Anthem BlueCross BlueShield

HMO Blue NE Choice HNECV702VN / Rx $10/$30/$50 / Embedded vision rider

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2015 - 06/30/2016

Coverage For: Individual/Family | Plan Type: HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-855-333-5735.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2000 single / $4000 family for Tier 1 $4000 single / $8000 family for Tier 2 $0 for Non-Network Provider Does not apply to Preventive Care, Copayments, Prescription Drugs, lab services provided in a preferred lab.	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always, January 1st.) See the chart starting on page 3 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes; Single: $6600, Family: $13,200 Tier 1 and Tier 2 cost sharing applies to the out-of-pocket limit.	The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Balance-Billed Charges, Pre-Authorization Penalties, Health Care This Plan Doesn't Cover, Premiums.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the insurer pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.anthem.com or call 1-855-333-5735 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to see a specialist?	Yes, you need written approval to see a specialist. There may be some providers or services for which referrals are not required. Please see the formal contract of coverage for details.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 9. See your policy or plan document for additional information about excluded services.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use In-Network by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1	Your Cost If You Use a Tier 2	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	$30 copay per visit	Not covered	————none————
	Specialist visit	$40 copay per visit	$40 copay per visit	Not covered	————none————
	Other practitioner office visit	Chiropractor $40 copay per visit Acupuncture Not covered	Chiropractor $40 copay per visit Acupuncture Not covered	Chiropractor Not covered Acupuncture Not covered	————none————
	Preventive care/screening/ immunizations	No charge	No charge	Not covered	————none————
If you have a test	Diagnostic test (x-ray, blood work)	Lab - Office No charge X-Ray - Office 0% coinsurance after deductible	Lab - Office No charge X-Ray - Office 20% coinsurance after deductible	Lab - Office Not covered X-Ray - Office Not covered	Lab - Office There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1	Your Cost If You Use a Tier 2	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	$75 copay before deductible and 20% coinsurance after deductible	Not covered	————none————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.anthem.com/pharmacyinformation/	Tier 1 – Typically Generic	$10 copay/ prescription (retail only) and $20 copay/ prescription (mail order only)	$10 copay/ prescription (retail only) and $20 copay/ prescription (mail order only)	Not covered	You pay additional copays for retail fills that exceed a 30 day supply. Covers up to a 90 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 2 – Typically Preferred/Formulary Brand	$30 copay/ prescription (retail only) and $60 copay/ prescription (mail order only)	$30 copay/ prescription (retail only) and $60 copay/ prescription (mail order only)	Not covered	You pay additional copays for retail fills that exceed a 30 day supply. Covers up to a 90 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 3 – Typically Non-preferred/non-Formulary Drugs	$50 copay/ prescription (retail only) and $150 copay/ prescription (mail order only)	$50 copay/ prescription (retail only) and $150 copay/ prescription (mail order only)	Not covered	You pay additional copays for retail fills that exceed a 30 day supply. Covers up to a 90 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 4 – Typically Specialty Drugs	$50 copay/ prescription (retail only) and $150 copay/ prescription (mail order only)	$50 copay/ prescription (retail only) and $150 copay/ prescription (mail order only)	Not covered	You pay additional copays for retail fills that exceed a 30 day supply. Covers up to a 90 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1	Your Cost If You Use a Tier 2	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have outpatient Surgery	Facility Fee (e.g., ambulatory surgery center)	$125 copay per visit	$125 copay per visit	Not covered	$125 copay applies to preferred ambulatory surgical center locations. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Physician/Surgeon Fees	0% coinsurance after deductible	0% coinsurance after deductible	Not covered	Costs may vary by site of service. You should refer to your formal contract of coverage for details.
If you need immediate medical attention	Emergency Room Services	$250 copay before deductible and 0% coinsurance after deductible	$250 copay before deductible and 0% coinsurance after deductible	$250 copay before deductible and 0% coinsurance after deductible	copay waived if admitted
	Emergency Medical Transportation	0% coinsurance after deductible	0% coinsurance after deductible	0% coinsurance after deductible	————none————
	Urgent Care	$125 copay before deductible and 0% coinsurance after deductible	$125 copay before deductible and 0% coinsurance after deductible	$125 copay before deductible and 0% coinsurance after deductible	In Network Urgent Care benefit limited to preferred New Hampshire locations.
If you have a hospital stay	Facility Fee (e.g., hospital room)	0% coinsurance after deductible	20% coinsurance after deductible	Not covered	————none————
	Physician/surgeon fee	0% coinsurance after deductible	20% coinsurance after deductible	Not covered	————none————

