Small Business Service Bureau, Inc.®

Fallon Health

# SBSB Group Health Insurance Program for Sole-Proprietors and Small Employers in Massachusetts

***Welcome!*** Enrollment in the health insurance plan of your choice is simple – ***only 3 easy steps***. Our Benefit Specialists are available to assist you and all information is confidential.

**Step 1: Obtain a premium quote** by contacting an SBSB Benefit Specialist at 1-800-472-7199, or by visiting us at www.SBSBHealth.com and click on Small Business Shopping for my Employees.

**Step 2: Apply for health insurance** by submitting the following to SBSB.

___ Completed Health Plan Group Census and Selection Form

___ Health Insurance Premium Quote

___ Have each employee participating in your group plan complete, sign, and date an Enrollment/Change Form. *(**Please note:** all dependent information including dates of birth must be accurate.)*

___ Waiver of Coverage Form for each employee opting out of your group insurance plan

___ Pediatric Dental Coverage Attestation Form (if applicable)

___ Include Proof of Business Documentation **(choose at least 1)**

- Tax Documentation: Schedule C, WR1 SE
- Business License or Permit for Commercial Operation
- Validation from MA Secretary of State's Office or applicable city/town clerk's office
- Copy of Business related Bank Statement
- Report from a business credit rating agency
- Declaration Statement of Worker's Compensation or Commercial Property/Casualty Insurance

___ Complete the SBSB Membership Application

**Step 3: Submit** the first month premium and SBSB Annual Membership Dues ($85 for 1-4 employees; $125 for 5-9 employees) payable to SBSB.

**Mail to:** Small Business Service Bureau, Inc.
38 Austin Street
P.O. Box 15014
Worcester, MA 01615-0014

**or FAX to:**
1-508-792-3872

**or scan and email to:**
enroll@sbsb.com

*All groups subject to health plan eligibility and underwriting requirements.*
*All enrollment documents, including the employee's enrollment form, must be completed, signed, dated, and submitted to the Small Business Service Bureau, Inc. prior to the desired effective date.*

# Join SBSB!
# A Big PLUS for Small Business Success!

## Member Information

**Business Name** ______________________

**Name of Owner/Operator** ☐ Mr. ☐ Mrs. ☐ Ms.

FIRST NAME  MIDDLE INITIAL  LAST NAME

TITLE  DATE OF BIRTH

**Business Address**

STREET (NO P.O. BOXES)

CITY  STATE  ZIP

**Mailing Address** (if different from street address above)

STREET / P.O. BOX

CITY  STATE  ZIP

Is your business address the same as your home address?

☐ Yes ☐ No  Do you: ☐ Rent ☐ Own ☐ Lease?

**Business Telephone** (______) ______________________

**Home Telephone** (______) ______________________

**Fax No.** (______) ______________________

**E-mail** ______________________

**Number of Full-Time Employees** ______________________

**Description of Business:** ______________________

EXAMPLES: ACCOUNTING, LAW, RETAIL CLOTHING SALES, COMPUTER CONSULTING, ETC.)

**Business Structure** (check one)

☐ Corporation ☐ Sole Proprietorship
☐ Partnership ☐ Subchapter S

Does your company have a probationary period for new employees? ☐ No ☐ Yes  If yes, what is it? ______________

**AUTHORIZED SIGNATURE**  **TITLE**

/ /

**PRINT NAME**  **DATE**

Please use the SBSB return-addressed envelope provided to submit your application(s).

A National Membership Organization for Small Business
38 Austin Street • P.O. Box 15014 • Worcester, MA 01615-0014

☐ **Yes, I want to save money on group insurance and other benefits for my small business!**

## Complete this section only if applying for health insurance through SBSB.

**Health Insurance Effective Date Desired** ____ / ____ / ____

If you are applying for health insurance, do not cancel any insurance until you are certain your new coverage is in effect.

I hereby certify and attest the information provided herein is true and complete to the best of my knowledge, and that I have the legal authority to execute this document on behalf of the company named herein. I certify that 100% of eligible people who are not covered by a spouse, parent or Medicare are enrolled in the SBSB Health Insurance Program. Furthermore, I certify that all current and future employees to be enrolled actively work full-time, as defined by state and federal laws, for financial compensation. I understand all health coverage becomes effective upon the approval of the provider or carrier. I further state I am aware the health provider retains the right to terminate coverage at any time if the statements made herein are not true and complete.

