SCHEDULE OF BENEFITS:
BMC HealthNet Plan
GOLD

BOSTON MEDICAL CENTER
HEALTHNet PLAN

A Qualified Health Plan and Employer Choice Direct Plan¤

PROVIDER NETWORK: QHP Select Network¤¤

This Schedule of Benefits provides a summary of your benefits and *member cost-sharing*. It also tells you the name of your *provider network* (see above). Please be sure to read the BMC HealthNet Plan Evidence of Coverage (EOC) for a full description of your benefits, including exclusions, and other *plan* provisions. All *covered services* must be *medically necessary* and some require prior authorization. Always check with your provider to find out if necessary prior authorization has been obtained. If any terms in this summary differ from those in your EOC, the terms of your EOC apply. Italicized words in this Schedule of Benefits are defined in your EOC. For more information about your benefits, and to find *network providers*, go to www.bmchp.org or call Member Services at 1-855-833-8120.

BMCHP-GLD2022ver.1

Deductible (per *benefit year*)	Amount
Per Individual *Member*	None
	$50 (Pediatric Dental – Type II and Type III Services Only)
Per Family	None
Out-of-Pocket maximum (per *benefit year*)	**Amount**
Per Individual *Member*	$5,000 (includes Medical, Pediatric Dental*, and Rx) $350 (Pediatric Dental, if applicable, counts toward the Individual and Family OOPM)
Per Family	$10,000 (includes Medical, Pediatric Dental, and Rx)

Covered Services Note about Prior Authorization: Some services require prior authorization. Please see your EOC for more information.		Your Cost (*Cost-sharing*)
Inpatient Hospital Care	Acute hospital *inpatient care* for medical, surgical and maternity services. See also, "Newborn Coverage", below.	$750 *copayment* per admission
	Extended care in a chronic disease hospital.	$750 *copayment* per admission
	Extended care in a rehabilitation hospital. *Benefit limit:* limited to 60 days per *benefit year*.	$750 *copayment* per admission
	Extended care in a skilled nursing facility. *Benefit limit:* limited to 100 days per *benefit year*.	$750 *copayment* per admission
	Mental health and substance abuse+ *Inpatient* admission to a general or mental hospital, or substance abuse facility.	$750 *copayment* per admission
Abortion	Outpatient Surgery	$500 *copayment* per visit
Allergy Services	Testing and Treatment.	$50 *copayment* per visit
	Lab tests.	See Lab Tests, below
	Allergy injections.	$10 per injection
Ambulance	Covered ambulance.	Nothing
Autism Spectrum Disorder Services+	• *Outpatient* office visits. • *Outpatient* rehabilitation (physical, occupational, speech therapy and social work visits) – as is *medically necessary*. • Lab tests and other diagnostic tests. • Habilitative services.	You pay the *cost-sharing* applicable to the service(s) rendered.
Cardiac Rehabilitation	*Outpatient* services.	$50 *copayment* per visit
Chemotherapy and Radiation Therapy	*Outpatient* services.	Nothing after *deductible*
Chiropractor Care	*Outpatient* office visits, including supportive medical treatment services and spinal manipulation	$50 *copayment* per visit
	Outpatient lab test and x-rays	See lab test, x-rays, and other test
Dialysis Services	*Outpatient* services.	Nothing
Durable Medical Equipment, Prosthetics, Orthotics, Medical Supplies, Medical Formulas and Low Protein Foods++	• Durable medical equipment • Prosthetics • Orthotics • Medical supplies • Medical formulas • Wigs (scalp hair prostheses): • *Coinsurance* does not apply • Low protein foods • Ostomy supply • Oxygen and respiratory equipment	20% *coinsurance*
Early Intervention Services	For an eligible *child* through age 2.	Nothing

