MNHG: Fallon Select Care Network

Coverage Period: 6/1/2013 - 5/31/2014

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.fchp.org**. or by calling **1-800-868-5200**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** person/**$750** 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 certain covered services with participating providers **$2,000** person / **$4,000** 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.fchp.org 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	$20 co-pay/visit	Not covered	----------None----------
	Specialist visit	$35 co-pay/visit	Not covered	Referral and preauthorization required for certain covered services.
	Other practitioner office visit	$20 co-pay/visit with your PCP and certain other providers; $35 co-pay/visit with a specialist	Not covered	Chiropractic care limited to 12 visits per year. 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)	No charge	Not covered	You must first meet your plan deductible.
	Imaging (CT/PET scans, MRIs)	$100 co-pay/test	Not covered	Limited to one payment per day when performed at the same facility for the same diagnosis. Your deductible applies after you pay the in-network amount. 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.fchp.org.	Tier 1 plus Mail Order	$10 co-pay/prescription (retail and emergency); $20 co-pay/prescription (mail order)	$10 co-pay/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	$25 co-pay/prescription (retail and emergency); $50 co-pay/prescription (mail order)	$25 co-pay/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 co-pay/prescription (retail and emergency); $110 co-pay/prescription (mail order)	$50 co-pay/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)	$150 co-pay/surgery	Not covered	Your deductible applies after you pay the in-network amount. Referral and preauthorization required for certain covered services.
	Physician/surgeon fees	No charge	Not covered	Your deductible applies to these services. Referral and preauthorization required for certain covered services.
If you need immediate medical attention	Emergency room services	$100 co-pay/visit	$100 co-pay/visit	These services may be subject to your deductible.
	Emergency medical transportation	No charge	No charge	You must first meet your plan deductible.
	Urgent care	$20 co-pay/visit	$20 co-pay/visit	----------None----------

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 have a hospital stay	Facility fee (e.g., hospital room)	$500 co-pay/admission	Not covered	Your deductible applies after you pay the in-network amount. Referral and preauthorization required for certain covered services.
	Physician/surgeon fee	No charge	Not covered	Your deductible applies to these services. Referral and preauthorization required for certain covered services.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral Health Outpatient Services	$20 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	$20 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	$20 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	$500 co-pay/admission	Not covered	Your deductible applies after you pay the in-network amount. 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	No charge	Not covered	You must first meet your plan deductible. Referral and preauthorization required for certain covered services.
	Rehabilitation services	No charge in a facility; $20 co-pay/visit in an office	Not covered	Short-term physical and occupational therapy limited to 60 visits combined per year. You must first meet your plan deductible. Referral and preauthorization required for certain covered services.
	Habilitation services	$20 co-pay/visit	Not covered	Referral and preauthorization required for certain covered services.
	Skilled nursing care	No charge	Not covered	Up to 100 days per year. You must first meet your plan deductible. Referral and preauthorization required for certain covered services.
	Durable medical equipment	No charge	Not covered	You must first meet your plan deductible. Referral and preauthorization required for certain covered services.
	Hospice service	No charge	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	$10 co-pay	Not covered	----------None----------

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
- Hearing Aids
- 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.)

- Bariatric Surgery
- Chiropractic Care (limited to 12 visits per year)
- Dental Care (Adult)
- 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 Health and Life Assurance Co., Inc., Member Appeals and Grievances Department, 10 Chestnut Street, Worcester, MA, 01608, 1-800-868-5200, ext. 69950, grievance@fchp.org. 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.

----------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 $6,600**
- **Patient pays $940**

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	$250
Co-pays	$540
Co-insurance	$0
Limits or exclusions	$150
Total	**$940**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,070**
- **Patient pays $1,330**

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	$1,110
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,330**

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.