
 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 ? | \$2000 Individual / \$4,000 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 ? | \$7,350 Individual /\$14,700 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 http://www.providerlookuponline.com/BMCHP/po7/Search.aspx 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 specialist you chose without a referral. |

 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 | \$50/ 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) | \$25/ Visit | Not Covered | Preauthorization may be required |
| | Imaging (CT/PET scans, MRIs) | \$500/ Visit | Not Covered | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.bmchp.org/pharmacy/members/drug-search?carrierid=BMCM AQHP18&siteCode=5818404397 | Generic drugs | \$20/ Retail and \$40/ mail order prescription (Deductible does not apply) | Not Covered | - Covers up to a 30-day supply (retail); - Covers up to a 90-day supply (mail order). |
| | Preferred brand drugs | \$60/ Retail and \$120/ mail order prescription (Deductible does not apply) | 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 |
| | Non-preferred brand drugs | \$90/ Retail and \$270/ mail order prescription | Not Covered | - Medication Assisted Treatment drugs are covered in full. - Preauthorization may be required. |
| | Specialty drugs | \$90/ Retail and \$270/ 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) | \$750/ Visit | Not Covered | - Includes diagnostic colonoscopies and endoscopies. - Preauthorization may be required. |
| | Physician/surgeon fees | \$0 | | |
| If you need immediate medical attention | Emergency room care | \$700/Visit | | - ER Copayment is waived if admitted directly to the hospital from the ER. |
| | Emergency medical | \$0 | | |

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

| 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) | |
| | transportation | | | * 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 . |
| | Urgent care | Your cost sharing will vary depending on the location and type of service rendered.* | | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$1000/ 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 3 rd party contractor, Beacon Health Strategies, LLC. |
| | Inpatient services | \$1000/ 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 | \$1000/ 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 | \$50/ visit (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 | \$50/ visit (Deductible does not apply) | Not Covered | - Limited to 60 combined visits per benefit year. -Limits do not apply to members with Autism Spectrum Disorders or for children under age 3 who are receiving Early Intervention Services. |

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

| 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) | |
| | | | | - Preauthorization is required |
| | Skilled nursing care | \$1000/ admission | Not Covered | - Limited to 100 days per benefit year. - Preauthorization is required. |
| | Durable medical equipment | 20% Coinsurance | Not Covered | - Coinsurance does not apply to wigs. - Preauthorization may be required from our 3 rd party vendor, Northwood, Inc. |
| | Hospice services | \$0 | Not Covered | -Authorization is required. |
| If your child needs dental or eye care | Children's eye exam | No charge for routine exam. \$50/ visit for non-routine exams (Deductible does not apply) | Not Covered | - Routine 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"> Acupuncture Cosmetic Surgery Early Intervention services for children age 3 and older. Hearing Aids for members over age 21 Long-term care | <ul style="list-style-type: none"> Non-Emergency care when traveling outside the U.S Private-duty nursing Routine foot care except for members with Diabetes Dental Care (Adult) | <ul style="list-style-type: none"> 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.)

| | | |
|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> Abortion Bariatric Surgery | <ul style="list-style-type: none"> Chiropractic Care Dental Services for Cleft Lip/Palate Repair | <ul style="list-style-type: none"> 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 1-877-563-4467. The U.S. Department of Labor, Employee Benefits Security

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

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? No

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 [plan's](#) overall [deductible](#) \$2000
- [Specialist Copayment](#) \$50
- Hospital (facility) [Copayment](#) \$1000
- Other [Copayment](#) \$25

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|---------------|
| Deductibles | \$2000 |
| Copayments | \$1270 |
| Coinsurance | \$ |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$ |
| The total Peg would pay is | \$3270 |

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

- The [plan's](#) overall [deductible](#) \$2000
- [Specialist Copayment](#) \$50
- Hospital (facility) [Copayment](#) \$1000
- Other [Copayment](#) \$25

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 | \$ |
|---------------------------|-----------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|-----------|
| Deductibles | \$ |
| Copayments | \$ |
| Coinsurance | \$ |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$ |
| The total Joe would pay is | \$ |

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

- The [plan's](#) overall [deductible](#) \$2000
- [Specialist Copayment](#) \$50
- Hospital (facility) [Copayment](#) \$1000
- Other [Copayment](#) \$25

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$970 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$ |
| The total Mia would pay is | \$970 |