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>Important 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>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></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td></td>
<td></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 $60 co-pay, Non Lab Services $60 co-pay.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$450 co-pay/test after deductible</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)</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>$60 co-pay/ prescription (retail and emergency); $120 co-pay/ prescription (mail order) 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>$100 co-pay/ prescription (retail and emergency); $300 co-pay/ prescription (mail order) 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>$100 co-pay/prescription (retail and emergency); $300 co-pay/prescription (mail order) 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>
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</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$750 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><strong>Emergency room care</strong></td>
<td>$350 co-pay/visit</td>
<td>$350 co-pay/visit</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>$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></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></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></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>$750 co-pay/admission after deductible</td>
<td>Not covered</td>
</tr>
<tr>
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<td>What You Will Pay</td>
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<td>-----------------------</td>
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<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></td>
<td></td>
<td>Deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>$55 co-pay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$750 co-pay/admission after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$55 co-pay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>Deductible</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 except when medically necessary for members with systemic circulatory disease
- Routine Eye Care (Adult)
- Chiropractic Care
- Infertility Treatment
- 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 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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**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: $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: $22,712

In this example, Peg would pay:
- Deductibles: $2,000
- Copayments: $800
- Coinsurance: $0

What isn’t covered:
- Limits or exclusions: $30

The total Peg would pay is: $2,830

### 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: $12,674

In this example, Joe would pay:
- Deductibles: $0
- Copayments: $2,310
- Coinsurance: $0

What isn’t covered:
- Limits or exclusions: $20

The total Joe would pay is: $2,330

### 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

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

In this example, Mia would pay:
- Deductibles: $1,280
- Copayments: $1,270
- Coinsurance: $80

What isn’t covered:
- Limits or exclusions: $0

The total Mia would pay is: $2,630

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:

如果您或您正在帮助的人对Fallon Health有疑问，您有权免费获得语言帮助和信息。如需与翻译沟通，拨打1-800-868-5200。

Vietnamese:

Nếu bạn hoặc những người bạn đang giúp đỡ có câu hỏi về Fallon Health, bạn có quyền nhận hỗ trợ và thông tin bằng ngôn ngữ mà bạn hiểu mà không phải trả bất kỳ chi phí nào. Để liên hệ với dịch ngôn ngữ, hãy gọi 1-800-868-5200.

Russian:

Если у вас или человека, которому вы помогаете, есть вопросы о Fallon Health, у вас есть право получать помощь и информацию на вашем языке без оплаты. Чтобы связаться с переводчиком, позвоните по номеру 1-800-868-5200.

Arabic:

إذا كنت أو الشخص الذي تقوم به مساعدة لديك أسئلة关于 Fallon Health، فإنك تحصل على الحق في الحصول على مساعدة وتحديثات باللغة التي تفهمها بدون نفقات. للتحدث مع ترجمة، اتصل بـ 1-800-868-5200.

Haitian Creole:

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Fallon Health, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, se dwa w pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-868-5200.

Khmer/Cambodian:

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.
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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 does not discriminate on the basis of race, color, national origin, age, disability or sex.

所提供的服务包括但不限于：
- 为听障人士提供合格的手语译员
- 提供其他可访问的电子格式（大字体、音频等）
- 为非英语使用者提供合格的口译服务

如果您需要这些服务，或者认为Fallon Health未遵守这些权利，您可以通过以下方式提出投诉：

Compliance Director
Fallon Health
10 Chestnut St.
Worcester, MA 01608
Phone: 1-508-368-9988 (TRS 711)
Email: compliance@fallonhealth.org

您也可以通过邮件、电话或邮寄方式提出投诉。

您还可以通过以下方式提出投诉：

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 301F, HHI Building
Washington, DC 20201
Phone: 1-800-368-1019 (TDD: 1-800-537-7697)

如果您需要帮助填写投诉表格，可以联系Compliance Director寻求帮助。


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.