

State of NH Summary of Benefits

Retirees Over 65 or Retirees on Medicare Parts A & B Due to Disability

*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). Participating providers agree to accept the MAB as payment in full. However, if you receive services from a non-participating provider, it is your responsibility to pay the difference between the MAB and the provider's charge.*

Service Received	Your Share of the Cost
<p>Preventive Care <i>(Services must be provided by an Anthem/Blue Cross Blue Shield participating provider)</i></p> <ul style="list-style-type: none"> • Annual Physical Exams • Immunizations • Mammograms • General health tests and lab work <i>(i.e. pap smears, lipid panel, urinalysis, sigmoidoscopy, tine skin test and fecal occult test)</i> 	<p>No Charge, Medicare is primary.</p>
<p>Physician's Services</p> <ul style="list-style-type: none"> • Office visits • Surgery • Anesthesia • X-ray & laboratory tests • Inhospital medical care • Consultations • Radiologist Services • Maternity care 	
<p>Hospital Services</p> <p><i>Inpatient Benefits</i></p> <ul style="list-style-type: none"> • Semiprivate room and board (including Intensive Care Unit) • Operating, treatment and recovery rooms • Medications, drugs and solutions • X-ray & lab tests • Radiation therapy <p><i>Outpatient Benefits</i></p> <ul style="list-style-type: none"> • Emergency & operating rooms • X-ray & laboratory tests • Radiation therapy <p>Skilled Nursing Facility and Physical Rehabilitation Facility <i>(up to 100 combined inpatient days per member per calendar year)</i></p>	
<p>Mental Health and Substance Abuse Services</p> <ul style="list-style-type: none"> • Office visits • Inpatient care • Partial hospitalization • Outpatient care such as therapeutic services and diagnostic tests 	
<p>Other Services & Supplies</p> <ul style="list-style-type: none"> • Durable medical equipment • Emergency ambulance transportation • Prosthetics • Private duty nursing • Physical therapy, occupational therapy, speech therapy, pulmonary, cognitive, cardiac and chiropractic <i>(up to 60 days combined per member per calendar year)</i> • Home Health Agency services 	

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

Benefit Maximums

The maximums are unlimited.

Exclusions and Limitations

This is a partial list of services that are not covered by this plan. Please review your Subscriber Certificate 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) • Artificial insemination, assisted reproduction technologies and infertility treatments • 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 related to conditions that are not covered • Human organ transplants other than those listed in the subscriber certificate 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, eyeglasses, contact lenses (except after cataract surgery), dentures and support devices for the feet and corrective shoes • 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 • Sterilization reversal • Vision Services

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 we pay benefits in error • 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.

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.