**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 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 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 deductible?** | **$1,000** individual/**$3,000** family. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan 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 deductible?** | Yes. Network preventive care, network office visits and prescription drugs are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. **plan**for Durable Medical Equipment coverage. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | **For medical expenses**: **$5,000** individual/**$10,000** family. **For prescription drug expenses**: **$1,600** individual/**$3,200** family.<br>For the 2017 coverage period only, out-of-pocket **medical expenses** incurred during the 18-month period 1/1/17-6/30/18 will apply toward this limit. | The out-of-pocket limit 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 out-of-pocket limit?** | Premiums, balance-billing charges, out-of-network expenses and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |

| | | |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. Access Blue. See www.anthem.com or call 1-800-870-3122 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-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 do not need a referral to see a network specialist. | 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) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15 copay per visit, deductible does not apply | Not covered | --------none-------- |
| | Specialist visit | $40 copay per visit, deductible does not apply | Not covered | --------none-------- |
| | Preventive care/screening/ immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | Not covered | --------none-------- |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | Not covered | --------none-------- |



* 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) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at 1-888-726-1631 or www.caremark.com | Generic drugs | $10/prescription (retail) $10/prescription (mail service), deductible does not apply | Your copay and any balance billing, deductible 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 network copay when using a CVS/caremark participating pharmacy. |
| | Preferred brand drugs | $25/prescription (retail) $40/prescription (mail service), deductible does not apply | Your copay and any balance billing, deductible does not apply. | |
| | Non-preferred brand drugs | $40/prescription (retail) $70/prescription (mail service), deductible does not apply | Your copay and any balance billing, deductible does not apply. | |
| | Specialty drugs | No coverage (retail); Prescription copay (mail service) | Not covered | Specialty drugs are available through preferred mail service only. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | Not covered | Costs may vary by site of service. |
| | Physician/surgeon fees | 0% coinsurance | Not covered | Costs may vary by site of service. |
| **If you need immediate medical attention** | Emergency room care | $250 copay before deductible and 0% coinsurance after deductible. | Covered as In-Network | Copay waived if admitted |
| | Emergency medical transportation | 0% coinsurance | Covered as In-Network | --------none-------- |
| | Urgent care | $125 copay before deductible and 0% coinsurance after deductible. | Covered as In-Network | --------none-------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% coinsurance | Not covered | --------none-------- |
| | Physician/surgeon fees | 0% coinsurance | Not covered | --------none-------- |



* 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) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit<br>$15 copay per visit, deductible does not apply<br>Other Outpatient<br>0% coinsurance | Office Visit<br>Not covered<br>Other Outpatient<br>Not covered | --------none-------- |
| | Inpatient services | 0% coinsurance | Not covered | --------none-------- |
| **If you are pregnant** | Office visits | 0% coinsurance | Not covered | --------none-------- |
| | Childbirth/delivery professional services | 0% coinsurance | Not covered | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery facility services | 0% coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 0% coinsurance | Not covered | --------none-------- |
| | Rehabilitation services | $40 copay per visit, deductible does not apply | Not covered | Coverage for physical, speech and occupational therapy services is limited to 60 combined visits per member per year. |
| | Habilitation services | $40 copay per visit, deductible does not apply | Not covered | All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded. |
| | Skilled nursing care | 0% coinsurance | Not covered | Maximum of 100 days per member per year. |
| | Durable medical equipment | 20% coinsurance | Not covered | --------none-------- |
| | Hospice services | 0% coinsurance | 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 | --------none-------- |
| | 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.

## 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<br>• Cosmetic surgery<br>• Dental care (Adult) | • Infertility treatment<br>• Long-term care<br>• Non-emergency care when traveling outside the U.S. | • Private duty nursing<br>• Routine foot care unless you have been diagnosed with diabetes.<br>• 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<br>• 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. 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 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 58072-2084

**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.*



* For more information about limitations and exceptions, see the plan or policy document at www.healthtrustnh.org.

## 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** **$1000**
- **Specialist copayment** **$40**
- **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)*

| **Total Example Cost** | **$12,840** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1000 |
| Copayments | $70 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1130** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1000**
- **Specialist copayment** **$40**
- **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 drug
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$7460** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $835 |
| Coinsurance | $346 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$1336** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1000**
- **Specialist copayment** **$40**
- **Hospital (facility) *coinsurance*** **0%**
- **Other *coinsurance*** **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)*

| **Total Example Cost** | **$1970** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1046 |
| Copayments | $530 |
| Coinsurance | $40 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1616** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.