**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services **Coverage Period: 01/01/2018 – 12/31/2018 BMC HealthNet Plan – ConnectorCare Plan Type 3 Coverage for:** Individual and Family | **Plan Type:** HMO



|  |  |  |
| --- | --- | --- |
| The Summary of Benefits and Coverage (SBC) document will help you choose a health [**plan**.](http://www.healthcare.gov/sbc-glossary/) The SBC shows you how you and the [**plan**](http://www.healthcare.gov/sbc-glossary/) would share the cost for covered health care services. NOTE: Information about the cost of this [**plan**](http://www.healthcare.gov/sbc-glossary/) (called the [**premium**](http://www.healthcare.gov/sbc-glossary/)) 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,](http://www.healthcare.gov/sbc-glossary/) 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**](http://www.healthcare.gov/sbc-glossary/)**?** | **$0** | See the chart starting on page 2 for how much you pay for covered services after you meet the [deductible.](http://www.healthcare.gov/sbc-glossary/) |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/)**?** | Yes. [Preventive care](http://www.healthcare.gov/sbc-glossary/) and primary care services are covered before you meet your [deductible.](http://www.healthcare.gov/sbc-glossary/) | This [plan](https://www.healthcare.gov/sbc-glossary/) covers some items and services even if you haven’t yet met the [deductible](https://www.healthcare.gov/sbc-glossary/) amount. But a [copayment](https://www.healthcare.gov/sbc-glossary/) or [coinsurance](https://www.healthcare.gov/sbc-glossary/) may apply. For example, this [plan](https://www.healthcare.gov/sbc-glossary/) covers certain [preventive services](https://www.healthcare.gov/sbc-glossary/) without [cost-sharing](https://www.healthcare.gov/sbc-glossary/) and before you meet your [deductible.](https://www.healthcare.gov/sbc-glossary/) See a list of covered [preventive](https://www.healthcare.gov/sbc-glossary/) [services](https://www.healthcare.gov/sbc-glossary/) at [https://www.healthcare.gov/coverage/preventive-care-benefits/.](https://www.healthcare.gov/coverage/preventive-care-benefits/) |
| **Are there other**  [**Deductibles**](https://www.healthcare.gov/sbc-glossary/) **for specific services?** | No. | You don’t have to meet [deductibles](https://www.healthcare.gov/sbc-glossary/) for specific services. |
| **What is the** [**out-of-pocket**](http://www.healthcare.gov/sbc-glossary/)[**limit**](http://www.healthcare.gov/sbc-glossary/) **for this** [**plan**](http://www.healthcare.gov/sbc-glossary/)**?** | **$1500** Individual **/$3000** family for medical expenses and **$750** Individual/**$1500** for prescription drug | The [out-of-pocket limit](http://www.healthcare.gov/sbc-glossary/) is the most you could pay in a year for covered services. If you have other family members in this [plan,](http://www.healthcare.gov/sbc-glossary/) they have to meet their own [out-of-pocket limits](http://www.healthcare.gov/sbc-glossary/) until the overall family [out-of-pocket limit](http://www.healthcare.gov/sbc-glossary/) has been met. |
| **What is not included in the** [**out-of-pocket limit**](http://www.healthcare.gov/sbc-glossary/)**?** | 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.](http://www.healthcare.gov/sbc-glossary/) |
| **Will you pay less if you use a** [**network provider**](http://www.healthcare.gov/sbc-glossary/)**?** | Yes. See [http://www.providerlookuponline.c](http://www.providerlookuponline.com/BMCHP/po7/Search.aspx) [om/BMCHP/po7/Search.aspx](http://www.providerlookuponline.com/BMCHP/po7/Search.aspx) or call 1-855-833-8120 for a list of [network providers.](http://www.healthcare.gov/sbc-glossary/) | This [plan](http://www.healthcare.gov/sbc-glossary/) uses a provider [network.](http://www.healthcare.gov/sbc-glossary/) You will pay less if you use a [provider](http://www.healthcare.gov/sbc-glossary/) in the plan’s [network.](http://www.healthcare.gov/sbc-glossary/) 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,](https://www.healthcare.gov/sbc-glossary/) the plan will not pay, and you will have to pay the provider’s bill. |
| **Do you need a** [**referral**](http://www.healthcare.gov/sbc-glossary/) **to**  **see a** [**specialist**](http://www.healthcare.gov/sbc-glossary/)**?** | No. | You can see the [network specialist](https://www.healthcare.gov/sbc-glossary/) you chose without a referral. |

