



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.healthtrustnh.org](http://www.healthtrustnh.org) or call 1-800-527-5001. 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 [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-870-3122 to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| What is the overall <a href="#">deductible</a> ?                                | \$0   | See the Common Medical Events 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> ?    | Yes. There are no <a href="#">deductibles</a> for any services covered under this <a href="#">plan</a> .  | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.   |
| Are there other <a href="#">deductibles</a> for specific services?              | No.   | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <b>For medical expenses: \$5,000 individual/\$10,000 family. For <a href="#">prescription drug expenses</a>: \$1,600 individual/\$3,200 family.</b><br>For the 2017 coverage period only, <a href="#">out-of-pocket medical expenses</a> incurred during the 18-month period 1/1/17-6/30/18 will apply toward this limit. | 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> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, out-of-network expenses and health care this <a href="#">plan</a> 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. Access Blue. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-870-3122 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 do not need a <a href="#">referral</a> to see a <a href="#">network specialist</a> .  | You can see the <a href="#">specialist</a> you choose 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<br>(You will pay the least)                               | Out-of-Network Provider<br>(You will pay the most)                   |   |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>   | Primary care visit to treat an injury or illness                              | \$5 <a href="#">copay</a> per visit  | Not covered  | -----none-----  |
|   | <a href="#">Specialist</a> visit  | \$5 <a href="#">copay</a> per visit  | Not covered  | -----none-----  |
|   | <a href="#">Preventive care</a> / <a href="#">screening</a> /<br>immunization | No charge  | Not covered  | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.   |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)                           | No charge  | Not covered  | -----none-----  |
|   | Imaging (CT/PET scans, MRIs)  | No charge  | Not covered  | -----none-----  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at 1-888-726-1631 or <a href="http://www.caremark.com">www.caremark.com</a> | Generic drugs   | \$5/prescription (retail)<br>\$5/prescription (mail service)               | Your <a href="#">copay</a> and any <a href="#">balance billing</a> . | There is a limit of a 34 day supply at retail and a 90 day supply at mail service. Limitations may apply to specific drugs and programs. You pay the <a href="#">network copay</a> when using a CVS/caremark participating pharmacy. <a href="#">Specialty drugs</a> are available through preferred mail service only. |
|   | Preferred brand drugs   | \$15/prescription (retail)<br>\$15/prescription (mail service)             | Your <a href="#">copay</a> and any <a href="#">balance billing</a> . |   |
|   | Non-preferred brand drugs   | \$30/prescription (retail)<br>\$30/prescription (mail service)             | Your <a href="#">copay</a> and any <a href="#">balance billing</a> . |   |
|   | <a href="#">Specialty drugs</a>   | No coverage (retail);<br>Prescription <a href="#">copay</a> (mail service) | Not covered  |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)                                | No charge  | Not covered  | -----none-----  |
|   | Physician/surgeon fees  | No charge  | Not covered  | -----none-----  |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>   | \$25 <a href="#">copay</a> per visit                                       | Covered as In-Network  | <a href="#">Copay</a> waived if admitted  |
|   | <a href="#">Emergency medical transportation</a>                              | No charge  | No charge  | -----none-----  |
|   | <a href="#">Urgent care</a>   | \$25 <a href="#">copay</a> per visit                                       | Covered as In-Network  | -----none-----  |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)  | No charge  | Not covered  | -----none-----  |
|   | Physician/surgeon fees  | No charge  | Not covered  | -----none-----  |

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



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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)             |   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Office Visit<br>\$5 <a href="#">copay</a> per visit<br>Other Outpatient<br>No charge | Office Visit<br>Not covered<br>Other Outpatient<br>Not covered | -----none-----  |
|   | Inpatient services                        | No charge  | Not covered  | -----none-----  |
| If you are pregnant   | Office visits                             | \$5 <a href="#">copay</a> for initial visit  | Not covered  | <a href="#">Copay</a> applies only to initial visit   |
|   | Childbirth/delivery professional services | No charge  | Not covered  | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)                           |
|   | Childbirth/delivery facility services     | No charge  | Not covered  |   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | No charge  | Not covered  | -----none-----  |
|   | <a href="#">Rehabilitation services</a>   | \$5 <a href="#">copay</a> per visit  | Not covered  | Coverage for physical, speech and occupational therapy services is limited to 60 combined visits per member per year.     |
|   | <a href="#">Habilitation services</a>     | \$5 <a href="#">copay</a> per visit  | Not covered  | All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded. |
|   | <a href="#">Skilled nursing care</a>      | No charge  | Not covered  | Maximum of 100 days per member per year.  |
|   | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>  | Not covered  | -----none-----  |
|   | <a href="#">Hospice services</a>          | No charge  | Not covered  | -----none-----  |
| If your child needs dental or eye care                                    | Children's eye exam                       | No charge  | Not covered  | Limited to one exam per year.   |
|   | Children's glasses                        | Not covered  | Not covered  | \$40 reimbursement per member per year for frames and lenses.   |
|   | Children's dental check-up                | Not covered  | Not covered  | -----none-----  |

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

## 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
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric surgery
- Chiropractic care (12 visits per year)
- Hearing aids (limited to one hearing aid per ear each time a prescription changes)
- Routine eye care (Adult) (limit of one exam every two years)

**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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.ciio.cms.gov](http://www.ciio.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 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:

For Medical Claims:

Anthem Blue Cross and Blue Shield  
PO BOX 518  
North Haven, CT 06473-0518

For Prescription Drug Claims:

Prescription Claim appeals MC109  
CVS Caremark  
PO Box 52084  
Phoenix, AZ 85002-2084

**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](#).

—————*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$5 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,840</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |             |
|-----------------------------------|-------------|
| Deductibles                       | \$0         |
| Copayments                        | \$10        |
| Coinsurance                       | \$0         |
| <i>What isn't covered</i>         |             |
| Limits or exclusions              | \$60        |
| <b>The total Peg would pay is</b> | <b>\$70</b> |

### Managing Joe's type 2 Diabetes

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

|   |     |
|---|-----|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$5 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 0%  |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drug  
 Durable medical equipment (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,460</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |               |
|-----------------------------------|---------------|
| Deductibles                       | \$0           |
| Copayments                        | \$1400        |
| Coinsurance                       | \$0           |
| <i>What isn't covered</i>         |               |
| Limits or exclusions              | \$21          |
| <b>The total Joe would pay is</b> | <b>\$1421</b> |

### Mia's Simple Fracture

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

|   |     |
|---|-----|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$5 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 0%  |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic tests (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,970</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$110        |
| Coinsurance                       | \$47         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$157</b> |