Null
- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven’t met your deductible.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower **deductibles**, **co-payments**, and **co-insurance** amounts.

### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 co-pay/visit</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$20 co-pay/visit</td>
<td>Not covered</td>
<td>Chiropractic care limited to 12 visits per benefit period. Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$20 co-pay/visit</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Not covered</td>
<td>Limited to one payment per day when performed at the same facility for the same diagnosis. Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$50 co-pay/test</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your Cost If You Use an In-Network Provider</td>
<td>Your Cost If You Use an Out-of-Network Provider</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 plus Mail Order</td>
<td>$10 copay/prescription (retail and emergency); $20 copay/prescription (mail order)</td>
<td>$10 copay/prescription (emergency only)</td>
</tr>
<tr>
<td></td>
<td>Tier 2 plus Mail Order</td>
<td>$25 copay/prescription (retail and emergency); $50 copay/prescription (mail order)</td>
<td>$25 copay/prescription (emergency only)</td>
</tr>
<tr>
<td></td>
<td>Tier 3 plus Mail Order</td>
<td>$45 copay/prescription (retail and emergency); $90 copay/prescription (mail order)</td>
<td>$45 copay/prescription (emergency only)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$125 copay/surgery</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$100 co-pay/visit</td>
<td>$100 co-pay/visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 co-pay/visit</td>
<td>$20 co-pay/visit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250 co-pay/admission</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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## Fallon: Select Care

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

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral Health Outpatient Services</td>
<td>$20 co-pay/visit</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral Health Inpatient Services</td>
<td>No charge</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$20 co-pay/visit</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>No charge</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$20 co-pay/visit</td>
<td>Not covered</td>
<td>For prenatal care, you pay an office visit co-pay for your first visit only.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$250 co-pay/admission</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$20 co-pay/visit in an office</td>
<td>Not covered</td>
<td>Short-term physical and occupational therapy limited to 60 visits combined per year. Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$20 co-pay/visit in an office</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$250 co-pay/admission</td>
<td>Not covered</td>
<td>Up to 100 days per year. Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>30% coinsurance</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No charge</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>No charge</td>
<td>Not covered</td>
<td>Routine eye exams are limited to one per 12 month period.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
<tr>
<td></td>
<td>Dental check up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Referral and preauthorization required for certain covered services.</td>
</tr>
</tbody>
</table>

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### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover
(This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids (over the age of 21)
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care

#### Other Covered Services
(This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care (limited to 12 visits per year)
- Infertility Treatment
- Routine Eye Care (Adult)
- Weight Loss Programs

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-868-5200. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Fallon Community Health Plan, Member Appeals and Grievances Department, 10 Chestnut Street, Worcester, MA, 01608, 1-800-868-5200, ext. 69950, grievance@fchp.org. You may also contact your state insurance department at Massachusetts Division of Insurance Consumer Service Section 1-617-521-7794. Additionally, a consumer assistance program can help file your appeal. Contact Health Care for All, 30 Winter St., Ste. 1004, Boston, MA, 02108, 1-800-272-4232, www.massconsumerassistance.org. Group members may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage.

Language Access Services

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-868-5200.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
About these Coverage Examples:
These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.
Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

---

### Having a baby (normal delivery)
- **Amount owed to providers:** $7,540
- **Plan pays** $7230
- **Patient pays** $310

#### Sample care costs:
- Hospital charges (mother) $2,700
- Routine obstetric care $2,100
- Hospital charges (baby) $900
- Anesthesia $900
- Laboratory tests $500
- Prescriptions $200
- Radiology $200
- Vaccines, other preventive $40

**Total** $7,540

#### Patient pays:
- Deductibles $0
- Co-pays $280
- Co-insurance $0
- Limits or exclusions $30

**Total** $310

---

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)
- **Amount owed to providers:** $5,400
- **Plan pays** $4480
- **Patient pays** $920

#### Sample care costs:
- Prescriptions $2,900
- Medical Equipment and Supplies $1,300
- Office Visits and Procedures $700
- Education $300
- Laboratory tests $100
- Vaccines, other preventive $100

**Total** $5,400

#### Patient pays:
- Deductibles $0
- Co-pays $880
- Co-insurance $0
- Limits or exclusions $40

**Total** $920

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

- No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Fallon: Select Care

Coverage Examples

Coverage Period: 01/01/2015 - 12/31/2015

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

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