**For information or assistance with this application, call an SBSB Membership Representative Toll Free at**

## 1-800-472-7199.

FOR SBSB USE ONLY

| DATE ______ | 090 ______ | 260 ______ | 400 ______ |
|---|---|---|---|
| 250 ______ | 210 ______ | 490 ______ | 410 ______ |
| 240 ______ | INITIAL BILL ______ | EFF. DATE ______ | |
| REASON ______ | | | |

# FALLON HEALTH GROUP CENSUS AND PLAN SELECTION FORM

*Include all full-time and part-time employees on payroll*

Company Name: ______________________________ Address: ______________________________

EIN: ______________________________ Company Email Address: ______________________________

Tax ID: ______________________________ SIC Code: ______________________________

Total number of employees (ACA Definition*):
Number of full-time and full-time equivalent employees (FTE's), including any part-time and seasonal employees who are employed at the time of the policy effective date working 30 or more hours per week. ______________

Do you regularly employ at least one individual that is not an owner and/or family member of an owner?
__________Yes __________No

Broker Name: ______________________________ Broker Phone #: ____________________ BR#: __________
*(if applicable)*

**Plan Selection:** All members of a common employer group must participate in the same Benefit Plan Design and Network Option. All plans include Pediatric Dental coverage as required by the ACA.

**HMO Plans** ***(Select Care or Direct Care Network selection is required)***

| Select | Direct | Plan |
|---|---|---|
| ❑ | ❑ | Copay 1000 Hybrid |
| ❑ | ❑ | Deductible 1250 Hybrid |
| ❑ | ❑ | Deductible 2000 Hybrid |
| ❑ | ❑ | Deductible 2500 Hybrid |
| ❑ | ❑ | Deductible 3000 Hybrid |
| ❑ | ❑ | Coinsurance 35% |

| Select | Direct | Plan |
|---|---|---|
| ❑ | ❑ | Deductible 2000 Low |
| ❑ | ❑ | Deductible 2500 Low |
| ❑ | ❑ | Deductible 3000 Low |
| ❑ | ❑ | Deductible 4000 Low |
| ❑ | ❑ | Deductible 5000 Low |
| ❑ | ❑ | QHD 2000 HSA |
| ❑ | ❑ | QHD 3000 HSA |

*Include all benefit eligible employees on payroll and any COBRA participants. Please attach additional listing if needed.*

| Employee Name | Waivers** (include reason) | Date of Birth | Date of Hire |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

*To determine the FTE count we recommend using https://www.healthcare.gov/shop-calculators-fte/.
**If waiving right to group health care coverage at this time, please attach a completed waiver of coverage form.

## Employer Certification & Eligibility Guidelines

**A. EMPLOYER CERTIFICATION:**

1. I hereby certify and attest the information provided above is true and complete to the best of my knowledge and that I have the legal authority to execute this document on behalf of the company named above. I understand all health coverage becomes effective upon the approval of the provider or carrier.
2. I further state that I am aware the health plan retains the right to terminate coverage at any time if the statements made herein are not true and complete.

**B. TO BE ELIGIBLE, A BUSINESS MUST:**

1. In the judgment of Fallon Health be a business operated for purposes other than to secure health insurance.
2. Be a primary business rather than a hobby or part-time business.
3. Employ no more than ten people. Employers with ten or fewer total employees may enroll any person who meets the requirement of Section B.1 or B.2., provided that the employer shall offer all such people the same coverage options.
4. Be an active member of the Small Business Service Bureau, Inc. (SBSB).

**C. ELIGIBLE SUBSCRIBERS:**

1. OWNER
   The owner of a business who does not draw a salary must provide a copy of a Business License, Contract or other proof deemed appropriate by Fallon Health. **THE OWNER MUST DEMONSTRATE THAT THE BUSINESS IS OPERATED AS A PRIMARY MEANS OF LIVELIHOOD.**
2. EMPLOYEE
   Active employee who permanently lives or works in the Plan's Service Area and meets each of the following criteria.
   a. Works at least 20 hours per week for reasonable financial compensation and receives the benefit of 25% minimum company contribution to both Individual and Family premiums or works at least 30 hours per week for reasonable financial compensation and receives the benefit of company contribution of at least 50% for Individual and 33% for Family premiums.
   b. Pays State, Federal and FICA taxes on that financial compensation with the employer paying his/her appropriate portions.
   c. Is actively employed on their effective date and in the judgment of Fallon Health, capable of performing their duties.
   d. Has employer provided Worker's Compensation Insurance.
   e. Coverage is not allowed for Directors or Officers who are not employees.
   f. A new employee must apply for Fallon Health coverage within 30 days of the hire date if the employer does not require a probationary period. Coverage will become effective on the 1st of the month after the hire date. If date of hire is the 1st of the month, coverage will become effective on that day or the 1st of the next month. If a probationary period exists, must be consistently applied to all new employees; Fallon Health will allow company probationary periods up to 90 days.