Covered Services Note about Prior Authorization: Some services require prior authorization. Please see your EOC for more information.		Your Cost (*Cost-sharing*)
Emergency Services	Visits to an emergency room (or for observation services in a hospital setting without use of the emergency room). If you are admitted as an inpatient immediately following the provision of *emergency* services: • Your *emergency* services *copayment* is waived; and • If admitted to a non-*network hospital*, you or someone acting for you must call the *plan* within 2 working days. If you receive *emergency* services from a non-network provider, the plan pays up to the *allowed amount*.	$300 *copayment* per visit
Habilitative Services and Devices	O*utpatient* physical and occupational therapy as well as medically necessary habilitative devices. *Benefit limit:* limited to 60 combined visits per *benefit year*. (*Benefit limit* does not apply to these services when provided to *members* with autism spectrum disorder, or when receiving early intervention services)	$50 *copayment* per visit
Hearing Aids for Children	For an eligible *child* age 21 or younger *Benefit limit:* Covered for one hearing aid up to two thousand dollars ($2,000) every 36 months per hearing impaired ear.	20% *coinsurance*
	Hearing aid evaluations and exams	$50 *copayment* per visit
	Hearing aid related services and supplies	20% *coinsurance*
Hearing Exams	PCP exams and evaluations.	$25 *copayment* per visit
	Specialist exams and evaluations.	$50 *copayment* per visit
Home Health Care	Home care program.	Nothing
Hospice Services	Hospice services for terminally ill.	Nothing
Infertility Services	*Inpatient, outpatient surgery*; lab and x-rays; *outpatient* office visits; and prescription drugs.	You pay the *cost-sharing* applicable to the service(s) rendered.
Lab Tests, Radiology and Other Outpatient Diagnostic Procedures (Non-Routine Diagnostic Services)	Diagnostic laboratory tests (includes HLA testing).	$50 *copayment*
	X-rays.	$75 *copayment*
	Diagnostic high tech imaging: CT/CTA scan, MRI/MRA, PET scan and NCI/NPI (nuclear cardiac imaging).	$400 *copayment* per visit
Lipodystrophy Syndrome Treatment	Medical and/or drug treatment such as reconstructive surgery (for example, suction assisted lipectomy)	You pay the *cost-sharing* applicable to the service(s) rendered.
	Other restorative procedures including dermal injections or fillers	You pay the *cost-sharing* applicable to the service(s) rendered.
Long Term Antibiotic Therapy for Lyme Disease	Primary care provider (PCP) office visit.	$25 *copayment* per visit
	Specialist office visit.	$50 *copayment* per visit
Maternity Services	Outpatient prenatal office visits	You pay the cost-sharing applicable to the service(s) rendered. No charge for services considered preventive
	Outpatient postpartum office visit(s)	

Covered Services Note about Prior Authorization: Some services require prior authorization. Please see your EOC for more information.		Your Cost (*Cost-sharing*)
Medical Formulas	Nonprescription enteral formulas and prescription formulas	See Durable Medical Equipment
Medical Supplies	Includes ostomy, tracheostomy and oxygen supplies; and supplies for insulin pumps.	See Durable Medical Equipment
Mental Health and Substance Abuse Treatment – Outpatient+	*Outpatient* office visits.	$25 *copayment* per visit
	Medication-Assisted Treatment (MAT) and Associated Services for Opioid Dependence	$25 copayment per visit
Nutritional Counseling	*Outpatient* office visits by a registered dietician.	Nothing
Observation Services		$300 *copayment* per visit If you are admitted to observation status from the emergency room, the emergency room *copayment* is waived.
Outpatient Office Visits for Medical Care (to evaluate and treat illness or injury)	Primary care provider (PCP) office visit.	$25 *copayment* per visit
	Specialist office visit.	$50 *copayment* per visit
Outpatient Surgery	Same day surgery in a hospital or ambulatory surgery setting. (Includes diagnostic colonoscopies and endoscopies.)	$500 *copayment* per visit
Pediatric Dental++++ (Ages 18 and under)	Type I Services: Preventive & Diagnostic • Comprehensive Evaluation (Once per dentist per location) • Periodic Oral Exams (Twice per dentist location every 12 months) • Limited Oral evaluation (Two per calendar year per patient) • Oral evaluation under 3 years of age • Full Mouth X-Ray (Once per dentist location every 36 months) • Panoramic X-Ray(Once per dentist location every 36 months) • Bitewing X-Rays (Two per dentist location every 12 months) • Single Tooth X-Ray (As needed) • Teeth Cleaning (Twice every 12 months) • Fluoride Treatments (Once every 3 months) • Space Maintainers (covered) • Sealants (Once per tooth per dentist location every 26 months)	Nothing

