



Fallon Health Copay Plan Options

Benefits effective January 1, 2019 and beyond.

Benefit	Copay 500	Copay 1000 Hybrid
Office visits—routine exams	\$0	\$0
Office visits—other primary care	\$15	\$10
Office visits—specialty care	\$30	\$20
Telehealth	\$5	\$5
Prescriptions retail (up to a 30-day supply)	\$5/\$15/\$30/\$60	\$5/\$10/\$40/\$250
Prescriptions—mail order (up to a 90-day supply)	\$10/\$30/\$60/\$180	\$10/\$20/\$80/\$750
Emergency room (waived if admitted)	\$150	\$250
Inpatient hospital	\$500	\$1,000
Same-day surgery	\$250	\$1,000
ART services (IVF, GIFT, ZIFT)	\$250	\$250
Preventive services*	Covered in full	Covered in full
Diagnostic services (Lab)*	Covered in full	Covered in full
Diagnostic services (non-lab) X-ray/Imaging	Covered in full	Covered in full
Imaging (CAT, PET, MRI scans, nuclear cardiology)	\$100	\$500
Durable medical equipment (unlimited)	30% coinsurance	20% coinsurance
Physical/occupational/speech therapy	\$20	\$20
Cardiac rehab	\$0	\$0
Physical/occupational/speech therapy (Autism services)	\$15	\$10
Chiropractic care	\$20	\$20
Pediatric dental	Included	Included
Pediatric vision	Included	Included
Deductible (ind./fam.)	Not applicable	Not applicable
Out-of-pocket maximum (ind./fam.)	\$4,000/\$8,000	\$4,500/\$9,000

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Fallon Health Classic Deductible HMO Plan Options

Benefits effective January 1, 2019 and beyond.

Benefit	Deductible 1000 Classic	Deductible 1500 Classic	Deductible 2000 Classic	Deductible 3000 Classic
Office visits—routine exams	\$0	\$0	\$0	\$0
Office visits—other primary care	\$15	\$25	\$25	\$25
Office visits—specialty care	\$25	\$45	\$45	\$45
Telehealth	\$5	\$5	\$5	\$5
Prescriptions retail (up to a 30-day supply)	\$5/\$15/\$30/\$50	\$5/\$25/\$55/\$75	\$5/\$25/\$55/\$75	\$5/\$25/\$55/\$75
Prescriptions—mail order (up to a 90-day supply)	\$10/\$30/\$60/\$150	\$10/\$50/\$110/\$225	\$10/\$50/\$110/\$225	\$10/\$50/\$110/\$225
Emergency room (waived if admitted)	\$150	\$325	\$325	\$325
Inpatient hospital	\$125 after deductible	\$125 after deductible	\$125 after deductible	\$125 after deductible
Same-day surgery	\$50 after deductible	\$75 after deductible	\$75 after deductible	\$75 after deductible
ART services (IVF, GIFT, ZIFT)	\$50 after deductible	\$75 after deductible	\$75 after deductible	\$75 after deductible
Preventive services*	Covered in full	Covered in full	Covered in full	Covered in full
Diagnostic services (Lab)*	Covered in full	Covered in full	Covered in full	Covered in full
Diagnostic services (non-lab) X-ray/Imaging	Deductible	Deductible	Deductible	Deductible
Imaging (CAT, PET, MRI scans, nuclear cardiology)	Deductible	Deductible	Deductible	Deductible
Durable medical equipment (unlimited)	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Physical/occupational/speech therapy (Cardiac rehab)	\$15 after deductible	\$25 after deductible	\$25 after deductible	\$25 after deductible
Physical/occupational/speech therapy (Autism services)	\$15	\$25	\$25	\$25
Chiropractic care	\$15	\$25	\$25	\$25
Pediatric dental	Included	Included	Included	Included
Pediatric vision	Included	Included	Included	Included
Deductible (ind./fam.)	\$1,000/2,000	\$1,500/3,000	\$2,000/4,000	\$3,000/6,000
Out-of-pocket maximum (ind./fam.)	\$7,900/\$15,800	\$7,900/\$15,800	\$7,900/\$15,800	\$7,900/\$15,800

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Fallon Health Coinsurance and Deductible Plan Options

Benefits effective for January 1, 2019 and beyond.

