Fallon: Direct Care Coinsurance 35%

Coverage Period: Beginning on or after 01/01/2016

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

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.fallonhealth.org/plandocs**. or by calling **1-800-868-5200**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,000 person/$4,000 family. Doesn't apply to preventive care.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For covered services with participating providers $6,850 person / $13,700 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.fallonhealth.org/plandocs or call 1-800-868-5200 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I 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 the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the section *Excluded Services & Other Covered Services*. See your policy or plan document for additional information about excluded services.

- **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	Your Cost if You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 co-pay/visit	Not covered	----------None----------
	Specialist visit	$60 co-pay/visit	Not covered	Referral and preauthorization required for certain covered services.
	Other practitioner office visit	$35 co-pay/visit with your PCP and certain other providers; $60 co-pay/visit with a specialist	Not covered	Chiropractic care limited to 12 visits per benefit period. Referral and preauthorization required for certain covered services.
	Preventive care/screening/immunization	No charge	Not covered	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	35% coinsurance after deducutible	Not covered	----------None----------
	Imaging (CT/PET scans, MRIs)	35% coinsurance after deductible	Not covered	Referral and preauthorization required for certain covered services.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.fallonhealth.org.	Tier 1 plus Mail Order	$5 copay/ prescription (retail and emergency); $10 copay/ prescription (mail order)	$5 copay/ prescription (emergency only)	Retail covers up to a 30-day supply; Emergency services covers up to a 14-day supply; Mail order covers up to a 90 day supply.
	Tier 2 plus Mail Order	$15 copay/ prescription (retail and emergency); $30 copay/ prescription (mail order)	$15 copay/ prescription (emergency only)	Retail covers up to a 30-day supply; Emergency services covers up to a 14-day supply; Mail order covers up to a 90 day supply.
	Tier 3 plus Mail Order	$50 copay/ prescription (retail and emergency); $100 copay/ prescription (mail order)	$50 copay/ prescription (emergency only)	Retail covers up to a 30-day supply; Emergency services covers up to a 14-day supply; Mail order covers up to a 90 day supply.
	Tier 4 plus Mail Order	$100 copay/ prescription (retail and emergency); $300 copay/ prescription (mail order)	$100 copay/ prescription (emergency only)	Retail covers up to a 30-day supply; Emergency services covers up to a 14-day supply; Mail order covers up to a 90 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% coinsurance after deductible	Not covered	Referral and preauthorization required for certain covered services.
	Physician/surgeon fees	35% coinsurance after deductible	Not covered	Referral and preauthorization required for certain covered services.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$250 co-pay/visit	$250 co-pay/visit	These services may be subject to your deductible.
	Emergency medical transportation	35% coinsurance after deductible	35% coinsurance after deductible	----------None----------
	Urgent care	$35 co-pay/visit	$35 co-pay/visit	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance after deductible	Not covered	Referral and preauthorization required for certain covered services.
	Physician/surgeon fee	35% coinsurance after deductible	Not covered	Referral and preauthorization required for certain covered services.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral Health Outpatient Services	$35 co-pay/visit	Not covered	Referral and preauthorization required for certain covered services.
	Mental/Behavioral Health Inpatient Services	No charge	Not covered	Referral and preauthorization required for certain covered services.
	Substance use disorder outpatient services	$35 co-pay/visit	Not covered	Referral and preauthorization required for certain covered services.
	Substance use disorder inpatient services	No charge	Not covered	Referral and preauthorization required for certain covered services.
If you are pregnant	Prenatal and postnatal care	$35 co-pay/visit	Not covered	For prenatal care, you pay an office visit co-pay for your first visit only.
	Delivery and all inpatient services	35% coinsurance after deductible	Not covered	Referral and preauthorization required for certain covered services.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	35% coinsurance after deductible	Not covered	Referral and preauthorization required for certain covered services.
	Rehabilitation services	$35 co-pay after deductible in an office	Not covered	Short-term physical and occupational therapy limited to 60 visits combined per year. Referral and preauthorization required for certain covered services.
	Habilitation services	$35 co-pay after deductible in an office	Not covered	Referral and preauthorization required for certain covered services.
	Skilled nursing care	35% coinsurance after deductible	Not covered	Up to 100 days per year. Referral and preauthorization required for certain covered services.
	Durable medical equipment	35% coinsurance after deductible	Not covered	Referral and preauthorization required for certain covered services.
	Hospice service	Deductible	Not covered	Referral and preauthorization required for certain covered services.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Routine eye exams are limited to one per 12 month period.
	Glasses	Not covered	Not covered	----------None----------
	Dental check up	No charge	Not covered	Dental check ups are limited to two per 12 month period.

