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 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 deductible?	$3000 Individual / $6,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses is paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other Deductibles 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 deductible amount before this plan begins to pay for these services. This deductible will count toward the overall deductible.
What is the out-of-pocket limit for this plan?	$7,900 Individual /$15,800 family for medical expenses and prescription drug combined (which includes $350 per individual for pediatric dental services).	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://www.bmchp.org/Provider-Search/Qualified-Health-Plan or call 1-855-833-8120 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You must get authorization from the plan to use an out-of-network provider. If you do not get authorization from the plan to use an out-of-network provider, the plan will not pay, and you will have to pay the provider's bill.
Do you need a referral to see a specialist?	No.	You can see the network provider you chose without a referral.

[* For more information about limitations and exceptions, see the plan or policy document at www.bmchp.org

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 provider's office or clinic	Primary care visit to treat an injury or illness	$30 / Visit (Deductible does not apply)	Not Covered	Specialist visits may require a preauthorization.
	Specialist visit	$55 / Visit (Deductible does not apply)	Not Covered	
	Preventive care screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check you're your plan will pay for. Visit https://www.healthcare.gov/coverage/preventive-care-benefits/ for info on services that are considered preventive
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance	Not Covered	Preauthorization may be required
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available athttps://www.bmchp.org/I-Am-A/Member/Get-Prescriptions	Generic drugs	$30 / Retail and $60 / 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	35% Coinsurance/ Retail and 35% Coinsurance/ mail order prescription	Not Covered	- Oral and other forms of prescription contraceptives are covered in full. - Oral anti-cancer drugs are covered in full. - Opioid antagonists and generic Medication -Assisted Treatment drugs are covered in full. - Preauthorization may be required.
	Non-preferred brand drugs	35% Coinsurance/ Retail and 35% Coinsurance/ mail order prescription	Not Covered	
	Specialty drugs	35% Coinsurance/ Retail and 35% Coinsurance/ mail order prescription	Not Covered	- Covers up to a 30-day supply from participating specialty pharmacies. -Preauthorization may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 / Visit	Not Covered	- Includes diagnostic colonoscopies and endoscopies. - Preauthorization may be required.
	Physician/surgeon fees	$0		

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 need immediate medical attention	Emergency room care	$500 / Visit		- ER Copayment is waived if admitted directly to the hospital from the ER. * If a service is received from an Out-of-Network provider, you are also liable for the difference between the billed charge and the Allowed amount.
	Emergency medical transportation	$0		
	Urgent care	$55 / Visit (Deductible does not apply)		
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance / admission	Not Covered	- Inpatient Rehabilitation hospitals are limited to 60 days per benefit year. - Preauthorization may be required.
	Physician/surgeon fees	$0		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 / Visit (Deductible does not apply)	Not Covered	- Preauthorization may be required from our 3rd party contractor, Beacon Health Strategies, LLC.
	Inpatient services	30% Coinsurance/ admission	Not Covered	
If you are pregnant	Office visits	No charge for pre-natal or postnatal visits	Not Covered	Office visits for medical conditions may be subject to cost-sharing.
	Childbirth/delivery professional services	30% Coinsurance admission	Not Covered	
	Childbirth/delivery facility services		Not Covered	
If you need help recovering or have other special health needs	Home health care	$0	Not Covered	-Preauthorization is required
	Rehabilitation services	30% Coinsurance / visit $30 / visit for members with a diagnosis of Autism Spectrum Disorder (Deductible does not apply)	Not Covered	- Outpatient Physical and Occupational therapy is limited to 60 combined visits per benefit year. - PT/OT limits do not apply to members with Autism Spectrum Disorders or for children under age 3 who are receiving Early Intervention Services. - Early Intervention and Cardiac Rehabilitation services are covered in full. - Preauthorization is required.
	Habilitation services	30% Coinsurance / visit $30 / visit for members with a diagnosis of	Not Covered	- Limited to 60 combined visits per benefit year. - Limits do not apply to members with Autism

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)	
		Autism Spectrum Disorder (Deductible does not apply)		Spectrum Disorders or for children under age 3 who are receiving Early Intervention Services. -Preauthorization is required
	Skilled nursing care	30% Coinsurance / admission	Not Covered	- Limited to 100 days per benefit year. -Preauthorization is required.
	Durable medical equipment	30% Coinsurance	Not Covered	- Coinsurance does not apply to wigs. - Preauthorization may be required from our 3rd party vendor, Northwood, Inc.
	Hospice services	$0	Not Covered	-Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No charge for preventive exam. $55 / visit for non-routine exams (Deductible does not apply)	Not Covered	- Preventive eye exams are limited to one every 12 months.
	Children's glasses	30% 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.)

- Acupuncture
- Cosmetic Surgery
- Early Intervention services for children age 3 and older.
- Hearing Aids for members over age 21
- Long-term care
- Non-Emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care except for members with Diabetes
- Dental Care (Adult)
- Services beyond any benefit or monetary limit listed in this Summary of Benefits and Coverage
- Vision Hardware except as described in the Evidence of Coverage.
- Weight loss programs, except as described in the Evidence of Coverage.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Bariatric Surgery
- Chiropractic Care
- Dental Services for Cleft Lip/Palate Repair
- Hearing Aids for Children
- Infertility treatment

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, 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. 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 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 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, kwiijigo 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 plan's overall deductible	$3000
Specialist Copayment	$55
Hospital (facility) Coinsurance	30%
Other Coinsurance	30%

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)*

Total Example Cost	$12,000

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	$3,000

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3000
Specialist Copayment	$55
Hospital (facility) Coinsurance	30%
Other Coinsurance	30%

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)*

Total Example Cost	$7,390

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1000
Copayments	$120
Coinsurance	$100
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	$1220

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3000
Specialist Copayment	$55
Hospital (facility) Coinsurance	30%
Other Coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,840

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$150
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	$350

The plan would be responsible for the other costs of these EXAMPLE covered services.