



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> 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 (You will pay the least)	Out-of-Network Provider (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	\$10 <a href="#">copay</a> per visit	Not covered	-----none-----
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a> per visit	Not covered	-----none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / 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> 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	\$10/prescription (retail) \$10/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	\$20/prescription (retail) \$20/prescription (mail service)	Your <a href="#">copay</a> and any <a href="#">balance billing</a> .	
	Non-preferred brand drugs	\$45/prescription (retail) \$45/prescription (mail service)	Your <a href="#">copay</a> and any <a href="#">balance billing</a> .	
	<a href="#">Specialty drugs</a>	No coverage (retail); 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>	\$50 <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>	\$50 <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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$10 <a href="#">copay</a> per visit Other Outpatient No charge	Office Visit Not covered Other Outpatient Not covered	-----none-----
	Inpatient services	No charge	Not covered	-----none-----
If you are pregnant	Office visits	\$10 <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>	\$10 <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>	\$10 <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 [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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>
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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 [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$50
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$21
<b>The total Joe would pay is</b>	<b>\$71</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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*)

<b>Total Example Cost</b>	<b>\$1,970</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$185
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$185</b>