Fallon: Preferred Care QHD 2000 HSA

Coverage Period: Beginning on or after 01/01/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual and Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.fallonhealth.org/plandocs**. or by calling **1-888-468-1541**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person/**$4,000** family for in-network services. **$4,000** person/**$8,000** family for out-of-network services. Doesn't apply to in-network preventive care services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For in-network covered services **$6,550** person / **$13,100** family. For out-of-network covered services **$6,550** person / **$13,100** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.fallonhealth.org/plandocs or call 1-888-468-1541** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the section *Excluded Services & Other Covered Services*. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 co-pay/visit after deductible	20% coinsurance after deductible	----------None----------
	Specialist visit	$45 co-pay/visit after deductible	20% coinsurance after deductible	Preauthorization required for certain covered services.
	Other practitioner office visit	$35 co-pay/visit with your PCP and certain other providers after deductible; $45 co-pay/visit with a specialist after deductible	20% coinsurance after deductible	Chiropractic care limited to 12 visits per benefit period. Preauthorization required for certain covered services.
	Preventive care/screening/immunization	No charge	20% coinsurance after deductible	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	Deductible	20% coinsurance after deductible	----------None----------
	Imaging (CT/PET scans, MRIs)	$150 co-pay/test after deductible	20% coinsurance after deductible	Preauthorization required for certain covered services.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.fallonhealth.org.	Tier 1 plus Mail Order	$5 co-pay /prescription after deductible (retail and emergency); $10 co-pay /prescription (mail order) after deductible	20% coinsurance after deductible	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 plus Mail Order	$30 co-pay /prescription after deductible (retail and emergency); $60 co-pay /prescription (mail order) after deductible	20% coinsurance after deductible	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 plus Mail Order	$55 co-pay /prescription after deductible (retail and emergency); $110 co-pay /prescription (mail order) after deductible	20% coinsurance after deductible	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 plus Mail Order	50% coinsurance after deductible	20% coinsurance after deductible	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible	Not covered	Referral and preauthorization required for certain covered services.
	Physician/surgeon fees	Deductible	Not covered	Referral and preauthorization required for certain covered services.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 co-pay/visit after deductible	$150 co-pay/visit after deductible	----------None----------
	Emergency medical transportation	Deductible	Deductible	----------None----------
	Urgent care	$35 co-pay/visit after deductible	20% coinsurance after deductible	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible	20% coinsurance after deductible	Preauthorization required for certain covered services.
	Physician/surgeon fee	Deductible	20% coinsurance after deductible	Preauthorization required for certain covered services.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral Health Outpatient Services	$35 co-pay/visit after deductible	20% coinsurance after deductible	Preauthorization required for certain covered services.
	Mental/Behavioral Health Inpatient Services	Deductible	20% coinsurance after deductible	Preauthorization required for certain covered services.
	Substance use disorder outpatient services	$35 co-pay/visit after deductible	20% coinsurance after deductible	Preauthorization required for certain covered services.
	Substance use disorder inpatient services	Deductible	20% coinsurance after deductible	Preauthorization required for certain covered services.
If you are pregnant	Prenatal and postnatal care	$35 co-pay/visit	20% coinsurance after deductible	For prenatal care, you pay an office visit co-pay for your first visit only.
	Delivery and all inpatient services	Deductible	20% coinsurance after deductible	Preauthorization required for certain covered services.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible	20% coinsurance after deductible	Preauthorization required for certain covered services.
	Rehabilitation services	$35 co-pay/visit in an office after deductible	20% coinsurance after deductible	Short-term physical and occupational therapy limited to 60 visits combined in- and out-of-network per year. Preauthorization required for certain covered services.
	Habilitation services	$35 co-pay/visit in an office after deductible	20% coinsurance after deductible	Preauthorization required for certain covered services.
	Skilled nursing care	Deductible	20% coinsurance after deductible	Up to 100 days per year combined in- and out-of-network. Preauthorization required for certain covered services.
	Durable medical equipment	30% coinsurance after deductible	30% coinsurance after deductible	Preauthorization required for certain covered services.
	Hospice service	Deductible	20% coinsurance after deductible	Preauthorization required for certain covered services.
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance after you meet your deductible	Routine eye exams are limited to one per 12 month period.
	Glasses	Not covered	Not covered	----------None----------
	Dental check up	No charge	Not covered	Dental check ups are limited to two per 12 month period.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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

Excluded Services & Other Covered Services:

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Abortion Services
- Bariatric Surgery
- Chiropractic Care (limited to 12 visits per year)
- Infertility Treatment
- Routine Eye Care (Adult)
- Weight Loss Programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-888-468-1541. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: If you are a Massachusetts resident: Fallon, Member Appeals, 10 Chestnut Street, Worcester, MA, 01608, 1-800-333-2535, ext. 69950. For non-Massachusetts residents: American Health Holding, Inc., 1-800-641-5566. You may also contact your state insurance department at Massachusetts Division of Insurance Consumer Service Section 1-617-521-7794. Additionally, a consumer assistance program can help file your appeal. Contact Health Care for All, 30 Winter St., Ste. 1004, Boston, MA 02108, 1-800-272-4232, www.massconsumerassistance.org.