***Please Note:* Fallon Health requires 100% participation of all eligible employees in groups of 1-5 and 75% participation of all eligible employees in groups of 6-10.**

Signed:______________________________________________ Date:______________
Authorized Company Representative

Name: ______________________________________________
Please Print

*All groups subject to health plan eligibility and underwriting requirements.*
*All enrollment documents, including the employee's application, must be completed, signed, dated, and submitted to SBSB five (5) business days prior to the desired effective date.*

**If you have any questions, please contact SBSB at 1-800-472-7199.**

**Mail to:** Small Business Service Bureau, Inc.
38 Austin Street
P.O. Box 15014
Worcester, MA 01615-0014

**or FAX to:**
1-508-792-3872
**or scan and email to:**
enroll@sbsb.com

Small Business Service Bureau, Inc.®

# Waiver/Verification of Alternative Coverage

**Eligible Employees who refuse the SBSB Group Insurance Plan offered through their employer must verify they have alternative coverage.**

I,_________________________ , certify that I am an employee of and that I am eligible for group health care coverage through______________________ , my employer. I also certify that I am waiving my right to group health care coverage through my employer at this time because I have chosen health care coverage through ***(Check box that applies):***

❑ COBRA ❑ Parent/Spouse ❑ Union ❑ Medicare ❑ Alternate group health program

Parent's / Spouse's Name: ________________________________________

Current Health Plan: ________________________________________

Health Plan Identification Number: ________________________________

Group / Policy Number:________________________________________

**Notice of Enrollment Rights**

*If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this health plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.*

I understand that any person choosing to enroll later must meet the health plan's requirements for eligibility and for late enrollees.

____________________________________________________

Employee Name *(please print)*

____________________________________________________

Signature Date

**I affirm that the assertions in this form are true and complete to the best of my knowledge, and I understand that the health plan has the right to terminate coverage, retroactive to the effective date of coverage, for any material misinformation (including omissions) contained in this form.**

____________________________________________________

Signature of Authorized Company Representative Date

**If you have any questions, please contact SBSB at 1-800-472-7199.**

**Return with the completed census and required documents to:**
**Small Business Service Bureau, Inc.**
**38 Austin Street • PO Box 15014 • Worcester, MA 01615-0014**

# Member Transaction Form

Please print clearly and complete all applicable fields.

Fallon Community Health Plan
Fallon Health & Life Assurance Co., Inc.

## THE FOLLOWING SECTION IS TO BE FILLED OUT BY THE EMPLOYER:

| Group number | Group name | Effective date: MM/DD/YYYY |
|---|---|---|
| | | |

**Type of coverage:** ❑ Individual ❑ Two-person ❑ Family ❑ Other ____________

**Provider network:** ❑ FCHP Direct Care* ❑ FCHP Select Care ❑ Fallon Preferred Care ❑ FCHP Steward Community Care* ❑ FCHP Tiered Choice*

**Plan name:** ____________

### Please check off the reason you are filling out this form:

**Adding coverage:** ❑ New hire ❑ Annual open enrollment ❑ Other (Please explain in the Remarks section below.)

**Ending coverage:**

❑ Termination of employment ❑ Change to other insurance (Please provide the name of the other insurance in the Remarks section below.)

❑ Other (Please explain in the Remarks section below.)

**Changes to existing coverage: (Please choose an option and explain in the Remarks section below.)**

**Change to:** ❑ Individual plan ❑ Two-person plan ❑ Family plan ❑ COBRA ❑ Other

❑ Addition of a dependent (Please complete the dependent section of this form.) Date of qualifying event: ____________

❑ Removal of a dependent

❑ Change in name, address or other application information

❑ Other

**Remarks:**

**This form is not complete without an authorized employer signature on page 2.**

## THE FOLLOWING SECTIONS ARE TO BE FILLED OUT BY THE EMPLOYEE (subscriber):

*Please complete all applicable fields in this section.*

| First name | Middle initial (MI) | Last name | Gender ❑ Male ❑ Female |
|---|---|---|---|

| Maiden name | Primary language | Birth date (MM/DD/YYYY ) |
|---|---|---|

Physical address

| City | State | ZIP code |
|---|---|---|

Mailing address *(if different from physical above)*

| City | State | ZIP code |
|---|---|---|

| Would you be interested in receiving communications from FCHP via e-mail? If so, please check the box and provide your e-mail address: ❑ | Home phone |
|---|---|

| Social Security # | Date hired (MM/DD/YYYY ) | Work phone |
|---|---|---|

Race (please choose one) ❑ White ❑ Black ❑ Hispanic ❑ Asian/Pacific Islander ❑ American Indian/Alaskan Native ❑ Other

Work status (please choose one) ❑ Full-time ❑ Part-time ❑ Retired ❑ COBRA

| Average # of hours worked weekly | Department # | Employee # |
|---|---|---|

Does your spouse have health insurance from another source? ❑ Yes ❑ No

Please provide the name of your selected primary care physician (PCP). Are you currently being treated by this PCP? ❑ Yes ❑ No

First name MI Last name

**Benefits administrator:** Please mail the white and yellow copies of this form to: FCHP Service Operations, 10 Chestnut St., Worcester, MA 01608.

