



**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](http://www.fallonhealth.org/plandocs). or by calling 1-888-468-1541.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$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 <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.fallonhealth.org/plandocs">www.fallonhealth.org/plandocs</a> or call 1-888-468-1541 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.

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# Fallon Health: Preferred Care QHD 2000 HSA

Coverage Period: Beginning on or after 01/01/2017

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

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

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 <i>Excluded Services &amp; Other Covered Services</i> . See your policy or plan document for additional information about <u>excluded services</u> .

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- **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 <u>provider's</u> 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	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)	Lab Services \$30 co-pay after deductible, Non Lab Services Covered in Full after 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.

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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
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.fallonhealth.org">www.fallonhealth.org</a>.</p>	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	\$60 co-pay /prescription after deductible (retail and emergency); \$120 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 /prescription (retail, emergency and 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.
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	Deductible	20% coinsurance after deductible	Preauthorization required for certain covered services.
	Physician/surgeon fees	Deductible	20% coinsurance after deductible	Preauthorization required for certain covered services.

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# Fallon Health: Preferred Care QHD 2000 HSA

Coverage Period: Beginning on or after 01/01/2017

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

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

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.

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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	No charge	20% coinsurance after you meet your deductible	One designated set, once per calendar year.
	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
- Hearing Aids (over the age of 21)
- Private-Duty Nursing
- Cosmetic Surgery
- Long-Term Care
- Routine Foot Care
- Dental Care (Adult)
- Non-Emergency Care When Traveling Outside the U.S.

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## 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
- 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](http://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](http://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](http://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.**

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## 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.*-----

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## 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$2,000
Co-pays	\$50
Co-insurance	\$0
Limits or exclusions	\$30
<b>Total</b>	<b>\$2,080</b>

### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$2,000
Co-pays	\$630
Co-insurance	\$0
Limits or exclusions	\$40
<b>Total</b>	<b>\$2,670</b>

## 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.

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**French:**

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.

**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:**

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Fallon Health에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-868-5200로 전화하십시오.

**Greek:**

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω από το Fallon Health, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-800-868-5200.

**Polish:**

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie Fallon Health, masz prawo do uzyskania bezpłatnej informacji i pomocy w własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-868-5200.

**Hindi:**

यदि आपके ,या आप द्वारा सहायता ककर जा रहे ककसी व्यक्तत के Fallon Health [के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िभाषणर से बात करने के लिए ,1-800-868-5200 पर कॉि करें।

**Gujarati:**

જો તમે અથવા તમે શેઇને મદદ કરી રહ્યાં તેમ ાંથી શેઇને Fallon Health વિશે પ્રશ્નો શેર તો તમને મદદ અને મહત્તી મેળિેનો અલિક ર છે. તે ખર્ચ વિન તમ શી ભ ષ મ ાં પુ પ્ત કરી શક ર છે. દ ભ વર્ણો િ ત કરિ મ ડે,આ 1-800-868-5200 પર શેલ કરો.

**Laotian:**

້າທ່ານ, ຫຼື ື່ນທ່ານກ້າວຽວຂະຫຼື້, ມາຮ້າງາມກ້ວາງບໍ່ Fallon Health, ທ່ານມາສິດທ ັ່ລາດັບການຊ່ວຍເຫຼືອເລະຂໍ້ມູນຂ່າວສານທ່ຽວຜາສາຂອງທ່ານບໍ່ມາໃຊ້ລ່າຍ. ການຮ້ວນກ້ບາຍລາສາ, ໃຫ້ທ່າ 1-800-868-5200.

# 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 with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

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](mailto:cs@fallonhealth.org).

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: 1-508-368-9382 (TRRS 711)  
Email: [compliance@fallonhealth.org](mailto:compliance@fallonhealth.org)

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Compliance Director is available to help you.

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

U.S. Department of Health and Human Services  
200 Independence Avenue SW., Room 509F, HHH Building  
Washington, D.C., 20201

Phone: 1-800-368-1019 (TDD: 1-800-537-7697)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.