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1	Your Cost If You Use a Tier 2	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/ Behavioral Health Office Visit $15 copay per visit Mental/ Behavioral Health Facility Visit - Facility Charges 0% coinsurance after deductible	Mental/ Behavioral Health Office Visit $15 copay per visit Mental/ Behavioral Health Facility Visit - Facility Charges 0% coinsurance after deductible	Mental/ Behavioral Health Office Visit Not covered Mental/ Behavioral Health Facility Visit - Facility Charges Not covered	————none————
	Mental/Behavioral health inpatient services	0% coinsurance after deductible	0% coinsurance after deductible	Not covered	————none————
	Substance use disorder outpatient services	Substance Abuse Office Visit $15 copay per visit Substance Abuse Facility Visit - Facility Charges 0% coinsurance after deductible	Substance Abuse Office Visit $15 copay per visit Substance Abuse Facility Visit - Facility Charges 0% coinsurance after deductible	Substance Abuse Office Visit Not covered Substance Abuse Facility Visit - Facility Charges Not covered	————none————
	Substance use disorder inpatient services	0% coinsurance after deductible	0% coinsurance after deductible	Not covered	————none————
If you are pregnant	Prenatal and postnatal care	0% coinsurance after deductible	20% coinsurance after deductible	Not covered	Copay applies to initial visit. Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	0% coinsurance after deductible	20% coinsurance after deductible	Not covered	Applies to inpatient facility. Other cost shares may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1	Your Cost If You Use a Tier 2	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home Health Care	0% coinsurance after deductible	20% coinsurance after deductible	Not covered	————none————
	Rehabilitation Services	$40 copay per visit	$40 copay per visit	Not covered	Coverage for physical therapy is limited to 20 visits per year, occupational therapy is limited to 20 visits per year, and speech therapy is limited to 20 visits per year.
	Habilitation Services	$40 copay per visit	$40 copay per visit	Not covered	All rehabilitation and habilitation visits count towards your rehabilitation limit.
	Skilled Nursing Care	0% coinsurance after deductible	0% coinsurance after deductible	Not covered	Coverage is limited to 100 days per year. Separate limit of 60 days annual max for inpatient physical rehabilitation..
	Durable medical equipment	0% coinsurance after deductible	0% coinsurance after deductible	Not covered	————none————
	Hospice service	No charge	No charge	Not covered	————none————
If your child needs dental or eye care	Eye exam	$20 copay	$20 copay	See Limitations and Exclusions	Coverage is limited to 1 occurrence every 12 months for Blue View Vision Benefit. In Network: Covered in Full after copay. Non-Network: Reimbursed up to $48. The copay listed applies to Blue View Vision provider services only. Coverage under the medical vision benefit is no charge for the office visit. 1 occurrence every 24 months.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1	Your Cost If You Use a Tier 2	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Glasses	See Limitations and Exclusions	See Limitations and Exclusions	See Limitations and Exclusions	Frames: In Network – One pair of formulary eyeglass frames at $0 copay, once every 24 months from last date of purchase. Non Network - Reimbursed up to $52.Standard Lenses: In Network - $20 copay. Non Network: Allowance varies by service rendered. The above benefits are under Blue View Vision benefit. There is no lens/frame coverage under the medical vision benefit.
	Dental check-up	Not covered	Not covered	Not covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Long- term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-333-5735. You may also contact your state insurance department, the Department of Labor's Employee Benefits
Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

Anthem BlueCross BlueShield
ATTN: Appeals
P.O. Box 518
North Haven, CT 06473-0218

Or Contact:

Department of Labor's Employee Benefits
Security Administration at
1-866-444-EBSA(3272) or

www.dol.gov/ebsa/healthreform

New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301
Consumer Hotline: 800-852-3416

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as minimum essential coverage. This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

— — — — —*To see examples of how this plan might cover costs for a sample medica/situation, see the next page.* — — — — —

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'lligoo ei dooda'i, shi.kaa adoolwol iinizinigo t'aa dine k'ejiigo, t'aa shoodi ba na'alnihi ya sidahi bich'i naabidiilkiid. E1doo biigha daago ni ba'nija'go ho'aalagff bich'i hodiilni. Hai'd !iiini'taago eiya, t'aa shoodi dine ya acih halne'igff ni beesh bee hane'i w6lta' bi'ki si'niiligif bi'kehgo bich'i hodiilni.

Si no es miembro todavia y necesita ayuda en idioma espaiiol, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya esci inscrito, le rogamos que llame al nfunero de servicio de atenci6n al cliente que aparece en su tarjeta de identificaci6n.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays: $2,820
- Patient pays: $4,720

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Total Deductibles	$4,000
Co-pays	$20
Co-insurance	$550
Limits or exclusions	$150
Total	$4,720

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays: $1,110
- Patient pays: $4,290

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Total Deductibles	$4,000
Co-pays	$210
Co-insurance	$0
Limits or exclusions	$80
Total	$4,290

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.