



State Of New Hampshire
DIVISION OF PERSONNEL
Department of Administrative Services
State House Annex – 25 Capitol Street
Concord, New Hampshire 03301

LINDA M. HODGDON

Commissioner
(603) 271-3201

KAREN D. HUTCHINS

Director of Personnel
(603) 271-3262

To: Open Enrollment Participants
Subject: Summary of Benefits and Coverage
Date: November 1, 2012

Choosing a health plan option is an important decision. To help employees make an informed choice, the State has made available a Summary of Benefits and Coverage (SBC), which present important information about the State's health plan options. The SBCs are available on the web at:

http://admin.state.nh.us/hr/open_enrollment_active.html

A paper copy of SBCs is also available, free of charge, by calling 603-271-3261.

Please remember that SBCs only provide a *summary* of coverage for the HMO and POS benefit options available to active employees. Benefits apply when care is medically necessary. More detail about the terms and conditions of coverage is located in the applicable HMO or POS benefit booklet.

The format and descriptions detailed by SBCs are prescribed by the federal Affordable Care Act (ACA) and are designed to enable you to compare benefit options. Highlighted below are some additional benefits not incorporated into SBCs that may further assist your decision making process during open enrollment.

HMO: Health Club Benefit OR Fitness Equipment Reimbursement

The HMO health plan option includes coverage for either a health club benefit up to \$450 per employee per calendar year OR reimbursement of \$200 towards the purchase of eligible fitness equipment. This benefit is *not* available as part of the POS health plan option.

HMO: Eyewear Benefit

The HMO health plan option includes an eyewear benefit of \$100 every two years per family member towards the purchase of eyeglasses or contact lenses. This benefit is *not* available as part of the POS health plan option.

HMO and POS: Health Assessment Tool (HAT) and Health Reimbursement Arrangement (HRA)

Subscribers to both the HMO or POS health plan options are also eligible to participate annually in an HRA upon completion and proper submission of a health risk appraisal through a HAT. The HRA provides up to \$200 for the payment of state health plan medical and prescription drug copayments, POS deductibles and coinsurance amounts.

Dental Benefits - Separate Election Required

The State also sponsors dental benefits through Northeast Delta Dental that are available upon separate election. SBCs do not describe dental benefits because they are not incorporated into either the HMO or POS benefit options and are not automatically available upon enrollment in either of those options. Employees must separately elect to enroll to receive dental benefits. A summary description of the dental benefit is available on the web here:

http://admin.state.nh.us/hr/documents/SoNH_Active_Dental_Benefit_Chart.pdf

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.Anthem.com or by calling 1-800-933-8415.

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>For out-of-network providers \$150 individual / \$450 family Doesn't apply to in-network care.</p>	<p>You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u>.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes. \$100 deductible for Durable Medical Equipment and External Prosthetic Devices out-of-network.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.</p>
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Yes. For in-network providers for Medical Services: \$500 individual / \$1,000 family For out-of-network providers for Medical Services: \$1,500 individual / \$3,000 family</p> <p>For in-network providers for Pharmacy Services: \$750 individual / \$1,500 family</p> <p>For out-of-network providers for Pharmacy Services: No limit</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Premiums, balance-billed charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

Questions: Call 1-800-933-8415 or visit us at www.Anthem.com

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.Anthem.com or call 1-800-933-8415 to request a copy.

State of New Hampshire: Active POS

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: Individual/Family | Plan Type: POS

Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers , see www.Anthem.com or call 1-800-933-8415.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15/visit	20% coinsurance	—————none—————
	Specialist visit	\$30/visit	20% coinsurance	—————none—————
	Other practitioner office visit	\$15/visit	20% coinsurance	Chiropractic care limited to 20 visits per calendar year for in-network and out-of-network.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Preventive care/screening/immunization	No Charge	Balance over the maximum allowed amount	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	_____none_____
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com or by calling 888-726-1630	Generic drugs	\$10 script at retail; \$1/ script at mail	Your copay and any balance billing	Retail limit of 31 days; Mail service limit of 90 days.
	Preferred brand drugs	\$25 script at retail; \$40/ script at mail	Your copay and any balance billing	Retail limit of 31 days; Mail service limit of 90 days.
	Non-preferred brand drugs	\$40 script at retail; \$70/ script at mail	Your copay and any balance billing	Retail limit of 31 days; Mail service limit of 90 days.
	Specialty drugs	Mail only; See retail copays amounts if filled 31 days or less; See mail copays if 90 day supply	Your copay and any balance billing	Specialty medication available through preferred mail network only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance	_____none_____
	Physician/surgeon fees	No Charge	20% coinsurance	_____none_____

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State of New Hampshire: Active POS

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: Individual/Family | Plan Type: POS

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	\$100/visit	\$100/visit	Copay waived if admitted for in-network and out-of-network.
	Emergency medical transportation	No Charge	No Charge	_____none_____
	Urgent care	\$50/visit	\$50/visit	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	_____none_____
	Physician/surgeon fee	No Charge	20% coinsurance	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15/visit	20% coinsurance	In-network or out-of-network must be authorized in advance by Anthem Behavioral Health. Call 1-800-228-5975.
	Mental/Behavioral health inpatient services	No Charge	20% coinsurance	
	Substance use disorder outpatient services	\$15/visit	20% coinsurance	
	Substance use disorder inpatient services	No Charge	20% coinsurance	
If you are pregnant	Prenatal and postnatal care	No Charge	20% coinsurance	_____none_____
	Delivery and all inpatient services	No Charge	20% coinsurance	_____none_____
If you need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance	_____none_____
	Rehabilitation services	\$15/visit	20% coinsurance	_____none_____
	Habilitation services	\$15/visit	20% coinsurance	_____none_____
	Skilled nursing care	No Charge	20% coinsurance	30 day maximum per calendar year
	Durable medical equipment	No Charge	20% coinsurance	\$100 deductible for out-of-network.
	Hospice service	No Charge	20% coinsurance	_____none_____
If your child needs dental or eye care	Eye exam	No Charge	20% coinsurance	Limit of one exam every year.
	Glasses	Not Covered	Not Covered	_____none_____
	Dental check-up	Not Covered	Not Covered	_____none_____

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limits apply)
- Coverage provided outside the United States. See www.BCBS.com/bluecardworldwide
- Hearing aids (birth to age 18 only)
- Infertility treatment
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-599-3059. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

Prescription Claim Appeals MC 109

CVS Caremark
P.O Box 52084
Phoenix, AZ 85072-2084

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,360
- Patient pays \$180

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$150
Coinsurance	\$0
Limits or exclusions	\$30
Total	\$180

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,770
- Patient pays \$630

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$590
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$630

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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