**1 of 6**

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|  | All [**copayment**](http://www.healthcare.gov/sbc-glossary/) and [**coinsurance**](http://www.healthcare.gov/sbc-glossary/) costs shown in this chart are after your [**deductible**](http://www.healthcare.gov/sbc-glossary/) has been met, if a [**deductible**](http://www.healthcare.gov/sbc-glossary/) applies. | | | | |  |
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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)** |
| **If you visit a health care** [**provider’s**](http://www.healthcare.gov/sbc-glossary/) **office or clinic** | | Primary care visit to treat an  injury or illness | $15/Visit | Not Covered | Specialist visits may require a [preauthorization.](https://www.healthcare.gov/sbc-glossary/) | |
| [Specialist](http://www.healthcare.gov/sbc-glossary/) visit | $22/ Visit | Not Covered |
| [Preventive care/screening/](https://www.healthcare.gov/sbc-glossary/) immunization | No Charge | Not Covered | Visit [https://www.healthcare.gov/coverage/preventiv](https://www.healthcare.gov/coverage/preventive-care-benefits/)  [e-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/) for info on services that are considered preventive | |
| **If you have a test** | | [Diagnostic test](http://www.healthcare.gov/sbc-glossary/) (x-ray, blood  work) | No Charge | Not Covered | [Preauthorization](https://www.healthcare.gov/sbc-glossary/) may be required | |
| Imaging (CT/PET scans, MRIs) | $60/ Visit | Not Covered |
| **If you need drugs to treat your illness or condition**  More information about [**prescription drug**](http://www.healthcare.gov/sbc-glossary/)[**coverage**](http://www.healthcare.gov/sbc-glossary/) is available at [https://www.bmchp.org/](https://www.bmchp.org/pharmacy/members/drug-search?carrierid=BMCMAQHP18&siteCode=5818404397) [pharmacy/members/dru](https://www.bmchp.org/pharmacy/members/drug-search?carrierid=BMCMAQHP18&siteCode=5818404397) [g-](https://www.bmchp.org/pharmacy/members/drug-search?carrierid=BMCMAQHP18&siteCode=5818404397) [search?carrierid=BMCM](https://www.bmchp.org/pharmacy/members/drug-search?carrierid=BMCMAQHP18&siteCode=5818404397) [AQHP18&siteCode=581](https://www.bmchp.org/pharmacy/members/drug-search?carrierid=BMCMAQHP18&siteCode=5818404397) [8404397](https://www.bmchp.org/pharmacy/members/drug-search?carrierid=BMCMAQHP18&siteCode=5818404397) | | Generic drugs | $12.50/ Retail and $25/ 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 | $25/ Retail and $50/  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](https://www.healthcare.gov/sbc-glossary/) may be required. | |
| Non-preferred brand drugs | $50/ Retail and $100/ mail order prescription | Not Covered |
| [Specialty drugs](http://www.healthcare.gov/sbc-glossary/) | $50/ Retail and $100/ mail order prescription | Not Covered | * Covers up to a 30-day supply from   participating specialty pharmacies.   * [Preauthorization](https://www.healthcare.gov/sbc-glossary/) may be required. | |
| **If you have outpatient surgery** | | Facility fee (e.g., ambulatory  surgery center) | $125/ Visit | Not Covered | * Includes diagnostic colonoscopies and endoscopies. * [Preauthorization](https://www.healthcare.gov/sbc-glossary/) may be required. | |
| Physician/surgeon fees | No Charge |
| **If you need immediate medical attention** | | [Emergency room care](http://www.healthcare.gov/sbc-glossary/) | $100/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,](https://www.healthcare.gov/sbc-glossary/) you are also liable for the difference between the billed charge and the [Allowed amount.](https://www.healthcare.gov/sbc-glossary/) | |
| [Emergency medical](http://www.healthcare.gov/sbc-glossary/)  [transportation](http://www.healthcare.gov/sbc-glossary/) | No Charge | |
| [Urgent care](http://www.healthcare.gov/sbc-glossary/) | Your cost sharing will vary depending on the location and type of service rendered.\* | |
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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)** |
| **If you have a hospital**  **stay** | Facility fee (e.g., hospital room) | $250/ admission | Not Covered | * Inpatient Rehabilitation hospitals are limited   to 60 days per benefit year.   * [Preauthorization](https://www.healthcare.gov/sbc-glossary/) may be required. |
| Physician/surgeon fees | No Charge |
| **If you need mental**  **health, behavioral health, or substance abuse services** | Outpatient services | $15/ Visit | Not Covered | - [Preauthorization](https://www.healthcare.gov/sbc-glossary/) may be required from our 3rd  party contractor, Beacon Health Strategies, LLC. |
| Inpatient services | $250/ 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.](https://www.healthcare.gov/sbc-glossary/) |
| Childbirth/delivery professional  services | $250/ admission | Not Covered |
| Childbirth/delivery facility  services | Not Covered |
| **If you need help recovering or have other special health needs** | [Home health care](http://www.healthcare.gov/sbc-glossary/) | No Charge | Not Covered | -[Preauthorization](https://www.healthcare.gov/sbc-glossary/) is required |
| [Rehabilitation services](http://www.healthcare.gov/sbc-glossary/) | $20/ 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. * [Preauthorization](https://www.healthcare.gov/sbc-glossary/) is required. |
| [Habilitation services](http://www.healthcare.gov/sbc-glossary/) | $20/ 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.  -[Preauthorization](https://www.healthcare.gov/sbc-glossary/) is required |
| [Skilled nursing care](http://www.healthcare.gov/sbc-glossary/) | $250/ admission | Not Covered | * Limited to 100 days per benefit year. * [Preauthorization](https://www.healthcare.gov/sbc-glossary/) is required. |
| [Durable medical equipment](http://www.healthcare.gov/sbc-glossary/) | No Charge | Not Covered | * [Coinsurance](https://www.healthcare.gov/sbc-glossary/) does not apply to wigs. * [Preauthorization](https://www.healthcare.gov/sbc-glossary/) may be required from |

