

## Fallon Health & Life Assurance Co., Inc. Schedule of Benefits

This *Schedule of Benefits* is part of your  
Teamsters Local 170 Health and Welfare Plan  
Using the Fallon Health Select Care network – Premium Value Plan  
*Member Handbook*.  
It describes your costs for health care.

This Schedule of Benefits shows your copayments and coinsurance for the covered services outlined in the Teamsters Local 170 Health and Welfare Plan using the Fallon Health Select Care network *Member Handbook*. It also outlines any of your benefits that differ from those shown in the *Member Handbook*. The information in this document replaces any information in your *Member Handbook* that conflicts with it. If you have any questions about your benefits, please call Customer Service at 1-800-868-5200 (TRS 711).

✓ This health plan **meets Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance.

### MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009 the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the **Minimum Creditable Coverage standards** set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information, call the Connector at 1-877-MA-ENROLL or visit the Connector website ([www.mahealthconnector.org](http://www.mahealthconnector.org)).

This health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2017 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2017. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at [www.mass.gov/doi](http://www.mass.gov/doi).

The following apply to your *Member Handbook*:

#### **Out-of-pocket maximum**

There is a limit to your out-of-pocket costs each benefit period. This is called your out-of-pocket maximum. The out-of-pocket maximum includes coinsurance and copayments you pay. It does not include your plan premium. **Your out-of-pocket maximum is \$3,000 per member/\$6,000 per family.** Each member must meet the per-member out-of-pocket maximum unless the family out-of-pocket maximum applies. The family out-of-pocket maximum is considered met when any combination of members in a family reaches the family out-of-pocket maximum. Please note that once any one member in a family accumulates **\$3,000** in out-of-pocket costs, that family member's out-of-pocket maximum is considered met, and that family member will have no additional out-of-pocket costs for the remainder of the benefit period.

#### **Deletion of domestic partner coverage**

You **do not** have coverage for domestic partners under this plan. A domestic partner is defined as a partner of the same or opposite sex whom you would have registered with your employer for eligibility for benefits, and would have included under your family coverage for health insurance.

#### ***It Fits!*™ benefit**

Your contract includes coverage for services provided under the *It Fits!*™ program to a maximum of \$200 per member/\$400 per family.

**Covered services**

The following chart shows your costs for covered services. These costs apply to the services in the **Description of benefits** section of your *Member Handbook*. In summary, your responsibilities are as follows:

Covered services	Benefits
<b>Ambulance services</b> 1. Ambulance transportation for an emergency 2. Ambulance transportation for non-emergency situations, when medically necessary	Covered in full Covered in full
<b>Autism services</b> <i>Prior authorization required</i> 1. Habilitative and rehabilitative care 2. Applied behavior analysis when supervised by a board certified behavioral analyst 3. Therapeutic care, services including speech, physical and occupational therapy.	\$20 copayment per visit Covered in full \$20 copayment per visit
<b>Durable medical equipment and prosthetic/orthotic devices</b> <i>Referral and prior authorization required for most services</i> 1. The purchase or rental of durable medical equipment and prosthetic/ orthotic devices (including the fitting, preparing, repairing and modifying of the appliance). 2. Scalp hair prosthesis (wigs) for individuals who have suffered hair loss as a result of the treatment of any form of cancer or leukemia. Coverage is provided for one scalp hair prosthetic (wig) per member per benefit period when the prosthesis is determined to be medically necessary by a plan physician and the plan 3. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy 4. Prosthetic limbs which replace, in whole or in part, an arm or leg. 5. Insulin pump and insulin pump supplies 6. Breast pumps 7. Hearing aids and supplies, when prescribed by a plan physician and obtained from a network provider 8. Up to \$2,000 per ear for hearing aid device only, every 36 months (must be 21 years of age or younger) <ul style="list-style-type: none"> <li>• Related services and supplies for hearing aids (not subject to the \$2,000 limit)</li> </ul>	30% coinsurance 30% coinsurance 30% coinsurance 20% coinsurance Covered in full Covered in full Covered in full up to \$2,000 in each 36 month period 30% coinsurance
<b>Emergency and urgent care</b> 1. Emergency room visits 2. Emergency room visits when you are admitted to an observation room 3. Emergency room visits when you are admitted as an inpatient 4. Urgent care visits in a doctor's office or at an urgent care facility 5. Emergency prescription medication provided out of the Select Care service area as part of an approved emergency treatment	\$150 copayment per visit Covered in full Covered in full \$20 copayment per visit Tier 1: \$15 copayment Tier 2: \$30 copayment Tier 3: \$50 copayment for up to a 14-day supply