Covered Services Note about Prior Authorization: Some services require prior authorization. Please see your EOC for more information.		Your Cost (*Cost-sharing*)
Pediatric Dental++++ (Ages 18 and under) (Continued)	Type II Services: Basic Covered Services • Amalgam Restoration (Once per tooth per surface every 12 months) • Composite Resin Restorations (Once per tooth per surface every 12 months) • Recement crown/onlays (covered) • Rebase or reline dentures (Once with 24 months) • Root canals on permanent teeth (Once per tooth) • Prefabricated Stainless Steel Crowns (Four per patient per day) • Periodontal Scaling and Root Planing (Once per quadrant every 24 months) • Simple Extractions (covered.) • Surgical Extractions (covered.) • Vital pulpotomy (Limited to deciduous teeth) • Apicoectomy (Once per permanent tooth per lifetime) • Palliative care • Anesthesia (Allowed with covered surgical procedure)	25% *coinsurance* after *deductible*
	Type III Services: Major Restorative Services • Crown, resin (Once per tooth within 60 months) • Porcelain/ceramic crowns (Once per within 60 months)	50% *coinsurance* after *deductible*
	Type IV Services: Orthodontia (Once per lifetime) (Covered only when medically necessary; patient must have severe and handicapping malocclusion as defined by HLD index score of 28 and/or one or more auto qualifiers; requires prior authorization)	50% *coinsurance*
Pediatric Vision (Ages 18 and under)	• Conventional* Lenses: One pair every calendar year • Conventional* Frames: Covered once every calendar year • Contact Lenses: Covered once every calendar year – instead of eyeglasses	20% *coinsurance*
Podiatry Services	Non-routine foot care.	$50 *copayment* per visit
	Outpatient lab tests and x-rays.	See Lab Tests, X-Rays and Other Tests
	Routine foot care for diabetics.	Nothing
Prescription Drugs¤¤¤ From a *network* Retail Pharmacy: (up to a 30-day supply)	Tier 1	$25 *copayment*
	Tier 2	$50 *copayment*
	Tier 3	$75 *copayment*
Prescription Drugs¤¤¤ From Mail Service Pharmacy: (up to a 90-day supply)	Tier 1	$50 *copayment*
	Tier 2	$100 *copayment*
	Tier 3	$225 *copayment*
Note: You pay nothing for: (1) oral and other forms of prescription drug contraceptives; and (2) Certain oral anti-cancer drugs (3) statins (4) smoking cessation items (5) aspirin (6) Preexposure prophylaxis (PrEP) with effective antiretroviral therapy.		

