Your summary of benefits

Anthem BlueCross BlueShield

Anthem Blue Cross and Blue Shield

Your Contract Code: 3HUT

Your Plan: Anthem Silver HMO Blue New England Choice 4000/20%/7500

Your Network: HMO Blue New England

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use a Value Tier 1 Provider	Cost if you use a Tier 2 Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$4,000 person / $8,000 family	$6,650 person / $13,300 family	Not covered
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum. The Out-of-Pocket limit for Value Tier 1 Providers and Tier 2 Providers Provider is combined. Satisfying one helps satisfy the other.*	$7,500 person / $15,000 family	$7,500 person / $15,000 family	Not covered
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Contraceptive methods approved by FDA and prescribed for a woman by her health care provider, subject to reasonable medical management, will be covered without cost sharing requirements.*	No charge	No charge	Not covered
Doctor Home and Office Services			
Primary Care Office Visit to treat an injury or illness	$40 copay per visit deductible does not apply	$60 copay per visit deductible does not apply	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use a Value Tier 1 Provider	Cost if you use a Tier 2 Provider	Cost if you use a Non-Network Provider
Specialist Care Office Visit	$80 copay per visit deductible does not apply	$80 copay per visit deductible does not apply	Not covered
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
Other Practitioner Visits:			
Retail Health Clinic	$40 copay per visit deductible does not apply	$40 copay per visit deductible does not apply	Not covered
On-line Medical Visit *Live Health Online is the preferred telehealth solutions (www.livehealthonline.com)*	$15 copay per visit deductible does not apply	$15 copay per visit deductible does not apply	Not covered
Chiropractic Services	$40 copay per visit deductible does not apply	$40 copay per visit deductible does not apply	Not covered
Acupuncture *Coverage is limited to 12 visits per benefit period combined across all outpatient settings. Limit is combined Value Tier 1 Providers and Tier 2 Providers.*	$40 copay per visit deductible does not apply	$40 copay per visit deductible does not apply	Not covered
Other Services in an Office:			
Allergy Testing	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
Chemo/Radiation Therapy	20% coinsurance after deductible is met	20% coinsurance after deductible is met	Not covered
Hemodialysis	20% coinsurance after deductible is met	20% coinsurance after deductible is met	Not covered
Prescription Drugs	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use a Value Tier 1 Provider	Cost if you use a Tier 2 Provider	Cost if you use a Non-Network Provider
Diagnostic Services			
Lab:			
Office *Office Cost Share applies only when Freestanding/Reference Labs are not used.*	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
Freestanding/Reference Lab	No charge	No charge	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
X-Ray:			
Office	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	$150 copay per visit deductible does not apply	$150 copay per visit deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):			
Office	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	$250 copay per service deductible does not apply	$250 copay per service deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
Emergency and Urgent Care			

Your summary of benefits

Covered Medical Benefits	Cost if you use a Value Tier 1 Provider	Cost if you use a Tier 2 Provider	Cost if you use a Non-Network Provider
Urgent Care (Office Setting) *Costs may vary by site of service*	$100 copay per visit deductible does not apply	$100 copay per visit deductible does not apply	Covered as In-Network
Urgent care(Facility Setting)			
Urgent Care: Facility fees	20% coinsurance after deductible is met	20% coinsurance after deductible is met	Covered as In-Network
Urgent Care: Doctor and other services	20% coinsurance after deductible is met	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted.*	$300 copay per visit after deductible is met	$300 copay per visit after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	20% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air and Ground)	20% coinsurance after deductible is met	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder			
Doctor Office Visit and Online Visit	$40 copay per visit deductible does not apply	$40 copay per visit deductible does not apply	Not covered
Facility visit:			
Facility Fees	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
Doctor Services	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use a Value Tier 1 Provider	Cost if you use a Tier 2 Provider	Cost if you use a Non-Network Provider
Outpatient Surgery			
Facility Fees:			
Hospital	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	$250 copay per visit deductible does not apply	$250 copay per visit deductible does not apply	Not covered
Doctor and Other Services:			
Hospital	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	No charge	No charge	Not covered
Hospital Stay (all Inpatient stays including Maternity):			
Facility fees (for example, room & board) *Coverage for Value Tier 1 providers and Tier 2 providers Inpatient physical medicine and rehabilitation including day rehabilitation programs is limited to 100 days per benefit period.*	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
Doctor and other services	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
Recovery & Rehabilitation			
Home Health Care *Coverage excludes Private Duty nursing services.*	20% coinsurance after deductible is met	20% coinsurance after deductible is met	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy):			