The pink copy is for the employee.

## **DEPENDENT** SECTION:

In this section, please list all dependents covered under this plan. If you need more room, please use an additional Member Transaction Form.

**Dependent 1:** First name MI Last name (include maiden name if applicable) Gender ❑ Male ❑ Female

Relation to you Social Security #

Primary language Race Birth date (MM/DD/YYYY )

Please provide the name of this dependent's primary care physician (PCP). Is this dependent currently being treated by this PCP? ❑ Yes ❑ No

First name MI Last name

**Dependent 2:** First name MI Last name (include maiden name if applicable) Gender ❑ Male ❑ Female

Relation to you Social Security #

Primary language Race Birth date (MM/DD/YYYY )

Please provide the name of this dependent's primary care physician (PCP). Is this dependent currently being treated by this PCP? ❑ Yes ❑ No

First name MI Last name

**Dependent 3:** First name MI Last name (include maiden name if applicable) Gender ❑ Male ❑ Female

Relation to you Social Security #

Primary language Race Birth date (MM/DD/YYYY )

Please provide the name of this dependent's primary care physician (PCP). Is this dependent currently being treated by this PCP? ❑ Yes ❑ No

First name MI Last name

**Dependent 4:** First name MI Last name (include maiden name if applicable) Gender ❑ Male ❑ Female

Relation to you Social Security #

Primary language Race Birth date (MM/DD/YYYY )

Please provide the name of this dependent's primary care physician (PCP). Is this dependent currently being treated by this PCP? ❑ Yes ❑ No

First name MI Last name

**Dependent 5:** First name MI Last name (include maiden name if applicable) Gender ❑ Male ❑ Female

Relation to you Social Security #

Primary language Race Birth date (MM/DD/YYYY )

Please provide the name of this dependent's primary care physician (PCP). Is this dependent currently being treated by this PCP? ❑ Yes ❑ No

First name MI Last name

*I understand that my signature below means that I have read and I understand the contents of this form, and that I agree to the terms and conditions located on the back of this form.*

X ______________________________ ______________
**Employee signature** Print name here Date

X ______________________________ ______________
**Employer signature** Print name here Date

Group name (please print) ______________________________

* FCHP Direct Care, FCHP Steward Community Care and FCHP Tiered Choice provide access to networks that are smaller than the FCHP Select Care network. In these plans, members have access to network benefits only from the providers in their respective network. Please consult the respective provider directory—paper copies can be requested by calling our Customer Service Department at 1-800-868-5200—or visit the provider search tool at fchp.org to determine which providers are included in FCHP Direct Care, FCHP Steward Community Care and FCHP Tiered Choice.

FCHP Tiered Choice members have access to network benefits only from the providers in FCHP Tiered Choice, and may pay different levels of copayments, coinsurance and/or deductibles depending on the tier of the provider delivering a covered service or supply. This plan may make changes to a provider's benefit tier annually on January 1.

# Welcome!

Thank you for choosing us to provide your health coverage. You will soon receive a New Member Kit in the mail. This kit will include information about your membership and your membership card(s). Also included in your New Member Kit will be information on how to obtain a *Member Handbook/Evidence of Coverage,* which defines your benefits and regulates benefit decisions. If you, or a dependent, need to seek medical services or fill a prescription before you receive your Member ID card in the mail, all you have to do is give us a call. A member of our Customer Service team can help you. Simply ask for the following information:

1. Your Member ID card number
2. If you need to fill a prescription, ask for your BIN number, and your PCN number.
   These are codes that your pharmacy will need to ensure that your drugs are covered, and that you pay the right out-of-pocket cost-sharing amount.

## If you are an FCHP Direct Care, FCHP Select Care, FCHP Steward Community Care or an FCHP Tiered Choice plan member:

### You must choose a primary care physician (PCP):

Each person covered under one of these contracts must choose a PCP. A PCP is a doctor of internal medicine or family practice for adults and a pediatrician or family practice doctor for children. Please refer to fchp.org or your plan's *Provider Network* directory for a complete list of providers and their locations. You must make these selections now and list your choices on this Membership Transaction Form. Informing FCHP of your PCP selection(s) as soon as possible will help ensure that any bills for health services you receive from your PCP are processed as quickly as possible.