Benefit	Coinsurance 35%	Deductible 2000 Low	Bronze Deductible 3000
Office visits—routine exams	\$0	\$0	\$0
Office visits—other primary care	\$40	\$40	\$60 after deductible
Office visits—specialty care	\$70	\$65	\$75 after deductible
Telehealth	\$5	\$5	\$5 after deductible
Prescriptions retail (up to a 30-day supply)	\$5/\$40/\$70/\$150	\$5/\$30/\$65/\$100	\$5/\$40/\$100/\$250
Prescriptions—mail order (up to a 90-day supply)	\$10/\$80/\$140/\$450	\$10/\$60/\$130/\$300	\$10/\$80/\$200/\$750
Emergency room (waived if admitted)	35% coinsurance after deductible	\$700 after deductible	\$1,000 after deductible
Inpatient hospital	35% coinsurance after deductible	\$1,000 after deductible	\$1,000 after deductible
Same-day surgery	35% coinsurance after deductible	\$1,000 after deductible	\$1,000 after deductible
ART services (IVF, GIFT, ZIFT)	\$250 after deductible	\$250 after deductible	\$250 after deductible
Preventive services*	Covered in full	Covered in full	Covered in full
Diagnostic services (Lab)*	35% coinsurance after deductible	\$50 after deductible	\$50 after deductible
Diagnostic services (non-lab) X-ray/ Imaging	35% coinsurance after deductible	\$100 after deductible	\$200 after deductible
Imaging (CAT, PET, MRI scans, nuclear cardiology)	\$350 after deductible	\$700 after deductible	\$1,000 after deductible
Durable medical equipment (unlimited)	35% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Physical/occupational/speech therapy (Cardiac rehab)	\$40 after deductible	\$40 after deductible	\$75 after deductible
Physical/occupational/speech therapy (Autism services)	\$40	\$40	\$60
Chiropractic care	\$40	\$40	\$60
Pediatric dental	Included	Included	Included
Pediatric vision	Included	Included	Included
Deductible (ind./fam.)	\$2,000/\$4,000	\$2,000/4,000	\$3,000/6,000
Out-of-pocket maximum (ind./fam.)	\$7,900/\$15,800	\$7,900/\$15,800	\$7,900/\$15,800

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Fallon Health Qualified High Deductible HSA HMO Plan Options

Benefits effective January 1, 2019 and beyond.

Benefit	QHD 2000 HSA	QHD 3000 HSA
Office visits—routine exams	\$0	\$0
Office visits—other primary care	\$25 after deductible	\$25 after deductible
Office visits—specialty care	\$40 after deductible	\$40 after deductible
Telehealth	\$5 after deductible	\$5 after deductible
Prescriptions retail (up to a 30-day supply)	\$5/\$30/\$100/50% coinsurance after deductible	\$5/\$30/\$100/50% coinsurance after deductible
Prescriptions—mail order (up to a 90-day supply)	\$10/\$60/\$200/50% coinsurance after deductible	\$10/\$60/\$200/50% coinsurance after deductible
Emergency room (waived if admitted)	\$250 after deductible	\$250 after deductible
Inpatient hospital	Deductible	Deductible
Same-day surgery	Deductible	Deductible
ART services (IVG, GIFT, ZIFT)	Deductible	Deductible
Preventive services*	Covered in full	Covered in full
Diagnostic services (Lab)*	Deductible	Deductible
Diagnostic services (non-lab) X-ray/Imaging	Deductible	Deductible
Imaging (CAT, PET, MRI scans, nuclear cardiology)	\$250 after deductible	\$250 after deductible
Durable medical equipment (unlimited)	30% coinsurance after deductible	30% coinsurance after deductible
Physical/occupational/speech therapy (Cardiac rehab)	\$25 after deductible	\$25 after deductible
Physical/occupational/speech therapy (Autism services)	\$25 after deductible	\$25 after deductible
Chiropractic care	\$25 after deductible	\$25 after deductible
Pediatric dental	Included	Included
Pediatric vision	Included	Included
Deductible (ind./fam.)	\$2,000/\$4,000	\$3,000/\$6,000
Out-of-pocket maximum (ind./fam.)	\$6,700/\$13,400	\$6,700/\$13,400

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Fallon Preferred Care PPO Plan Options

Benefits effective January 1, 2019, and beyond.

