



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 1-833-385-9056 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">network</a> benefits: <b>\$0</b> individual/ <b>\$0</b> family. For out-of-network benefits: <b>\$1,000</b> individual/ <b>\$3,000</b> family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, <a href="#">network</a> preventive care is not subject to the <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. <b>\$100</b> for <a href="#">Durable Medical Equipment</a> coverage. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>For medical and prescription expenses combined:</b> <a href="#">network</a> benefits: <b>\$3,000</b> individual/ <b>\$6,000</b> family. For out-of-network benefits: <b>Not Applicable</b> individual/ <b>Not Applicable</b> family.	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 plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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. Open Access. See <a href="http://www.anthem.com">www.anthem.com</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-</a>

or call 1-833-385-9056 for a list of [network providers](#).

[network provider](#), and you might receive a bill from a [provider](#) for the difference between the [provider's](#) charge and what your [plan](#) pays ([balance billing](#)). Be aware, your [network provider](#) might use an [out-of-network provider](#) for some services (such as lab work). Check with your [provider](#) before you get services.

**Do you need a [referral](#) to see a [specialist](#)?**

No.

You can see the [specialist](#) you choose without a [referral](#).



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	20% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> per visit	20% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	No charge	20% <a href="#">coinsurance</a>	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	20% <a href="#">coinsurance</a> (unless at in-network facility or an emergency department)	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">coinsurance</a> (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> ; <a href="#">deductible</a> does not apply	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	\$20/prescription (retail) \$20/prescription (mail service)	Your <a href="#">copay</a> and any <a href="#">balance billing</a> ; <a href="#">deductible</a> does not apply	
	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="#">deductible</a> does not apply	
	<a href="#">Specialty drugs</a>	No coverage (retail);	Not covered	

\* 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)	
		Prescription <a href="#">copay</a> (mail service)		preferred mail service only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a> (unless at in-network facility)	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <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	Covered as In-Network	-----none-----
	<a href="#">Urgent care</a>	\$75 <a href="#">copay</a> per visit	Covered as In-Network	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a> (unless at in-network facility)	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$20 <a href="#">copay</a> per visit Other Outpatient No charge	Office Visit 20% <a href="#">coinsurance</a> Other Outpatient 20% <a href="#">coinsurance</a> (unless at in-network facility)	Virtual visits (Telehealth) benefits available.
	Inpatient services	No charge	20% <a href="#">coinsurance</a> (unless at in-network facility)	-----none-----
If you are pregnant	Office visits	\$20 <a href="#">copay</a> for initial visit	20% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	20% <a href="#">coinsurance</a> (unless at in-network facility)	
	Childbirth/delivery facility services	No charge	20% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	20% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> per visit	20% <a href="#">coinsurance</a> (unless at in-network facility)	-----none-----
	<a href="#">Habilitation services</a>	\$20 <a href="#">copay</a> per visit	20% <a href="#">coinsurance</a> (unless at in-network facility)	-----none-----

\* 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)	
	<a href="#">Skilled nursing care</a>	No charge	20% <a href="#">coinsurance</a> (unless at in-network facility)	Maximum of 100 days per member per year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Hospice services</a>	No charge	20% <a href="#">coinsurance</a> (unless at in-network facility)	-----none-----
<b>If your child needs dental or eye care</b>	Children’s eye exam	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Limited to one exam per year.
	Children’s glasses	Not covered	Not covered	-----none-----
	Children’s dental check-up	Not covered	Not covered	-----none-----

**Excluded Services & Other Covered Services:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental check-up</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-Emergency/Urgent Care when traveling outside the U.S.</li> <li>• Private duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care unless medically necessary</li> <li>• Weight loss programs</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your <a href="#">plan</a> document.)</b>		
<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>

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

**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 Prescription Drug Claims:

Prescription Claim appeals MC109  
CVS Caremark  
PO Box 52084  
Phoenix, AZ 85072-2084

**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>	\$30
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$90</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 drug](#)  
[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>	\$100
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$100
<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>	\$100
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$440</b>

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