




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, <https://eoc.anthem.com/eocdps/8NZFSMG01012025>. 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 (855) 748-1805 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$7,000/person or \$14,000/family for <u>In-Network Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive Care</u> . Vision. For more information see below.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$8,000/person or \$16,000/family for <u>In-Network Providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.anthem.com/find-care/?alphaprefix=YGP or call (855) 748-1805 for a list of <u>network providers</u> . Benefits may be limited by Site of Service. Costs may vary by site of service and how the <u>provider</u> bills.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>Out-of-Network Provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>Out-of-Network Provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 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
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	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	Not Applicable	PPC 0% <u>coinsurance</u> PCP \$50/visit	Not covered	Please see http://www.anthem.com for a list of <u>Preferred Primary Care (PPC) Providers</u> . <u>Copayment</u> waived after <u>deductible</u> is met for members under 19 years old. Virtual visits (Telehealth) benefits available.
	<u>Specialist</u> visit	Not Applicable	\$70/visit	Not covered	Virtual visits (Telehealth) benefits available.
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	Not Applicable	No charge	Not covered	Prescribed FDA approved contraceptives are not subject to cost shares. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab – Office Not Applicable X-Ray – Office Not Applicable	Lab – Office 0% <u>coinsurance</u> X-Ray – Office 50% <u>coinsurance</u>	Lab – Office Not covered X-Ray – Office Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	Not Applicable	50% <u>coinsurance</u>	Not covered	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription</u>	Typically Lower Cost Generic (Tier 1a)	\$3/prescription (retail) and \$6/prescription (home delivery)	\$13/prescription (retail only)	Not covered (retail and home delivery)	For more information, refer to "Select Drug List" at http://www.anthem.com/pharmacyinformation/
	Typically Generic (Tier 1b)	\$25/prescription (retail) and	\$35/prescription (retail only)	Not covered (retail and home delivery)	*See Prescription Drug section.

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/8NZFSMG01012025>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
drug coverage is available at http://www.anthem.com/pharmacyinformation/	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$50/prescription (home delivery)	\$80/prescription (retail) and \$160/prescription (home delivery)	\$90/prescription (retail only)	Not covered (retail and home delivery)
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	30% <u>coinsurance</u> up to \$400/prescription (retail) and 30% <u>coinsurance</u> up to \$800/prescription (home delivery)	40% <u>coinsurance</u> up to \$500/prescription (retail only)	Not covered (retail and home delivery)	
	Typically Preferred <u>Specialty</u> (brand and generic) (Tier 4)	40% <u>coinsurance</u> up to \$550/prescription (retail and home delivery)	50% <u>coinsurance</u> up to \$650/prescription (retail only)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	50% <u>coinsurance</u>	Not covered	\$250/visit for Ambulatory Surgical Center.
	Physician/surgeon fees	Not Applicable	50% <u>coinsurance</u>	Not covered	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	Not Applicable	\$350/visit	Covered as In- <u>Network</u>	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	Not Applicable	50% <u>coinsurance</u>	Covered as In- <u>Network</u>	Non-emergency <u>Out-of-Network</u> Ambulance Services are limited to \$50,000 per trip.
	<u>Urgent care</u>	Not Applicable	\$100/visit	Covered as In- <u>Network</u>	In- <u>Network</u> <u>Urgent Care</u> benefit limited to preferred New Hampshire locations.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	50% <u>coinsurance</u>	Not covered	100 days/benefit period for Inpatient rehabilitation and skilled nursing services combined for In- <u>Network</u> <u>Providers</u> .

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/8NZFSMG01012025>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	Not Applicable	50% <u>coinsurance</u>	Not covered	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable	Office Visit \$25/visit Other Outpatient 50% <u>coinsurance</u>	Office Visit Not covered Other Outpatient Not covered	Office Visit <u>Copayment</u> waived after <u>deductible</u> is met for members under 19 years old. Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	Not Applicable	50% <u>coinsurance</u>	Not covered	-----none-----
If you are pregnant	Office visits	Not Applicable	50% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> does not apply for In- <u>Network preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Postpartum office visits are part of the professional maternity services.
	Childbirth/delivery professional services	Not Applicable	50% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	Not Applicable	50% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	Not Applicable	50% <u>coinsurance</u>	Not covered	-----none-----
	<u>Rehabilitation services</u>	Not Applicable	\$50/visit	Not covered	*See Therapy Services section.
	<u>Habilitation services</u>	Not Applicable	\$50/visit	Not covered	
	<u>Skilled nursing care</u>	Not Applicable	50% <u>coinsurance</u>	Not covered	100 days/benefit period for Inpatient rehabilitation and skilled nursing services combined for In- <u>Network Providers</u> .
	<u>Durable medical equipment</u>	Not Applicable	50% <u>coinsurance</u>	Not covered	*See <u>Durable Medical Equipment</u> section.
	<u>Hospice services</u>	Not Applicable	0% <u>coinsurance</u>	Not covered	-----none-----
If your child needs dental or eye care	Children's eye exam	Not Applicable	No charge	Not covered	*See Vision Services section.
	Children's glasses	Not Applicable	No charge	Not covered	
	Children's dental check-up	Not Applicable	0% <u>coinsurance</u>	Not covered	*See Dental Services section.