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

Excluded Services & Other Covered Services:

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.)

- Abortion 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.

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 $3,890**
- **Patient pays $3,650**

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	$2,000
Co-pays	$50
Co-insurance	$1,570
Limits or exclusions	$30
Total	**$3,650**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $4,190**
- **Patient pays $1,210**

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	$140
Co-pays	$1,030
Co-insurance	$0
Limits or exclusions	$40
Total	**$1,210**

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.

Direct Care Coinsurance 35%

Benefit Summary—*Benefits effective January 1, 2016 and beyond*

The Fallon difference

Direct Care is a Limited Provider Network. With Direct Care Coinsurance 35%, you get everything you need to live a healthy life. This plan features comprehensive medical benefits for lower monthly premiums and slightly higher out-of-pocket expenses compared to our other plans. Your monthly premiums are reduced further through the use of coinsurance for certain services. Plus, you get:

- **A fitness reimbursement of up to $150** that can be used for gym memberships at the gym of your choice with no limitations, school and town sports fees, home fitness equipment, exercise classes, ski lift tickets, and more!
- **$0 copayments for routine physical exams** and other preventive services, including mammograms, cholesterol screenings and immunizations
- **$0 copayments for routine annual eye exams**
- **Pedi-Dental** up to age 19 included.
- **Nurse Connect:** A free 24/7 nurse call line
- **Member discounts** on products and services to keep you healthy and features you won't find anywhere else.

How to receive care:

This plan provides access to a network that is smaller than Fallon's Select Care provider network. In this plan, members have access to network benefits only from the providers in Direct Care. Please consult the Direct Care provider directory; a paper copy can be requested by calling Customer Service at 1-800-868-5200, or visit the provider search tool at fallonhealth.org to determine which providers are included in Direct Care.

Choosing a primary care provider (PCP)

Your relationship with your PCP is very important because he or she will work with Fallon to provide or arrange most of your care. As a member of Direct Care Coinsurance 35%, you must select a PCP. To do this, just complete the section on your Fallon membership enrollment form. If you need help choosing a PCP, please visit the "Find a Doctor" tool on fallonhealth.org or call Customer Service.

Obtaining specialty care

When you want to visit a specialist, talk with your PCP first. He or she will help arrange specialty care for you. The following services do not require a referral when you see a provider in the Direct Care network: routine obstetrics/gynecology care, screening eye exams and behavioral health services. For more information on referral procedures for specialty services, consult your Direct Care *Member Handbook/Evidence of Coverage.*

Emergency medical care

Emergency services do not require referral or authorization. When you have an emergency medical condition, you should go to the nearest emergency department or call your local emergency communications system (police, fire department or 911). For more information on emergency benefits and plan procedures for emergency services, consult your Direct Care *Member Handbook/Evidence of Coverage.*

Plan specifics	
Benefit period The benefit period, sometimes referred to as a "benefit year," is the 12-month span of plan coverage, and the time during which the deductible, out-of-pocket maximum and specific benefit maximums accumulate.	Varies by employer
Deductible A deductible is the amount of allowed charges you pay per benefit period before payment is made by the plan for certain covered services. The amount that is put toward your deductible is calculated based on the allowed charge or the provider's actual charge—whichever is less.	$2,000 individual $4,000 family
Embedded deductible Please note that once any one member in a family accumulates $2,000 of services that are subject to the family deductible, that individual member's deductible is considered met, and that family member will receive benefits for covered services less any applicable copayments.	$2,000
Deductible carryover Any deductible amount that is incurred by the member for services rendered during the last three months of the benefit period will be applied toward the deductible for the next benefit period. Deductible amounts are incurred as of the date of the service.	Included
Out-of-pocket maximum The out-of-pocket maximum is the total amount of deductible, coinsurance and copayments you are responsible for in a benefit period. The out-of-pocket maximum also does not include your premium charge or any amounts you pay for services that are not covered by the plan.	$6,850 individual/ $13,700 family

