Fallon Health Intermediary Hybrid HMO Plan Options

Benefits effective January 1, 2017.

Benefit	Copay 1000 Hybrid	Deductible 1200 Hybrid	Deductible 2000 Hybrid
Metallic Tier	**Platinum**	**Gold**	**Gold**
Office visits—primary care provider/specialist	$5/$10	$5/$15	$5/$15
Prescriptions—retail (up to a 30-day supply)	$1/$5/$30/50% coinsurance $400 max per 30-day supply (per medication)	$1/$5/$30/50% coinsurance $400 max per 30-day supply (per medication)	$1/$5/$30/50% coinsurance $400 max per 30-day supply (per medication)
Prescriptions—mail-order (up to a 90-day supply)	$2/$10/$60/50% coinsurance $1,200 max per 90-day supply	$2/$10/$60/50% coinsurance $1,200 max per 90-day supply	$2/$10/$60/50% coinsurance $1,200 max per 90-day supply
Emergency room (waived if admitted)	$250	$400	$250
Inpatient hospital	$1,000	$1000 after deductible	$1,000 after deductible
Same-day surgery	$500	$1000 after deductible	$500 after deductible
Preventive services*	Covered in full	Covered in full	Covered in full
Diagnostic services (Lab services)*	Covered in full	Covered in full	Covered in full
Diagnostic Services (Non-lab) X-ray/Imaging*	Covered in full	Covered in full	Covered in full
Imaging (CAT, PET, MRI scans, nuclear cardiology)	$250	$350 after deductible	$350 after deductible
Durable medical equipment (unlimited)	20% coinsurance	20% coinsurance	20% coinsurance
Physical/occupational/speech therapy	$10	$20	$15
Chiropractic care	$10	$20	$15
Pediatric dental	Included	Included	Included
Pediatric vision	**Included**	**Included**	**Included**
Deductible	N/A	$1,200/$2,400	$2,000/$4,000
Out-of-pocket maximum	$4,500/$9,000	$7,150/$14,300	$6,850/$13,700

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** 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.*

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15-720-035 Rev. 01 9/16

Fallon Health Intermediary Classic Deductible HMO Plan Options

Benefits effective January 1, 2017 and beyond.

Benefit	Deductible 1000 Classic	Deductible 1500 Classic	Deductible 2000 Classic	Deductible 3000 Classic
Office visits—routine exams	$0	$0	$0	$0
Office visits—other primary care	$15	$25	$25	$15
Office visits—specialty care	$25	$45	$40	$25
Prescriptions retail (up to a 30-day supply)	$5/$15/$30/$50	$5/$25/$45/$75	$5/$20/$35/$60	$5/$15/$25/$50
Prescriptions—mail order (up to a 90-day supply)	$10/$30/$60/$150	$10/$50/$90/$225	$10/$40/$70/$180	$10/$30/$50/$150
Emergency room (waived if admitted)	$150	$275	$200	$200
Inpatient hospital	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible
Same-day surgery	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible
Diagnostic services/lab services*	Covered in full	Covered in full	Covered in full	Covered in full
Diagnostic services/non-lab services (X-ray, EKG, etc.)*	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible
Imaging (CAT, PET, MRI scans, nuclear cardiology)	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full 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	$15 after deductible	$25 after deductible	$25 after deductible	$15 after deductible
Chiropractic care	$15	$25	$25	$15
Pediatric dental	Included	Included	Included	Included
Pediatric vision	Included	Included	Included	Included
Deductible (ind./fam.)	$1,000/2,000	$1,500/3,000	$2,000/4,000	$3,000/6,000
Out-of-pocket maximum (ind./fam.)	$1,500/3,000	$6,850/$13,700	$6,850/$13,700	$6,850/$13,700

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Fallon Health Intermediary Copayment, Coinsurance and Deductible Plan Options

Benefits effective January 1, 2017 and beyond.

Benefit	Copay 500	Coinsurance 35%	Deductible 2000 Low
Office visits—routine exams	$0	$0	$0
Office visits—other primary care	$15	$35	$35
Office visits—specialty care	$30	$60	$60
Prescriptions retail (up to a 30-day supply)	$5/$15/$30/$60	$5/$15/$50/$100	$5/$20/$50/$100
Prescriptions—mail order (up to a 90-day supply)	$10/$30/$60/$180	$10/$30/$100/$300	$10/$40/$100/$300
Emergency room (waived if admitted)	$150	35% coinsurance after deductible	$600 after deductible
Inpatient hospital	$500	35% coinsurance after deductible	$1,000 after deductible
Same-day surgery	$250	35% coinsurance after deductible	$1,000 after deductible
Diagnostic services* (lab services)	Covered in full	35% coinsurance after deductible	Covered in full after deductible
Diagnostic services (non-lab)* X-rays/imaging	Covered in full	35% coinsurance after deductible	$100 after deductible
Imaging (CAT, PET, MRI scans, nuclear cardiology)	$100	35% coinsurance after deductible	$600 after deductible
Durable medical equipment (unlimited)	30% coinsurance	35% coinsurance after deductible	30% coinsurance after deductible
Physical/occupational/speech therapy	$20	$35 after deductible	$35 after deductible
Chiropractic care	$20	$35	$35
Pediatric dental	Included	Included	Included
Pediatric vision	Included	Included	Included
Deductible (ind./fam.)	Not applicable	$2,000/$4,000	$2,000/4,000
Out-of-pocket maximum (ind./fam.)	$4,000/$8,000	$7,150/$14,300	$7,150/$14,300

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15-715-342nc Rev. 01 9/16

Fallon Health Intermediary Qualified High Deductible HMO Plan Options

Benefits effective January 1, 2017 and beyond.

Benefit	QHD 2000 HSA	QHD 3000 HSA
Office visits—routine exams	$0	$0
Office visits—other primary care	$35 after deductible	$25 after deductible
Office visits—specialty care	$45 after deductible	$40 after deductible
Prescriptions retail (up to a 30-day supply)	$5/$30/$60/50% coinsurance after deductible	$5/$15/$30/50% coinsurance after deductible
Prescriptions—mail order (up to a 90-day supply)	$10/$60/$120/50% coinsurance after deductible	$10/$30/$60/50% coinsurance after deductible
Emergency room (waived if admitted)	$150 after deductible	$150 after deductible
Inpatient hospital	Covered in full after deductible	Covered in full after deductible
Same-day surgery	Covered in full after deductible	Covered in full after deductible
Diagnostic services (Lab services)*	$30 after deductible	Covered in full after deductible
Diagnostic services (non-lab) X-rays/Imaging*	Covered in full after deductible	Covered in full after deductible
Imaging (CAT, PET, MRI scans, nuclear cardiology)	$150 after deductible	$100 after deductible
Durable medical equipment (unlimited)	30% coinsurance after deductible	30% coinsurance after deductible
Physical/occupational/speech therapy	$35 after deductible	$25 after deductible
Chiropractic care	$35 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.)	$6,550/$13,100	$6,550/$13,100

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15-715-343nc Rev. 01 9/16