## Important Questions and Answers

### What is the overall deductible?

- **Answers:** $2,000 person/$4,000 family. Doesn’t apply to preventive care.

**Why This Matters:** Generally you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you elect individual coverage, you must meet the individual coverage deductible amount. If you have family coverage, family members must meet their own individual minimum annual deductible of $2,700 as defined by the IRS guidelines until the family deductible has been met.

### Are there services covered before you meet your deductible?

- **Answers:** Yes. Preventive care is covered before you meet your deductible.

**Why This Matters:** This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply.

### Are there other deductibles for specific services?

- **Answers:** No.

**Why This Matters:** You don’t have to meet deductibles for specific services.

### What is the out-of-pocket limit for this plan?

- **Answers:** For covered services with in-network providers: $6,700/person or $13,400/family.

**Why This Matters:** 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.

### What is not included in the out-of-pocket limit?

- **Answers:** Premiums, balance-billed charges, and health care this plan doesn’t cover.

**Why This Matters:** Even though you pay these expenses, they don’t count toward the out-of-pocket limit.

### Will you pay less if you use a network provider?

- **Answers:** Yes. See www.fallonhealth.org/plandocs or call 1-800-868-5200 for a list of participating providers.

**Why This Matters:** 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 network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

### Do you need a referral to see a specialist?

- **Answers:** Yes.

**Why This Matters:** This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.
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>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 co-pay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 co-pay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab Services $50 co-pay after deductible, Non Lab Services $50 co-pay after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$250 co-pay/test after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1</td>
<td>$25 co-pay/prescription (retail and emergency); $50 co-pay/prescription (mail order) after deductible</td>
<td>Retail covers up to a 30-day supply; Emergency services covers up to a 14-day supply; Mail order covers up to a 90 day supply.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.fallonhealth.org">www.fallonhealth.org</a></td>
<td>Tier 2</td>
<td>$50 co-pay/prescription (retail and emergency); $100 co-pay/prescription (mail order) after deductible</td>
<td>Retail covers up to a 30-day supply; Emergency services covers up to a 14-day supply; Mail order covers up to a 90 day supply.</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>$100 co-pay/prescription (retail and emergency); $300 co-pay/prescription (mail order) after deductible</td>
<td>Retail covers up to a 30-day supply; Emergency services covers up to a 14-day supply; Mail order covers up to a 90 day supply.</td>
</tr>
<tr>
<td></td>
<td>Tier 4</td>
<td>$100 co-pay/prescription (retail and emergency); $300 co-pay/prescription (mail order) after deductible</td>
<td>Retail covers up to a 30-day supply; Emergency services covers up to a 14-day supply; Mail order covers up to a 90 day supply.</td>
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<td>--------------------------------------</td>
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<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$250 co-pay/surgery after 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>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$250 co-pay/visit after deductible</td>
<td>$250 co-pay/visit after deductible</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 co-pay/visit after deductible</td>
<td>$50 co-pay/visit after deductible</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$500 co-pay/admission after 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>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$25 co-pay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$25 co-pay/visit</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>$500 co-pay/admission after deductible</td>
<td>Not covered</td>
</tr>
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<td>Out-of-Network Provider</td>
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<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>Home health care</td>
<td>Deductible</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$50 co-pay/visit in an office after deductible</td>
<td>Not covered</td>
<td>Short-term physical and occupational therapy limited to 60 visits combined per year. Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$25 co-pay/visit in an office after deductible</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>$500 co-pay/admission after deductible</td>
<td>Not covered</td>
<td>Up to 100 days per year. Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance after deductible</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>Deductible</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>Children's eye exam</td>
<td>No charge</td>
<td>Not covered</td>
<td>Routine eye exams are limited to one per 12 month period.</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>No charge</td>
<td>Not covered</td>
<td>One designated set, once per calendar year.</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Deductible</td>
<td>Not covered</td>
<td>Dental check ups are limited to two per 12 month period.</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)
- Hearing Aids (over the age of 21)
- 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
- Chiropractic Care
- Bariatric Surgery
- Routine Eye Care (Adult)
- Infertility Treatment
- Weight Loss Programs

Your Rights to Continue Coverage:
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:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-868-5200.
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.

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

- The plan's overall deductible: $2,000
- PCP: $25
- Specialist: $50
- Hospital Stay: $500

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)

**Total Example Cost**: $16,780

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$540</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn't covered</strong></td>
<td>$80</td>
</tr>
</tbody>
</table>

**The total Peg would pay is**: $2,620

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

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

- The plan's overall deductible: $2,000
- PCP: $25
- Specialist: $50
- 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)

**Total Example Cost**: $7,360

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,190</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn't covered</strong></td>
<td>$60</td>
</tr>
</tbody>
</table>

**The total Joe would pay is**: $3,250

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

- The plan's overall deductible: $2,000
- PCP: $25
- Specialist: $50
- Emergency Room: $250
- Durable Medical Equipment: 20%

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

**Total Example Cost**: $2,670

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$350</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn't covered</strong></td>
<td>$0</td>
</tr>
</tbody>
</table>

**The total Mia would pay is**: $2,350

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, tiene derecho a obtener ayuda e 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 assistência e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-868-5200.
French:

Si vous, ou quelqu'un que vous êtes en train d'aider, a 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.

Korean:

Fallon Health, you have the right to receive assistance and information in your language for free. To speak with an interpreter, call 1-800-868-5200.

Greek:

Si vous, ou quelqu'un que vous êtes en train d'aider, a 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.
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.

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Fallon Health:

- Provides free aids and services to people with disabilities to communicate effectively.
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Written information in other languages
  - Forms, other formats
  - Qualified sign language interpreters

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.

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)**

You can file a grievance in person or by mail, fax or email. If you need help filling a grievance, contact the Compliance Director.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available 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)**


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