



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 1-833-388-1239 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 and prescription expenses combined: \$3,000 individual/\$6,000 family.</b>	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 New England. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-833-388-1239 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	\$20 <a href="#">copay</a> per visit	Not covered	Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> per visit	Not covered	Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care/ screening/ immunization</a>	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 (unless at in-network facility or an emergency department)	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge	Not covered (unless at in-network facility or an emergency department)	-----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="#">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.
	Preferred brand drugs	\$25/prescription (retail) \$40/prescription (mail service)	Your <a href="#">copay</a> and any <a href="#">balance billing</a> .	
	Non-preferred brand drugs	\$40/prescription (retail) \$70/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	<a href="#">Specialty drugs</a> are available through preferred mail service only.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgical facility)	No charge	Not covered	-----none-----
	Physician/surgeon fees	No charge	Not covered (unless at in-network facility)	-----none-----
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> per visit	Covered as In-Network	<a href="#">Copay</a> waived if admitted

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

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)	
	<a href="#">Emergency medical transportation</a>	No charge	Covered as In-Network	-----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 (unless at in-network facility)	-----none-----
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visit \$20 <a href="#">copay</a> per visit Other Outpatient No charge	Office Visit Not covered Other Outpatient Not covered (unless at in-network facility)	Virtual visits (Telehealth) benefits available.
	Inpatient services	No charge	Not covered (unless at in-network facility)	-----none-----
<b>If you are pregnant</b>	Office visits	\$20 <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 (unless at in-network facility)	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	No charge	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	Not covered	-----none-----
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> per visit	Not covered (unless at in-network facility)	Coverage for physical, speech and occupational therapy services is limited to 60 combined visits per member per year.
	<a href="#">Habilitation services</a>	\$20 <a href="#">copay</a> per visit	Not covered (unless at in-network facility)	All <a href="#">rehabilitation</a> and <a href="#">habilitation</a> visits count towards your <a href="#">rehabilitation</a> limit.
	<a href="#">Skilled nursing care</a>	No charge	Not covered (unless at in-network facility)	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 (unless at in-network facility)	-----none-----
<b>If your child needs dental or eye care</b>	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 more information about limitations and exceptions, see the [plan](#) or policy document at [www.healthtrustnh.org](http://www.healthtrustnh.org).

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)	
	Children's dental check-up	Not covered	Not covered	for frames and lenses. -----none-----

**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](#).)**

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental check-up</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-Emergency/Urgent Care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine foot care unless medically necessary</li> <li>• Weight loss programs</li> </ul> |
|---|---|--|

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

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|---|---|--|
| <ul style="list-style-type: none"> <li>• Acupuncture (unlimited medically necessary visits)</li> <li>• Bariatric surgery</li> <li>• Chiropractic care (unlimited medically necessary visits)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids (limited to one hearing aid per ear each time a prescription changes or every five years)</li> <li>• Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult) (limit of one exam every two years)</li> </ul> |
|---|---|--|

**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.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. 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  
 ATTN: Grievance and Appeals  
 PO BOX 518  
 North Haven, CT 06473-0518

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

For Prescription Drug Claims:  
Prescription Claim appeals MC109  
CVS Caremark  
PO Box 52084  
Phoenix, AZ 58072-2084

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**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](#).

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*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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>	\$20
■ 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>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$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>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	20%

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>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,120</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>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	20%

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>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$260</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.