The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.healthtrustnh.org or call 1-800-527-5001. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-870-3122 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. There are no deductibles for any services covered under this plan.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**For medical expenses**: **$5,000** individual/**$10,000** family. **For** prescription drug **expenses**: **$1,600** individual/**$3,200** family. For the 2017 coverage period only, out-of-pocket **medical expenses** incurred during the 18-month period 1/1/17-6/30/18 will apply toward this limit.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. Access Blue. See www.anthem.com or call 1-800-870-3122 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You do not need a referral to see a network specialist.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay per visit	Not covered	--------none--------
	Specialist visit	$5 copay per visit	Not covered	--------none--------
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	--------none--------
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-888-726-1631 or www.caremark.com	Generic drugs	$10/prescription (retail) $10/prescription (mail service)	Your copay and any balance billing.	There is a limit of a 34 day supply at retail and a 90 day supply at mail service. Limitations may apply to specific drugs and programs. You pay the network copay when using a CVS/caremark participating pharmacy.
	Preferred brand drugs	$20/prescription (retail) $20/prescription (mail service)	Your copay and any balance billing.	
	Non-preferred brand drugs	$30/prescription (retail) $30/prescription (mail service)	Your copay and any balance billing.	
	Specialty drugs	No coverage (retail); Prescription copay (mail service)	Not covered	Specialty drugs are available through preferred mail service only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	--------none--------
	Physician/surgeon fees	No charge	Not covered	--------none--------
If you need immediate medical attention	Emergency room care	$25 copay per visit	Covered as In-Network	Copay waived if admitted
	Emergency medical transportation	No charge	No charge	--------none--------
	Urgent care	$25 copay per visit	Covered as In-Network	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	--------none--------
	Physician/surgeon fees	No charge	Not covered	--------none--------

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $5 copay per visit Other Outpatient No charge	Office Visit Not covered Other Outpatient Not covered	--------none--------
	Inpatient services	No charge	Not covered	--------none--------
If you are pregnant	Office visits	$5 copay for initial visit	Not covered	Copay applies only to initial visit
	Childbirth/delivery professional services	No charge	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	--------none--------
	Rehabilitation services	$5 copay per visit	Not covered	Coverage for physical, speech and occupational therapy services is limited to 60 combined visits per member per year.
	Habilitation services	$5 copay per visit	Not covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No charge	Not covered	Maximum of 100 days per member per year.
	Durable medical equipment	20% coinsurance	Not covered	--------none--------
	Hospice services	No charge	Not covered	--------none--------
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam per year.
	Children's glasses	Not covered	Not covered	$40 reimbursement per member per year for frames and lenses.
	Children's dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (12 visits per year)
- Hearing aids (limited to one hearing aid per ear each time a prescription changes)
- Routine eye care (Adult) (limit of one exam every two years)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$5
Hospital (facility) *coinsurance*	0%
Other *coinsurance*	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$5
Hospital (facility) *coinsurance*	0%
Other *coinsurance*	0%

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drug
Durable medical equipment (glucose meter)

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1055
Coinsurance	$0
What isn't covered	
Limits or exclusions	$21
The total Joe would pay is	**$1076**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$5
Hospital (facility) *coinsurance*	0%
Other *coinsurance*	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$110
Coinsurance	$47
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$157**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.