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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$2,750 person/$5,500 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 is 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: $8,700/person or $17,400/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>

Coverage for: Individual and Individual + Family | Plan Type: HMO

Coverage Period: Beginning on or after 01/01/2022
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</td>
<td>$35 co-pay/visit after deductible, Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist</strong> visit</td>
<td>$75 co-pay/visit after deductible, Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td></td>
<td><strong>Preventive care/screening/immunization</strong></td>
<td>No charge, Not covered</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td>Lab Services $75 co-pay after deductible, Non Lab Services $100 co-pay after deductible, Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$800 co-pay/test after deductible, 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>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1</td>
<td>$30 co-pay/ prescription (retail and emergency); $60 co-pay/ prescription (mail order) after deductible, $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></td>
<td>Tier 2</td>
<td>$100 co-pay/ prescription (retail and emergency); $200 co-pay/ prescription (mail order) after deductible, $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></td>
<td>Tier 3</td>
<td>$150 co-pay/ prescription (retail and emergency); $450 co-pay/ prescription (mail order) after deductible, $150 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></td>
<td>Tier 4</td>
<td>$150 co-pay/prescription (retail and emergency); $450 co-pay/prescription (mail order) after deductible, $150 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>

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><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)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$500 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><strong>If you need immediate medical attention</strong></td>
<td><strong>Emergency room care</strong></td>
<td>$750 co-pay/visit after deductible</td>
<td>$750 co-pay/visit after deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency medical transportation</strong></td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Urgent care</strong></td>
<td>$75 co-pay/visit after deductible</td>
<td>$75 co-pay/visit after deductible</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$1,200 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><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$35 co-pay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>$35 co-pay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Childbirth/delivery professional services</strong></td>
<td>See childbirth/delivery facility services.</td>
<td>See childbirth/delivery facility services.</td>
</tr>
<tr>
<td></td>
<td><strong>Childbirth/delivery facility services</strong></td>
<td>$1,200 co-pay/admission after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
## Common Medical Event

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

<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><strong>Home health care</strong></td>
<td>Deductible</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td><strong>Rehabilitation services</strong></td>
<td>$75 co-pay/visit in an office after deductible</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td><strong>Habilitation services</strong></td>
<td>$75 co-pay/visit in an office after deductible</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td><strong>Skilled nursing care</strong></td>
<td>$1,200 co-pay/admission after deductible</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td>20% coinsurance after deductible</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td><strong>Hospice services</strong></td>
<td>Deductible</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>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>Children's eye exam</strong></td>
<td>No charge</td>
<td>Routine eye exams are limited to one per 12 month period.</td>
</tr>
<tr>
<td><strong>Children's glasses</strong></td>
<td>No charge</td>
<td>One designated set, once per calendar year.</td>
</tr>
<tr>
<td><strong>Children's dental check-up</strong></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

- 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 except when medically necessary for members with systemic circulatory disease

#### Other Covered Services

- Abortion Services
- Bariatric Surgery
- Chiropractic Care
- 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 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.
### 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 prenatal care and a hospital delivery)

- The plan’s overall deductible: $2,750
- PCP: $35
- Specialist: $75
- Hospital Stay: $1,200

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:** $22,712

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Peg would pay</th>
<th>Peg would pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,750</td>
<td>$5,220</td>
</tr>
<tr>
<td>Copayments</td>
<td>$2,440</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $30

**The total Peg would pay is:** $5,220

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

- The plan’s overall deductible: $2,750
- PCP: $35
- Specialist: $75
- 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:** $12,674

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Joe would pay</th>
<th>Joe would pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,750</td>
<td>$4,580</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,810</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $20

**The total Joe would pay is:** $4,580

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

- The plan’s overall deductible: $2,750
- PCP: $35
- Specialist: $75
- Emergency Room: $750
- 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:** $3,541

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Mia would pay</th>
<th>Mia would pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,750</td>
<td>$3,250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$490</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $20

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

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 ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-868-5200.

Chinese:
如果有人寻求帮助，如果你或你帮助的人有关于Fallon Health的问题，你有权利获得语言帮助和信息。如需转接至同语种的翻译，请拨打1-800-868-5200。
Si vous, ou quelqu'un que vous êtes en train d'aider, avez 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, 당신은 Fallon Health에 대해 질문하기 위해 도움을 받을 수 있습니다. 한국어로 정보를 얻는게 가능할 때, 1-800-868-5200에 연락해보세요.

Greek:
Εάν έχετε ερωτήσεις για το Fallon Health, έχετε το δικαίωμα να αποκτήσετε βοήθεια και πληροφορίες στην ίδια ομιλωτική σας γλώσσα. Για να μιλήσετε με έναν μετάφραση, θα μπορούσετε να κλήσετε 1-800-868-5200.

Polish:
Jeśli masz pytania dotyczące Fallon Health, masz prawo do otrzymania pomocy w Twojej ojczystej języku i bezpłatnie. Aby skontaktować się z przełożonym, mogą dołączyć do telefonu 1-800-868-5200.

Hindi:
Fallon Health में से कोई सविता हो या आपके साथ मदद कर रहे कोई भी, आपको अपनी भाषा में मदद और जानकारी का अधिकार है। 1-800-868-5200 पर एक अनुवादक से बात करने का भी संभावना है।

Laotian:
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 does not discriminate on the basis of race, color, national origin, age, disability or sex. Fallon 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 aids and services to people with disabilities to communicate effectively.
- Provides free aids and services to people with disabilities to communicate effectively.

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) Wcree, MA 01608
10 Christian St.
Fallon Health
Compliance Director

The Compliance Director is available to help you.

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) Wcree, MA 01608
10 Christian St.
Fallon Health
Compliance Director

If you believe that Fallon Health has failed to provide these services or discriminate in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance.

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 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.

Information written in other languages
Qualified interpreters

as:

- Provides free aids and services to people whose primary language is not English, such as:
  - Provides free aids and services to people whose primary language is not English, such as:
  - Provides free aids and services to people whose primary language is not English, such as:


You can file a grievance in person or by mail, fax or email. If you need help filling a grievance:

Phone: 1-800-368-1019 (TDD: 1-800-537-7697)
Washington, D.C., 20010
200 Independence Avenue SW, Room 509F, HHH Building
U.S. Department of Health and Human Services

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) Wcree, MA 01608
10 Christian St.
Fallon Health
Compliance Director

If you believe that Fallon Health has failed to provide these services or discriminate in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance.

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.