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 1-800-868-5200 or visit www.fallonhealth.org/plandocs. 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/plandocs or call 1-800-868-5200 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$1,000 person/$2,000 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 the 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>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>For covered services with in-network providers: $7,900/person or $15,800/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/plandocs">www.fallonhealth.org/plandocs</a> or call 1-800-868-5200 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><strong>Do you need a referral to see a specialist?</strong></td>
<td>Yes.</td>
<td>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.</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&lt;br&gt;Specialist visit&lt;br&gt;Preventive care/ screening/immunization</td>
<td>Network Provider (You will pay the least)&lt;br&gt;$25 co-pay/visit&lt;br&gt;$40 co-pay/visit&lt;br&gt;No charge</td>
<td>Out-of-Network Provider (You will pay the most)&lt;br&gt;Not covered&lt;br&gt;Not covered&lt;br&gt;Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)&lt;br&gt;Imaging (CT/PET scans, MRIs)</td>
<td>Lab Services $25 co-pay, Non Lab Services $50 co-pay after deductible&lt;br&gt;Deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1&lt;br&gt;$5 copay/ prescription (retail and emergency); $10 copay/ prescription (mail order)</td>
<td>$5 copay/ prescription (emergency only)</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 2&lt;br&gt;$30 copay/ prescription (retail and emergency); $60 copay/ prescription (mail order)</td>
<td>$30 copay/ prescription (emergency only)</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&lt;br&gt;$70 copay/ prescription (retail and emergency); $140 copay/ prescription (mail order)</td>
<td>$70 copay/ prescription (emergency only)</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&lt;br&gt;$150 copay/ prescription (retail and emergency); $450 copay/ prescription (mail order)</td>
<td>$150 copay/ prescription (emergency only)</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>
</tbody>
</table>

More information about prescription drug coverage is available at www.fallonhealth.org
<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 have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Network Provider (You will pay the least) $150 co-pay/surgery after deductible</td>
<td>Out-of-Network Provider (You will pay the most) - Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Deductible</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$325 co-pay/visit</td>
<td>Copayment waived if admitted.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 co-pay/visit</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250 co-pay/admission after deductible</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Deductible</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance</td>
<td>Outpatient services</td>
<td>$25 co-pay/visit</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>abuse services</td>
<td>Inpatient services</td>
<td>No charge</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td></td>
<td>Office visits</td>
<td>$25 co-pay/visit</td>
<td>For prenatal care, you pay an office visit co-pay for your first visit only.</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>If you are pregnant</td>
<td>Childbirth/delivery facility services</td>
<td>$250 co-pay/admission after deductible</td>
<td>Referral and preauthorization required for certain covered services. Inpatient amount is inclusive of Childbirth/delivery professional services.</td>
</tr>
</tbody>
</table>
### Common Medical Event

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

<table>
<thead>
<tr>
<th>Service You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<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>$40 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>$40 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>$250 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>30% 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>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Service</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's eye exam</td>
<td>No charge</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>One designated set, once per calendar year.</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>No charge</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
- Routine Eye Care (Adult)
- Weight Loss Programs

**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
- Infertility Treatment
- Infertility Treatment
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:
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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe's type 2 Diabetes</th>
<th>Mia's Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(9 months of in-network pre-natal care and a hospital delivery)</strong></td>
<td><strong>(a year of routine in-network care of a well-controlled condition)</strong></td>
<td><strong>(in-network emergency room visit and follow up care)</strong></td>
</tr>
<tr>
<td><strong>The plan’s overall deductible.</strong></td>
<td><strong>The plan’s overall deductible.</strong></td>
<td><strong>The plan’s overall deductible.</strong></td>
</tr>
<tr>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>PCP</td>
<td>PCP</td>
<td>PCP</td>
</tr>
<tr>
<td>$25</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td>Specialist</td>
<td>Specialist</td>
<td>Specialist</td>
</tr>
<tr>
<td>$40</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>Hospital Stay</td>
<td>Durable Medical Equipment</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>$250</td>
<td>30%</td>
<td>$325</td>
</tr>
<tr>
<td><strong>This EXAMPLE event includes services like:</strong></td>
<td><strong>This EXAMPLE event includes services like:</strong></td>
<td><strong>This EXAMPLE event includes services like:</strong></td>
</tr>
<tr>
<td>Specialist office visits (prenatal care)</td>
<td>Primary care physician office visits (including disease education)</td>
<td>Emergency room care (including medical supplies)</td>
</tr>
<tr>
<td>Childbirth/Delivery Professional Services</td>
<td>Diagnostic tests (blood work)</td>
<td>Diagnostic test (x-ray)</td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services</td>
<td>Prescription drugs</td>
<td>Durable medical equipment (crutches)</td>
</tr>
<tr>
<td>Diagnostic tests (ultrasounds and blood work)</td>
<td>Durable medical equipment (glucose meter)</td>
<td>Rehabilitation services (physical therapy)</td>
</tr>
<tr>
<td>Specialist visit (anesthesia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Example Cost</strong></td>
<td><strong>Total Example Cost</strong></td>
<td><strong>Total Example Cost</strong></td>
</tr>
<tr>
<td>$16,780</td>
<td>$7,360</td>
<td>$2,670</td>
</tr>
<tr>
<td><strong>In this example, Peg would pay:</strong></td>
<td><strong>In this example, Joe would pay:</strong></td>
<td><strong>In this example, Mia would pay:</strong></td>
</tr>
<tr>
<td><strong>Cost Sharing</strong></td>
<td><strong>Cost Sharing</strong></td>
<td><strong>Cost Sharing</strong></td>
</tr>
<tr>
<td>Deductibles</td>
<td>Deductibles</td>
<td>Deductibles</td>
</tr>
<tr>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>Copayments</td>
<td>Copayments</td>
</tr>
<tr>
<td>$70</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Coinsurance</td>
<td>Coinsurance</td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>What isn’t covered</strong></td>
<td><strong>What isn’t covered</strong></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>Limits or exclusions</td>
<td>Limits or exclusions</td>
</tr>
<tr>
<td>$80</td>
<td>$60</td>
<td>$0</td>
</tr>
<tr>
<td><strong>The total Peg would pay is</strong></td>
<td><strong>The total Joe would pay is</strong></td>
<td><strong>The total Mia would pay is</strong></td>
</tr>
<tr>
<td>$1,150</td>
<td>$1,560</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

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.
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.
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 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 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: written information in other languages, qualified interpreters, fax, TTY.
- Provides free language services to people whose primary language is not English, such as: written information in other languages, qualified interpreters, fax, TTY.

If you have questions or need further information, please 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)
Email: compliance@fallonhealth.org

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

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)
Email: compliance@fallonhealth.org