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/8NZFSMG01012025>.

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.)

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

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

- Abortion
- Acupuncture 20 visits/benefit period
- Bariatric surgery
- Chiropractic care 36 visits/benefit period
- Hearing aids
- Infertility treatment
- Routine eye care (Adult) 1 exam/benefit period

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: New Hampshire Insurance Department, 21 So Fruit St, Suite 14, Concord, NH 03301, Consumer Hotline (800) 852-3416, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, or contact Anthem at the number on the back of your ID card. 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 on how 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:

ATTN: Grievances and Appeals, P.O. Box 518, North Haven, CT 06473-0518

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

New Hampshire Insurance Department, 21 So Fruit St, Suite 14, Concord, NH 03301, Consumer Hotline (800) 852-3416

Additionally, a consumer assistance program can help you file your appeal. Contact New Hampshire State Insurance Department 21 South Fruit Street, Suite 14, Concord, NH 03301, (800) 852-3416, TTY/TDD Relay Services: (800) 735-2964, <http://www.nh.gov/insurance/>, consumerservices@ins.nh.gov

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/8NZFSMG01012025>.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
<ul style="list-style-type: none"> ■ The <u>plan's overall deductible</u> \$7,000 ■ <u>Specialist copayment</u> \$70 ■ <u>Hospital (facility) coinsurance</u> 50% ■ <u>Other coinsurance</u> 0% 		<ul style="list-style-type: none"> ■ The <u>plan's overall deductible</u> \$7,000 ■ <u>Specialist copayment</u> \$70 ■ <u>Hospital (facility) coinsurance</u> 50% ■ <u>Other coinsurance</u> 0% 		<ul style="list-style-type: none"> ■ The <u>plan's overall deductible</u> \$7,000 ■ <u>Specialist copayment</u> \$70 ■ <u>Hospital (facility) coinsurance</u> 50% ■ <u>Other coinsurance</u> 0% 	
<p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> <u>Specialist office visits</u> (<i>prenatal care</i>) <u>Childbirth/Delivery Professional Services</u> <u>Childbirth/Delivery Facility Services</u> <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist visit</u> (<i>anesthesia</i>) 		<p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> <u>Primary care physician office visits</u> (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>) 		<p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>) 	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<u>Cost Sharing</u>		<u>Cost Sharing</u>		<u>Cost Sharing</u>	
<u>Deductibles</u>	\$7,000	<u>Deductibles</u>	\$5,400	<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0	<u>Copayments</u>	\$0	<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,000	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$8,060	The total Joe would pay is	\$5,420	The total Mia would pay is	\$2,800

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

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 748-1805

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 748-1805 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 748-1805.

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) 748-1805:

Bassa (Bàsɔ̀ Wùdù): M̄ d̄yì d̄yì-diè-d̄è b̄é b̄édé b̄á céè-d̄è nià ke dyí ní, w̄ mò nì dyí-b̄èd̄è-in-d̄è b̄é m̄ ké gbo-kpá-kpá kè b̄ǎ̄ kpǎ d̄é m̄ bíd̄í-wùdù̀̀̀n b̄ó pídyì. B̄é m̄ ké wuɗu-ziīn-nyò d̄ò gbo wùdù ke, dá (855) 748-1805.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 748-1805 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 748-1805 သို့ ခေါ်ဆိုပါ။

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) 748-1805。

Dinka (Dinka): Na n̄ɔŋ thiëc nē ke de yā thorē, ke yin n̄ɔŋ loŋ bē yi kuony ku w̄er alēu bē ḡēer yic yin ne thoŋ du ke cin w̄eū tā̄auē ke piny. Te k̄or yin ba jam w̄enē ran ye thok geryic, ke yin cōl (855) 748-1805.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 748-1805.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 748-1805 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 748-1805.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 748-1805.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 748-1805.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 748-1805.

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) 748-1805.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 748-1805 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 748-1805.

Igbo (Igbo): O bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 748-1805.

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