Your summary of benefits

Anthem® Health Plans of NH, INC. (DBA Anthem® Blue Cross and Blue Shield)

Your Plan: Anthem BlueChoice New England POS 250/0%/6450 Rx 3 Tier

Your Network: Blue Choice NE POS

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Deductible	$250 person / $750 family	$250 person / $750 family
Out-of-Pocket Limit	$6,450 person / $12,900 family	$6,450 person / $12,900 family
The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family out-of-pocket maximum. No one member will pay more than the per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out-of-pocket amount(s).		
Preventive Care / Screening / Immunization	No charge	20% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	$20 copay per visit	20% coinsurance after medical deductible is met
Mental Health and Substance Abuse care	$20 copay per visit	20% coinsurance after medical deductible is met
Specialist	$20 copay per visit	20% coinsurance after medical deductible is met
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	$20 copay per visit	

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care	$20 copay per visit	
Visits in an Office		
Primary Care (PCP)	$20 copay per visit	20% coinsurance after medical deductible is met
Specialist Care	$20 copay per visit	20% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-network preventive prenatal and postnatal services are covered at 100%.*	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Retail Health Clinic	$20 copay per visit	20% coinsurance after medical deductible is met
Manipulation Therapy	$20 copay per visit	20% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	No charge	20% coinsurance after medical deductible is met
Chemo/Radiation Therapy	$20 copay per visit	20% coinsurance after medical deductible is met
Dialysis/Hemodialysis	No charge	20% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	No charge	20% coinsurance after medical deductible is met
Surgery	$20 copay per visit	20% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services **Lab**		
Office	No charge	20% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	20% coinsurance after medical deductible is met
Outpatient Hospital	No charge	20% coinsurance after medical deductible is met
X-Ray		
Office	No charge	20% coinsurance after medical deductible is met
Freestanding Radiology Center	No charge	20% coinsurance after medical deductible is met
Outpatient Hospital	No charge	20% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	No charge	20% coinsurance after medical deductible is met
Freestanding Radiology Center	No charge	20% coinsurance after medical deductible is met
Outpatient Hospital	No charge	20% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$50 copay per visit	Covered as In-Network
Urgent Care Doctor and Other Services	No charge	Covered as In-Network
Emergency Room Facility Services	$100 copay per visit	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Copay waived if admitted.		
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	No charge	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$20 copay per visit	20% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	No charge	20% coinsurance after medical deductible is met
Doctor Services	No charge	20% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Freestanding Surgical Center	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	No charge	20% coinsurance after medical deductible is met
Freestanding Surgical Center	No charge	20% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees *Coverage for Inpatient Rehabilitation is limited to 60 days and Skilled Nursing services is limited to 100 days per benefit period. Applies to In-Network and Out of Network.*	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor and other services	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Recovery & Rehabilitation **Home Health Care**	No charge	20% coinsurance after medical deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.* Office	$20 copay per visit	20% coinsurance after medical deductible is met
Outpatient Hospital	$20 copay per visit	20% coinsurance after medical deductible is met
Cardiac rehabilitation Office	$20 copay per visit	20% coinsurance after medical deductible is met
Outpatient Hospital	$20 copay per visit	20% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient Rehabilitation is limited to 60 days and Skilled Nursing services is limited to 100 days per benefit period. Applies to In-Network and Out of Network.*	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Inpatient Hospice	No charge	20% coinsurance after medical deductible is met
Durable Medical Equipment	No charge	20% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices	No charge	20% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the National drug list appear below. Drugs not included on the National drug list will not be covered. Your plan uses the Base Network. You may receive up to a 90-day supply of medication at any retail pharmacy.*		
Tier 1 - Typically Cost Generic *Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery or any retail pharmacy).*	$5 copay per prescription, deductible does not apply (retail) and $5 copay per prescription, deductible does not apply (home delivery)	$5 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery or any retail pharmacy).*	$15 copay per prescription, deductible does not apply (retail) and $30 copay per prescription, deductible does not apply (home delivery)	$15 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs *Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery or any retail pharmacy).*	$35 copay per prescription, deductible does not apply (retail) and $70 copay per prescription, deductible does not apply (home delivery)per prescription, deductible does not apply (home delivery)	$35 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)

Notes:

- Your plan requires the selection of a Primary Care Physician (PCP). Choosing a PCP is an important decision. Call us at the number on your ID card and we'll help you pick a doctor.

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 772-4122

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 772-4122 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 772-4122:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 772-4122。

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French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 772-4122.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 772-4122.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 772-4122.

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (833) 772-4122.

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Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 772-4122.

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