Covered services	Benefits
<p><b>Enteral formulas and low protein foods</b>  <i>Referral and prior authorization required for enteral formulas</i></p> <ol style="list-style-type: none"> <li>1. Enteral formulas, upon a physician's written order, for home use in the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids</li> <li>2. Food products that have been modified to be low in protein for individuals with inherited diseases of amino acids and organic acids. You may be required to purchase these products over the counter and submit claims to the plan for reimbursement.</li> </ol>	<p>Covered in full</p> <p>Covered in full</p>
<p><b>Home health care services</b></p> <ol style="list-style-type: none"> <li>1. Part-time or intermittent skilled nursing care and physical therapy provided in your home by a home health agency</li> <li>2. Additional services and supplies that are determined to be a medically necessary component of skilled nursing care and physical therapy</li> <li>3. Home dialysis services and non-durable medical supplies</li> </ol>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>
<p><b>Hospice care services</b>  <i>Referral and prior authorization required</i></p>	<p>Covered in full</p>
<p><b>Hospital inpatient services</b>  <i>Referral and prior authorization required</i></p> <ol style="list-style-type: none"> <li>1. Inpatient hospital services including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient</li> </ol>	<p>\$500 copayment per admission</p>
<p><b>Infertility/assisted reproductive technology (art) services*</b>  <i>Referral and prior authorization required (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP)</i></p> <ol style="list-style-type: none"> <li>1. Office visits for the consultation, evaluation and diagnosis of fertility</li> <li>2. Diagnostic laboratory services</li> <li>3. Diagnostic X-ray services</li> <li>4. Artificial insemination, such as intrauterine insemination (IUI)</li> <li>5. Assisted reproductive technologies* except for those services listed below</li> <li>6. Assisted reproductive technologies for: <ul style="list-style-type: none"> <li>• In vitro fertilization (IVF-ET)</li> <li>• Gamete intrafallopian transfer (GIFT)</li> <li>• Zygote intrafallopian transfer (ZIFT)</li> </ul> </li> <li>7. Sperm, egg, and/or inseminated egg procurement, assisted hatching, cryopreservation, processing and banking for plan members in active infertility treatment, to the extent that such costs are not covered by the donor's insurer</li> </ol> <p>* See the <b>Description of benefits</b> section of your <i>Member Handbook</i> for a list of covered infertility/ART services.</p>	<p>\$20 copayment per visit with a PCP and certain other providers</p> <p>\$35 copayment per visit with a specialist</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>\$250 copayment per procedure</p> <p>Covered in full</p>

Questions? Contact Customer Service at: 1-800-868-5200 (TRS 711) or at [fallonhealth.org](http://fallonhealth.org).

