The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-344-4442 or visit www.fallonhealth.org/gic. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.fallonhealth.org/gic or call 1-866-344-4442 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$500 person/$1,000 family. Doesn't apply to preventive care.</td>
<td>Generally you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on this plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive care and primary care services are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes. $100 person/$200 family for prescription drug coverage. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>For in-network providers: $5,000/person or / $10,000/family.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billed charges, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.fallonhealth.org/gic">www.fallonhealth.org/gic</a> or call 1-866-344-4442 for a list of participating providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Important Questions</td>
<td>Answers</td>
<td>Why This Matters:</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------</td>
<td>------------------</td>
</tr>
<tr>
<td>Do you need a <strong>referral</strong> to see a <strong>specialist</strong>?</td>
<td>Yes. Your Primary Care Provider can provide you with a copy of the <strong>referral</strong> form when you need to see a <strong>specialist</strong>.</td>
<td>This plan will pay some or all of the costs to see a <strong>specialist</strong> for covered services but only if you have a <strong>referral</strong> from your PCP before you see the <strong>specialist</strong>.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are either before or after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least): $20 copay/visit</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Tier 1: $30 copay/visit; Tier 2: $60 copay/visit; Tier 3: $75 copay/visit</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
|                       | Imaging (CT/PET scans, MRIs) | $100 copay/test then deductible | Limited to one copay per day when performed at the same facility for the same diagnosis. Referral and preauthorization required for certain covered services.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1</td>
<td>$10 copay/prescription (retail and emergency); $25 copay/prescription (mail order) after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>$30 copay/prescription (retail and emergency); $75 copay/prescription (mail order) after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>$65 copay/prescription (retail and emergency); $165 copay/prescription (mail order) after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Tier 4</td>
<td>SPECIALTY DRUGS: Limited to a 30-day supply with appropriate tier copay (see above) when purchased at a designated specialty pharmacy.</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$250 copay/surgery then deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td><strong>Emergency room care</strong></td>
<td>$100 copay/visit then deductible</td>
<td>$100 copay/visit then deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency medical transportation</strong></td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Urgent care</strong></td>
<td>$20 copay/visit</td>
<td>$20 copay/visit</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>Tier 1: $275 copay; Tier 2: $500 copay; Tier 3: $1,500 copay then deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$20 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>Tier 1: $15 copay; Tier 2: $20 copay; Tier 3: $30 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>See childbirth/delivery facility services.</td>
<td>See childbirth/delivery facility services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>Tier 1: $275 copay; Tier 2: $500 copay; Tier 3: $1,500 copay/admission then deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover** (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care

**Other Covered Services** (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion Services
- Bariatric Surgery
- Chiropractic Care (limited to 12 visits per benefit year)
- Hearing Aids
- Infertility Treatment
- Routine Eye Care (Adult)
- Weight Loss Programs

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
</tbody>
</table>

#### If you need help recovering or have other special health needs

- **Home health care**
  - Deductible
  - Not covered
  - Referral and preauthorization required for certain covered services.

- **Rehabilitation services**
  - $20 copay/visit in an office
  - Not covered
  - Prior authorization required after 90 days for short-term physical and occupational therapy.

- **Habilitation services**
  - $20 copay/visit in an office
  - Not covered
  - Early intervention services covered for children from birth to age 3 with no copayment. Referral and preauthorization required for certain covered services.

- **Skilled nursing care**
  - Deductible
  - Not covered
  - Up to 100 days per year. Referral and preauthorization required for certain covered services.

- **Durable medical equipment**
  - 20% coinsurance after deductible
  - Not covered
  - Referral and preauthorization required for certain covered services.

- **Hospice services**
  - No charge
  - Not covered
  - Referral required.

#### If your child needs dental or eye care

- **Children's eye exam**
  - $20 copay/visit
  - Not covered
  - Routine eye exams are limited to one per 24 month period.

