## Important Questions and Answers

### What is the overall deductible?

- **Answers:** $3,000 person/$6,000 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 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.

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

- **Answers:** Yes. Preventive care and primary care services are 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: $8,150/person or $16,300/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 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>Network Provider (You will pay the least): $60 co-pay/visit after deductible</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$75 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>
</tbody>
</table>

| If you have a test | Diagnostic test (x-ray, blood work) | Lab Services $50 co-pay after deductible, Non Lab Services $200 co-pay after deductible. | Not covered |
| Imaging (CT/PET scans, MRIs) | $1,000 co-pay/test after deductible | Not covered |

| If you need drugs to treat your illness or condition | Tier 1 | $5 copay/ prescription (retail and emergency); $10 copay/ prescription (mail order) | 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. |
| | Tier 2 | $40 copay/ prescription (retail and emergency); $80 copay/ prescription (mail order) | 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. |
| | Tier 3 | $100 copay/ prescription (retail and emergency); $200 copay/ prescription (mail order) | 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. |
| | Tier 4 | $250 copay/ prescription (retail and emergency); $750 copay/ prescription (mail order) | 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. |

You may have to pay for services that aren't **preventive**. Ask your **provider** if the services you need are preventive. Then check what your **plan** will pay for.

Limited to one payment per day when performed at the same facility for the same diagnosis. Referral and preauthorization required for certain covered services.

More information about **prescription drug coverage** is available at [www.fallonhealth.org](http://www.fallonhealth.org).
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Network Provider (You will pay the least): $1,000 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>Not covered</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>Emergency medical transportation</td>
<td>Urgent care</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$1,000 co-pay/visit after deductible</td>
<td>$1,000 co-pay/visit after deductible</td>
</tr>
<tr>
<td>Emergency room care</td>
<td>$1,000 co-pay/visit after deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>Deductible</td>
<td>Deductible</td>
<td>None</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$60 co-pay/visit after deductible</td>
<td>$60 co-pay/visit after deductible</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$1,000 co-pay/admission after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>Deductible</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$60 co-pay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>No charge</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>$60 co-pay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>See childbirth/delivery facility services.</td>
<td>See childbirth/delivery facility services.</td>
<td>See Childbirth/Delivery facility services</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>$1,000 co-pay/admission after deductible</td>
<td>Not covered</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

<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</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<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>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$75 co-pay/visit in an office after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$75 co-pay/visit in an office after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>$1,000 co-pay/admission after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>30% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hospice services</td>
<td>Deductible</td>
<td>Not covered</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**
  - $75 co-pay/visit in an office after deductible
  - Not covered
  - Short-term physical and occupational therapy limited to 60 visits combined per year. Referral and preauthorization required for certain covered services.

- **Habilitation services**
  - $75 co-pay/visit in an office after deductible
  - Not covered
  - Referral and preauthorization required for certain covered services.

- **Skilled nursing care**
  - $1,000 co-pay/admission after deductible
  - Not covered
  - Up to 100 days per year. Referral and preauthorization required for certain covered services.

- **Durable medical equipment**
  - 30% coinsurance after deductible
  - Not covered
  - Referral and preauthorization required for certain covered services.

- **Hospice services**
  - Deductible
  - Not covered
  - Referral and preauthorization required for certain covered services.

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

- **Children's eye exam**
  - No charge
  - Not covered
  - Routine eye exams are limited to one per 12 month period.

- **Children's glasses**
  - No charge
  - Not covered
  - One designated set, once per calendar year.

- **Children's dental check-up**
  - No charge
  - Not covered
  - Dental check ups are limited to two per 12 month period.

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**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
- Infertility Treatment
- Routine Eye Care (Adult)
- Weight Loss Programs
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>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>The plan's overall deductible.</td>
<td>The plan's overall deductible.</td>
<td>The plan's overall deductible.</td>
</tr>
<tr>
<td>$3,000</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>PCP</td>
<td>PCP</td>
<td>PCP</td>
</tr>
<tr>
<td>$60</td>
<td>$60</td>
<td>$60</td>
</tr>
<tr>
<td>Specialist</td>
<td>Specialist</td>
<td>Specialist</td>
</tr>
<tr>
<td>$75</td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td>Hospital Stay</td>
<td>Durable Medical Equipment</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>$1,000</td>
<td></td>
<td>$1,000</td>
</tr>
</tbody>
</table>

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*)

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*)

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>$16,780</th>
<th>$7,360</th>
<th>$2,670</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,000</td>
<td>$1,690</td>
<td>$2,670</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,070</td>
<td>$760</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn't covered
- Limits or exclusions             $80                                           $60                                         $0

The total Peg would pay is $4,150

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 de 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 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人有关Fallon Health的问题，您有权免费获得语言帮助。如需与口译员通话，请拨打1-800-868-5200。

Arabic: إذا كنت محتاجًا إلى الترجمة، يمكنك محاولة الاتصال برقم 1-800-868-5200.

Russian: Если у вас есть вопросы по отношению к Fallon Health, вы имеете право получать помощь и информацию на родном языке бесплатно. Для разговора с толкователем дайте 1-800-868-5200.

Khmer/Cambodian: ក្រោយពីយើងសម្រាប់អ្នកជាមួយអ្នកបង្ហាញអំពូលជាពិសោធន៍របស់អ្នកពោលជាពិសោធន៍របស់Fallon Health, អ្នកមានឈ្នះឈ្នះបានទិញនូវជំនួយជាពិសោធន៍ជាពិសោធន៍ទាំងអស់។ សូមចូលហៅ 1-800-868-5200 ដែលអាចមានឈ្នះឈ្នះបាន់សំរាប់អ្នក។
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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:

- Provides free aids and services to people with disabilities to communicate effectively.
- Provides free aids and services to people whose primary language is not English, such as: 
  - Qualified interpreters
  - Written information in other languages (large print, audio, accessible electronic formats)

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