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? | Not Applicable | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible? | Yes | This plan covers items and services even if you haven't met the deductible amount. |
| Are there other Deductibles for specific services? | No | You don't have to meet deductible for specific services. |
| What is the out-of-pocket limit for this plan? | No Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| What is not included in the out-of-pocket limit? | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| Will you pay less if you use a network provider? | Not Applicable. | |
| Do you need a referral to see a specialist? | No. | You can see the network specialist you choose 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 |
|---|---|---|---|---|
| | | Indian Health Care Provider (ICHP) (You will pay the least) | Non-IHCP 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 | No Charge | No Charge | |
| | Specialist visit | No Charge | No Charge | Specialist visit may require Preauthorization |
| | Preventive care/screening/ immunization | No Charge | No Charge | 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) | No Charge | No Charge | -- Includes diagnostic colonoscopies and endoscopies.<br>-Preauthorization may be required |
| | Imaging (CT/PET scans, MRIs) | No Charge | No Charge | |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at https://www.bmchp.org/I-Am-A/Member/Get-Prescriptions | Generic drugs | No Charge | No Charge | - Covers up to a 30-day supply (retail); - Covers up to a 90-day supply (mail order). |
| | Preferred brand drugs | No Charge | No Charge | - Oral and other forms of prescription contraceptives are covered in full.<br>- Oral anti-cancer drugs are covered in full.<br>- Opioid antagonists and generic Medication-Assisted Treatment drugs are covered in full.<br>- Preauthorization may be required. |
| | Non-preferred brand drugs | No Charge | No Charge | |
| | Specialty drugs | No Charge | No Charge | - Covers up to a 30-day supply from participating specialty pharmacies.<br>- Preauthorization may be required. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge | No Charge | |
| | Physician/surgeon fees | No Charge | No Charge | |
| If you need immediate medical attention | Emergency room care | No Charge | No Charge | |
| | Emergency medical transportation | No Charge | No Charge | |
| | Urgent care | No Charge | No Charge | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge | No Charge | - Inpatient Rehabilitation hospitals are limited to 60 days per benefit year. |

* 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 |
|---|---|---|---|---|
| | | Indian Health Care Provider (ICHP) (You will pay the least) | Non-IHCP Provider (You will pay the most) | |
| | | | | - Preauthorization may be required. |
| | Physician/surgeon fees | No Charge | No Charge | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No Charge | No Charge | - Preauthorization may be required from our 3rd party contractor, Beacon Health Strategies, LLC. |
| | Inpatient services | No Charge | No Charge | |
| If you are pregnant | Office visits | No Charge | No Charge | |
| | Childbirth/delivery professional services | No Charge | No Charge | |
| | Childbirth/delivery facility services | No Charge | No Charge | |
| If you need help recovering or have other special health needs | Home health care | No Charge | No Charge | -Preauthorization is required |
| | Rehabilitation services | No Charge | No Charge | - Outpatient Physical and Occupational therapy is limited to 60 combined visits per benefit year.<br>- PT/OT limits do not apply to members with Autism Spectrum Disorders or for children under age 3 who are receiving Early Intervention Services.<br>- Early Intervention and Cardiac Rehabilitation services are covered in full.<br>- Preauthorization is required. |
| | Habilitation services | No Charge | No Charge | - Limited to 60 combined visits per benefit year.<br>- Limits do not apply to members with Autism Spectrum Disorders or for children under age 3 who are receiving Early Intervention Services.<br>-Preauthorization is required |
| | Skilled nursing care | No Charge | No Charge | - Limited to 100 days per benefit year.<br>-Preauthorization is required. |
| | Durable medical equipment | No Charge | No Charge | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Indian Health Care Provider (ICHP) (You will pay the least) | Non-IHCP Provider (You will pay the most) | |
| | | | | - Preauthorization may be required from our 3rd party vendor, Northwood, Inc. |
| | Hospice services | No Charge | No Charge | -Preauthorization is required. |
| If your child needs dental or eye care | Children's eye exam | No Charge | No Charge | - Preventiveeye exams are limited to one every 12 months. |
| | Children's glasses | No Charge | No Charge | - Coverage is limited to eyeglasses, conventional lenses, and contact lenses |
| | Children's dental check-up | No Charge | No Charge | |

## 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,

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

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. Note:These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist Copayment | $0 |
| Hospital (facility) Copayment | $0 |
| Other Copayment | $0 |

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 | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| The total Peg would pay is | $0 |

### 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 Copayment | $0 |
| Hospital (facility) Copayment | $0 |
| Other Copayment | $0 |

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 | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| The total Joe would pay is | $0 |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist Copayment | $0 |
| Hospital (facility) Copayment | $0 |
| Other Copayment | $0 |

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 | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| The total Mia would pay is | $0 |

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