

**State of NH Summary of Benefits  
Active Employees POS  
Effective January 1, 2015**

*This is only a brief summary of your coverage. Benefits apply when care is **medically necessary**. Services are covered up to the Maximum Allowable Benefit (MAB). Network providers agree to accept the MAB as payment in full. However, if you receive services from a non-network provider, under Self Referred benefits, it is your responsibility to pay the difference between the MAB and the provider's charge.*

Service Received	Your Share of the Cost	
	In-Network Benefits	Out-of-Network Benefits <input type="checkbox"/>
<b>Preventive Care</b>		
<ul style="list-style-type: none"> <li>Immunization (including travel), lead screening, PSA (prostate screening)</li> </ul>	No Charge	Covered up to MAB
<ul style="list-style-type: none"> <li>Routine physical exam and well baby care</li> <li>Routine hearing screening</li> <li>Routine prenatal and postpartum care</li> <li>Preventive colonoscopy</li> <li>Family planning</li> </ul> <i>See "Other Services" for additional Preventive Care information</i>	No Charge	Subject to deductible and coinsurance:  Individual: \$1,000 deductible per member per calendar year and 20% coinsurance up to \$2,000 per member  Family: \$2,000 per family per calendar year and 20% coinsurance up to \$4,000 per family per calendar year  Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details. Call 1-800-531-4450 to precertify.
<b>Office Visit</b>	\$15 PCP/\$30 Specialist Copay	
<b>Other Outpatient Care</b>	\$15 Copay	
<ul style="list-style-type: none"> <li>Allergy treatments and injections</li> <li>Short term rehabilitative therapy-physical, occupational, cardiac or speech (<i>unlimited</i>)</li> </ul>		
<ul style="list-style-type: none"> <li>Surgery-Outpatient department of a hospital (<i>non-site of service location</i>)</li> <li>Lab-Outpatient department of a hospital (<i>non-site of service location</i>)</li> <li>CT scan, MRI, X-ray and ultrasound</li> </ul>	In-Network deductible applies	
<b>Site of Service</b>		
<ul style="list-style-type: none"> <li>Surgery rendered at independent Ambulatory Surgery Center (<i>if labs associated with surgery are sent to a non-site of service location deductible will apply</i>)</li> <li>Lab rendered at an independent facility</li> </ul>	No Charge	
<b>Inpatient Care</b> (as a bed patient in an acute care hospital)		
<ul style="list-style-type: none"> <li>Semi-private room and board</li> <li>Physician in-hospital care, surgery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy</li> <li>Maternity care-Delivery</li> </ul>	In-Network deductible applies	
<b>Skilled Nursing Facility and Rehabilitation Facility Care</b>		
<ul style="list-style-type: none"> <li>(<i>Limited to 100 days combined maximum per member per calendar year</i>)</li> </ul>		
<b>Other Services</b>		
<ul style="list-style-type: none"> <li>Routine vision exam (<i>one exam every calendar year</i>)</li> <li>Chiropractic visit (<i>24 visit maximum per member per calendar year</i>)</li> <li>Infertility (tests, counseling)</li> <li>Treatment for surgical and non-surgical TMJ (<i>excluding appliances and orthodontic treatment</i>)</li> </ul>	No Charge	
<ul style="list-style-type: none"> <li>Hearing aids—birth to age 18; 19 and over hearing aid maximum of \$1500 for each ear every 60 months</li> <li>Nutritional Counseling (<i>if billed as an office visit, services will be subject to an office visit co-pay, 3 visits per member per calendar year, unlimited for diabetes or organic disease</i>)</li> </ul>	No Charge	
<ul style="list-style-type: none"> <li>OB/GYN care-well women exam annually</li> <li>Mammogram and pap smear</li> </ul>	No Charge	Covered up to MAB

<b>Hospital Emergency Room (ER)/Urgent Care Facility</b> <ul style="list-style-type: none"> <li>ER charge (<i>copay waived if admitted</i>)</li> <li>Urgent Care</li> <li>Walk In Center</li> </ul>	\$100 Copay	\$100 Copay
	\$50 Copay	\$50 Copay
	\$30 Copay	Deductible and coinsurance apply
	No Charge	No Charge
<ul style="list-style-type: none"> <li>ER/UC physician fee, lab, medical supplies</li> </ul>	In-Network deductible applies	Deductible and coinsurance apply
<ul style="list-style-type: none"> <li>CT scan, MRI, X-ray and ultrasound</li> </ul>	No Charge	No Charge
<b>Ambulance</b> ( <i>medically necessary emergency transport only</i> )	No Charge	No Charge
<b>Durable Medical Equipment (DME) and External Prosthetic Devices</b> ( <i>unlimited</i> )	No Charge	Deductible and coinsurance apply

For these services, **All Inpatient** care must be authorized in advance by Anthem Behavioral Health (ABH) at 1-800-228-5975. You will pay less if you utilize a network provider.