- **Children's glasses**
  - Not covered
  - Not covered
  - None

- **Children's dental check-up**
  - Not covered
  - Not covered
  - None
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information, contact the insurer at 1-800-868-5200. You may also contact your state insurance department at Massachusetts Division of Insurance Consumer Service Section 1-877-563-4467. The U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact your state insurance department at Massachusetts Division of Insurance Consumer Service Section 1-877-563-4467. Contact Health Care for All, One Federal St., Boston, MA 02110, 1-617-350-7279, www.massconsumerassistance.org. Group members may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

Does this plan provide Minimum Essential Coverage? Yes
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage.

Does this plan meet Minimum Value Standards? Yes
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: **$500**
- PCP: **$20**
- Specialist: **$30**
- Hospital Stay: **$275**

This EXAMPLE event includes services like:
- Specialist office visits *(prenatal care)*
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests *(ultrasounds and blood work)*
- Specialist visit *(anesthesia)*

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$16,780</th>
</tr>
</thead>
</table>

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$320</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: **$80**

**The total Peg would pay is**
- **$400**

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: **$500**
- PCP: **$20**
- Specialist: **$30**
- Durable Medical Equipment: **20%**

This EXAMPLE event includes services like:
- Primary care physician office visits *(including disease education)*
- Diagnostic tests *(blood work)*
- Prescription drugs
- Durable medical equipment *(glucose meter)*

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$7,360</th>
</tr>
</thead>
</table>

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$150</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,070</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: **$60**

**The total Joe would pay is**
- **$1,280**

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: **$500**
- PCP: **$20**
- Specialist: **$30**
- Emergency Room: **$100**

This EXAMPLE event includes services like:
- Emergency room care *(including medical supplies)*
- Diagnostic test *(x-ray)*
- Durable medical equipment *(crutches)*
- Rehabilitation services *(physical therapy)*

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$2,670</th>
</tr>
</thead>
</table>

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$510</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$20</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: **$0**

**The total Mia would pay is**
- **$1,030**

The plan would be responsible for the other costs of these EXAMPLE covered services.
Important!

If you, or someone you’re helping, has questions about Fallon Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-868-5200.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas sobre Fallon Health, usted tiene el derecho de obtener ayuda y información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-868-5200.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Fallon Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-868-5200.

Chinese: 如果您或您正在帮助的某人有关Fallon Health的问题，您有权获得语言无障碍的帮助和信息。如需与译员通话，请拨打1-800-868-5200。

Russian: Если вы или кто-то, кого вы помогаете, имеет вопросы о Fallon Health, у вас есть право получать помощь и информацию на вашем естественном языке бесплатно. Чтобы позвонить переводчику, звоните по номеру 1-800-868-5200.

Arabic: إذا كان لديك أسئلة عن Fallon Health، فإنك ملتزم بالحصول على المعلومة والمفادة باللغة الأم مجانًا. لتحدث إلى перевод، اتصل ب1-800-868-5200.

Haitian Creole: Si oumen m ase sa yon moun w ap ede gen kesyon konsènan Fallon Health, se dwa w li pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-868-5200.

Vietnamese: Nếu bạn hoặc ai ai người bạn đang giúp đỡ có thắc mắc về Fallon Health, bạn có quyền nhận thông tin, hỗ trợ bằng ngôn ngữ của mình mà không phải trả phí. Để nói chuyện với một phiên dịch viên, gọi 1-800-868-5200.

Khmer/Cambodian: If you or someone you’re helping, has questions about Fallon Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-868-5200.
French:
Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de Fallon Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-868-5200.

Italian:
Se tu o qualcuno che stai aiutando avete domande su Fallon Health, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-868-5200.
Notice of nondiscrimination

Fallon Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Fallon does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Fallon does not discriminate on the basis of race, color, national origin, age, disability or sex.

If you believe that Fallon Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Compliance Director
Fallon Health
10 Chestnut St.
Worcester, MA 01608
Phone: 1-508-368-9382 (TRS 711)
Email: compliance@fallonhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance,

Email: compliance@fallonhealth.org
Phone: 1-508-368-9382 (TRS 711)

With: Fallon Health

If you need these services, contact Customer Service at the phone number on the back of your member ID card, or by email at cs@fallonhealth.org.

Provided free language services to people whose primary language is not English, such as:

- Written information in other languages
- Qualified interpreters

Provided free aids and services to people with disabilities to communicate effectively

Fallon Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.