Your summary of benefits

Covered Medical Benefits	Cost if you use a Value Tier 1 Provider	Cost if you use a Tier 2 Provider	Cost if you use a Non-Network Provider
Office *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined Value Tier 1 Providers and Tier 2 Providers across outpatient and other professional visits.*	$40 copay per visit deductible does not apply	$40 copay per visit deductible does not apply	Not covered
Outpatient Hospital *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined Value Tier 1 Providers and Tier 2 Providers across outpatient and other professional visits.*	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
Habilitation services (for example, physical/speech/occupational therapy):			
Office *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined Value Tier 1 Providers and Tier 2 Providers across outpatient and other professional visits.*	$40 copay per visit deductible does not apply	$40 copay per visit deductible does not apply	Not covered
Outpatient Hospital *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined Value Tier 1 Providers*	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use a Value Tier 1 Provider	Cost if you use a Tier 2 Provider	Cost if you use a Non-Network Provider
and Tier 2 Providers across outpatient and other professional visits.			
Cardiac rehabilitation			
Office Visit	$80 copay per visit deductible does not apply	$80 copay per visit deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	25% coinsurance after deductible is met	Not covered
Skilled Nursing Care (in a facility) *Coverage is limited to 100 days per benefit period. Applies to Value Tier 1 Providers and Tier 2 Providers.*	20% coinsurance after deductible is met	20% coinsurance after deductible is met	Not covered
Hospice	0% coinsurance after deductible is met	0% coinsurance after deductible is met	Not covered
Durable Medical Equipment *Coverage for hearing aids services is limited to 1 item per ear each time a hearing aid prescription changes or one hearing aid per ear as needed every 60 months, whichever occurs first. Applies to Value Tier 1 Providers and Tier 2 Providers.*	20% coinsurance after deductible is met	20% coinsurance after deductible is met	Not covered
Prosthetic Devices	20% coinsurance after deductible is met	20% coinsurance after deductible is met	Not covered

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not covered
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Not covered
Prescription Drug Coverage *Select Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1a - Typically Lower Cost Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$3 copay per Prescription deductible does not apply (retail only). $8 copay per Prescription deductible does not apply (home delivery Only).	Not covered
Tier 1b - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$25 copay per Prescription deductible does not apply (retail only). $63 copay per Prescription deductible does not apply (home delivery only).	Not covered
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$50 copay per prescription or 30% coinsurance, whichever is greater up to $300 maximum per Prescription	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	deductible does not apply (retail only). $150 copay per Prescription or 30% coinsurance, whichever is greater up to $900 maximum per Prescription deductible does not apply (home delivery only).	
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$80 copay per Prescription or 30% coinsurance, whichever is greater up to $300 maximum per Prescription deductible does not apply (retail only). $240 copay per Prescription or 30% coinsurance, whichever is greater up to $900 maximum per Prescription deductible does not apply (home delivery only).	Not covered
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). Certain specialty medications are limited to a 30 day supply for specialty pharmacy only. No coverage for non-formulary drugs.*	30% coinsurance up to $500 maximum per Prescription deductible does not apply (retail and home delivery).	Not covered

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	$0 person	Not covered
Vision exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	No charge	Not covered
Frames *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Elective contact lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Non-Elective Contact Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Adult Vision (age 19 and older)		
Adult Vision Deductible	$0 person	Not covered
Vision exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	$20 copay per visit	Not covered
Frames *Coverage for In-Network Providers is limited to 1 unit every 2 years.*	$130 Allowance	Not covered
Lenses *Coverage for In-Network Providers is limited to 1 unit every 2 years.*	$20 copay per unit	Not covered
Elective contact lenses *Coverage for In-Network Providers is limited to 1 unit every 2 years.*	$80 Allowance	Not covered
Non-Elective Contact Lenses *Coverage for In-Network Providers is limited to 1 unit every 2 years.*	No charge	Not covered

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's dental services count towards your out of pocket limit.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Coverage for In-Network Providers is limited to 2 visits per 12 months.*	0% coinsurance after deductible is met	Not covered
Basic services	40% coinsurance after deductible is met	Not covered
Major services	50% coinsurance after deductible is met	Not covered
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	Not covered
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Not covered
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Annual maximum	Not covered	Not covered

Your summary of benefits

Your plan also includes the following Reward features.