Does this Coverage Meet the Minimum Value Standard?

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.**

Does this Coverage Provide Minimum Essential Coverage?

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.**

Language Access Services

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-468-1541.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $5,460**
- **Patient pays $2,080**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Co-pays	$50
Co-insurance	$0
Limits or exclusions	$30
Total	**$2,080**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $2,730**
- **Patient pays $2,670**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Co-pays	$630
Co-insurance	$0
Limits or exclusions	$40
Total	**$2,670**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Fallon Preferred Care QHD 2000 HSA

Benefit Summary— *Benefits effective January 1, 2016 and beyond*

The Fallon difference

With Fallon Preferred Care QHD 2000 HSA, you get everything you need to live a healthy life. This plan has a high deductible to keep your monthly premium low. It can be partnered with a health savings account to help pay for out-of-pocket costs. Plus, you get:

- **A fitness reimbursement of up to $150** for individual contracts and families that can be used for gym memberships at the gym of your choice with no limitations, school and town sports fees, exercise classes, ski lift tickets, and more!
- **$0 copayments for routine physical exams** and other preventive services, including mammograms, cholesterol screenings and immunizations
- **$0 copayments for routine annual eye exams**
- **Pedi-Dental** up to age 19 included
- **Nurse Connect:** A free 24/7 nurse call line
- **Member discounts** on products and services to keep you healthy and features you won't find anywhere else.

How to receive care:

With Fallon Preferred Care QHD 2000 HSA, you have an extensive regional and national network of providers from which to choose. The Fallon Preferred Care network is comprised of over 600,000 network providers—giving you the flexibility to receive care close to where you live and work.

In-network and out-of-network coverage

Fallon Preferred Care is a preferred provider organization (PPO) plan, and as such, we contract with a network of participating providers who have agreed to provide health care services to our members—your use of participating providers is strictly voluntary.

When you obtain covered services from participating providers, you will receive the in-network level of benefits. We pay participating providers directly; you will not have to file claims when you use participating providers. When you obtain covered services from nonparticipating providers, you get the out-of-network level of benefits. You may need to submit a claim for covered services you receive from nonparticipating providers. For information on claims submission, refer to your Fallon Preferred Care *Evidence of Coverage*.

Emergency medical care

Emergency services do not require referral or authorization. When you have an emergency medical condition, you should go to the nearest emergency department or call your local emergency communications system (police, fire department or 911). For more information on emergency benefits and plan procedures for emergency services, consult your Fallon Preferred Care *Evidence of Coverage*.

Plan specifics	In-network	Out-of-network
Benefit period The benefit period, sometimes referred to as a "benefit year," is the 12-month span of plan coverage, and the time during which the deductible, out-of-pocket maximum and specific benefit maximums accumulate.		
Deductible A deductible is the amount of allowed charges you pay per benefit period before payment is made by the plan for certain covered services. The amount that is put toward your deductible is calculated based on the allowed charge or the provider's actual charge—whichever is less.	$2,000 individual $4,000 family	$4,000 individual $8,000 family
Embedded deductible Please note that once any one member in a family accumulates $2,600 of services that are subject to the family deductible, that individual member's deductible is considered met, and that family member will receive benefits for covered services less any applicable copayments.	$2,600	$5,200
Out-of-pocket maximum The out-of-pocket maximum is the total amount of deductible, coinsurance and copayments you are responsible for in a benefit period. The out-of-pocket maximum does not include your premium charge or any amounts you pay for services that are not covered by the plan.	$6,550 individual $13,100 family	$6,550 individual $13,100 family
Coinsurance Coinsurance is the percentage of medical expense you are required to pay after the deductible amount is satisfied.	n/a	20%
Penalty for failure to follow medical management procedures*	$200 per occurrence	$500 per occurrence

Benefits	Your cost in-network	Your cost out-of-network (after your deductible)
Office		
Routine physical exams	$0	20% coinsurance
Office visits (primary care provider)	$35 per visit after deductible	20% coinsurance
Office visits (specialist)	$45 per visit after deductible	20% coinsurance
Office visits (limited service clinics, e.g., Minute Clinic)	$35 per visit after deductible	20% coinsurance
Routine eye exams (one every 12 months)	$0	20% coinsurance
Short-term rehabilitative services (60 visits combined in- and out-of-network per benefit period)	$35 per visit after deductible	20% coinsurance
Prenatal care	$35 first visit only	20% coinsurance
Preventive services Tests, immunizations and services geared to help screen for diseases and improve early detection when symptoms or diagnosis are not present	Covered in full	20% coinsurance