Covered services	Benefits
<p><b>Maternity services</b></p> <ol style="list-style-type: none"> <li>Obstetrical services including prenatal, childbirth, postnatal and postpartum care</li> <li>Inpatient maternity and newborn child care for a minimum of 48 hours of care following a vaginal delivery, or 96 hours of care following a Caesarean section delivery, including the charges for the following services when provided during an inpatient maternity admission: childbirth, nursery charges, circumcision, routine examination, hearing screening and medically necessary treatments of congenital defects, birth abnormalities or premature birth. The covered length of stay may be reduced if the mother and the attending physician agree upon an earlier discharge. If you or your newborn are discharged earlier, you are covered for home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however that the first home visit shall be conducted by a registered nurse, physician or certified nurse midwife; and provided further, that any subsequent home visit determined to be clinically necessary shall be provided by a licensed health care provider.</li> </ol> <p><i>(Fallon Health members are eligible for childbirth classes (refresher class or siblings class))</i></p>	<p>Prenatal: \$20 copayment (first visit only)</p> <p>Postnatal: \$20 copayment per visit</p> <p>\$500 copayment per admission</p> <p>Covered in full through member reimbursement</p>
<p><b>Mental health and substance abuse services</b></p> <p><b>Inpatient services</b> <i>Prior authorization required</i></p> <ol style="list-style-type: none"> <li>Inpatient hospital care for as many days as your condition requires, including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, individual, family and group therapy, pharmacological therapy, and diagnostic laboratory services.</li> </ol> <p><b>Intermediate services</b> <i>Prior authorization required</i> <i>Intermediate services include but are not limited to:</i></p> <ol style="list-style-type: none"> <li>Acute and other residential treatment: Mental health services provided in a 24-hour setting therapeutic environments.</li> <li>Clinically managed detoxification services: 24 hour, 7 days a week, clinically managed de-tox services in a licensed non-hospital setting that include 24 hour per day supervision</li> <li>Partial Hospitalization: Short-term day/evening mental health programming available 5 to 7 days per week.</li> <li>Intensive outpatient programs: Multimodal, inter-disciplinary, structured behavioral health treatment provided 2-3 hours per day, multiple days per week.</li> <li>Day treatment: Program encompasses some portion of the day or week rather than a weekly visit</li> <li>Crisis Stabilization: Short-term psychiatric treatment in a structured, community based therapeutic environments.</li> </ol>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p>

Covered services	Benefits
<p><i>Mental health and substance abuse services, continued</i></p> <p>7. In-home therapy services</p> <p><b>Outpatient services</b></p> <p>1. Outpatient office visits, including individual, group or family therapy. The actual number of visits authorized beyond the initial eight is based on medical necessity as determined by the plan, and may include individual, group, or family therapy.</p> <p>2. Psychopharmacological services, such as visits with a physician to review, monitor and adjust the levels of prescription medication to treat a mental condition</p> <p>3. Neuropsychological assessment services when medically necessary</p> <p>Note: For substance abuse services, prior authorization rules will follow Massachusetts state law as established by Chapter 258 of the Acts of 2014. We will not require prior authorization for substance abuse services in any circumstances where this is not allowed by Chapter 258.</p>	<p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p>
<p><b>Office visits and outpatient services</b></p> <p>1. Office visits, to diagnose or treat an illness or an injury</p> <p>2. A second opinion, upon your request, with another plan provider</p> <p>3. Injections and injectables that are included on the formulary, that are for covered medical benefits, and that are ordered, supplied and administered by a plan provider</p> <p>4. Allergy injections</p> <p>5. Radiation therapy and Chemotherapy</p> <p>6. Respiratory therapy</p> <p>7. Hormone replacement services in the doctor's office for perimenopausal or postmenopausal women</p> <p>8. Diagnostic lab services ordered by a plan provider, in relation to a covered office visit</p> <p>9. Diagnostic X-ray services ordered by a plan provider, in relation to a covered office visit</p>	<p>\$20 copayment per visit with a PCP and certain other providers</p> <p>\$35 copayment per visit with a specialist</p> <p>\$20 copayment per visit with a PCP and certain other providers</p> <p>\$35 copayment per visit with a specialist</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>\$20 copayment per visit</p> <p>Covered in full</p> <p>Covered in full</p>

