BlueChoice® New England† Anthem

State of NH Summary of Benefits

Retirees Under Age 65 Retirees Residing in New England (POS)

(Effective 01/01/2016)

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. However, if you receive services from a non-network provider, under Self Referred benefits, it is your responsibility to pay the difference between the MAB and the provider's charge.**

Service Received	Your Share of the Cost	
Preventive Care	**In-Network Benefits**	**Out-Of-Network Benefits∩**
• Immunization (including travel), lead screening, PSA (prostate screening)	No charge	Covered up to MAB
• Routine physical exam and well baby care • Routine hearing screening (*through age 18)* *See "Other Services" for additional Preventive Care information*	No charge	Subject to deductible and coinsurance: Individual: $650 deductible per member per calendar year and 20% coinsurance up to $1350 per member Family: $1350 per family per calendar year and 20% coinsurance up to $2,650 per family per calendar year Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details. Call 1-800-531-4450 to precertify.
Office Visit • Medical exam, family planning, and office surgery	$10 PCP/$30 Specialist Copay	
Other Outpatient Care • Allergy treatments and injection	$10 Copay	
• High Cost Radiology (CTA CAT, MRI, MRA, SPECT, PET)	$150 Copay	
• Lab, X-ray and ultrasound • Surgery in hospital outpatient department or ambulatory surgery center • outpatient facility fees	$500 deductible per member, no more than $1,000 per family per calendar year	
Inpatient Care (as a bed patient in an acute care hospital) • Semi-private room and board • Physician in-hospital care, surgery, delivery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy		
Skilled Nursing Facility and Rehabilitation Facility Care (Limited to 100 days combined maximum per member per calendar year)θ		
Durable Medical Equipment (DME) and External Prosthetic Devices (unlimited)		
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)*	$10 Copay	
• Short term rehabilitative therapy-Physical, occupational, cardiac speech (*unlimited in-network; $3,000 per calendar year out-of network for all therapies combined)* θ	Subject to deductible	
• Chiropractic visit *(20 visit maximum per calendar year)*	$10 Copay	
• Infertility diagnosis and treatment • Treatment for surgical and non-surgical TMJ *(excluding appliances and orthodontic treatment)*	$30 copay	
• Hearing aids – birth to age 18 • Nutritional Counseling – *(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)* • OB/GYN care (performed by an OB/GYN provider) - Well women exam (1 per year)	No Charge	
- Maternity care (routine prenatal, delivery and postpartum)	Subject to deductible	
• Mammogram and Pap smear	No charge	Covered to MAB
Emergency Room (ER) or Urgent Care Center Visit • ER/Urgent Care physician fee, medical supplies, etc.	No charge	Same as Network benefits
• ER charge (the copayment is waived if you are admitted) • Urgent Care Center charge	$150 per visit $50 per visit	$150 per visit
Ambulance *(medically necessary emergency transport only)*	Subject to deductible	Same as Network benefits

θ Any combination of benefits from either column count toward this maximum.

∩ Services are covered up to the MAB. Out of network providers may bill you for amounts that exceed the

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For these services, ALL inpatient care must be authorized in advance by Anthem Behavioral Health (ABH) at 1-800-228-5975. You will pay less if you utilize a network provider.

Mental Health (MH)	Network Benefits	Out-of-Network Benefits∩
• Outpatient services - Individual Therapy - Group Therapy - Intensive Outpatient Treatment Program (IOP)	$10 Copay	Individual: $650 deductible per member per calendar year and 20% coinsurance up to $1350 per member Family: $1350 per family per calendar year and 20% coinsurance up to $2,650 per family per calendar year Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details. Call 1-800-531-4450 to precertify.
• Inpatient services - Inpatient - Partial Hospitalization Program (PHP)	Subject to deductible	
Substance Abuse (SA) • Outpatient services - Individual Therapy - Group Therapy - Intensive Outpatient Treatment Program (IOP)	$10 Copay	
• Inpatient services - Inpatient (*Including medical detoxification & SA rehabilitation)* - Partial Hospitalization Program (PHP)	Subject to deductible	

Prescription Drugs

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

Maximums (For covered medical costs)

	Network Benefits	Out-of-Network Benefits∩
• Individual Out-Of Pocket Maximum	$1000 per person per calendar year	$2000 per person per calendar year
• Family Out-of-Pocket Maximum	$2000 per family per calendar year	$4000 per family per calendar year
• Life Time Benefit Maximum	Unlimited	Unlimited

Other

- Health Education Reimbursement: N/A
- Fitness Equipment Reimbursement or Health Club Benefit: N/A
- Eyewear benefits: N/A

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, hearing aids (except for children under 19) , 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 • Eye glasses and contact lenses (except after cataract surgery)

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.

∩ Services are covered up to the MAB. Out of network providers may bill you for amounts that exceed the MAB.

† BlueChoice New England is administered by Anthem Blue Cross and Blue Shield.