Covered Services Note about Prior Authorization: Some services require prior authorization. Please see your EOC for more information.		Your Cost (*Cost-sharing*)
Preventive Health Services The *plan* covers certain preventive health services, defined as services toprevent any disease or injury rather than diagnose or treat a complaint or symptom, with no *cost-sharing*, in accordance with the *plan*'s medical policy guidelines and the Affordable Care Act (ACA). For more information about which preventive services are included, see the Preventive Health Services section at the end of your EOC, and visit the *plan's* website at www.bmchp.org or the federal government's website at https://www.healthcare.gov/coverage/preventive-care-benefits/	Preventive health services for children: • Physical exams at specific intervals from birth to 6 years. • Annual Exam (6 years or older). • Preventive immunizations. • Preventive screening tests. • Preventive hearing exams and tests (includes newborn hearing screening) • Preventive vision exams (one exam per *member* every 12 months). Preventive health services for adults: • Annual physical exams. • Preventive immunizations. • Preventive screening tests and procedures (including screening colonoscopies). • Preventive hearing exams and tests. • Preventive vision exams (one exam per *member* every 24 months). Preventive health services for women, including pregnant women: • Annual GYN exams, including screening pap smears. • Routine Prenatal care, including one postpartum visit. • Screening mammograms. • Voluntary sterilization procedures. • Breast pumps and related supplies. • Family Planning.	Nothing
Prosthetic Devices	Includes wigs (scalp hair prostheses) for hair loss due to treatment for cancer or leukemia.	See Durable Medical Equipment
Rehabilitation Therapies	Short term *outpatient* physical and occupational therapy. *Benefit limit:* limited to 60 combined visits per *benefit year*. (*Benefit limit* does not apply to these services when provided to *members* with autism spectrum disorder; or when receiving early intervention services.)	$50 *copayment* per visit
	Aural and pulmonary therapy.	$50 *copayment* per visit
Second Opinions	*Outpatient second and third opinions*	See Outpatient Office Visits for Medical Care
Speech-Language and Hearing Disorder Services (no limits other than *medical necessity*)	*Outpatient* office visits for medical care.	See Outpatient Office Visits for Medical Care
	Outpatient speech therapy.	$50 *copayment* per visit
	Outpatient diagnostic tests.	See Lab Tests, X-Rays and Other Tests
TMJ Disorder Treatment	*Outpatient* x-rays, surgical services, physical therapy or medical care services.	You pay the *cost-sharing* applicable to the service(s) rendered.
Urgent Care		$50 *copayment* per visit

Covered Services Note about Prior Authorization: Some services require prior authorization. Please see your EOC for more information.		Your Cost (*Cost-sharing*)
Vision Services	Eye exams and treatment (to treat or diagnose a medical condition of the eye). Preventive Vision Exams – see "Preventive Health Services" above.	$50 *copayment* per visit
Member Extras+++	*Get Fit!* Fitness Reimbursement or *Wear It!* Fitness Tracker Reimbursement Reimbursement of 25% of annual membership fees in a Qualifying Health Club – limited to one *member* per family per calendar year. Reimbursement of 50% on a wearable technology device, up to $50 per year – Limited to one member per family per year (Each family is eligible for the fitness reimbursement or fitness tracker reimbursement within one calendar year, not both) Weight Watchers® Reimbursement of 25% of fees for certain Weight Watchers® programs – limited to one *member* per family per calendar year. Eyewear Discounts For Adults You must use a Vision Services Provider (VSP): • 20% off the retail price of complete sets of prescription glasses – frames and lenses 15% off the professional fee for prescription contact lens fitting and evaluation	
Member Incentives and VBID Programs	Diabetes Incentive Program Members with diabetes will receive a $25 gift card for completing the following within a calendar year (or plan year for members enrolled through an employer group). • PCP Visit • Eye Exam • One HbA1c Test • Kidney Function Test	
	Insulin VBID Program The plan offers an additional program providing coverage of at least one of each type of insulin at the lowest cost share tier for your plan. Please refer to the plan formulary for which products are covered as part of this program and all other insulin coverage available.	
Newborn Coverage	Newborns are automatically covered for routine nursery charges and well newborn care. Newborns must be enrolled in the *plan* within 30 days of date of birth in order for the *plan* to cover any other *medically necessary* services rendered to the newborn.	

Note: In the course of receiving certain *outpatient* services (which may or may not be subject to *cost-sharing*), you may also receive other *covered services* that require separate *cost-sharing*. (For example, during a preventive health services office visit (no *cost-sharing*), you may have a lab test that does require *cost-sharing*.)

Note: Not all prenatal or postpartum office visits are considered routine/preventive. Maternity services rendered related to complications or risks with pregnancy, may be subject to cost sharing.

¤ Qualified Health Plans are offered through the MA Health Connector. Employer Choice Direct plans are offered directly from BMC HealthNet Plan to MA businesses.

¤¤ The BMC HealthNet Plan QHP Select Network may contain different *providers* from those in the *plan's* other *provider networks*. When looking up *Network providers* on our website, please be sure to look under the BMC HealthNet Plan QHP Select Network.

¤¤¤ The *plan* contracts with EnvisionRx to manage prescription drug benefits for *members*. To locate *network pharmacies*, go to our website www.bmchp.org or call EnvisionRx Options at 1-800-361-4542.

