Fallon Health: Select Care

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

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 1-866-344-4442 or visit www.fallonhealth.org/gic. 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/gic or call 1-866-344-4442 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 person/$1,000 family. Doesn't apply to preventive care.	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.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. $100 person/$200 family for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers: $5,000/person or / $10,000/family.	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 .
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.
Will you pay less if you use a network provider?	Yes. See www.fallonhealth.org/gic or call 1-866-344-4442 for a list of participating providers.	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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	Yes. Your PCP can provide you with a copy of the referral form when you need to see a specialist.	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.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered	----------None----------
	Specialist visit	Tier 1: $30 copay/visit; Tier 2: $60 copay/visit; Tier 3: $75 copay/visit	Not covered	Referral and preauthorization required for certain covered services.
	Preventive care/ screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible	Not covered	----------None----------
	Imaging (CT/PET scans, MRIs)	$100 copay/test then deductible	Not covered	Limited to one copay per day when performed at the same facility for the same diagnosis. Referral and preauthorization required for certain covered services.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Tier 1	$10 copay /prescription (retail and emergency); $25 copay/ prescription (mail order)	$10 copay/ prescription (emergency only)	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	$30 copay/ prescription (retail and emergency); $75 copay/ prescription (mail order)	$30 copay/ prescription (emergency only)	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	$65 copay/ prescription (retail and emergency); $165 copay/ prescription (mail order)	$65 copay/ prescription (emergency only)	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)	$250 copay/surgery then deductible	Not covered	Up to four copayments per member per benefit year. 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	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/visit then deductible	$100 copay/visit then deductible	----------None----------
	Emergency medical transportation	Deductible	Deductible	----------None----------
	Urgent care	$20 copay/visit	$20 copay/visit	Includes visits to contracted limited service clinics.
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1: $275 copay; Tier 2: $500 copay; Tier 3: $1,500 copay then deductible	Not covered	One copayment, per member, per quarter each benefit year. Referral and preauthorization required for certain covered services.
	Physician/surgeon fees	Deductible	Not covered	Referral and preauthorization required for certain covered services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	Not covered	Referral and preauthorization required for certain covered services.
	Inpatient services	No charge	Not covered	Referral and preauthorization required for certain covered services.
If you are pregnant	Office visits	Tier 1: $15 copay; Tier 2: $20 copay; Tier 3: $30 copay	Not covered	For prenatal care, you pay an office visit co-pay for your first visit only.
	Childbirth/delivery professional services	See childbirth/delivery facility services.	See childbirth/delivery facility services.	See childbirth/delivery facility services.
	Childbirth/delivery facility services	Tier 1: $275 copay; Tier 2: $500 copay; Tier 3: $1,500 copay/admission then deductible	Not covered	One copayment, per member, per quarter each benefit year. Referral and preauthorization required for certain covered services. Inpatient amount is inclusive of childbirth/delivery professional services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Deductible	Not covered	Referral and preauthorization required for certain covered services.
	Rehabilitation services	$20 copay/visit in an office	Not covered	Prior authorization required after 90 days for short-term physical and occupational therapy.
	Habilitation services	$20 copay/visit in an office	Not covered	Early intervention services covered for children from birth to age 3 with no copayment. Referral and preauthorization required for certain covered services.
	Skilled nursing care	Deductible	Not covered	Up to 100 days per year. Referral and preauthorization required for certain covered services.
	Durable medical equipment	20% coinsurance after deductible	Not covered	Referral and preauthorization required for certain covered services.
	Hospice services	No charge	Not covered	Referral required.
If your child needs dental or eye care	Children's eye exam	$20 copay/visit	Not covered	Routine eye exams are limited to one per 24 month period.
	Children's glasses	Not covered	Not covered	----------None----------
	Children's dental check-up	Not covered	Not covered	----------None----------

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)
- 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 (limited to 12 visits per benefit year)
- Hearing Aids
- 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. 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 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
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.

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 1-866-344-4442.
————————————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 pre-natal care and a hospital delivery)

The plan's overall deductible.	$500
PCP	$20
Specialist	$30
Hospital Stay	$275

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:

Cost Sharing	
Deductibles	$0
Copayments	$320
Coinsurance	$0
What isn't covered	
Limits or exclusions	$80
The total Peg would pay is	$400

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

The plan's overall deductible.	$500
PCP	$20
Specialist	$30
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:

Cost Sharing	
Deductibles	$150
Copayments	$1,070
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,280

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

The plan's overall deductible.	$500
PCP	$20
Specialist	$30
Emergency Room	$100

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:

Cost Sharing	
Deductibles	$500
Copayments	$510
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,640

The plan would be responsible for the other costs of these EXAMPLE covered services.