**Worldwide emergency 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 *Member Handbook/Evidence of Coverage*.

**Out-of-area urgent care:** When you are out of the service area, you are covered for any unexpected illness or injury that needs prompt medical attention and can go to the nearest medical facility for care. You will need to contact your PCP to coordinate all follow-up care, including any additional care you require outside of the service area.

**Remember:** FCHP will not pay for any services that are not provided or appropriately arranged by Fallon Community Health Plan, except in life-threatening emergencies in the area or any emergencies out of the service area.

**Questions?** Call FCHP Customer Service at 1-800-868-5200 (TTY users, please call TRS Relay 711), or visit our Web site at fchp.org.

## If you are a Fallon Preferred Care PPO plan member:

Fallon Preferred Care is a preferred provider organization (PPO) plan that offers you access to a network of more than 600,000 participating providers across the country. The network of participating providers includes the Private Healthcare Systems (PHCS) network as well as the Fallon Preferred Care providers. PHCS has created one of the largest proprietary PPO networks in the country, and received endorsements of quality from both the National Committee for Quality Assurance and URAC. You may elect to obtain health care services, including specialty care, from any provider with no referral requirements. However, you may need to receive prior authorizations from the Plan for certain services. Additionally, when you seek care out of the network, you will share a larger portion of the cost.

**Worldwide emergency 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). If you are admitted, Fallon Preferred Care requires that you notify FCHP within 72 hours or as soon as medically possible. For more information on benefits and procedures for emergency services, consult your Fallon Preferred Care *Member Handbook/Evidence of Coverage*.

**Questions?** Call Fallon Preferred Care Customer Service at 1-888-468-1541 (TTY users, please call TRS Relay 711) or visit our Web site at fchp.org.

**Consent:** Submission of this form indicates that you authorize anyone who provides medical services to you, your spouse or dependents to release to the plan any health information or medical records relating to those services for such routine needs as coordination of benefits, disease management programs, quality management, coordination of care, health services management, accreditation, processing and payment of related claims.

**Agreement:** I am employed by the company named on this form, working at least 30 hours per week, full time, or 20 hours part time, and I receive employer contribution to health insurance coverage (or I am otherwise eligible for the named company's health insurance coverage, e.g., as a former employee covered under COBRA). I hereby authorize my employer to deduct from my wages (if necessary) the amount I am responsible for contributing for the FCHP/FHLAC coverage I have selected. I understand that FCHP is a Health Maintenance Organization (Fallon Preferred Care is a Preferred Provider Organization) and that membership becomes effective in accordance with the FCHP/FHLAC Group Agreement and the *Member Handbook/Evidence of Coverage*. I have read this Member Transaction Form and understand how to obtain and use services under my FCHP/FHLAC coverage. I certify that all information is correct to the best of my knowledge. NOTE: The requested effective date may not be the actual effective date if it is not in accordance with the FCHP/FHLAC Group Agreement and your plan's *Member Handbook/Evidence of Coverage*.

# Fallon Health Intermediary Group Copay 1000 Hybrid Plan Option

Benefits effective January 1, 2019 and beyond.

| Benefit | Copay 1000 Hybrid |
|---|---|
| Office visits—routine exams | $0 |
| Office visits—other primary care | $10 |
| Office visits—specialty care | $20 |
| Telehealth | $5 |
| Prescriptions retail (up to a 30-day supply) | $5/$10/$40/$250 |
| Prescriptions—mail order (up to a 90-day supply) | $10/$20/$80/$750 |
| Emergency room (waived if admitted) | $250 |
| Inpatient hospital | $1,000 |
| Same-day surgery | $1,000 |
| ART services (IVF, GIFT, ZIFT) | $250 |
| Preventive services* | Covered in full |
| Diagnostic services (Lab)* | Covered in full |
| Diagnostic services (non-lab) X-ray/Imaging | Covered in full |
| Imaging (CAT, PET, MRI scans, nuclear cardiology) | $500 |
| Durable medical equipment (unlimited) | 20% coinsurance |
| Physical/occupational/speech therapy | $20 |
| Cardiac rehab | $0 |
| Physical/occupational/speech therapy (Autism services) | $10 |
| Chiropractic care | $20 |
| Pediatric dental | Included |
| Pediatric vision | Included |
| Deductible (ind./fam.) | Not applicable |
| Out-of-pocket maximum (ind./fam.) | $4,500/$9,000 |