Benefits	Your cost
Office	
Routine physical exams (according to MHQP preventive guidelines)	$0
Office visits (primary care provider)	$35 per visit
Office visits (specialist)	$60 per visit
Office visits (limited service clinics, e.g., Minute Clinic)	$35 per visit
Routine eye exams (one every 12 months)	$0
Short-term rehabilitative services (60 visits per benefit period)	$35 per visit after deductible
Prenatal care	$35 first visit only
Preventive services Tests, immunizations and services geared to help screen for diseases and improve early detection when symptoms or diagnosis are not present	Covered in full
Diagnostic services Tests, immunizations and services that are intended to diagnose, check the status of, or treat a disease or condition	35% coinsurance after deductible
Imaging (CAT, PET, MRI, Nuclear Cardiology)	35% coinsurance after deductible

Benefits	Your cost
Office (continued)	
Chiropractic care (12 visits per benefit period)	$35 per visit
Prescriptions *Please note: Specialty medication that falls under the medical benefit will apply towards your deductible. For more information, please contact FCHP's Customer Service Department at 1-800-868-5200.*	**Tier 1/Tier 2/Tier 3/ Tier 4**
Prescription drugs, insulin and insulin syringes	$5/$15/$50/$100 (30-day supply)
Generic contraceptives and contraceptive devices	$0 (30-day supply)
Brand contraceptives with no generic equivalent (prior authorization required)	With prior authorization: $0 (30-day supply)
Brand contraceptives with a generic equivalent (prior authorization required)	Tier 3: $50 Tier 4: $100 (30-day supply)
Prescription medication refills obtained through the mail order program	$10/$30/$100/$300 (90-day supply)
Prilosec OTC, Prevacid 24HR, omeprazole OTC (prescription required)	$5
Inpatient hospital services	
Room and board in a semiprivate room (private when medically necessary)	35% coinsurance after deductible
Physicians' and surgeons' services	35% coinsurance after deductible
Physical and respiratory therapy	35% coinsurance after deductible
Intensive care services	35% coinsurance after deductible
Maternity care	35% coinsurance after deductible
Same-day surgery	
Same-day surgery in a hospital outpatient or ambulatory care setting	35% coinsurance after deductible
Emergencies	
Emergency room visit	$250 per visit after deductible (waived if admitted)
Skilled nursing	
Skilled care in a semiprivate room	35% coinsurance after deductible
Substance abuse	
Office visits	$35 per visit
Detoxification in an inpatient setting	Covered in full

Benefits	Your cost
Rehabilitation in an inpatient setting	Covered in full
Mental health	
Office visits	$35 per visit
Services in a general or psychiatric hospital	Covered in full
Other health services	
Skilled home health care services	35% coinsurance after deductible
Durable medical equipment	35% coinsurance after deductible
Medically necessary ambulance services	35% coinsurance after deductible
Value-added features	
It Fits!, an annual benefit period fitness reimbursement (including school and town sports programs, gym memberships, home fitness equipment, Weight Watchers®, aerobics, Pilates and yoga classes)	$150 individual $150 family
The Healthy Health Plan!, a program that allows you to enroll in a customized action health plan that may include regular health coaching, wellness workshops, interactive tools and more!	Included
Oh Baby!, a program that provides prenatal vitamins, a convertible car seat, breast pump and other "little extras" for expectant parents—all at no additional cost.	Included
Fallon Smart Shopper Transparency tool and incentive program	Included
Free 24/7 nurse call line	Included
Free chronic care management	Included
Free stop-smoking program	Included
Member discount program	Included
Free online access to health and wellness encyclopedia	Included
CVS Caremark ExtraCare Health Card – provides 20% discount on CVS/pharmacy-brand health related items.	Included
Exclusions	
Hearing aids and the evaluation for a hearing aid (for age 22 and above) Long-term rehabilitative services Cosmetic surgery Experimental procedures or services that are not generally accepted medical practice Dental services not described in your *Schedule of Benefits* Routine foot care Custodial confinement	

Some services may require prior authorization. A complete list of benefits and exclusions is in the Direct Care *Member Handbook/Evidence of Coverage*, available by request. This is only a summary of benefits and exclusions.

Questions?

If you have any questions, please contact Fallon Health Customer Service at 1-800-868-5200 (TTY users, please call TRS Relay 711), or visit our Web site at fallonhealth.org.

*This health plan **meets minimum creditable coverage standards** and **will satisfy** the individual mandate that you have health insurance. As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years and older, must have health coverage that meets the minimum creditable coverage standards set by the Commonwealth Health Insurance Connector.*

Benefits may vary by employer group.
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