To see your rewards and additional information log into the Anthem website at www.anthem.com or call the customer service number on your member ID card.

- *Additional rules and limitations may apply to incentives such as requiring completion of multiple activities in order to earn the rewards.*
- *You should consult with a tax professional for possible tax implications.*

Living Healthy	Subscriber and spouse/domestic partner may earn rewards for participating in this program. If you participate, you will earn points by completing designated steps and milestones. The points will be redeemed for rewards.	Up to $150 per member per year.
Processed Claim: Annual Flu Shot	Subscriber and spouse/domestic partner may earn a reward if you get your annual flu shot and it is verified by an Anthem claim. This activity requires completion of the Adult Wellness Exam in order to earn the rewards.	Up to $50 per member per year.
Processed Claim: Adult Wellness Exam	Subscriber and spouse/domestic partner may earn a reward if you complete an annual preventive wellness exam and it is verified by an Anthem claim. This activity requires completion of the Annual Flu Shot in order to earn the rewards.	Up to $50 per member per year.
Tobacco Certification Program	Subscriber and spouse/domestic partner may earn a reward when you confirm you're tobacco free. It will be only for the current year of your employer's program; you will need to confirm this each year to receive your reward. In some cases, this activity may require the completion of the Health Assessment in order to earn the rewards.	Up to $50 per member per year.
Gym Reimbursement	Subscriber, spouse, and dependents age 18 and over can get money back for using a gym. Fitness membership dues, up to $400, are covered if you're a member of this plan. Work out 35 times at a qualifying fitness center for each six-month period within your benefit plan year. Benefit plan year is the yearly period of coverage that starts at the effective date of coverage.	

Your summary of benefits

Notes:

- Tier 1 and Tier 2 services both accumulate to one out-of-pocket limit. For plans that include adult Vision, cost sharing for this benefit does not count towards your out-of-pocket limit and still applies after your out-of-pocket limit is met.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- The family deductible and out-of-pocket maximum are embedded indicating the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; additionally, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- Your plan requires a selection of a Primary Care Physician. Your plan requires a referral from your Primary Care Physician for select covered services.
- All medical and pharmacy deductibles, copayments and coinsurance apply to the out of pocket maximum.
- To view your prescription formulary list log on to www.anthem.com/health-insurance/customer-care/forms-library
- You can save money on in-network lab tests, x-rays, ultrasounds, Advanced Diagnostic imaging, and outpatient surgery. Visit anthem.com/siteofservicenh or view your SBC for plan details.
- Exclusions and Limitations:
  The services listed below are not covered by this plan. Complete details on exclusions and limitations are stated in the Subscriber Certificate.
  • 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)• Cosmetic surgery • Custodial or convalescent care • Educational testing and therapy • Experimental and/or investigational services except as required by law for clinical trials • Hospitalization for conditions that are not covered • Human organ transplants other than those listed in the Subscriber Certificate as Covered Services• Miscellaneous devices, materials, and supplies, including, but not limited to, dentures and support devices for the feet and corrective shoes • Permanent dental restoration, most oral surgery (general anesthesia, hospital or surgical day care facility charges for dental procedures are covered for certain individuals only to the extent required by law) • Personal comfort items • Radial keratotomy or other surgery to correct vision • Routine foot care unless Medically Necessary • Services covered by government programs to the extent permitted by law • Services for work-related illness or injury • Services, treatments, procedures or programs for weight or appetite control, weight loss, weight management or control of obesity, except for diabetes education, nutrition counseling, and medically necessary surgical and non-surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity
- For services subject to the deductible where the same member cost sharing is listed for Tier 1 In-Network Providers as Tier 2 In-Network Providers, the deductible that applies before the copay or coinsurance is the Tier 1 In-Network Provider deductible amount even if services are rendered at a Tier 2 provider or location. Otherwise, the Tier 1 In-Network Provider deductible amount applies to Tier 1 providers and the Tier 2 In-network Provider deductible amount applies to Tier 2 providers.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefit Coverage."

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (855) 330-1103

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 330-1103 (855) .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 330-1103:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(855) 330-1103。

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 330-1103 تماس بگیرید.

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Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 330-1103.

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Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(855) 330-1103 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 330-1103로 문의하십시오.

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih nínízingo kojį' hodíílnih (855) 330-1103.

Language Access Services:

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (855) 330-1103.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 330-1103 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 330-1103.

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