+ The *plan* contracts with *Beacon Health Strategies LLC (Beacon)* to manage all mental health and substance abuse services for *members*. To locate a *Network provider* of mental health or substance abuse services, go to our website www.bmchp.org or call Beacon at 1-877-957-5600.

++ The *plan* contracts with Northwood, Inc. to manage most durable medical equipment, prosthetics, orthotics, medical supplies, medical formulas and low protein foods. Contact the *plan's* Member Services for more information.

+++ See your EOC for further information on member extras and how to access these Member Extras, or visit www.bmchp.org.

++++ The plan contracts with Delta Dental to manage all pediatric dental covered services for eligible members. For assistance call Delta Dental at 1-844-260-6097.

*Conventional lenses are defined under the Federal Vision Insurance Plan as single vision, lined bifocal, lined trifocal, lenticular glass or plastic lenses, all lens powers, fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses. Polycarbonate lenses are covered for children, monocular patients and patients with prescriptions greater than or equal to +/- 6.00 diopters. All lenses include scratch resistant coating.

Notice for American Indian and Alaskan Native (AI/AN) Members:
According to Federal law, you may be able to enroll in a QHP plan that has limited or no cost sharing. Depending on your income, you may have no copays, deductibles, or coinsurance when you receive services from an Indian Health or Tribal provider, or when your Indian Health or Tribal provider refers you to another provider. The Massachusetts Health Connector will determine your eligibility for this benefit when you submit your QHP application. In addition to verifying your income, the Health Connector may also ask for documentation that proves your AI/AN status. If you qualify, the Health Connector will send us your information so that we can share it with our providers. If you have any questions, you may reach out to the MA Health Connector or to Member Services 855-833-8120

This health plan **meets Minimum Creditable Coverage standards** and will satisfy the individual mandate that you have health insurance.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

Minimum Creditable Coverage Standards. This health plan meets applicable Minimum Creditable Coverage standards that are effective January 1, 2021 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE January 1, 2021. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance: (617) 521-7794 or visiting its website at www.mass.gov/doi.

BOSTON MEDICAL CENTER HEALTHNet PLAN

Multi-language Interpreter Services

Important! This information is about your BMC HealthNet Plan benefits. It needs to be translated right away. BMC HealthNet Plan can translate it for you. If you do not speak English, language assistance services, free of charge, are available to you. Call **1-855-833-8120 (TTY: 711)**.

هام! هذه المعلومات تخص مزايا خطتك مع BMC HealthNet Plan. لا بد من ترجمتها على الفور. يُمكن لـBMC HealthNet Plan أن تترجمها لك. إن كنت لا تتحدث الإنجليزية، فسنوفر لك مجانًا خدمات الترجمة. اتصل على **1-855-833-8120 (TTY: 711)**.

重要提示！這是關於您 BMC HealthNet Plan 相關福利的資訊，需要立即翻譯。BMC HealthNet Plan 可為您翻譯。如果您使用繁體中文，您可以免費獲得語言援助服務請致電：**1-855-833-8120 (TTY: 711)**。(CHT)

Important ! Ces informations concernent votre régime d'assurance BMC HealthNet Plan. Elles doivent donc être traduites immédiatement. BMC HealthNet Plan peut les traduire pour vous. Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-855-833-8120 (TTY: 711)**. (FR)

Σημαντικό! Οι παρούσες πληροφορίες αφορούν τις παροχές σας σχετικά με το BMC HealthNet Plan. Πρέ πει να μεταφραστούν αμέσως. Το BMC HealthNet Plan μπορείναταμεταφράσειγιαεσάς. Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-855-833-8120 (TTY: 711).** (GR)

મહત્વપૂર્ણ! આ તમારા BMC HealthNet Plan ના લાભ વિશેની માહિતી છે. તેને વિના વિલંબે અનુવાદ કરવાની આવશ્યકતા છે. BMC HealthNet Plan તમારા માટે તેનું ભાષાંતર કરી શકે છે. જો તમે અંગ્રેજી નથી જાણતા તો ભાષા સહાય સેવાઓ, વિના મૂલ્યે, તમારા માટે ઉપલબ્ધ છે. **1-855-833-8120 (TTY: 711)** પર કૉલ કરો. (GUJ)

