Preferred Care QHD 2000 HSA

Benefit Summary—*Benefits effective January 1, 2020*

The Fallon Health difference

With Fallon Preferred Care, you get everything you need to live a healthy life. This plan features comprehensive medical benefits for lower monthly premiums and slightly higher out-of-pocket expenses compared to our other plans. Your monthly premiums are reduced further through the use of an annual deductible. Plus, you get:

- **A fitness reimbursement: It Fits!,** an annual benefit period fitness reimbursement including school and town sports programs, gym memberships, home fitness equipment, Weight Watchers®, aerobics, Pilates and yoga classes!
- **$0 copayments for routine physical exams** and other preventive services, including mammograms, cholesterol screenings and immunizations.
- **$0 copayments for routine annual eye exams.**
- **Nurse Connect:** A free 24/7 nurse call line.
- **Teladoc™ telemedicine:** Commercial members get 24/7 access to a national network of U.S. board-certified doctors to discuss non-emergency conditions by phone, mobile device or online. Doctors can diagnose and treat over fifty types of common illnesses.

How to receive care:
With Fallon Preferred Care, you have an extensive regional and national network of providers from which to choose. The Fallon Preferred Care network is comprised of over 1,000,000 network providers—giving you the flexibility to receive care close to where you live and work.

In-network and out-of-network coverage
Fallon Preferred Care is a preferred provider organization (PPO) plan, and as such, we contract with a network of participating providers who have agreed to provide health care services to our members—your use of participating providers is strictly voluntary.

When you obtain covered services from participating providers, you will receive the in-network level of benefits. We pay participating providers directly; you will not have to file claims when you use participating providers. When you obtain covered services from nonparticipating providers, you get the out-of-network level of benefits. You may need to submit a claim for covered services you receive from nonparticipating providers. For information on claims submission, refer to your Fallon Preferred Care *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 Fallon Preferred Care *Evidence of Coverage.*

Plan specifics	Your cost in-network	Your cost out-of-network (after your deductible)
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	$4,000 individual $8,000 family
Embedded deductible Please note that once any one member in a family accumulates $2,800 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.	$2,800	$5,600
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.	Not Included	
Out-of-pocket maximum The out-of-pocket maximum is the total amount of deductible, copayments and coinsurance you are responsible for in a benefit period. The out-of-pocket maximum also does not include your premium charge or any amounts you pay for services that are not covered by the plan.	$6,900 individual $13,800 family	$6,900 individual $13,800 family
Coinsurance Coinsurance is the percentage of medical expense you are required to pay after the deductible amount is satisfied.	n/a	20%
Penalty for failure to follow medical management procedures*	**$200 per occurrence**	**$500 per occurrence**

Benefits	Your cost in-network	Your cost out-of-network (after your deductible)
Office		
Routine physical exams	$0	20% coinsurance
Office visits (primary care provider)	$25 per visit after deductible	20% coinsurance
Office visits (specialist)	$40 per visit after deductible	20% coinsurance
Office visits (limited service clinics, e.g., Minute Clinic)	$25 per visit after deductible	20% coinsurance
Routine eye exams (one every 12 months)	$0	20% coinsurance
Telemedicine via Teladoc™ (24/7 access to doctors to discuss non-emergency conditions by phone, mobile app or online)	$5 copayment after deductible	
Short-term rehabilitative services (60 visits combined in- and out-of-network per benefit period)	$25 per visit after deductible	20% coinsurance

** Some services require plan notification or prior authorization. A penalty will be applied for failure to follow the plan's medical management procedures. The penalty does not apply toward the deductible or out-of-pocket maximum.*

