




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> ?	\$5,000 Individual /\$10,000 Family	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 <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
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	\$25 / Visit	Not Covered	<a href="#">Specialist</a> 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. Then check what 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)	\$75 / Visit (X-Ray) \$50/Visit (Blood Work)	Not Covered	- <a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained payment for services could be denied.
	Imaging (CT/PET scans, MRIs)	\$400 / 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	\$25 / Retail and \$50 / mail order prescription	Not Covered	<ul style="list-style-type: none"> <li>- Covers up to a 30-day supply (retail);</li> <li>- Covers up to a 90-day supply (mail order).</li> <li>- Oral and other forms of prescription contraceptives are covered in full.</li> <li>- Certain oral anti-cancer drugs are covered in full.</li> <li>- Step therapy may be required.</li> <li>- <a href="#">Preauthorization</a> may be required.</li> <li>- Covers up to a 30-day supply from participating specialty pharmacies.</li> <li>- <a href="#">Preauthorization</a> may be required.</li> </ul>
	Preferred brand drugs	\$50 / Retail and \$100 / mail order prescription	Not Covered	
	Non-preferred brand drugs	\$75 / Retail and \$225 / mail order prescription	Not Covered	
	<a href="#">Specialty drugs</a>	\$75 / Retail and \$225 / mail order prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500/Visit	Not Covered	<ul style="list-style-type: none"> <li>-Includes diagnostic colonoscopies and endoscopies.</li> <li>- <a href="#">Preauthorization</a> may be required.</li> </ul>
	Physician/surgeon fees	No Charge	Not Covered	
If you need immediate	<a href="#">Emergency room care</a>	\$300 / Visit	\$300 / Visit	- ER <a href="#">Copayment</a> is waived if admitted

\* 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)	
medical attention				directly to the hospital from the ER - If you receive emergency services from a non-network provider, the plan pays up to the allowed amount.
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	Emergency transportation only. Non-emergency transportation requires <a href="#">Preauthorization</a> . If <a href="#">preauthorization</a> is not obtained payment for services could be denied.
	<a href="#">Urgent care</a>	\$50 / Visit	\$50 / Visit	<a href="#">Urgent care</a> from non-network providers outside of the service area is covered for medically necessary covered services.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 / Admission	Not Covered	- Inpatient Rehabilitation hospitals are limited to 60 days per benefit year. - <a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained payment for services could be denied.
	Physician/surgeon fees	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 / Visit	Not Covered	- <a href="#">Preauthorization</a> may be required from our 3 <sup>rd</sup> party contractor, Beacon Health Strategies, LLC.
	Inpatient services	\$750 / Admission	Not Covered	
If you are pregnant	Office visits	\$25/Visit with a PCP \$50/Visit with a Specialist	Not Covered	- <a href="#">Cost-sharing</a> does not apply to preventive services
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	\$750 / Admission	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	Not Covered	- <a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained payment for services could be denied.
	<a href="#">Rehabilitation services</a>	\$50 / Visit	Not Covered	- Outpatient Physical and Occupational

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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)	
				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. - No limit on speech therapy visits - <a href="#">Preauthorization</a> may be required after initial evaluation.
	<a href="#">Habilitation services</a>	\$50 / Visit	Not Covered	- Outpatient Physical and Occupational therapy is limited to 60 combined visits per benefit year. -- <a href="#">Preauthorization</a> may be required after initial evaluation.
	<a href="#">Skilled nursing care</a>	\$750 / Admission	Not Covered	- Limited to 100 days per benefit year. - <a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained payment for services could be denied.
	<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	- <a href="#">Preauthorization</a> is required. If you do not get <a href="#">preauthorization</a> , payment for services could be denied.
If your child needs dental or eye care	Children's eye exam	No Charge for preventive exam. \$50 / visit for non-routine exams.	Not Covered	- Preventive eye exams are limited to one every 12 months for members age 18 and younger
	Children's glasses	20% Coinsurance	Not Covered	
	Children's dental check-up	No Charge	Not Covered	-Only covered for members age 18 and younger --Check-up refers to preventive and diagnostic visits (Type I services). Type II, Type III and Type IV services are subject to

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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)	
				cost-sharing*

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<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>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> 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>

**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 or [mass.gov/doi](http://mass.gov/doi), The U.S. Department of Labor's 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 Service's 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.

**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 on how 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:

- BMC Healthnet Plan Member Service at 1-855-833-8120
- The U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa)
- Massachusetts Division of Insurance at 617-521-7794

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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### 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](#).

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

### 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.

**\*\*Small Group Coverage Period: 12 months from effective date**

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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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](#) \$0
- [Specialist copayments](#) \$50
- Hospital (facility) [copayments](#) \$750

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>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,500
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
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Limits or exclusions	\$0
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<b>The total Peg would pay is</b>	<b>\$1,500</b>
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**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayments](#) \$50
- Hospital (facility) [copayments](#) \$750
- [Durable medical equipment coinsurance](#) 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>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,600
<a href="#">Coinsurance</a>	\$200

<i>What isn't covered</i>	
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Limits or exclusions	\$0
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<b>The total Joe would pay is</b>	<b>\$1,800</b>
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**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayments](#) \$50
- [Emergency room copayments](#) \$750
- [Durable medical equipment coinsurance](#) 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>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$50

<i>What isn't covered</i>	
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Limits or exclusions	\$
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<b>The total Mia would pay is</b>	<b>\$850</b>
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.