Enpòtan! Enfòmasyon sa yo konsène avantaj BMC HealthNet Plan ou. Nou bezwen tradui yo touswit. BMC HealthNet Plan kapab tradui yo pou ou. Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-855-833-8120 (TTY: 711)**. (HC)

महत्वपूर्ण! यह जानकारी आपके BMC HealthNet Plan से संबंधित लाभों के बारे में है। इसका तुरंत अनुवाद करना होगा। BMC HealthNet Plan इसका आपके लिए अनुवाद कर सकता है। अगर आप अंग्रेजी नहीं बोलते हैं, तो भाषा से जुड़ी सहायता सेवाएँ आपके लिए नि:शुल्क उपलब्ध है। **1-855-833-8120 (TTY: 711)** पर कॉल करें। (HIN)

Importante! Questa informazione riguarda i benefici del suo BMC HealthNet Plan. È necessario tradurla subito. BMC HealthNet Plan può tradurla per lei. In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-855-833-8120 (TTY: 711)**. (IT)

កំណត់សម្គាល់! ព័ត៌មាននេះគឺស្តីអំពីអត្ថប្រយោជន៍ BMC HealthNet Plan របស់អ្នក។ ព័ត៌មាននេះត្រូវមានការបកប្រែភ្លាមៗ។ BMC HealthNet Plan អាចបកប្រែវាសម្រាប់អ្នក។ ប្រសិនបើអ្នកមិននិយាយភាសាអង់គ្លេស មានសេវាកម្មជំនួយភាសាដោយឥតគិតថ្លៃសម្រាប់អ្នកផងដែរ។ សូមទូរស័ព្ទទៅលេខ **1-855-833-8120 (TTY: 711)**។ (KHM)

중요사항! 본 정보는 귀하의 BMC HealthNet Plan 수당에 대한 것으로, 즉시 번역해야 합니다. BMC HealthNet Plan 이 귀하를 대신해 번역해드리겠습니다. 한국어 사용자라면 언어 지원 서비스를 무료로 제공해드립니다. **1-855-833-8120 (TTY: 711)** 로 전화하십시오. (KOR)

ສຳຄັນ! ຂໍ້ມູນນີ້ກ່ຽວກັບສິດທິປະໂຫຍດແຜນປະກັນ BMC HealthNet Plan ຂອງທ່ານ. ຈຳເປັນຕ້ອງແປຂໍ້ມູນນີ້ໃນທັນທີ. BMC HealthNet Plan ສາມາດແປມັນໃຫ້ທ່ານໄດ້. ຖ້າທ່ານບໍ່ເວົ້າພາສາອັງກິດ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານນຳໃຊ້ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາ **1-855-833-8120 (TTY: 711)**. (LAO)

Ważne! Te informacje dotyczącą korzyści zapewnianych przez BMC HealthNet Plan. Konieczne jest ich natychmiastowe przetłumaczenie. BMC HealthNet Plan może przetłumaczyć je dla Ciebie. Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-855-833-8120 (TTY: 711)**. (POL)

Important! This material can be requested in an accessible format by calling 1-855-833-8120 (TTY: 711).

Notice About Nondiscrimination and Accessibility Requirements and
Nondiscrimination Statement: Discrimination is Against the Law

Boston Medical Center HealthNet Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender, moral or religious grounds or limited English proficiency. Boston Medical Center HealthNet Plan does not exclude people or treat them differently because of race, color national origin, age, disability, sex, gender sexual orientation, gender identity, limited English proficiency, moral or religious grounds (including limiting or not providing coverage for counseling or referral services).

Boston Medical Center HealthNet Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - TTY
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Boston Medical Center HealthNet Plan.

If you believe that Boston Medical Center HealthNet Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
529 Main Street, Suite 500
Charlestown, MA 02129
Phone: 855-833-8120 (TTY/TDD 711)
Fax: 617-897-0805

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, BMC HealthNet Plan is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are also available at http://www.hhs.gov/ocr/office/file/index.html.