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 1-800-438-9672 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For PCP-referred benefits: $0 individual/$0 family. For self-referred benefits: $250 individual/$500 family.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Deductible does not apply to PCP-referred benefits or prescription drugs. Only self-referred benefits are subject to an overall deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $100 for Durable Medical Equipment coverage. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For medical and prescription expenses: $3,000 individual/$6,000 family.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, out-of-network expenses and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. BlueChoice. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-438-9672 for a list of network providers.</td>
<td>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.</td>
</tr>
</tbody>
</table>

1 of 6
Do you need a referral to see a specialist?

Yes. For PCP-referred benefits your PCP must provide a referral for services from a specialist. No referral is required for self-referred benefits.

This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

---

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>PCP-Refereed Benefits (You will pay the least)</th>
<th>Self-Refereed Benefits (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay per visit, deductible does not apply</td>
<td>20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$20 copay per visit, deductible does not apply</td>
<td>20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive care/screening/imunization</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$10/prescription (retail), $10/prescription (mail service), deductible does not apply</td>
<td>Your copay and any balance billing, deductible does not apply</td>
<td></td>
<td>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 PCP-referred benefit copay when using a CVS Caremark participating pharmacy.</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>$25/prescription (retail), $40/prescription (mail service), deductible does not apply</td>
<td>Your copay and any balance billing, deductible does not apply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>$40/prescription (retail), $70/prescription (mail service), deductible does not apply</td>
<td>Your copay and any balance billing, deductible does not apply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>No coverage (retail); Prescription copay (mail service), deductible does not apply</td>
<td>Not covered</td>
<td>Specialty drugs are available through preferred mail service only.</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.healthtrustnh.org](http://www.healthtrustnh.org).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>PCP-Referred Benefits (You will pay the least)</td>
<td>Self-Referred Benefits (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$100 copay per visit, deductible does not apply</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>Copay waived if admitted</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay per visit, deductible does not apply</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit $20 copay per visit Other Outpatient No charge</td>
<td>Office Visit 20% coinsurance Other Outpatient 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$20 copay for initial visit, deductible does not apply</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

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### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospice services</strong></td>
<td>PCP-Referred Benefits (You will pay the least)</td>
<td>Self-Referred Benefits (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

### 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)
- Long-term care
- Non-Emergency/Urgent Care when traveling outside the U.S.
- Private duty nursing
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs
- Bariatric surgery
- Chiropractic care (35 visits per year)
- Hearing aids (limited to one hearing aid per ear each time a prescription changes)
- Infertility treatment
- Routine eye care (Adult) (limit of one exam every two years)

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* For more information about limitations and exceptions, see the plan or policy document at www.healthtrustnh.org.
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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$0</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$20</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>0%</td>
<td>Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>0%</td>
<td>Other coinsurance</td>
</tr>
</tbody>
</table>

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)

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)

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

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,840</th>
<th>Total Example Cost</th>
<th>$7,460</th>
<th>Total Example Cost</th>
<th>$1,970</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$80</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $60 |

The total Peg would pay is $140

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$835</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$346</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $55 |

The total Joe would pay is $1,336

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$360</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$40</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $0 |

The total Mia would pay is $500

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