

**State of NH Summary of Benefits**  
**Active Employees HMO**  
**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. 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</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
<b>Office Visit</b> <ul style="list-style-type: none"> <li>Medical exam, office surgery</li> </ul>	\$15 PCP /\$30 Specialist Copay
<b>Other Outpatient Care</b> <ul style="list-style-type: none"> <li>Short term rehabilitative therapy-physical, occupational, cardiac or speech (<i>unlimited</i>)</li> <li>Allergy treatment and injections</li> </ul>	\$15 Copay
<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>	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>	Deductible Applies
<b>Skilled Nursing Facility and Rehabilitation Facility Care</b> <i>(limited to 100 days combined per member, per calendar year)</i>	
<b>Durable Medical Equipment (DME) and External Prosthetic Devices</b> <i>(unlimited)</i>	No Charge
<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>Routine vision exam (<i>one exam every calendar year</i>)</li> </ul>	No Charge
<ul style="list-style-type: none"> <li>Chiropractic visit (<i>limited to 24 visits per member per calendar year</i>)</li> </ul>	\$15 Copay
<ul style="list-style-type: none"> <li>Infertility office visits (tests, counseling)</li> <li>Treatment for surgical and non-surgical TMJ (<i>excluding appliances and orthodontic treatment</i>)</li> </ul>	\$30 Copay
<ul style="list-style-type: none"> <li>OB/GYN care-well women exam annually</li> <li>Mammogram and pap smear</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
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**These services DO NOT require a PCP referral for medical emergencies as defined by your Benefit Booklet.**

<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> <li>ER/UC physician fee, lab, medical supplies</li> <li>CT scan, MRI, X-ray and ultrasound</li> </ul>	\$100 Copay \$50 Copay \$30 Copay No Charge
<b>Ambulance</b> ( <i>medically necessary emergency transport only</i> )	Deductible applies No Charge

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

<b>Mental Health (MH)</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</li> </ul> </li> </ul>	\$15 Copay          No Charge          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          No Charge          Deductible Applies

**Prescription Drugs**

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

**Deductible**

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

**Copay Maximums (for covered medical costs)**

- Individual Out-of-Pocket Copay Maximum \$500 per member per calendar year
- Family Out-of-Pocket Copay Maximum \$1000 per family per calendar year

**Lifetime Dollar Limit**

- Unlimited

**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, 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.

\* This is a taxable benefit.

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