

## Fallon Health: Community Care Connector Low Gold

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 1-800-868-5200 or visit [www.fallonhealth.org/findphysician](http://www.fallonhealth.org/findphysician). 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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-868-5200 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                      | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | <b>\$2,000</b> person/ <b>\$4,000</b> family. Doesn't apply to preventive care.                                                                                              | Generally you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                                |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <b>Preventive care</b> and primary care services are covered before you meet your <a href="#">deductible</a> .                                                          | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                                                                                                        |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                          | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For covered services with in-network <a href="#">providers</a> :<br><b>\$6,000</b> /person or<br><b>\$12,000</b> /family.                                                    | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met .                                                                                                                                                                                                                                                                                                                                                            |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Premiums, balance-billing charges, and health care this plan doesn't cover.                                                                                                  | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.fallonhealth.org/findphysician">www.fallonhealth.org/findphysician</a> or call 1-800-868-5200 for a list of network <a href="#">providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | Yes.                                                                                                                                                                         | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are either before or 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<br>(You will pay the least)                                                                                | Out-of-Network Provider<br>(You will pay the most)                           |                                                                                                                                                                                                  |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                                                                                                                | Primary care visit to treat an injury or illness        | \$35 co-pay/visit; <b>Deductible</b> does not apply                                                                         | Not covered                                                                  | -----None-----                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                       | <a href="#">Specialist</a> visit                        | \$50 co-pay/visit; <b>Deductible</b> does not apply                                                                         | Not covered                                                                  | Referral and preauthorization required for certain covered services.                                                                                                                             |
|                                                                                                                                                                                                                                                                                                       | <a href="#">Preventive care/screening</a> /immunization | No charge; <b>Deductible</b> does not apply                                                                                 | Not covered                                                                  | You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are preventive. Then check what your <b>plan</b> will pay for.                  |
| If you have a test                                                                                                                                                                                                                                                                                    | <a href="#">Diagnostic test</a> (x-ray, blood work)     | Lab Services \$60 co-pay after deductible, Non Lab Services \$60 co-pay after deductible.                                   | Not covered                                                                  | -----None-----                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                       | Imaging (CT/PET scans, MRIs)                            | \$450 co-pay/test after deductible                                                                                          | Not covered                                                                  | Limited to one payment 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<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://fallonhealth.org/providers/pharmacy/online-drug-formulary.aspx">https://fallonhealth.org/providers/pharmacy/online-drug-formulary.aspx</a> | Tier 1                                                  | \$30 co-pay/ prescription (retail and emergency); \$60 co-pay/ prescription (mail order); <b>Deductible</b> does not apply  | \$30 co-pay/ prescription (emergency only); <b>Deductible</b> does not apply | 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. Preauthorization required for certain covered prescription drugs. |
|                                                                                                                                                                                                                                                                                                       | Tier 2                                                  | \$60 co-pay/ prescription (retail and emergency); \$120 co-pay/ prescription (mail order); <b>Deductible</b> does not apply | \$60 co-pay/ prescription (emergency only); <b>Deductible</b> does not apply | 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. Preauthorization required for certain covered prescription drugs. |
|                                                                                                                                                                                                                                                                                                       | Tier 3                                                  | \$100 co-pay/ prescription (retail and emergency); \$300 co-pay/ prescription (mail order) after deductible                 | \$100 co-pay/ prescription (emergency only) 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. Preauthorization required for certain covered prescription drugs. |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                    |                                                      | Limitations, Exceptions, & Other Important Information                                                                                                              |
|---------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)         | Out-of-Network Provider<br>(You will pay the most)   |                                                                                                                                                                     |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | \$750 co-pay/surgery after 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.                                                                                                |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$200 co-pay/visit; <b>Deductible</b> does not apply | \$200 co-pay/visit; <b>Deductible</b> does not apply | Copayment waived if admitted.                                                                                                                                       |
|                                                                           | <a href="#">Emergency medical transportation</a> | Deductible                                           | Deductible                                           | -----None-----                                                                                                                                                      |
|                                                                           | <a href="#">Urgent care</a>                      | \$50 co-pay/visit; <b>Deductible</b> does not apply  | \$50 co-pay/visit; <b>Deductible</b> does not apply  | -----None-----                                                                                                                                                      |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | \$750 co-pay/admission after 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.                                                                                                |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$35 co-pay/visit; <b>Deductible</b> does not apply  | Not covered                                          | Referral and preauthorization required for certain covered services.                                                                                                |
|                                                                           | Inpatient services                               | \$750 co-pay/admission after deductible              | Not covered                                          | Referral and preauthorization required for certain covered services.                                                                                                |
| If you are pregnant                                                       | Office visits                                    | No charge; <b>Deductible</b> does not apply          | Not covered                                          | <b>Cost sharing</b> does not apply to <b>preventive services</b> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                           | Childbirth/delivery professional services        | See childbirth/delivery facility services.           | See childbirth/delivery facility services.           | See Childbirth/Delivery facility services                                                                                                                           |
|                                                                           | Childbirth/delivery facility services            | \$750 co-pay/admission after deductible              | Not covered                                          | 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<br>(You will pay the least)        | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                           |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | Deductible                                          | Not covered                                        | Referral and preauthorization required for certain covered services.                                                                                      |
|                                                                | <a href="#">Rehabilitation services</a>   | \$50 co-pay/visit after deductible                  | Not covered                                        | Short-term physical and occupational therapy limited to 60 visits combined per year. Referral and preauthorization required for certain covered services. |
|                                                                | <a href="#">Habilitation services</a>     | \$50 co-pay/visit; <b>Deductible</b> does not apply | Not covered                                        | Referral and preauthorization required for certain covered services.                                                                                      |
|                                                                | <a href="#">Skilled nursing care</a>      | \$750 co-pay/admission after deductible             | Not covered                                        | Up to 100 days per year. Referral and preauthorization required for certain covered services.                                                             |
|                                                                | <a href="#">Durable medical equipment</a> | 20% coinsurance after deductible                    | Not covered                                        | Referral and preauthorization required for certain covered services.                                                                                      |
|                                                                | <a href="#">Hospice services</a>          | Deductible                                          | Not covered                                        | Referral and preauthorization required for certain covered services.                                                                                      |
| If your child needs dental or eye care                         | Children's eye exam                       | No charge; <b>Deductible</b> does not apply         | Not covered                                        | Routine eye exams are limited to once per calendar year.                                                                                                  |
|                                                                | Children's glasses                        | No charge; <b>Deductible</b> does not apply         | Not covered                                        | One designated set, once per calendar year.                                                                                                               |
|                                                                | Children's dental check-up                | No charge; <b>Deductible</b> does not apply         | Not covered                                        | Dental check ups are limited to two per 12 month period.                                                                                                  |

