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 – Supreme 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).

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.

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
Ambulance services	
1. Ambulance transportation for an emergency	Covered in full
2. Ambulance transportation for non-emergency situations, when medically necessary	Covered in full
Autism services *Prior authorization required*	
1. Habilitative and rehabilitative care	$15 copayment per visit
2. Applied behavior analysis when supervised by a board certified behavioral analyst	Covered in full
3. Therapeutic care, services including speech, physical and occupational therapy.	$15 copayment per visit
Durable medical equipment and prosthetic/orthotic devices *Referral and prior authorization required for most services*	
1. The purchase or rental of durable medical equipment and prosthetic/ orthotic devices (including the fitting, preparing, repairing and modifying of the appliance).	30% coinsurance
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	30% coinsurance
3. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy	30% coinsurance
4. Prosthetic limbs which replace, in whole or in part, an arm or leg.	20% coinsurance
5. Insulin pump and insulin pump supplies	Covered in full
6. Breast pumps	Covered in full
7. Hearing aids and supplies, when prescribed by a plan physician and obtained from a network provider	Covered in full up to $2,000 in each 36 month period
8. Up to $2,000 per ear for hearing aid device only, every 36 months (must be 21 years of age or younger) • Related services and supplies for hearing aids (not subject to the $2,000 limit)	30% coinsurance
Emergency and urgent care	
1. Emergency room visits	$100 copayment per visit
2. Emergency room visits when you are admitted to an observation room	Covered in full
3. Emergency room visits when you are admitted as an inpatient	Covered in full
4. Urgent care visits in a doctor's office or at an urgent care facility	$15 copayment per visit
5. Emergency prescription medication provided out of the Select Care service area as part of an approved emergency treatment	Tier 1: $10 copayment Tier 2: $15 copayment Tier 3: $15 copayment for up to a 14-day supply

Covered services	Benefits
Enteral formulas and low protein foods *Referral and prior authorization required for enteral formulas*	
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	Covered in full
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.	Covered in full
Home health care services	
1. Part-time or intermittent skilled nursing care and physical therapy provided in your home by a home health agency	Covered in full
2. Additional services and supplies that are determined to be a medically necessary component of skilled nursing care and physical therapy	Covered in full
3. Home dialysis services and non-durable medical supplies	Covered in full
Hospice care services *Referral and prior authorization required*	Covered in full
Hospital inpatient services *Referral and prior authorization required*	
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	Covered in full
Infertility/assisted reproductive technology (art) services* *Referral and prior authorization required (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP)*	
1. Office visits for the consultation, evaluation and diagnosis of fertility	$15 copayment per visit with a PCP and certain other providers $20 copayment per visit with a specialist
2. Diagnostic laboratory services	Covered in full
3. Diagnostic X-ray services	Covered in full
4. Artificial insemination, such as intrauterine insemination (IUI)	Covered in full
5. Assisted reproductive technologies*	Covered in full
6. Assisted reproductive technologies for: • In vitro fertilization (IVF-ET) • Gamete intrafallopian transfer (GIFT) • Zygote intrafallopian transfer (ZIFT)	Covered in full
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	Covered in full
* See the **Description of benefits section** of your *Member Handbook* for a list of covered infertility/ART services.	

Covered services	Benefits
Maternity services	
1. Obstetrical services including prenatal, childbirth, postnatal and postpartum care	Prenatal: $15 copayment (first visit only) Postnatal: $15 copayment per visit
2. 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.	Covered in full
(Fallon Health members are eligible for childbirth classes (refresher class or siblings class))	Covered in full through member reimbursement
Mental health and substance abuse services **Inpatient services** *Prior authorization required* 1. 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.	Covered in full
Intermediate services *Prior authorization required* *Intermediate services include but are not limited to:* 1. Acute and other residential treatment: Mental health services provided in a 24-hour setting therapeutic environments.	Covered in full
2. 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	Covered in full
3. Partial Hospitalization: Short-term day/evening mental health programming available 5 to 7 days per week.	$15 copayment per visit
4. Intensive outpatient programs: Multimodal, inter-disciplinary, structured behavioral health treatment provided 2-3 hours per day, multiple days per week.	$15 copayment per visit
5. Day treatment: Program encompasses some portion of the day or week rather than a weekly visit	$15 copayment per visit
6. Crisis Stabilization: Short-term psychiatric treatment in a structured, community based therapeutic environments.	$15 copayment per visit

