


Fallon Health: Direct 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 <u>deductible</u> ?	\$550 person/\$1,100 family. Doesn't apply to preventive care.	Generally you must pay all the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For in-network <u>providers</u> : \$5,000/person or / \$10,000/family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.fallonhealth.org/gic or call 1-866-344-4442 for a list of participating <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes. Your PCP can provide you with a copy of the <u>referral</u> form when you need to see a <u>specialist</u> .	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 **Copayment** and **coinsurance** costs shown in this chart are both before and 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	\$15 copay/visit	Not covered	-----None-----
	Specialist visit	Tier 1: \$30 copay/visit; Tier 2: \$60 copay/visit; Tier 3: \$90 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.fallonhealth.org/gic	Tier 1	\$10 copay /prescription (retail and emergency); \$25 copay/ prescription (mail order)	\$10 copay/ prescription (emergency only)	Includes specialty drugs in this tier. 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)	Includes specialty drugs in this tier. 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)	Includes specialty drugs in this tier. 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	\$15 copay/visit	\$15 copay/visit	Includes visits to contracted limited service clinics.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$275 copay/admission 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	\$15 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: \$10 copay /visit; Tier 2: \$15 copay /visit; Tier 3: \$25 copay /visit	Not covered	For prenatal care, you pay an office visit copay 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	\$275 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	\$15 copay/visit in an office	Not covered	Prior authorization required after 90 days for short-term physical and occupational therapy.
	Habilitation services	\$15 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 and preauthorization required for certain covered services.
If your child needs dental or eye care	Children's eye exam	\$15 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 | • Long-Term Care | • Private-Duty Nursing |
| • Cosmetic Surgery | • Non-Emergency Care When Traveling Outside the U.S. | • Routine Foot Care |
| • Dental Care (Adult) | | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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

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 <u>plan's overall deductible</u> .	\$550
■ PCP	\$15
■ <u>Specialist</u>	\$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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$550
Copayments	\$310
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$80
The total Peg would pay is	\$940

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's overall deductible</u> .	\$550
■ PCP	\$15
■ <u>Specialist</u>	\$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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$150
Copayments	\$1,050
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,260

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's overall deductible</u> .	\$550
■ PCP	\$15
■ <u>Specialist</u>	\$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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$550
Copayments	\$510
Coinsurance	\$20
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,080

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 acerca de 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，或是您正在協助的對象，有關於[插入項目的名稱 Fallon Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 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, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-868-5200.

Vietnamese:

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Fallon Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-868-5200.

Russian:

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Fallon Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-868-5200.

Arabic:

على الحصول في الحق في لديك ، Fallon Health بـ خصوص أسئلة تساعد شخص لدى أو لديك كان إن (ب) اتصل م ترجم مع ل ل تحدث بـ كل فة أية دون من بـ لغتك الضرورية والمعلومات المساعدة 1-800-868-5200.

Khmer/Cambodian:

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ម្ចាស់សំណួរអំពី Fallon Health បេ, អ្នកម្ចាស់សិទ្ធិទទួលបានជំនួយនិងព័ត៌មាន ប្រាកដន្នភាពសា រស់អ្នក បោយមិនអ្វីប្រាក់ ។ បើបើបីនិយាយជាមួយអ្នករកជម្រក សូម 1-800-868-5200 ។

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 απο 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 we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-868-5200.

Hindi:

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Gujarati:

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Laotian:

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ທ່ານມັດ ຈະໄດ້ ຮັບການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນ ຂ້າງຕໍ່ໜ້າ
' ເປັນພາສາຂອງທ່ານ ບໍ່ມີ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ນລັກ ບໍ່ນາຍພາສາ, ໃຫ້ໂທຫາ 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.

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 (TRS 711)

Email: 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>.