Covered services	Benefits
<i>Office visits and outpatient services, continued</i>	
10. High-tech imaging services, including but not limited to, MRI/MRA, CT/CTA, PET scans and nuclear cardiology imaging. (Prior authorization required.)	Covered in full
11. Chiropractic services for acute musculoskeletal conditions. The condition must be new or an acute exacerbation of a previous condition. Coverage is provided for up to 20 office visits in each benefit period. The actual number of visits provided is based on medical necessity as determined by your plan provider and the plan.	\$20 copayment per visit
<ul style="list-style-type: none"> <li>• Outpatient lab tests and X-rays</li> </ul>	See Diagnostic lab, X-ray and high-tech imaging services
12. Outpatient renal dialysis at a plan-designated center or continuous ambulatory peritoneal dialysis	Covered in full
13. Diabetes outpatient self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider	\$20 copayment per visit
14. Laboratory tests necessary for the diagnosis or treatment of diabetes, including glycosylated hemoglobin, or HbA1c, tests, and urinary/protein/ microalbumin and lipid profiles	Covered in full
15. Medical social services provided to assist you in adjustment to your or your family member’s illness. This includes assessment, counseling, consultation and assistance in accessing community resources.	\$20 copayment per visit
16. Outpatient surgery, anesthesia and the medically necessary preoperative and postoperative care related to the surgery	\$300 copayment per surgery when provided in a hospital outpatient, day surgery or ambulatory care facility
17. Visit to a contracted limited service clinic. Services are provided for a variety of common illnesses, including, but not limited to: <ul style="list-style-type: none"> <li>• strep throat</li> <li>• ear, eyes, sinus, bladder and bronchial infections</li> <li>• minor skin conditions (e.g. sunburn, cold sores)</li> </ul>	\$20 copayment per visit
18. Podiatry care <ul style="list-style-type: none"> <li>• Outpatient lab tests and X-rays</li> <li>• Outpatient surgical services</li> <li>• Outpatient medical care</li> </ul>	See Diagnostic lab, X-ray and imaging services  See Outpatient surgery  See Office visits

Covered services	Benefits
<p><b>Oral surgery and related services</b>  <i>Referral and prior authorization required (except for extraction of impacted teeth or lingual frenectomy)</i></p> <ol style="list-style-type: none"> <li>1. Removal or exposure of impacted teeth, including both hard and soft tissue impactions, or an evaluation for this procedure</li> <li>2. Surgical treatments of cysts, affecting the teeth or gums, that must be rendered by a plan oral surgeon</li> <li>3. Treatment of fractures of the jaw bone (mandible) or any facial bone</li> <li>4. Evaluation and surgery for the treatment of temporomandibular joint disorder when a medical condition is diagnosed, or for surgery related to the jaw or any structure connected to the jaw</li> <li>5. Extraction of teeth in preparation for radiation treatment of the head or neck</li> <li>6. Surgical treatment related to cancer</li> <li>7. Emergency medical care, such as, to relieve pain and stop bleeding as a result of accidental injury to sound natural teeth or tissues, when provided as soon as medically possible after the injury. This does not include restorative or other dental services. No referral or authorization is required. Go to the closest provider.</li> </ol> <p>Note: See <b>Office visits and outpatient services</b> for diagnostic lab and X-ray services.</p>	<p>\$35 copayment per visit</p> <p>\$35 copayment per visit</p> <p>\$35 copayment per visit</p> <p>\$35 copayment per visit</p> <p>\$35 copayment per visit</p> <p>\$35 copayment per visit</p> <p>\$20 copayment per visit to a physician's or dentist's office</p> <p>\$150 copayment per visit to an emergency room</p>
<p><b>Organ transplants</b>  <i>Referral and prior authorization required</i></p> <ol style="list-style-type: none"> <li>1. Office visits related to the transplant</li> <li>2. Inpatient hospital services, including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient</li> <li>3. Human leukocyte antigen (HLA) or histocompatibility locus antigen testing for A, B or DR antigens, or any combination thereof, necessary to establish bone marrow transplant donor suitability of a member</li> </ol>	<p>\$20 copayment per visit with a PCP and certain other providers</p> <p>\$35 copayment per visit with a specialist</p> <p>\$500 copayment per admission</p> <p>Covered in full</p>
<p><b>Pediatric dental services</b>  <i>(for members under the age of 19)</i></p>	<p>Not covered</p>
<p><b>Pediatric vision services</b>  <i>(for members under the age of 19)</i></p>	<p>Not covered</p>



