HMO Blue® New England†
Network Blue℠ New England†

Anthem

State of NH Summary of Benefits
Active Employees 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
These services MUST be provided by or referred by your Primary Care Provider (PCP).	
Preventive Care • Immunization (including travel), lead screening, PSA (prostate screening) • Routine physical exam and well baby care • Routine hearing screening *See "Other Services" for additional Preventive Care information*	No charge
Office Visit • Medical Exam, family planning, office surgery	$15 PCP /$30 Specialist Copay
Other Outpatient Care • Short term rehabilitative therapy- physical, occupational, cardiac or speech *(unlimited)* • Allergy treatment and injections	$15 Copay
• Surgery in hospital outpatient department or ambulatory surgery center • Lab, X-ray and ultrasound • CT scan and MRI, outpatient facility fees	No Charge
Inpatient Care (as a bed patient in an acute care hospital) • Semi-private room and board • Physician in-hospital care, surgery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy	No Charge
Skilled Nursing Facility and Rehabilitation Facility Care *(limited to 100 days combined per member, per calendar year)*	No Charge
Durable Medical Equipment (DME) and External Prosthetic Devices *(unlimited)*	No Charge
These services DO NOT require a PCP referral as long as you use designated network providers.	
Other Services • Routine vision exam – birth through age 18 *(one exam every year)* • Routine vision exam – age 19 and over *(one exam every two years)*	No Charge
• Chiropractic visit *(limited to 20 visits per member per calendar year)*	$15 Copay
• Infertility office visits (Tests, Counseling) • Treatment for surgical and non-surgical TMJ *(excluding appliances and orthodontic treatment)*	$30 Copay
• OB/GYN care (performed by an OB/GYN provider) - Well Women exam (1 per year) - Maternity care (routine prenatal, delivery and postpartum)	No Charge
• Mammogram and Pap smear	
• Hearing aids – birth to age 18 • Nutritional Counseling –(*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)*	
These services DO NOT require a PCP referral for medical emergencies as defined by your Benefit Booklet.	
Hospital Emergency Room (ER)/ Urgent Care Facility • ER charge *(copayment waived if admitted)*. . . . . . • Urgent Care Co-pay……. • ER physician fee, CT scan, MRI, medical supplies, etc.	$100 copay $50 copay No Charge
Ambulance (medically necessary emergency transport only)	No Charge

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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 - Intensive Outpatient Treatment Program (IOP)	$15 copay
- Group Therapy	No Charge
• Inpatient services - Inpatient - Partial Hospitalization Program (PHP)	No Charge
Substance Abuse (SA) • Outpatient services - Individual Therapy - Intensive Outpatient Treatment Program (IOP)	$15 copay
- Group Therapy	No Charge
• 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)

- Individual Out-Of Pocket Maximum $500
- Family Out-of-Pocket Maximum $1000
- Life Time Benefit Maximum 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, 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.

* This is a taxable benefit.