Benefit	Deductible 2000 Low	QHD 2000 HSA
Office visits—primary care provider/specialist	\$40/\$65	\$25 after deductible/ \$40 after deductible
Telehealth	\$5	\$5 after deductible
Prescriptions—retail (up to a 30-day supply)	\$5/\$30/\$65/\$100	\$5/\$30/\$100/50% coinsurance after deductible
Prescriptions—mail-order (up to a 90-day supply)	\$10/\$60/\$130/\$300	\$10/\$60/\$200/50% coinsurance after deductible
Emergency room (waived if admitted)	\$700 after deductible	\$250 after deductible
Inpatient hospital	\$1,000 after deductible	Deductible
Same-day surgery	\$1,000 after deductible	Deductible
ART Services (IVG, GIFT, ZIFT)	\$250 after deductible	Deductible
Preventive services*	Covered in full	Covered in full
Diagnostic services (Lab services)*	\$50 after deductible	Deductible
Diagnostic services (non-lab) X-ray/Imaging*	\$100 after deductible	Deductible
Imaging (CAT, PET, MRI scans, nuclear cardiology)	\$700 after deductible	\$250 after deductible
Durable medical equipment (unlimited)	30% coinsurance after deductible	30% coinsurance after deductible
Physical/occupational/speech therapy (Cardiac rehab)	\$40 after deductible	\$25 after deductible
Physical/occupational/speech therapy (Autism services)	\$40	\$25 after deductible
Chiropractic care	\$40	\$25 after deductible
Pediatric dental	Included	Included
Pediatric vision	Included	Included
Deductible: In-network/out-of-network	In: \$2,000/\$4,000 Out: \$4,000/\$8,000	In: \$2,000/\$4,000 Out: \$4,000/\$8,000
Out-of-pocket maximum: In-network/out-of-network	In: \$7,900/\$15,800 Out: \$7,900/\$15,800	In: \$6,700/\$13,400 Out: \$6,700/\$13,400
Out of network	20% coinsurance after deductible	20% coinsurance after deductible

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Fallon Health Deductible Hybrid HMO Plan Options

Benefits effective January 1, 2019 and beyond.

Benefit	Deductible 1250 Hybrid	Deductible 2000 Hybrid	Deductible 2500 Hybrid	Deductible 3000 Hybrid
Office visits—routine exams	\$0	\$0	\$0	\$0
Office visits—other primary care	\$10	\$10	\$10	\$15
Office visits—specialty care	\$20	\$20	\$20	\$25
Telehealth	\$5	\$5	\$5	\$5
Prescriptions retail (up to a 30-day supply)	\$5/\$10/\$40/\$250	\$5/\$10/\$40/\$250	\$5/\$15/\$40/\$250	\$5/\$15/\$50/\$250
Prescriptions—mail order (up to a 90-day supply)	\$10/\$20/\$80/\$750	\$10/\$20/\$80/\$750	\$10/\$30/\$80/\$750	\$10/\$30/\$100/\$750
Emergency room (waived if admitted)	\$500	\$500	\$500	\$500
Inpatient hospital	\$1,000 after deductible	\$1,000 after deductible	\$1,000 after deductible	\$1,000 after deductible
Same-day surgery	\$1,000 after deductible	\$1,000 after deductible	\$1,000 after deductible	\$1,000 after deductible
ART services (IVF, GIFT, ZIFT)	\$250 after deductible	\$250 after deductible	\$250 after deductible	\$250 after deductible
Preventive services*	Covered in full	Covered in full	Covered in full	Covered in full
Diagnostic services (Lab)*	Covered in full	Covered in full	Covered in full	Covered in full
Diagnostic services (non-lab) X-ray/Imaging	\$20	\$20	\$20	\$25
Imaging (CAT, PET, MRI scans, nuclear cardiology)	\$500 after deductible	\$500 after deductible	\$500 after deductible	\$500 after deductible
Durable medical equipment (unlimited)	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Physical/occupational/speech therapy	\$20	\$20	\$20	\$25
Cardiac rehab	\$20	\$20	\$20	\$25
Physical/occupational/speech therapy (Autism services)	\$10	\$10	\$10	\$15
Chiropractic care	\$20	\$20	\$20	\$25
Pediatric dental	Included	Included	Included	Included
Pediatric vision	Included	Included	Included	Included
Deductible (ind./fam.)	\$1,250/\$2,500	\$2,000/\$4,000	\$2,500/\$5,000	\$3,000/\$6,000
Out-of-pocket maximum (ind./fam.)	\$7,900/\$15,800	\$7,900/\$15,800	\$7,900/\$15,800	\$7,900/\$15,800

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