
 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> ?	\$2,500 Individual/ \$5,000 Family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> . If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses is paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</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. This deductible will count toward the overall <a href="#">deductible</a> .
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,350 Individual /\$14,700 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="http://www.providerlookuponline.com/BMCHP/po7/Search.aspx">http://www.providerlookuponline.com/BMCHP/po7/Search.aspx</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 authorization from the plan to use an <a href="#">out-of-network</a> provider. If you do not get authorization 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	\$30/Visit	Not Covered	Specialist visits may require a <a href="#">preauthorization</a> .
	<a href="#">Specialist</a> visit	\$50/ 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. 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)	\$25 / Visit	Not Covered	<a href="#">Preauthorization</a> may be required
	Imaging (CT/PET scans, MRIs)	\$25/ 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/pharmacy/members/drug-search?carrierid=BMCM AQHP18&amp;siteCode=5818404397">https://www.bmchp.org/pharmacy/members/drug-search?carrierid=BMCM AQHP18&amp;siteCode=5818404397</a>	Generic drugs	\$20/ Retail and \$40/ mail order prescription ( <a href="#">Deductible</a> 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	Not Covered	- Oral and other forms of prescription contraceptives are covered in full.
	Non-preferred brand drugs	\$90/ Retail and \$270/ 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>	\$90/ Retail and \$270/ 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)	\$750/ Visit	Not Covered	- Includes diagnostic colonoscopies and endoscopies. - <a href="#">Preauthorization</a> may be required.
	Physician/surgeon fees	\$0		
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$700/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 provider</a> , you are also liable for the difference between the billed charge and the	
	<a href="#">Emergency medical transportation</a>	\$0		
	<a href="#">Urgent care</a>	Your cost sharing will vary depending on the location and type of service rendered.*		

\* For more information about limitations and exceptions, see the plan or policy document at [www.bmchp.org](http://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)	
				<a href="#">Allowed amount.</a>
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. - <a href="#">Preauthorization</a> may be required.
	Physician/surgeon fees	\$0		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30/ Visit	Not Covered	- <a href="#">Preauthorization</a> may be required from our 3 <sup>rd</sup> party contractor, Beacon Health Strategies, LLC.
	Inpatient services	\$1000/ admission	Not Covered	
If you are pregnant	Office visits	No charge for prenatal or postnatal visits	Not Covered	Office visits for medical conditions may be subject to <a href="#">cost-sharing</a> .
	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	<a href="#">Home health care</a>	\$0	Not Covered	- <a href="#">Preauthorization</a> is required
	<a href="#">Rehabilitation services</a>	\$50/ visit	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. - <a href="#">Preauthorization</a> is required.
	<a href="#">Habilitation services</a>	\$50/ visit	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. - <a href="#">Preauthorization</a> is required
	<a href="#">Skilled nursing care</a>	\$1000/ admission	Not Covered	- Limited to 100 days per benefit year. - <a href="#">Preauthorization</a> is required.

\* For more information about limitations and exceptions, see the plan or policy document at [www.bmchp.org](http://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)	
	<a href="#">Durable medical equipment</a>	20% Coinsurance	Not Covered	- <a href="#">Coinsurance</a> 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>	\$0	Not Covered	- <a href="#">Preauthorization</a> 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.	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"> <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.

\* For more information about limitations and exceptions, see the plan or policy document at [www.bmchp.org](http://www.bmchp.org)

**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, kwijjigo 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](#) \$2,500
- [Specialist Copayment](#) \$50
- Hospital (facility) [Copayment](#) \$1000
- Other [Copayment](#) \$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:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$1,100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Peg would pay is</b>	<b>\$3,600</b>

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

- The [plan's](#) overall [deductible](#) \$2500
- [Specialist Copayment](#) \$50
- Hospital (facility) [Copayment](#) \$1000
- Other [Copayment](#) \$20

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:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$1,070
Coinsurance	\$220
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Joe would pay is</b>	<b>\$3,790</b>

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

- The [plan's](#) overall [deductible](#) \$2500
- [Specialist Copayment](#) \$50
- Hospital (facility) [Copayment](#) \$1000
- Other [Copayment](#) \$20

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:

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