### 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>$2,000 person/$4,000 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: $6,000/person or $12,000/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>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 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><strong>Primary care visit to treat an injury or illness</strong></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td><strong>Out-of-Network Provider</strong></td>
<td>$40 co-pay/visit</td>
<td>Not covered</td>
<td>------------None-------------</td>
</tr>
<tr>
<td><strong>Diagnostic test (x-ray, blood work)</strong></td>
<td>Lab Services $60 co-pay, Non Lab Services $60 co-pay.</td>
<td>Not covered</td>
<td>------------None-------------</td>
</tr>
<tr>
<td><strong>Imaging (CT/PET scans, MRIs)</strong></td>
<td>$450 co-pay/test after deductible</td>
<td>Not covered</td>
<td>Limited to one payment per day when performed at the same facility for the same diagnosis. Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td><strong>Tier 1</strong></td>
<td>$30 co-pay/ prescription (retail and emergency); $60 co-pay/ prescription (mail order)</td>
<td>$30 co-pay/ 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><strong>Tier 2</strong></td>
<td>$60 co-pay/ prescription (retail and emergency); $120 co-pay/ prescription (mail order) after deductible</td>
<td>$60 co-pay/ 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><strong>Tier 3</strong></td>
<td>$100 co-pay/ prescription (retail and emergency); $300 co-pay/ prescription (mail order) after deductible</td>
<td>$100 co-pay/ prescription (emergency only) 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><strong>Tier 4</strong></td>
<td>$100 co-pay/prescription (retail and emergency); $300 co-pay/prescription (mail order) after deductible</td>
<td>$100 co-pay/prescription (emergency only) 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>
</tbody>
</table>

**If you visit a health care provider’s office or clinic**

- **Specialist** visit: $55 co-pay/visit (Not covered)
- **Preventive care/screening/immunization**: No charge (Not covered)
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<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) $750 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>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$350 co-pay/visit</td>
<td>$350 co-pay/visit</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Urgent care</td>
<td>$55 co-pay/visit</td>
<td>$55 co-pay/visit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$750 co-pay/admission after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a hospital stay</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>$40 co-pay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</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>$40 co-pay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</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>$750 co-pay/admission after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------</td>
<td>------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$55 co-pay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$55 co-pay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$750 co-pay/admission after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>Deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>No charge</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. 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 on how 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
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual Market policies.

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.

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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: $2,000
- PCP: $40
- Specialist: $55
- Hospital Stay: $750

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:
- Deductibles: $2,000
- Copayments: $1,550
- Coinsurance: $0

**What isn't covered**
- Limits or exclusions: $30

**The total Peg would pay is:** $3,580

### 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: $40
- Specialist: $55
- 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:
- Deductibles: $0
- Copayments: $2,060
- Coinsurance: $0

**What isn't covered**
- Limits or exclusions: $20

**The total Joe would pay is:** $4,080

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)
- The plan's overall deductible: $2,000
- PCP: $40
- Specialist: $55
- Emergency Room: $350
- 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:
- Deductibles: $2,000
- Copayments: $660
- Coinsurance: $80

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

**The total Mia would pay is:** $2,740

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 sua língua e sem custo. Para falar com um intérprete, ligue para 1-800-868-5200.

Chinese:
如果您或您帮助的人对Fallon Health有疑问，您有权以您自己的语言获得帮助和信息，且无需支付费用。如要与翻译沟通，请拨打1-800-868-5200。

Khmer/Cambodian:

Russian:

Vietnamese:

Arabic:

Haitian Creole:

Interpretes de lengua se ofrecen a su disposición sin costo. Para solicitar un intérprete, llame al 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 speak with an interpreter, call 1-800-868-5200.

French:

If you, or the person you are assisting, have questions about Fallon Health, you have the right to receive help and information in your language at no cost. To speak with an interpreter, call 1-800-868-5200.

Italian:

Se tu o qualcuno con cui stai aiutando hai domande su Fallon Health, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, chiama il numero 1-800-868-5200.

Korean:

Fallon Health에 대한 여噜을 하고 싶으시다면 당신의 언어로 정보를 받아볼 수 있습니다. 번역 서비스로 이야기하려면 1-800-868-5200에 연락하십시오.

Greek:

Εάν έχετε ερωτήσεις για τη Fallon Health, έχετε το δικαίωμα να διαλέξετε τη γλώσσα σας για την προσφορά υπηρεσιών και πληροφοριών, χωρίς κόστος. Για να μιλήσετε με έναν μεταφράτη, επικοινωνήστε με το 1-800-868-5200.

Polish:

Jeśli masz pytania dotyczące Fallon Health, masz prawo do otrzymania pomocy i informacji w twoim języku, bez korzystania z tłumacza. Aby skorzystać z tej usługi, podajemy numer 1-800-868-5200.

Hindi:

यदि आप, या उसे सहायता किर, से कोई विवेक, तो आपको अपनी भाषा में समस्या और प्रश्नों के लिए मदद और जानकारी प्राप्त करने का हिस्सा है. भारतीय प्रतिवादकों के साथ बातचीत करने के लिए कॉल करें 1-800-868-5200.

Greek:

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

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: 1-508-368-9988 (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:

Email: compliance@fallonhealth.org
Phone: 1-508-368-9988 (TRS 711)

You can 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/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HH Building
Washington, D.C. 20201
Phone: 1-800-368-1019 (TDD: 1-800-537-7697)

Complaint forms are available at https://www.hhs.gov/ocr/office/filerequest.html.

Fallon Health:
- Provides free aids and services to people with disabilities to communicate effectively

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