Covered services	Benefits
<p><b>Prescription drugs</b>  <i>Covered prescription items:</i></p> <ul style="list-style-type: none"> <li>• Prescription medication</li> <li>• Prescription contraceptive drugs and devices*</li> <li>• Hormone replacement therapy for peri- and post-menopausal women</li> <li>• Injectable agents (self-administered**)</li> <li>• Insulin</li> <li>• Syringes (including insulin syringes) or needles when medically necessary</li> <li>• Supplies for the treatment of diabetes, as required by state law, including:                             <ul style="list-style-type: none"> <li>– blood glucose monitoring strips</li> <li>– urine glucose strips</li> <li>– lancets</li> <li>– ketone strips</li> </ul> </li> <li>• Special medical formulas to treat certain metabolic disorders required by state law (prior authorization required).</li> </ul> <p>*Generic prescription contraceptive drugs and devices are covered in full. Brand name prescription contraceptive drugs and devices with no generic equivalent are covered in full (prior authorization required).</p> <p>**Injectables administered in the doctor’s office or under other professional supervision are covered as a medical benefit.</p> <p>Generic prescription bowel preparation medication</p> <ul style="list-style-type: none"> <li>• when part of a preventive colonoscopy or sigmoidoscopy for the screening of colorectal cancer.</li> <li>• for adults beginning at age 50 and continuing until age 75 as recommended by the USPSTF.</li> </ul> <p>(Brand name prescription bowel preparation medication with no generic equivalent is covered in full.)</p> <p>Orally administered anticancer medications used to kill or slow the growth of cancerous cells</p>	<p><i>Network pharmacy:</i>                      Tier 1: \$15 copayment                      Tier 2: \$30 copayment                      Tier 3: \$50 copayment for up to a 30-day supply</p> <p><i>Mail-order pharmacy:</i>                      Tier 1: \$30 copayment                      Tier 2: \$60 copayment                      Tier 3: \$100 copayment for up to a 90-day supply</p> <p>Covered in full</p> <p>Covered in full</p>

Covered services	Benefits
<p><b>Preventive care</b></p> <ol style="list-style-type: none"> <li>1. Routine physical exams for the prevention and detection of disease</li> <li>2. Immunizations that are included on the formulary, that are for covered medical benefits and that are ordered, supplied and administered by a plan physician. If administered by a plan specialist, you will generally need to obtain a referral to see the specialist.</li> <li>3. A baseline mammogram for women age 35 to 40, and a yearly mammogram for women age 40 and older</li> <li>4. Routine gynecological care services, including an annual Pap smear (cytological screening) and pelvic exam</li> <li>5. Hearing and vision screening</li> <li>6. Well-child care and pediatric services, at least six times during the child’s first year after birth, at least three times during the next year, then at least annually until the child’s sixth birthday. This includes the following services, as recommended by the physician and in accordance with state law: <ul style="list-style-type: none"> <li>• physical examination</li> <li>• history</li> <li>• measurements</li> <li>• sensory screening</li> <li>• neuropsychiatric evaluation</li> <li>• development screening and assessment</li> </ul> </li> <li>7. Pediatric services including: <ul style="list-style-type: none"> <li>• appropriate immunizations</li> <li>• hereditary and metabolic screening at birth</li> <li>• newborn hearing screening test performed before the newborn infant is discharged from the hospital or birthing center</li> <li>• tuberculin tests, hematocrit, hemoglobin, and other appropriate blood tests and urinalysis</li> <li>• lead screening</li> </ul> </li> <li>8. Female consultations, examinations, procedures, contraceptive devices, and medical services related to the use of all contraceptive methods*</li> </ol> <p>*Prescription contraceptive devices are covered under the prescription drug benefit.</p>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>
<p><b>Reconstructive surgery</b>  <i>Referral and prior authorization required (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP)</i></p> <ol style="list-style-type: none"> <li>1. Inpatient hospital services including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are inpatient, including Massachusetts mandated services for cleft lip and cleft palate</li> </ol>	<p>\$500 copayment per admission</p>