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

**Diagnostic services are those tests and services that are intended to diagnose, check the status of or treat a disease or condition. Preventive services are services, tests and immunizations that are intended to screen for diseases or conditions and to improve early detection of disease when there are no diagnoses or symptoms. This excludes routine physical exams. For a guide to preventive and diagnostic services, please visit our website at fallonhealth.org. This fact sheet highlights some of the benefits of Direct Care and Select Care. For full benefits, please go to fallonhealth.org. The subscriber certificate and all riders define the terms, limitations and conditions of the plan. Should any questions arise, the subscriber certificate and riders will govern.*

18-720-025 Rev. 00 10/18

# Fallon Health Intermediary Group Deductible Hybrid HMO Plan Options

Benefits effective January 1, 2019 and beyond.

| Benefit | Deductible 1250 Hybrid | Deductible 2000 Hybrid | Deductible 2500 Hybrid | Deductible 3000 Hybrid |
|---|---|---|---|---|
| Office visits—routine exams | $0 | $0 | $0 | $0 |
| Office visits—other primary care | $10 | $10 | $10 | $15 |
| Office visits—specialty care | $20 | $20 | $20 | $25 |
| Telehealth | $5 | $5 | $5 | $5 |
| Prescriptions retail (up to a 30-day supply) | $5/$10/$40/$250 | $5/$10/$40/$250 | $5/$15/$40/$250 | $5/$15/$50/$250 |
| Prescriptions—mail order (up to a 90-day supply) | $10/$20/$80/$750 | $10/$20/$80/$750 | $10/$30/$80/$750 | $10/$30/$100/$750 |
| Emergency room (waived if admitted) | $500 | $500 | $500 | $500 |
| Inpatient hospital | $1,000 after deductible | $1,000 after deductible | $1,000 after deductible | $1,000 after deductible |
| Same-day surgery | $1,000 after deductible | $1,000 after deductible | $1,000 after deductible | $1,000 after deductible |
| ART services (IVF, GIFT, ZIFT) | $250 after deductible | $250 after deductible | $250 after deductible | $250 after deductible |
| Preventive services* | Covered in full | Covered in full | Covered in full | Covered in full |
| Diagnostic services (Lab)* | Covered in full | Covered in full | Covered in full | Covered in full |
| Diagnostic services (non-lab) X-ray/Imaging | $20 | $20 | $20 | $25 |
| Imaging (CAT, PET, MRI scans, nuclear cardiology) | $500 after deductible | $500 after deductible | $500 after deductible | $500 after deductible |
| Durable medical equipment (unlimited) | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| Physical/occupational/speech therapy | $20 | $20 | $20 | $25 |
| Cardiac rehab | $20 | $20 | $20 | $25 |
| Physical/occupational/speech therapy (Autism services) | $10 | $10 | $10 | $15 |
| Chiropractic care | $20 | $20 | $20 | $25 |
| Pediatric dental | Included | Included | Included | Included |
| Pediatric vision | Included | Included | Included | Included |
| Deductible (ind./fam.) | $1,250/$2,500 | $2,000/$4,000 | $2,500/$5,000 | $3,000/$6,000 |
| Out-of-pocket maximum (ind./fam.) | $7,900/$15,800 | $7,900/$15,800 | $7,900/$15,800 | $7,900/$15,800 |

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

**Diagnostic services are those tests and services that are intended to diagnose, check the status of or treat a disease or condition. Preventive services are services, tests and immunizations that are intended to screen for diseases or conditions and to improve early detection of disease when there are no diagnoses or symptoms. This excludes routine physical exams. For a guide to preventive and diagnostic services, please visit our website at fallonhealth.org.*

*This fact sheet highlights some of the benefits of Direct Care and Select Care. For full benefits, please go to fallonhealth.org. The subscriber certificate and all riders define the terms, limitations and conditions of the plan. Should any questions arise, the subscriber certificate and riders will govern.*

# Fallon Health Intermediary Group Coinsurance and Deductible Plan Options

Benefits effective for January 1, 2019 and beyond.