Covered services	Benefits
Mental health and substance abuse services, continued	
7. In-home therapy services	$15 copayment per visit
Outpatient services	
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.	$15 copayment per visit
2. Psychopharmacological services, such as visits with a physician to review, monitor and adjust the levels of prescription medication to treat a mental condition	$15 copayment per visit
3. Neuropsychological assessment services when medically necessary	$15 copayment per visit
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.	
Office visits and outpatient services	
1. Office visits, to diagnose or treat an illness or an injury	$15 copayment per visit with a PCP and certain other providers $20 copayment per visit with a specialist
2. A second opinion, upon your request, with another plan provider	$15 copayment per visit with a PCP and certain other providers $20 copayment per visit with a specialist
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	Covered in full
4. Allergy injections	Covered in full
5. Radiation therapy and Chemotherapy	Covered in full
6. Respiratory therapy	Covered in full
7. Hormone replacement services in the doctor's office for perimenopausal or postmenopausal women	$15 copayment per visit
8. Diagnostic lab services ordered by a plan provider, in relation to a covered office visit	Covered in full
9. Diagnostic X-ray services ordered by a plan provider, in relation to a covered office visit	Covered in full

Covered services	Benefits
Office visits and outpatient services, continued	
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.	$15 copayment per visit
• Outpatient lab tests and X-rays	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	$15 copayment per visit
14. Laboratory tests necessary for the diagnosis or treatment of diabetes, including glycosylated hemoglobin, or HbAlc, 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.	$15 copayment per visit
16. Outpatient surgery, anesthesia and the medically necessary preoperative and postoperative care related to the surgery	Covered in full 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: • strep throat • ear, eyes, sinus, bladder and bronchial infections • minor skin conditions (e.g. sunburn, cold sores)	$15 copayment per visit
18. Podiatry care	
• Outpatient lab tests and X-rays	See Diagnostic lab, X-ray and imaging services
• Outpatient surgical services	See Outpatient surgery
• Outpatient medical care	See Office visits

Covered services	Benefits
Oral surgery and related services *Referral and prior authorization required (except for extraction of impacted teeth or lingual frenectomy)*	
1. Removal or exposure of impacted teeth, including both hard and soft tissue impactions, or an evaluation for this procedure	$20 copayment per visit
2. Surgical treatments of cysts, affecting the teeth or gums, that must be rendered by a plan oral surgeon	$20 copayment per visit
3. Treatment of fractures of the jaw bone (mandible) or any facial bone	$20 copayment per visit
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	$20 copayment per visit
5. Extraction of teeth in preparation for radiation treatment of the head or neck	$20 copayment per visit
6. Surgical treatment related to cancer	$20 copayment per visit
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.	$15 copayment per visit to a physician's or dentist's office $100 copayment per visit to an emergency room
Note: See **Office visits and outpatient services** for diagnostic lab and X-ray services.	
Organ transplants *Referral and prior authorization required*	
1. Office visits related to the transplant	$15 copayment per visit with a PCP and certain other providers $20 copayment per visit with a specialist
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	Covered in full
3. Human leukocyte antigen (HLA) or histocompatability locus antigen testing for A, B or DR antigens, or any combination thereof, necessary to establish bone marrow transplant donor suitability of a member	Covered in full
Pediatric dental services *(for members under the age of 19)*	Not covered
Pediatric vision services *(for members under the age of 19)*	Not covered

