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>What is the overall deductible?</td>
<td>$1,500 person/$3,000 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>Are there services covered before you meet your deductible?</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>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</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>What is not included in the out-of-pocket limit?</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>Will you pay less if you use a network provider?</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 network 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>Do you need a referral to see a specialist?</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>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): $25 co-pay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Out-of-Network Provider (You will pay the most): $45 co-pay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>Network Provider (You will pay the least): 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: $25 co-pay, 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>Network Provider (You will pay the least): 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>$5 copay/ prescription (retail and emergency); $10 copay/ prescription (mail order)</td>
<td>$5 copay/ prescription (emergency only)</td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>$30 copay/ prescription (retail and emergency); $60 copay/ prescription (mail order)</td>
<td>$30 copay/ prescription (emergency only)</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>$70 copay/ prescription (retail and emergency); $140 copay/ prescription (mail order)</td>
<td>$70 copay/ prescription (emergency only)</td>
</tr>
<tr>
<td></td>
<td>Tier 4</td>
<td>$150 copay/ prescription (retail and emergency); $450 copay/ prescription (mail order)</td>
<td>$150 copay/ prescription (emergency only)</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></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (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>$150 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>$325 co-pay/visit</td>
<td>$325 co-pay/visit</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>$25 co-pay/visit</td>
<td>$25 co-pay/visit</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>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</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</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>$250 co-pay/admission after 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)
- 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
- Bariatric Surgery
- 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.

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

- **The plan's overall deductible.**: $1,500
- **PCP**: $25
- **Specialist**: $45
- **Hospital Stay**: $250

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$160</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**: $1,740

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

- **The plan's overall deductible.**: $1,500
- **PCP**: $25
- **Specialist**: $45
- **Durable Medical Equipment**: 30%

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,010</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**: $1,070

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

- **The plan's overall deductible.**: $1,500
- **PCP**: $25
- **Specialist**: $45
- **Emergency Room**: $325
- **Durable Medical Equipment**: 30%

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$960</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,090</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

**The total Mia would pay is**: $2,050

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 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:

如果贵公司或您在帮助的人对Fallon Health有任何疑问，您有权免费获得语言支持。如需通话翻译服务，请拨打1-800-868-5200。

Vietnamese:

Nếu quý vui lòng biết về Fallon Health và quý muốn hỏi về thông tin, quý có quyền được hỗ trợ ngôn ngữ hoàn toàn miễn phí. Để liên hệ với dịch giả, hãy gọi 1-800-868-5200.

Russian:

Если у вас есть вопросы по поводу Fallon Health, вы имеете право на бесплатную помощь в выборе языка. Для связи с переводчиком звоните по номеру 1-800-868-5200.

Arabic:

إذا تُعاني أي شخص من أسئلة بشأن Fallon Health، فإنه ليس من الضروري أن يصبح على علم باللغة. للاتصال بالترجمة، الرجاء الاتصال بمثل هذا الرقم: 1-800-868-5200.

Khmer/Cambodian:

Ifun lay na havey neak, neak neak, khan khon khum lai Fallon Health, lay na kay kheang lai neak neak. Neak lai 1-800-868-5200.
If you, or someone you are helping, have 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.

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 Health에서 질문이 있다면, 영어는 물론 다른 언어도 지원을 받을 수 있습니다. 번역관이 필요하시면 1-800-868-5200으로 대화해 보세요.

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.

Polish:
Fallon Health, masz prawo do dialogu w dowolnym języku otwartym na język polski. Dołącz do rozmowy przez numer 1-800-868-5200.

Hindi:
शितक ने ते ज्ञान ने ते, 1-800-868-5200 के जवाब देंगे.

Gujarati:
Fallon Health, તમારી સામે કોઈ હોતું હોવું, 1-800-868-5200 સાથે પરામર્શ માંગે શક્ય છે.

Laotian:
Fallon Health, ປ່າ ລາວ ແລະ ຍູ້ທີອີກຈາກ 1-800-868-5200 ໃຊ່ວນ ທ່ານ ໄດ້. 

Laotian:
Fallon Health, ປ່າ ລາວ ແລະ ຍູ້ທີອີກຈາກ 1-800-868-5200 ໃຊ່ວນ ທ່ານ ໄດ້.
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:**

provides free aids and services to people with disabilities to communicate effectively.

- qualified interpreters
- written information in other languages
- forms, other formats
- with us, such as:
  - provides 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.