** Some services require plan notification or prior authorization. A penalty will be applied for failure to follow the plan's medical management procedures. The penalty does not apply toward the deductible or out-of-pocket maximum.*

Benefits	Your cost in-network	Your cost out-of-network (after your deductible)
Diagnostic services Tests, immunizations and services that are intended to diagnose, check the status of, or treat a disease or condition	Covered in full after deductible	20% coinsurance
Imaging (CAT, PET, MRI, Nuclear Cardiology)	$150 copayment after deductible	20% coinsurance
Chiropractic care (12 visits per benefit period)	$35 per visit after deductible	20% coinsurance
Prescriptions	**Tier 1/Tier 2/Tier 3/Tier 4**	
Prescription drugs, insulin and insulin syringes	$5/$30/$55/50% coins (30-day supply) after deductible	20% coinsurance
Generic contraceptives and contraceptive devices	$0 (30-day supply)	20% coinsurance
Brand contraceptives with no generic equivalent (prior authorization required)	With prior authorization: $0 (30-day supply)	20% coinsurance
Brand contraceptives with a generic equivalent (prior authorization required)	Tier 3: $55 Tier 4: 50% coins (30-day supply) after deductible	20% coinsurance
Prescription medication refills obtained through the mail order program	$10/$60/$110/50% coins. (90-day supply) after deductible	20% coinsurance
Prilosec OTC, Prevacid 24HR, omeprazole OTC (prescription required)	$5 after the deductible	20% coinsurance
Inpatient hospital services		
Room and board in a semiprivate room (private when medically necessary)	Covered in full after deductible	20% coinsurance
Physicians' and surgeons' services	Covered in full after deductible	20% coinsurance
Physical and respiratory therapy	Covered in full after deductible	20% coinsurance
Intensive care services	Covered in full after deductible	20% coinsurance
Maternity care	Covered in full after deductible	20% coinsurance
Same-day surgery		
Same-day surgery in a hospital outpatient or ambulatory care setting	Covered in full after deductible	20% coinsurance
Emergencies		
Emergency room visit	$150 per visit after deductible (waived if admitted)	

Benefits	Your cost in-network	Your cost out-of-network (after your deductible)
Skilled nursing		
Skilled care in a semiprivate room	Covered in full after deductible	20% coinsurance
Substance abuse		
Office visits	$35 per visit after deductible	20% coinsurance
Detoxification in an inpatient setting	Covered in full after deductible	20% coinsurance
Rehabilitation in an inpatient setting	Covered in full after deductible	20% coinsurance
Mental health		
Office visits	$35 per visit after deductible	20% coinsurance
Services in a general or psychiatric hospital	Covered in full after deductible	20% coinsurance
Other health services		
Skilled home health care services	Covered in full after deductible	20% coinsurance
Durable medical equipment	30% coinsurance after deductible	30% coinsurance
Medically necessary ambulance services	Covered in full after deductible	Covered in full after deductible
Value-added benefits and features		
It Fits!, an annual fitness reimbursement (including school and town sports programs, gym memberships, Weight Watchers®, aerobics, Pilates and yoga classes)		$150 individual $150 family
The Healthy Health Plan!, a program for being—and becoming—healthy If you're already in great health, terrific! If you could use a little help to get healthier, you can choose to enroll in a customized action health plan that may include regular health coaching, wellness workshops, interactive tools and more!		Included
Oh Baby!, a program that provides prenatal vitamins, a convertible car seat, breast pump and other "little extras" for expectant parents—all at no additional cost.		Included
Fallon Smart Shopper Transparency tool and Incentive program		Included
Free 24/7 nurse call line		Included
Free chronic care management		Included
Free stop-smoking program		Included
Member discount program		Included
Free online access to health and wellness encyclopedia		Included
CVS Caremark ExtraCare Health Card – provides 20% discount on CVS/pharmacy-brand health related items.		Included

Exclusions
Dental benefits and discounts, other than those listed in your *Schedule of Benefits*
Hearing aids and the evaluation for a hearing aid (for age 22 and above)
Long-term rehabilitative services
Cosmetic surgery
Experimental procedures or services that are not generally accepted medical practice
Routine foot care
Custodial confinement

A complete list of benefits and exclusions is in the Fallon Preferred Care *Evidence of Coverage*, available by request. This is only a summary of benefits and exclusions.

Questions?

If you have any questions, please contact Fallon Community Health Plan Customer Service at 1-888-468-1541 (TTY users, please call TRS Relay 711), or visit our Web site at fchp.org.

*This health plan **meets minimum creditable coverage standards** and **will satisfy** the individual mandate that you have health insurance. As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years and older, must have health coverage that meets the minimum creditable coverage standards set by the Commonwealth Health Insurance Connector.*

Benefits may vary by employer group.
Weight Watchers® is a registered trademark of Weight Watchers International, Inc.
Fallon Health & Life Assurance Company, Inc., is a wholly owned subsidiary of Fallon Community Health Plan.