Covered services	Benefits
Prescription drugs *Covered prescription items:* • Prescription medication • Prescription contraceptive drugs and devices* • Hormone replacement therapy for peri- and post-menopausal women • Injectable agents (self-administered**) • Insulin • Syringes (including insulin syringes) or needles when medically necessary • Supplies for the treatment of diabetes, as required by state law, including: – blood glucose monitoring strips – urine glucose strips – lancets – ketone strips • Special medical formulas to treat certain metabolic disorders required by state law (prior authorization required). *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). **Injectables administered in the doctor's office or under other professional supervision are covered as a medical benefit.	*Network pharmacy:* Tier 1: $10 copayment Tier 2: $15 copayment Tier 3: $15 copayment for up to a 30-day supply *Mail-order pharmacy:* Tier 1: $5 copayment Tier 2: $15 copayment Tier 3: $15 copayment for up to a 90-day supply
Generic prescription bowel preparation medication • when part of a preventive colonoscopy or sigmoidoscopy for the screening of colorectal cancer. • for adults beginning at age 50 and continuing until age 75 as recommended by the USPSTF. (Brand name prescription bowel preparation medication with no generic equivalent is covered in full.)	Covered in full
Orally administered anticancer medications used to kill or slow the growth of cancerous cells	Covered in full

Covered services	Benefits
Preventive care	
1. Routine physical exams for the prevention and detection of disease	Covered in full
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.	Covered in full
3. A baseline mammogram for women age 35 to 40, and a yearly mammogram for women age 40 and older	Covered in full
4. Routine gynecological care services, including an annual Pap smear (cytological screening) and pelvic exam	Covered in full
5. Hearing and vision screening	Covered in full
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: • physical examination • history • measurements • sensory screening • neuropsychiatric evaluation • development screening and assessment	Covered in full
7. Pediatric services including: • appropriate immunizations • hereditary and metabolic screening at birth • newborn hearing screening test performed before the newborn infant is discharged from the hospital or birthing center • tuberculin tests, hematocrit, hemoglobin, and other appropriate blood tests and urinalysis • lead screening	Covered in full
8. Female consultations, examinations, procedures, contraceptive devices, and medical services related to the use of all contraceptive methods* *Prescription contraceptive devices are covered under the prescription drug benefit.	Covered in full
Reconstructive surgery *Referral and prior authorization required (unless provided by a Reliant Medical Group specialist and you have a Reliant Medical Group PCP)* 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	Covered in full

Covered services	Benefits
Rehabilitation and habilitation services *Referral required*	
1. 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.	$15 copayment per visit
2. 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.	$15 copayment per visit
3. 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)	$15 copayment per visit
4. Cardiac rehabilitation services to treat cardiovascular disease in accordance with state law and Department of Public Health regulations	Covered in full
5. 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.	Covered in full
6. 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)	Covered in full
Skilled nursing facility services *Referral and prior authorization required*	
1. 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	Covered in full

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: 1-508-368-9382 (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.

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:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Fallon Health، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب
1-800-868-5200.

Khmer/Cambodian:
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពី Fallon Health បេ, អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មាន បៅកនុងភាសា ររស់អ្នក បោយមិនអស់ប្រាក់ ។ បែើមបីនិយាយជាមួយអ្នករកដប្រ សូម 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 απο 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 ्िुभाषषए से बात करने के लिए ,1-800-868-5200 पर कॉ्ि करें।

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

Laotian:
้าท่าน, ห ูือค็นห ่ท่านกำลังช่อยเห ูือ, ม คำถามกังวกับ Fallon Health, ท่านม สิดห ่ะได้รับการช่อยเห ูือเอะข้มูนข่าวสารห ่เป็นภาสาของท่านบ่ม ค่าใช้จ่าย. การโอ้ลมกับบายพาสา, ให้โทหา 1-800-868-5200.