                                        |
| Childbirth/Inpatient maternity and newborn care                                                                                                                                                                                   |  | \$1,000 copayment after deductible                                      |
| <b>Same-day surgery</b>                                                                                                                                                                                                           |  |                                                                         |
| Same-day surgery in a hospital outpatient or ambulatory care setting                                                                                                                                                              |  | \$500 copayment after deductible                                        |

| Benefits                                                                                                                                                                                                                                                                                                                                         |  | Your cost                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------|
| <b>Emergencies</b>                                                                                                                                                                                                                                                                                                                               |  |                                                          |
| Emergency room visit                                                                                                                                                                                                                                                                                                                             |  | \$350 copayment after deductible<br>(waived if admitted) |
| <b>Skilled nursing</b>                                                                                                                                                                                                                                                                                                                           |  |                                                          |
| Skilled care in a semiprivate room                                                                                                                                                                                                                                                                                                               |  | \$1,000 copayment after deductible                       |
| <b>Mental health and substance use services</b>                                                                                                                                                                                                                                                                                                  |  |                                                          |
| Office visits (in-person or by telehealth)<br><i>(If you choose to get these services by telehealth, you must use a plan provider who offers the service by telehealth.)</i>                                                                                                                                                                     |  | \$25 per visit                                           |
| Detoxification in an inpatient setting                                                                                                                                                                                                                                                                                                           |  | \$1,000 copayment after deductible                       |
| Rehabilitation in an inpatient setting                                                                                                                                                                                                                                                                                                           |  | \$1,000 copayment after deductible                       |
| Services in a general or psychiatric hospital                                                                                                                                                                                                                                                                                                    |  | \$1,000 copayment after deductible                       |
| <b>Other health services</b>                                                                                                                                                                                                                                                                                                                     |  |                                                          |
| Skilled home health care services                                                                                                                                                                                                                                                                                                                |  | Covered in full after deductible                         |
| Durable medical equipment                                                                                                                                                                                                                                                                                                                        |  | 20% coinsurance after deductible                         |
| Medically necessary ambulance services                                                                                                                                                                                                                                                                                                           |  | Covered in full after deductible                         |
| Postpartum home care visit (prior authorization required beyond the first visit)                                                                                                                                                                                                                                                                 |  | \$0                                                      |
| <b>Value-added features</b>                                                                                                                                                                                                                                                                                                                      |  |                                                          |
| It Fits!, an annual benefit period fitness reimbursement (including streaming fitness programs, Peloton subscriptions, school and town sports programs, gym memberships, new cardiovascular home fitness equipment, WW® WeightWatchers, Noom weight loss program, registration costs for Jenny Craig, aerobics, Pilates, yoga classes and more). |  | \$150 individual<br>\$150 family                         |
| Oh Baby!, a program that provides prenatal vitamins, a convertible toddler car seat, electric breast pump and other “little extras” for expectant parents—all at no additional cost.                                                                                                                                                             |  | Included                                                 |
| Fallon’s cost transparency tool                                                                                                                                                                                                                                                                                                                  |  | Included                                                 |
| Free 24/7 nurse call line                                                                                                                                                                                                                                                                                                                        |  | Included                                                 |
| Free chronic care management                                                                                                                                                                                                                                                                                                                     |  | Included                                                 |
| Free stop-smoking program                                                                                                                                                                                                                                                                                                                        |  | Included                                                 |
| Free online access to health and wellness encyclopedia                                                                                                                                                                                                                                                                                           |  | Included                                                 |

## Exclusions

Hearing aids and the evaluation for a hearing aid (for age 22 and above)  
Long-term rehabilitative services  
Cosmetic surgery  
Experimental procedures or services that are not generally accepted medical practice  
Dental services not described in your *Schedule of Benefits*  
Routine foot care except when the care is medically necessary for members with systemic circulatory disease  
Custodial confinement

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**Some services may require prior authorization.** A complete list of benefits and exclusions is in the Fallon Health Community Care *Member Handbook/Evidence of Coverage*, available by request. This is only a summary of benefits and exclusions.

## Questions?

If you have any questions, please contact Fallon Health Customer Service at 1-800-868-5200 (TTY users, please call TRS Relay 711), or visit our website at [fallonhealth.org](http://fallonhealth.org).



This health plan meets minimum creditable coverage standards and will satisfy the individual mandate that you have health insurance. As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years and older, must have health coverage that meets the minimum creditable coverage standards set by the Commonwealth Health Insurance Connector.

*Benefits may vary by employer group.*

*Noom® products such as Noom Med and weight loss medications are not eligible for reimbursement.*

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