#### 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         | • Hearing Aids (over the age of 21)                  | • Private-Duty Nursing                                                                                               |
| • Cosmetic Surgery    | • Long-Term Care                                     | • Routine Foot Care except when medically necessary for members with systemic circulatory disease (such as diabetes) |
| • Dental Care (Adult) | • Non-Emergency Care When Traveling Outside the U.S. |                                                                                                                      |

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

- |                     |                         |                            |
|---------------------|-------------------------|----------------------------|
| • Abortion Services | • Chiropractic Care     | • Routine Eye Care (Adult) |
| • Bariatric Surgery | • 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](http://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](http://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](http://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 Fallon Health at 1-800-868-5200. Or you can contact your state insurance department at Massachusetts Division of Insurance at 1-877-563-4467, or 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). Contact Health Care for All, One Federal St., Boston, MA 02110, 1-617-350-7279, [www.massconsumerassistance.org](http://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](http://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, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the **premium tax credit**.

**Does this plan meet Minimum Value Standards? Yes**

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

**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.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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<br>(9 months of in-network pre-natal care and a hospital delivery)                                                                                                                                                                                                          |                 | Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)                                                                                                                                                   |                | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)                                                                                                                                                                              |                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| ■ The plan's overall <u>deductible</u> .                                                                                                                                                                                                                                                         | \$2,000         | ■ The plan's overall <u>deductible</u> .                                                                                                                                                                                                               | \$2,000        | ■ The plan's overall <u>deductible</u> .                                                                                                                                                                                                                   | \$2,000        |
| ■ Specialist copayment                                                                                                                                                                                                                                                                           | \$50            | ■ Specialist copayment                                                                                                                                                                                                                                 | \$50           | ■ Specialist copayment                                                                                                                                                                                                                                     | \$50           |
| ■ Hospital (facility) copayment                                                                                                                                                                                                                                                                  | \$750           | ■ Hospital (facility) copayment                                                                                                                                                                                                                        | \$750          | ■ Hospital (facility) copayment                                                                                                                                                                                                                            | \$750          |
| ■ Other coinsurance                                                                                                                                                                                                                                                                              | 20%             | ■ Other coinsurance                                                                                                                                                                                                                                    | 20%            | ■ Other coinsurance                                                                                                                                                                                                                                        | 20%            |
| <b>This EXAMPLE event includes services like:</b><br>Specialist office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br>Diagnostic tests ( <i>ultrasounds and blood work</i> )<br>Specialist visit ( <i>anesthesia</i> ) |                 | <b>This EXAMPLE event includes services like:</b><br>Primary care physician office visits ( <i>including disease education</i> )<br>Diagnostic tests ( <i>blood work</i> )<br>Prescription drugs<br>Durable medical equipment ( <i>glucose meter</i> ) |                | <b>This EXAMPLE event includes services like:</b><br>Emergency room care ( <i>including medical supplies</i> )<br>Diagnostic test ( <i>x-ray</i> )<br>Durable medical equipment ( <i>crutches</i> )<br>Rehabilitation services ( <i>physical therapy</i> ) |                |
| <b>Total Example Cost</b>                                                                                                                                                                                                                                                                        | <b>\$12,700</b> | <b>Total Example Cost</b>                                                                                                                                                                                                                              | <b>\$5,600</b> | <b>Total Example Cost</b>                                                                                                                                                                                                                                  | <b>\$2,800</b> |
| <b>In this example, Peg would pay:</b>                                                                                                                                                                                                                                                           |                 | <b>In this example, Joe would pay:</b>                                                                                                                                                                                                                 |                | <b>In this example, Mia would pay:</b>                                                                                                                                                                                                                     |                |
| <i>Cost Sharing</i>                                                                                                                                                                                                                                                                              |                 | <i>Cost Sharing</i>                                                                                                                                                                                                                                    |                | <i>Cost Sharing</i>                                                                                                                                                                                                                                        |                |
| Deductibles                                                                                                                                                                                                                                                                                      | \$2,000         | Deductibles                                                                                                                                                                                                                                            | \$2,000        | Deductibles                                                                                                                                                                                                                                                | \$2,000        |
| Copayments                                                                                                                                                                                                                                                                                       | \$800           | Copayments                                                                                                                                                                                                                                             | \$1,600        | Copayments                                                                                                                                                                                                                                                 | \$400          |
| Coinsurance                                                                                                                                                                                                                                                                                      | \$0             | Coinsurance                                                                                                                                                                                                                                            | \$0            | Coinsurance                                                                                                                                                                                                                                                | \$0            |
| <i>What isn't covered</i>                                                                                                                                                                                                                                                                        |                 | <i>What isn't covered</i>                                                                                                                                                                                                                              |                | <i>What isn't covered</i>                                                                                                                                                                                                                                  |                |
| Limits or exclusions                                                                                                                                                                                                                                                                             | \$0             | Limits or exclusions                                                                                                                                                                                                                                   | \$0            | Limits or exclusions                                                                                                                                                                                                                                       | \$0            |
| <b>The total Peg would pay is</b>                                                                                                                                                                                                                                                                | <b>\$2,800</b>  | <b>The total Joe would pay is</b>                                                                                                                                                                                                                      | <b>\$3,600</b> | <b>The total Mia would pay is</b>                                                                                                                                                                                                                          | <b>\$2,400</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Notice of availability of language assistance services and auxiliary aids and services