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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)** |
|  |  |  |  |  | our 3rd party vendor, Northwood, Inc. |
| [Hospice services](http://www.healthcare.gov/sbc-glossary/) | No Charge | Not Covered | -[Preauthorization](https://www.healthcare.gov/sbc-glossary/) is required. |
|  | **If your child needs dental or eye care** | Children’s eye exam | No charge for routine  exam. $22/ visit for non- routine exams | Not Covered | - Routine eye exams are limited to one every 12 months. |
| Children’s glasses | No Charge | 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](https://www.healthcare.gov/sbc-glossary/) and diagnostic  visits (Type I services). Type II, Type III and Type IV services are subject to [cost-sharing.](https://www.healthcare.gov/sbc-glossary/) |

# Excluded Services & Other Covered Services:

|  |  |  |
| --- | --- | --- |
| **Services Your** [**Plan**](http://www.healthcare.gov/sbc-glossary/) **Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other** [**excluded services**](http://www.healthcare.gov/sbc-glossary/)**.)** | | |
| * 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**](http://www.healthcare.gov/sbc-glossary/) **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,](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.](https://www.healthcare.gov/sbc-glossary/) For more information about the [Marketplace,](https://www.healthcare.gov/sbc-glossary/) 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.](https://www.healthcare.gov/sbc-glossary/) For more information about the [Marketplace,](https://www.healthcare.gov/sbc-glossary/) 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](https://www.healthcare.gov/sbc-glossary/) for a denial of a [claim.](https://www.healthcare.gov/sbc-glossary/) This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/) or [appeal.](https://www.healthcare.gov/sbc-glossary/) For more information about your rights, look at the explanation of benefits you will receive for that medical [claim.](https://www.healthcare.gov/sbc-glossary/) Your [plan](https://www.healthcare.gov/sbc-glossary/) documents also

provide complete information to submit a [claim, appeal,](https://www.healthcare.gov/sbc-glossary/) or a [grievance](https://www.healthcare.gov/sbc-glossary/) for any reason to your [plan.](https://www.healthcare.gov/sbc-glossary/) 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](https://www.healthcare.gov/sbc-glossary/) 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](https://www.healthcare.gov/sbc-glossary/) doesn’t meet the [Minimum Value Standards,](https://www.healthcare.gov/sbc-glossary/) you may be eligible for a [premium tax credit](https://www.healthcare.gov/sbc-glossary/) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/) through the [Marketplace.](https://www.healthcare.gov/sbc-glossary/)

# 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](http://www.healthcare.gov/sbc-glossary/) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](http://www.healthcare.gov/sbc-glossary/) charge, and many other factors. Focus on the [cost sharing](http://www.healthcare.gov/sbc-glossary/) amounts ([deductibles, copayments](http://www.healthcare.gov/sbc-glossary/) and [coinsurance](http://www.healthcare.gov/sbc-glossary/)) and [excluded services](http://www.healthcare.gov/sbc-glossary/) under the [plan.](http://www.healthcare.gov/sbc-glossary/) Use this information to compare the portion of costs you might pay under different health [plans.](http://www.healthcare.gov/sbc-glossary/) 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)

**Managing Joe’s type 2 Diabetes**

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

**Mia’s Simple Fracture**

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

* **The** [**plan’s**](http://www.healthcare.gov/sbc-glossary/) **overall** [**deductible**](http://www.healthcare.gov/sbc-glossary/) **$0**
* [**Specialist Copayment**](https://www.healthcare.gov/sbc-glossary/) **$22**
* **Hospital (facility)** [**Copayment**](https://www.healthcare.gov/sbc-glossary/) **$250**
* **Other** [**Copayment**](https://www.healthcare.gov/sbc-glossary/) **$12**
* **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/) **$0**
* [**Specialist Copayment**](https://www.healthcare.gov/sbc-glossary/) **$22**
* **Hospital (facility)** [**Copayment**](https://www.healthcare.gov/sbc-glossary/) **$250**
* **Other** [**Copayment**](https://www.healthcare.gov/sbc-glossary/) **$12**
* **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/) **$0**
* [**Specialist Copayment**](https://www.healthcare.gov/sbc-glossary/) **$22**
* **Hospital (facility)** [**Copayment**](https://www.healthcare.gov/sbc-glossary/) **$250**
* **Other** [**Copayment**](https://www.healthcare.gov/sbc-glossary/) **$100**

**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** | **$12000** |

# In this example, Peg would pay:

**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:

**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 | $350 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $ |
| **The total Peg would pay is** | **$350** |

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $1100 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $ |
| **The total Joe would pay is** | **$1,100** |

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $ |
| **The total Mia would pay is** | **$200** |