| Benefit | Coinsurance 35% | Deductible 2000 Low |
|---|---|---|
| Office visits—routine exams | $0 | $0 |
| Office visits—other primary care | $40 | $40 |
| Office visits—specialty care | $70 | $65 |
| Telehealth | $5 | $5 |
| Prescriptions retail (up to a 30-day supply) | $5/$40/$70/$150 | $5/$30/$65/$100 |
| Prescriptions—mail order (up to a 90-day supply) | $10/$80/$140/$450 | $10/$60/$130/$300 |
| Emergency room (waived if admitted) | 35% coinsurance after deductible | $700 after deductible |
| Inpatient hospital | 35% coinsurance after deductible | $1,000 after deductible |
| Same-day surgery | 35% coinsurance after deductible | $1,000 after deductible |
| ART services (IVF, GIFT, ZIFT) | $250 after deductible | $250 after deductible |
| Preventive services* | Covered in full | Covered in full |
| Diagnostic services (Lab)* | 35% coinsurance after deductible | $50 after deductible |
| Diagnostic services (non-lab) X-ray/ Imaging | 35% coinsurance after deductible | $100 after deductible |
| Imaging (CAT, PET, MRI scans, nuclear cardiology) | $350 after deductible | $700 after deductible |
| Durable medical equipment (unlimited) | 35% coinsurance after deductible | 30% coinsurance after deductible |
| Physical/occupational/speech therapy (Cardiac rehab) | $40 after deductible | $40 after deductible |
| Physical/occupational/speech therapy (Autism services) | $40 | $40 |
| Chiropractic care | $40 | $40 |
| Pediatric dental | Included | Included |
| Pediatric vision | Included | Included |
| Deductible (ind./fam.) | $2,000/$4,000 | $2,000/4,000 |
| Out-of-pocket maximum (ind./fam.) | $7,900/$15,800 | $7,900/$15,800 |

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

**Diagnostic services are those tests and services that are intended to diagnose, check the status of or treat a disease or condition. Preventive services are services, tests and immunizations that are intended to screen for diseases or conditions and to improve early detection of disease when there are no diagnoses or symptoms. This excludes routine physical exams. For a guide to preventive and diagnostic services, please visit our website at fallonhealth.org. This fact sheet highlights some of the benefits of Direct Care and Select Care. For full benefits, please go to fallonhealth.org. The subscriber certificate and all riders define the terms, limitations and conditions of the plan. Should any questions arise, the subscriber certificate and riders will govern.*

# Fallon Health Intermediary Group Qualified High Deductible HSA HMO Plan Options

Benefits effective January 1, 2019 and beyond.

| Benefit | QHD 2000 HSA | QHD 3000 HSA |
|---|---|---|
| Office visits—routine exams | $0 | $0 |
| Office visits—other primary care | $25 after deductible | $25 after deductible |
| Office visits—specialty care | $40 after deductible | $40 after deductible |
| Telehealth | $5 after deductible | $5 after deductible |
| Prescriptions retail (up to a 30-day supply) | $5/$30/$100/50% coinsurance after deductible | $5/$30/$100/50% coinsurance after deductible |
| Prescriptions—mail order (up to a 90-day supply) | $10/$60/$200/50% coinsurance after deductible | $10/$60/$200/50% coinsurance after deductible |
| Emergency room (waived if admitted) | $250 after deductible | $250 after deductible |
| Inpatient hospital | Deductible | Deductible |
| Same-day surgery | Deductible | Deductible |
| ART services (IVG, GIFT, ZIFT) | Deductible | Deductible |
| Preventive services* | Covered in full | Covered in full |
| Diagnostic services (Lab)* | Deductible | Deductible |
| Diagnostic services (non-lab) X-ray/Imaging | Deductible | Deductible |
| Imaging (CAT, PET, MRI scans, nuclear cardiology) | $250 after deductible | $250 after deductible |
| Durable medical equipment (unlimited) | 30% coinsurance after deductible | 30% coinsurance after deductible |
| Physical/occupational/speech therapy (Cardiac rehab) | $25 after deductible | $25 after deductible |
| Physical/occupational/speech therapy (Autism services) | $25 after deductible | $25 after deductible |
| Chiropractic care | $25 after deductible | $25 after deductible |
| Pediatric dental | Included | Included |
| Pediatric vision | Included | Included |
| Deductible (ind./fam.) | $2,000/$4,000 | $3,000/$6,000 |
| Out-of-pocket maximum (ind./fam.) | $6,750/$13,500 | $6,750/$13,500 |

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

**Diagnostic services are those tests and services that are intended to diagnose, check the status of or treat a disease or condition. Preventive services are services, tests and immunizations that are intended to screen for diseases or conditions and to improve early detection of disease when there are no diagnoses or symptoms. This excludes routine physical exams. For a guide to preventive and diagnostic services, please visit our website at fallonhealth.org. This fact sheet highlights some of the benefits of Direct Care and Select Care. For full benefits, please go to fallonhealth.org. The subscriber certificate and all riders define the terms, limitations and conditions of the plan. Should any questions arise, the subscriber certificate and riders will govern.*

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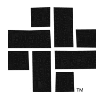

# Fallon Health Intermediary Group Deductible Low HMO Plan Options

Benefits effective April 1, 2019 and beyond.