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-800-868-5200 (TRS 711) Monday, Tuesday, Thursday, Friday, 8 a.m.–6 p.m., Wednesday, 9 a.m.–6 p.m. The call is free.

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.

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.

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.

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]。

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.

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.

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.

إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص Fallon Health، فلديك الحق في الحصول على المساعدة والمعلومات

الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-800-868-5200.

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពី Fallon Health ឬ អ្នកមានសិទ្ធិទទួលបាននូវព័ត៌មាន ប្រាកដប្រជា រឺសំណួរ ប្រយោជន៍អ្វីមួយ។  
បើមិនយល់យ៉ាងណាក៏ដោយសូម ទូរស័ព្ទ 1-800-868-5200 ។

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.

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.

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.

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.

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.

अगर आपको, या आपके द्वारा मदद किए जा रहे किसी व्यक्ति को, Fallon Health के बारे में कोई प्रश्न हैं, तो आपको अपनी भाषा में मुफ्त में सहायता और जानकारी प्राप्त करने का अधिकार है। दुभाषिए से बात करने के लिए, 1-800-868-5200 पर कॉल करें।

જો તમને, અથવા તમે જેને મદદ કરી રહ્યા છો, તેને Fallon Health વિશે કોઈ પ્રશ્નો હોય, તો તમને મફતમાં તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, 1-800-868-5200 પર કોલ કરો.

## Notice of inclusion resources

At Fallon Health, we believe everyone deserves access to **health care without discrimination**. We work every day to help people of any age, income level, race, color, ethnicity, national origin, disability, religion, sexual orientation, sex, gender identity, and health status achieve their health goals.

To make sure you have access to all the resources and information necessary to understand and access your health plan benefits, we provide:

- **Free aids and services**—such as qualified sign language interpreters and written information in other formats, including large print, braille, accessible electronic formats, and other formats.
- **Free language services**—such as qualified interpreters and information written in other languages—to people whose primary language is not English.
- **Dedicated resources, individuals, and teams** that specialize in reviewing our policies to ensure inclusion of the unique needs of our transgender and gender diverse members.

If you need access to or wish to discuss any of this information or resources, **please call us** at the phone number on the back of your member ID card. Or you can email us at [cs@fallonhealth.org](mailto:cs@fallonhealth.org).

We will provide these services and resources to you as quickly as possible and within reasonable expectations.

If you believe Fallon Health or a provider has **discriminated against you or didn't provide these resources**, please tell us. This is called a grievance. You can write, call, or email us at:

Section 1557 Coordinator  
Fallon Health

1 Mercantile St., Ste. 400, Worcester, MA 01608  
Phone: 1-800-868-5200 (TRS 711)  
Email: [Equity@fallonhealth.org](mailto:Equity@fallonhealth.org)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights online 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)

*This notice is also available on our website at [fallonhealth.org](http://fallonhealth.org).*