Benefits	Your cost in-network	Your cost out-of-network (after your deductible)
Office		
Prenatal care	$25 first visit only	20% coinsurance
Preventive services Tests, immunizations and services to help screen for diseases and improve early detection when symptoms or diagnosis are not present	Covered in full	20% coinsurance
Diagnostic lab services Tests and services that are intended to diagnose or check the status of a disease or condition	Covered in full after deductible	20% coinsurance
Diagnostic x-ray services Tests and services that are intended to diagnose, check the status of, or treat a disease or condition	Covered in full after deductible	20% coinsurance
Diagnostic other (EKG, ultrasound, colonoscopy, etc.) Tests and services that are intended to diagnose, check the status of, or treat a disease or condition	Covered in full after deductible	20% coinsurance
Imaging (CAT, PET, MRI, nuclear cardiology)	$250 per visit after deductible	20% coinsurance
Chiropractic care (12 visits per benefit period)	$25 per visit after deductible	20% coinsurance
Prescriptions	**Tier 1/Tier 2/Tier 3/Tier 4**	
Prescription drugs, insulin and insulin syringes	$5AD/$30AD/$100AD/$200AD (30-day supply)	20% coinsurance
Generic contraceptives and contraceptive devices	$0 (30-day supply)	20% coinsurance
Brand contraceptives with no generic equivalent (prior authorization required)	With prior authorization: $0 (30-day supply)	20% coinsurance
Brand contraceptives with a generic equivalent (prior authorization required)	Tier 3: $100AD Tier 4: $200AD (30-day supply)	20% coinsurance
Prescription medication refills obtained through the mail order program	$10AD/$60AD/$200AD/$600AD (90-day supply)	20% coinsurance
Generic prescription omeprazole, generic prescription lansoprazole, and generic and brand OTC esomeprazole (Nexium)	$5 AD	20% coinsurance
Inpatient hospital services		
Room and board in a semiprivate room (private when medically necessary)	$200 copayment after deductible	20% coinsurance
Physicians' and surgeons' services	Covered in full after deductible	20% coinsurance
Physical and respiratory therapy	Covered in full after deductible	20% coinsurance
Intensive care services	Covered in full after deductible	20% coinsurance
Maternity care	Covered in full after deductible	20% coinsurance

Benefits	Your cost in-network	Your cost out-of-network (after your deductible)
Same-day surgery		
Same-day surgery in a hospital outpatient or ambulatory care setting	$100 copayment after deductible	20% coinsurance
Emergencies		
Emergency room visit	$250 copayment after deductible (waived if admitted)	
Skilled nursing		
Skilled care in a semiprivate room	$200 copayment after deductible	20% coinsurance
Substance abuse		
Office visits	$25 per visit after deductible	20% coinsurance
Detoxification in an inpatient setting	$200 copayment after deductible	20% coinsurance
Rehabilitation in an inpatient setting	$200 copayment after deductible	20% coinsurance
Mental health		
Office visits	$25 per visit after deductible	20% coinsurance
Services in a general or psychiatric hospital	$200 copayment after deductible	20% coinsurance
Other health services		
Skilled home health care services	Covered in full after deductible	20% coinsurance
Durable medical equipment	30% coinsurance after deductible	30% coinsurance
Medically necessary ambulance services	Covered in full after deductible	Covered in full after deductible
Value-added benefits and features		
It Fits!, an annual fitness reimbursement (including school and town sports programs, gym memberships, new cardiovascular home fitness equipment, Weight Watchers®, aerobics, Pilates and yoga classes)		$150 individual $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
The Healthy Health Plan! a program that supports members (subscriber and spouse age 18 and older) in becoming, and staying, healthy. Simply fill out the health assessment, receive a personalized health report and then take advantage of all the tools available, including health coaching, to help you reach your health goals.		Included
Fallon SmartShopper cost transparency tool and Incentive program		Included
Free 24/7 nurse call line		Included

Benefits	
Value-added benefits and features (continued)	
Free chronic care management	Included
Free stop-smoking program	Included
Member discount program	Included
Free online access to health and wellness encyclopedia	Included
20% discount on more than 1,500 CVS/pharmacy- brand health related items.	Included

Exclusions

Dental benefits and discounts, other than those listed in the *Schedule of Benefits*
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
Routine foot care
Custodial confinement

A complete list of benefits and exclusions is in the Fallon Preferred Care 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's Customer Service at 1-888-468-1541 (TTY users, please call TRS Relay 711), or visit our website at 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.
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