Mental Health (MH)	In-Network Benefits	Out-of-Network Benefits <input type="checkbox"/>
<ul style="list-style-type: none"> <li>Outpatient services <ul style="list-style-type: none"> <li>Individual Therapy Office Visit</li> </ul> </li> </ul>	\$15 Copay	Individual: \$1,000 deductible per member per calendar year and 20% coinsurance up to \$2,000 per member  Family: \$2,000 per family per calendar year and 20% coinsurance up to \$4,000 per family per calendar year  Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details. Call 1-800-531-4450 to precertify.
<ul style="list-style-type: none"> <li>Group Therapy</li> <li>Intensive Outpatient Treatment Program (IOP)</li> <li>Partial Hospitalization Program (PHP)</li> </ul>	No Charge	
<ul style="list-style-type: none"> <li>Inpatient services <ul style="list-style-type: none"> <li>Inpatient</li> </ul> </li> </ul>	In-Network deductible applies	
<b>Substance Abuse (SA)</b> <ul style="list-style-type: none"> <li>Outpatient services <ul style="list-style-type: none"> <li>Individual Therapy Office Visit</li> </ul> </li> <li>Group Therapy</li> <li>Intensive Outpatient Treatment Program (IOP)</li> <li>Partial Hospitalization Program (PHP)</li> <li>Inpatient services <ul style="list-style-type: none"> <li>Inpatient (<i>Including medical detoxification &amp; SA rehabilitation</i>)</li> </ul> </li> </ul>	\$15 Copay	
<ul style="list-style-type: none"> <li>Group Therapy</li> <li>Intensive Outpatient Treatment Program (IOP)</li> <li>Partial Hospitalization Program (PHP)</li> </ul>	No Charge	
<ul style="list-style-type: none"> <li>Inpatient services <ul style="list-style-type: none"> <li>Inpatient (<i>Including medical detoxification &amp; SA rehabilitation</i>)</li> </ul> </li> </ul>	In-Network deductible applies	

**Prescription Drugs**

Prescription drug benefits are administered by Express Scripts. For assistance with prescription drug benefit inquiries, call: 866-544-1798

**In-Network Deductible**

- \$500 per member no more than \$1000 per family per calendar year

**Copay/Out-of-Network/In-Network Maximums (for covered medical costs)**

	Copay Maximum	In-Network Deductible Maximum	In-Network Out of Pocket Maximum	Out-of-Network Out of Pocket Maximum
<ul style="list-style-type: none"> <li>Individual Out-of-Pocket Maximum</li> </ul>	\$500 per member per calendar year	\$500 per member per calendar year	\$1000 per member per calendar year	\$3000 per member per calendar year
<ul style="list-style-type: none"> <li>Family Out-of-Pocket Maximum</li> </ul>	\$1000 per family per calendar year	\$1000 per family for Calendar year	\$2000 per family	\$6000 per family per calendar year
<ul style="list-style-type: none"> <li>Life Time Benefit Maximum</li> </ul>	Unlimited			

**Other**

- Health Education Reimbursement: \$150 per family per calendar year\*
- Fitness Equipment Reimbursement or Health Club Benefit: N/A
- Eyewear benefits: N/A

## Exclusions and Limitations

The services listed below are not covered by this plan. Please review your Benefit Booklet for complete details on exclusions and limitations.

### Services Not Covered

• Any service that is not medically necessary • Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met) • Claims for services received more than 12 months ago • Complementary and Alternative Therapies/ Medicine • Cosmetic surgery • Custodial or convalescent care • Educational testing and therapy • Experimental and/or investigational services • Hospitalization for conditions that are not covered • Human organ transplants other than those listed in the Benefit Booklet as covered benefits • Mental health services which do not usually result in favorable modification through short-term therapy • Miscellaneous devices, materials, and supplies, including, but not limited to, hearing aids (except for children under 19) , dentures and support devices for the feet and corrective shoes • Permanent dental restoration, orthognathic and most oral surgery • Personal comfort items • Radial keratotomy or other surgery to correct vision • Routine podiatry • Services covered by government programs to the extent permitted by law • Services for work-related illness or injury • Sex changes • Eye glasses and contact lenses (except after cataract surgery)

### Anthem Blue Cross and Blue Shield has the right to recover its costs for care of:

• Injuries which are the responsibility of other parties • Services for which another insurance carrier or Medicare is primary • Services related to illegal conduct

### This is only a brief summary of your coverage.

This summary of benefits is not a contract. It is a general description of the benefits and exclusions of this plan. Complete information about all benefits, limitations and exclusions is in the Benefit Booklet, which is available upon request. If you need further information, call Customer Service at 1-800-933-8415.

† HMO Blue New England and Network Blue New England are administered by Anthem Blue Cross and Blue Shield.

\* This is a taxable benefit.

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