Covered services	Benefits
<p><b>Rehabilitation and habilitation services</b>  <i>Referral required</i></p> <ol style="list-style-type: none"> <li>Physical therapy to restore function after medical illness, accident or injury. Coverage is provided for up to 60 non-consecutive office visits per illness or injury in each coverage period when medically necessary.</li> <li>Occupational therapy to restore function after medical illness, accident or injury. Coverage is provided for up to 60 non-consecutive office visits per illness or injury in each coverage period when medically necessary.</li> <li>Medically necessary services for the diagnosis and treatment of speech, hearing and language disorders when services are provided by a plan provider who is a speech-language pathologist or audiologist; and at a plan facility or a plan provider's office (Prior authorization required)</li> <li>Cardiac rehabilitation services to treat cardiovascular disease in accordance with state law and Department of Public Health regulations</li> <li>Medically necessary early intervention services delivered by a certified early intervention specialist, according to operational standards developed by the Department of Public Health, for children from birth to their third birthday.</li> <li>Pulmonary rehabilitation services for chronic obstructive pulmonary disease (COPD) are covered for up to two one-hour sessions per day, for up to 36 lifetime sessions (Prior authorization required)</li> </ol>	<p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>\$20 copayment per visit</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>
<p><b>Skilled nursing facility services</b>  <i>Referral and prior authorization required</i></p> <ol style="list-style-type: none"> <li>Inpatient hospital services, for up to 100 days in each benefit period provided criteria is met, including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient</li> </ol>	<p>\$500 copayment per admission</p>

## 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](mailto: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: 1-508-368-9382 (TRS 711)  
Email: [compliance@fallonhealth.org](mailto: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>.

# Important!

If you, or someone you're helping, has questions about Fallon Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-868-5200.

### Spanish:

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Fallon Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-868-5200.

### Portuguese:

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Fallon Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-868-5200.

### Chinese:

如果您，或是您正在協助的對象，有關於[插入項目的名稱 Fallon Health] 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-800-868-5200]。

### Haitian Creole:

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Fallon Health, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-868-5200.

### Vietnamese:

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Fallon Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-868-5200.

### Russian:

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Fallon Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-868-5200.

### Arabic:

المساعدة على الحصول في الحق في لذيك ، Fallon Health ، بخصوص أسئلة تساعد شخص لذي أو لذيك كان إن (ب ات صل مترجم مع ل ل تحدث .ت كافة اية دون من ب لغتك الضرورية والمعلومات 1-800-868-5200.

### Khmer/Cambodian:

ប្រសិនបើអ្នក ឬអ្នកណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពី Fallon Health ឬ អ្នកមានសំណួរណាមួយអំពីវិធីសាស្ត្រ ព័ត៌មាន ឬសេវាផ្សេងៗ របស់អ្នក ពោលមិនអ្វីប្រាកដ ។ បើសិនជាអ្នកចង់បានជំនួយអ្នកអាចទាក់ទង 1-800-868-5200 ។

**French:**

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Fallon Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-868-5200.

**Italian:**

Se tu o qualcuno che stai aiutando avete domande su Fallon Health, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-868-5200.

**Korean:**

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Fallon Health에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-868-5200로 전화하십시오.

**Greek:**

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω από το Fallon Health, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-800-868-5200.

**Polish:**

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie Fallon Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-868-5200.

**Hindi:**

यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Fallon Health [के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िुभाषण से बात करने के लिए ,1-800-868-5200 पर कॉि करें।

**Gujarati:**

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમ ાંથી કોઇને Fallon Health વિશે પ્રશ્નો છે તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ચ વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર છે. દ ભ વષરો િ ત કરિ મ ટે,આ 1-800-868-5200 પર કોલ કરો.

**Laotian:**

້າທ່ານ, ຫ ຼືອົນທ ັທ່ານກໍາລັງຊ່ວຍເຫ ຼືອ, ມ ຄໍາຖາມກ່ຽວກັບ Fallon Health, ທ່ານມ ສິດທ ັຈະໄດ້ຮັບການຊ່ວຍເຫ ຼືອແລະຂໍ້ມູນຂ່າວສານທ ັເປັນພາສາຂອງທ່ານບໍ່ມ ຄໍາໃຊ້ຈ່າຍ. ການໂອ້ນລັມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-800-868-5200.