

**State of NH Summary of Benefits**  
**Troopers HMO –**

*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. Services must be provided by a network provider.*

Service Received	Your Share of the Cost
<b>These services MUST be provided by or referred by your Primary Care Provider (PCP).</b>	
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>• Immunization (including travel), lead screening, PSA (prostate screening)</li> <li>• Routine physical exam and well baby care</li> <li>• Routine hearing screening (through age 18)</li> </ul> <i>See “Other Services” for additional Preventive Care information</i>	No charge
<b>Other Outpatient Care</b> <ul style="list-style-type: none"> <li>• Medical exam, family planning, and office surgery</li> </ul>	\$10 PCP/ \$20 Specialist copay
<ul style="list-style-type: none"> <li>• Surgery in hospital outpatient department or ambulatory surgery center</li> <li>• Short term rehabilitative therapy- physical, occupational, cardiac, or speech (<i>unlimited</i>)</li> <li>• Lab, X-ray and ultrasound</li> <li>• CT scan and MRI, outpatient facility fees</li> <li>• Allergy treatment and injections</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> </ul>	No Charge
<b>Skilled Nursing Facility and Rehabilitation Facility Care</b> <i>(limited to 100 days combined per member, per calendar year)</i>	No Charge
<b>Durable Medical Equipment (DME) &amp; External Prosthetic Devices</b>	\$100 deductible, then 20% coinsurance
<b>These services DO NOT require a PCP referral as long as you use designated network providers.</b>	
<b>Other Services</b> <ul style="list-style-type: none"> <li>• Infertility diagnosis and treatment</li> <li>• Treatment for surgical and non-surgical TMJ (<i>excluding appliances and orthodontic treatment</i>)</li> </ul>	\$20 Specialist copay
<ul style="list-style-type: none"> <li>• Routine vision exam – birth through age 18 (<i>one exam every year</i>)</li> <li>• Routine vision exam – age 19 and over (<i>one exam every two years</i>)</li> <li>• OB/GYN care (performed by an OB/GYN provider)               <ul style="list-style-type: none"> <li>- Well Women exam (1 per year) mammogram and pap smear</li> <li>- Maternity care (routine prenatal, delivery and postpartum)</li> </ul> </li> <li>• Hearing aids – birth to age 18</li> <li>• Chiropractic visit (<i>limited to 20 visits per member per calendar year</i>)</li> <li>• Nutritional Counseling – (<i>if billed as an office visit, service 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
<b>These services DO NOT require a PCP referral for medical emergencies as defined by your Benefit Booklet.</b>	
<b>Hospital Emergency Room (ER) / Urgent Care Facility</b> <ul style="list-style-type: none"> <li>• ER/Urgent Care charge (<i>waived if admitted or referral from PCP/Treating Physician</i>)</li> <li>• ER physician fee, CT scan, MRI, medical supplies, etc.</li> </ul>	\$50 copay No Charge
<b>Ambulance</b> (medically necessary emergency transport only)	No Charge

**For these services no PCP referral is required, but ALL care must be authorized in advance by Anthem Behavioral Health (ABH) at 1-800-228-5975.**

**Mental Health (MH)**

- Outpatient services
  - Individual Therapy
  - Group Therapy
  - Intensive Outpatient Treatment Program (IOP)
- Inpatient services
  - Inpatient
  - Partial Hospitalization Program (PHP)

No Charge

**Substance Abuse (SA)**

- Outpatient services
  - Individual Therapy
  - Group Therapy
  - Intensive Outpatient Treatment Program (IOP)
- Inpatient services
  - Inpatient (*Including medical detoxification & SA rehabilitation*)
  - Partial Hospitalization Program (PHP)

No Charge

**Prescription Drugs**

Prescription drug benefits are administered by Caremark. For assistance with prescription drug benefit inquiries, call:

- Local Government Center: 1-800-527-5001 or Caremark: 1-888-726-1630

**Maximums (For covered medical costs)**

Unlimited life time maximum.

Annual out-of-pocket maximum:

- Individual \$500 per calendar year
- Family \$1,000 per calendar year

**Other**

- Health Education Reimbursement : \$150 per family per calendar year\*
- Fitness Equipment Reimbursement: \$200 per employee per calendar year **OR** Health Club Benefit: \$450 per employee per calendar year\*
- Eyewear benefits: \$100 every two years per family member (Includes eyeglasses (frames and lenses) and contact lenses)

**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, breast pump, 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

**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.

**Grandfathered Health Plan Notification**

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 603.271.3180. You may also contact the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov).