Fallon Health: Community Care Connector High 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. 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 deductible?	**$1,000** person/**$2,000** 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. 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For covered services with in-network providers: **$7,500**/person or **$15,000**/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-billing 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/findphysician or call 1-800-868-5200** for a list of network 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.
Do you need a referral to see a specialist?	Yes.	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.

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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 (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 co-pay/visit; Deductible does not apply	Not covered	----------None----------
	Specialist visit	$45 co-pay/visit; Deductible does not apply	Not covered	Referral and preauthorization required for certain covered services.
	Preventive care/ screening/immunization	No charge; Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Services $25 co-pay after deductible, Non Lab Services $35 co-pay after deductible.	Not covered	----------None----------
	Imaging (CT/PET scans, MRIs)	$200 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 More information about prescription drug coverage is available at https://fallonhealth.org/providers/pharmacy/online-drug-formulary.aspx	Tier 1	$25 co-pay/ prescription (retail and emergency); $50 co-pay/ prescription (mail order); Deductible does not apply	$25 co-pay/ prescription (emergency only); Deductible 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	$45 co-pay/ prescription (retail and emergency); $90 co-pay/ prescription (mail order); Deductible does not apply	$45 co-pay/ prescription (emergency only); Deductible 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	$75 co-pay/ prescription (retail and emergency); $225 co-pay/ prescription (mail order) after deductible	$75 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 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	Emergency room care	$250 co-pay/visit after deductible	$250 co-pay/visit after deductible	Copayment waived if admitted.
	Emergency medical transportation	Deductible	Deductible	----------None----------
	Urgent care	$45 co-pay/visit; **Deductible** does not apply	$45 co-pay/visit; **Deductible** does not apply	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 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	$20 co-pay/visit; **Deductible** does not apply	Not covered	Referral and preauthorization required for certain covered services.
	Inpatient services	$500 co-pay/admission after deductible	Not covered	Referral and preauthorization may be required for certain covered services.
If you are pregnant	Office visits	No charge; **Deductible** does not apply	Not covered	**Cost sharing** does not apply to **preventive services**. 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	$500 co-pay/admission after deductible	Not covered	Referral and preauthorization may be 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	$45 co-pay/visit in an office; **Deductible** does not apply	Not covered	Short-term physical and occupational therapy limited to 60 visits combined per year. Speech therapy limited to 30 visits per year. Additional visits are covered when medically necessary. Referral and preauthorization required for certain covered services.
	Habilitation services	$45 co-pay/visit in an office; **Deductible** does not apply	Not covered	Short-term physical and occupational therapy limited to 60 visits combined per year. Speech therapy limited to 30 visits per year. Additional visits are covered when medically necessary. Referral and preauthorization required for certain covered services.
	Skilled nursing care	$500 co-pay/admission after 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	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; **Deductible** does not apply	Not covered	Routine eye exams are limited to once per calendar year.
	Children's glasses	No charge; **Deductible** does not apply	Not covered	One designated set, once per calendar year.
	Children's dental check-up	No charge; **Deductible** 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, 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 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. 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

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.

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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.	$1,000
Specialist copayment	$45
Hospital (facility) copayment	$500
Other coinsurance	20%

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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$1,500

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

The plan's overall deductible.	$1,000
Specialist copayment	$45
Hospital (facility) copayment	$500
Other coinsurance	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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$2,700

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

The plan's overall deductible.	$1,000
Specialist copayment	$45
Hospital (facility) copayment	$500
Other coinsurance	20%

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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$600
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,650

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 تساعده أسئلة بخصوص Fallon Health، فلديك الحق في الحصول على المساعدة والمعلومات

الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 1-800-868-5200.

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងដែជួយ ម្នាសំណួរអ្ពីFallon Health បេ,
អ្នកម្នាសិទ្ធិទទួលជំនួយនិងព័ត៌ម្នាន ជៅកនុងភាសា ររស់អ្នក ជោយមិនអ្ស់ប្ចាក់ ។
ប្ើមបីនិយាយជាមួយអ្នករកដ្ប្ សូម 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 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.

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 मुफ़्त 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 કૉલ કરો.