




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bmchp.org](http://www.bmchp.org) or by calling 1-855-833-8120. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-855-833-8120 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Event chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not applicable	This <a href="#">plan</a> does not have <a href="#">deductible</a> .
Are there other <a href="#">Deductibles</a> for specific services?	Yes, for Pediatric Dental Type II and Type III services ONLY, \$50 per individual.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3000 Individual /\$6000 family for medical expenses and prescription drug combined (which includes \$350 per individual for pediatric dental services).	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://www.bmchp.org/Provider-Search/Qualified-Health-Plan">https://www.bmchp.org/Provider-Search/Qualified-Health-Plan</a> or call 1-855-833-8120 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You must get Preauthorization from the plan to use an out-of-network provider. If you do not get Preauthorization from the plan to use an <a href="#">out-of-network</a> provider, the plan will not pay, and you will have to pay the provider's bill.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">network specialist</a> you chose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 / Visit	Not Covered	<a href="#">Specialist</a> visits may require a <a href="#">Preauthorization</a> .
	<a href="#">Specialist</a> visit	\$40 / Visit	Not Covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check you're your plan will pay for. Visit <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> for info on services that are considered preventive
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	Not Covered	<a href="#">Preauthorization</a> may be required
	Imaging (CT/PET scans, MRIs)	\$150 / Visit	Not Covered	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.bmchp.org/I-Am-A/Member/Get-Prescriptions">https://www.bmchp.org/I-Am-A/Member/Get-Prescriptions</a>	Generic drugs	\$10 / Retail and \$20 / mail order prescription	Not Covered	- Covers up to a 30-day supply (retail); - Covers up to a 90-day supply (mail order).
	Preferred brand drugs	\$25 / Retail and \$50 / mail order prescription	Not Covered	- Oral and other forms of prescription contraceptives are covered in full.
	Non-preferred brand drugs	\$50 / Retail and \$150 / mail order prescription	Not Covered	- Oral anti-cancer drugs are covered in full. - Opioid antagonists and generic Medication-Assisted Treatment drugs are covered in full. - <a href="#">Preauthorization</a> may be required.
	<a href="#">Specialty drugs</a>	\$50 / Retail and \$150 / mail order prescription	Not Covered	- Covers up to a 30-day supply from participating specialty pharmacies. - <a href="#">Preauthorization</a> may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 / Visit	Not Covered	-Includes diagnostic colonoscopies and endoscopies. - <a href="#">Preauthorization</a> may be required.
	Physician/surgeon fees			
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 / Visit		- ER <a href="#">Copayment</a> is waived if admitted directly to the hospital from the ER. * If a service is received from an <a href="#">Out-of-Network</a> provider, you are also liable for the difference between the billed charge and the
	<a href="#">Emergency medical transportation</a>	No Charge		
	<a href="#">Urgent care</a>	\$40 / Visit		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Allowed amount.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 / admission	Not Covered	<ul style="list-style-type: none"> <li>- Inpatient Rehabilitation hospitals are limited to 60 days per benefit year.</li> <li>- <a href="#">Preauthorization</a> may be required.</li> </ul>
	Physician/surgeon fees	No Charge		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / Visit	Not Covered	<ul style="list-style-type: none"> <li>- <a href="#">Preauthorization</a> may be required from our 3<sup>rd</sup> party contractor, Beacon Health Strategies, LLC.</li> </ul>
	Inpatient services	\$500 / admission	Not Covered	
If you are pregnant	Office visits	No charge for pre-natal care or postnatal visits	Not Covered	Office visits for medical conditions may be subject to <a href="#">cost-sharing</a> .
	Childbirth/delivery professional services	\$500 / admission	Not Covered	
	Childbirth/delivery facility services		Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	Not Covered	<ul style="list-style-type: none"> <li>- <a href="#">Preauthorization</a> is required</li> </ul>
	<a href="#">Rehabilitation services</a>	\$40 / visit \$40 / visit for members with a diagnosis of Autism Spectrum Disorder	Not Covered	<ul style="list-style-type: none"> <li>- Outpatient Physical and Occupational therapy is limited to 60 combined visits per benefit year.</li> <li>- PT/OT limits do not apply to members with Autism Spectrum Disorders or for children under age 3 who are receiving Early Intervention Services.</li> <li>- Early Intervention and Cardiac Rehabilitation services are covered in full.</li> <li>- <a href="#">Preauthorization</a> is required.</li> </ul>
	<a href="#">Habilitation services</a>	\$40 / visit \$40 / visit for members with a diagnosis of Autism Spectrum Disorder	Not Covered	<ul style="list-style-type: none"> <li>- Limited to 60 combined visits per benefit year.</li> <li>- Limits do not apply to members with Autism Spectrum Disorders or for children under age 3 who are receiving Early Intervention Services.</li> <li>- <a href="#">Preauthorization</a> is required</li> </ul>
	<a href="#">Skilled nursing care</a>	\$500 / admission	Not Covered	<ul style="list-style-type: none"> <li>- Limited to 100 days per benefit year.</li> <li>- <a href="#">Preauthorization</a> is required.</li> </ul>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	20% Coinsurance	Not Covered	- Coinsurance does not apply to wigs. - <a href="#">Preauthorization</a> may be required from our 3 <sup>rd</sup> party vendor, Northwood, Inc.
	<a href="#">Hospice services</a>	No Charge	Not Covered	-Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No Charge for preventive exam. \$40 / visit for non-routine exams.	Not Covered	- Preventive eye exams are limited to one every 12 months.
	Children's glasses	20% Coinsurance	Not Covered	- Coverage is limited to eyeglasses, conventional lenses, and contact lenses
	Children's dental check-up	No Charge	Not Covered	-Check-up refers to preventive and diagnostic visits (Type I services). Type II, Type III and Type IV services are subject to cost-sharing.

#### Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic Surgery</li> <li>Early Intervention services for children age 3 and older.</li> <li>Hearing Aids for members over age 21</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Non-Emergency care when traveling outside the U.S</li> <li>Private-duty nursing</li> <li>Routine foot care except for members with Diabetes</li> <li>Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Services beyond any benefit or monetary limit listed in this Summary of Benefits and Coverage</li> <li>Vision Hardware except as described in the Evidence of Coverage.</li> <li>Weight loss programs, except as described in the Evidence of Coverage.</li> </ul>
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

<ul style="list-style-type: none"> <li>Abortion</li> <li>Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic Care</li> <li>Dental Services for Cleft Lip/Palate Repair</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids for Children</li> <li>Infertility treatment</li> </ul>
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Massachusetts Division of Insurance Consumer Service Section 1-877-563-4467. The U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: You may submit your appeal or grievance orally in person or by calling Member Service at 1-855-833-8120. You may submit a written appeal to BMC HealthNet Plan Qualified Health Plan 529 Main St, Suite 500 Charlestown, MA 02129 Attention Member Appeals or fax it to 617-897-0805

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-833-8120.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-833-8120.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-833-8120.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-833-8120.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist Copayment</a>	\$40
■ Hospital (facility) <a href="#">Copayment</a>	\$500
■ Other <a href="#">Copayment</a>	\$20

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,000</b>
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$
<b>The total Peg would pay is</b>	<b>\$600</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist Copayment</a>	\$40
■ Hospital (facility) <a href="#">Copayment</a>	\$500
■ Other <a href="#">Copayment</a>	\$10

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,390</b>
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$910
Coinsurance	\$350
What isn't covered	
Limits or exclusions	\$
<b>The total Joe would pay is</b>	<b>\$1,260</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist Copayment</a>	\$40
■ Hospital (facility) <a href="#">Copayment</a>	\$500
■ Other <a href="#">Copayment</a>	\$150

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,840</b>
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$390
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$
<b>The total Mia would pay is</b>	<b>\$390</b>