| Benefit | Deductible 2500 Low | Deductible 3000 Low | Deductible 4000 Low | Deductible 5000 Low |
|---|---|---|---|---|
| Office visits—routine exams | $0 | $0 | $0 | $0 |
| Office visits—other primary care | $40 | $40 | $40 | $40 |
| Office visits—specialty care | $65 | $65 | $65 | $65 |
| Telehealth | $5 | $5 | $5 | $5 |
| Prescriptions retail (up to a 30-day supply) | $5/$30/$100/$250 | $5/$30/$100/$250 | $5/$30/50%/50% | $5/$30/50%/50% |
| Prescriptions—mail order (up to a 90-day supply) | $10/$60/$200/$750 | $10/$60/$200/$750 | $10/$60/50%/50% | $10/$60/50%/50% |
| Emergency room (waived if admitted) | $1,000 after deductible | $1,000 after deductible | $1,000 after deductible | $1,000 after deductible |
| Inpatient hospital | $1,000 after deductible | $1,000 after deductible | $1,000 after deductible | $1,000 after deductible |
| Same-day surgery | $1,000 after deductible | $1,000 after deductible | $1,000 after deductible | $1,000 after deductible |
| ART services (IVF, GIFT, ZIFT) | $250 after deductible | $250 after deductible | $250 after deductible | $250 after deductible |
| Preventive services** | Covered in full | Covered in full | Covered in full | Covered in full |
| Diagnostic services (Lab)** | $50 | $50 | $50 | $50 |
| Diagnostic services (non-lab) X-ray/Imaging | $200 after deductible | $200 after deductible | $200 after deductible | $200 after deductible |
| Imaging (CAT, PET, MRI scans, nuclear cardiology) | $1,000 after deductible | $1,000 after deductible | $1,000 after deductible | $1,000 after deductible |
| Durable medical equipment (unlimited) | 30% coinsurance after deductible | 30% coinsurance after deductible | 30% coinsurance after deductible | 30% coinsurance after deductible |
| Physical/occupational/speech therapy | $40 after deductible | $40 after deductible | $40 after deductible | $40 after deductible |
| Cardiac rehab | $40 after deductible | $40 after deductible | $40 after deductible | $40 after deductible |
| Physical/occupational/speech therapy (Autism services) | $40 | $40 | $40 | $40 |
| Chiropractic care | $40 | $40 | $40 | $40 |
| Pediatric dental | Included | Included | Included | Included |
| Pediatric vision | Included | Included | Included | Included |
| Deductible (ind./fam.) | $2,500/$5,000 | $3,000/$6,000 | $4,000/$8,000 | $5,000/$10,000 |
| Out-of-pocket maximum (ind./fam.) | $7,900/$15,800 | $7,900/$15,800 | $7,900/$15,800 | $7,900/$15,800 |

***Diagnostic services are those tests and services that are intended to diagnose, check the status of or treat a disease or condition. Preventive services are services, tests and immunizations that are intended to screen for diseases or conditions and to improve early detection of disease when there are no diagnoses or symptoms. This excludes routine physical exams. For a guide to preventive and diagnostic services, please visit our website at fallonhealth.org.*

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

*This fact sheet highlights some of the benefits of Direct Care and Select Care. For full benefits, please go to fallonhealth.org. The subscriber certificate and all riders define the terms, limitations and conditions of the plan. Should any questions arise, the subscriber certificate and riders will govern.*

# Notice of nondiscrimination

Fallon Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Fallon does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Fallon Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at the phone number on the back of your member ID card, or by email at cs@fallonhealth.org.

If you believe that Fallon Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Compliance Director
Fallon Health
10 Chestnut St.
Worcester, MA 01608

Phone: 1-508-368-9988 (TRS 711)
Email: compliance@fallonhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Compliance Director is available to help you.

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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## Multi-language Interpreter Services

**English:** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-325-5669 (TTY: TRS 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-325-5669 (TTY: TRS 711).

**Portuguese:** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-325-5669 (TTY: TRS 711).

**Chinese:** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-325-5669（TTY：TRS 711）。

**French Creole:** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-325-5669 (TTY: TRS 711).

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-325-5669 (TTY: TRS 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-325-5669 (телетайп: TRS 711).

**Arabic:**
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-325-5669 (رقم هاتف الصم والبكم: TRS 711).

**Khmer/Cambodian:** ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-325-5669 (TTY: TRS 711)។

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-325-5669 (ATS : TRS 711).

**Italian:** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-325-5669 (TTY: TRS 711).

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-325-5669 (TTY: TRS 711)번으로 전화해 주십시오.

**Greek:** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-325-5669 (TTY: TRS 711).

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-325-5669 (TTY: TRS 711).

**Hindi:** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-325-5669 (TTY: TRS 711) पर कॉल करें।

**Gujarati:** સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-325-5669 (TTY: TRS 711).

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