




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/8NWRSMG01012025>. 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/](http://www.healthcare.gov/sbc-glossary/) or call (855) 748-1805 to request a copy.

| Important Questions  | Answers  | Why This Matters:  |
|--|--|--|
| <b>What is the overall deductible?</b>                             | \$2,000/person or \$4,000/family for In- <u>Network Providers</u> .  | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , 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> .  |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Primary Care. <u>Specialist Visit</u> . <u>Preventive Care</u> . Vision. For more information see below.  | This <a href="#">plan</a> 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 <a href="#">plan</a> 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <b>Are there other deductibles for specific services?</b>          | Yes. \$250/person or \$500/family for <u>Prescription Drugs</u> for Level 1 Pharmacy- RX Only and In- <u>Network Providers</u> combined. There are no other specific deductibles.              | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <a href="#">plan</a> begins to pay for these services.  |
| <b>What is the out-of-pocket limit for this plan?</b>              | \$6,500/person or \$13,000/family for In- <u>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 <a href="#">plan</a> , 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.   |
| <b>What is not included in the out-of-pocket limit?</b>            | Premiums, <u>balance-billing</u> charges, and health care this <a href="#">plan</a> doesn't cover.   | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.anthem.com/find-care/?alphaprefix=ZZG">www.anthem.com/find-care/?alphaprefix=ZZG</a> or call (855) 748-1805 for a list of <u>network providers</u> . Benefits may | This <a href="#">plan</a> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <a href="#">plan's network</a> . 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 <a href="#">plan</a> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>Out-of-Network</u>   |

|  |  |  |
|--|--|--|
|  | be limited by Site of Service.<br>Costs may vary by site of service and how the <u>provider</u> bills. | <u>Provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b> | No.  | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                       |

 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)              |  |
| <b>If you visit a health care provider's office or clinic</b> | Primary care visit to treat an injury or illness                | Not Applicable  | PPC<br>No charge<br>PCP<br>\$20/visit,<br><u>deductible</u> does not apply | Not covered  | Please see <a href="http://www.anthem.com">http://www.anthem.com</a> for a list of <u>Preferred Primary Care (PPC) Providers</u> . <u>Copayment</u> waived for members under 19 years old. Virtual visits (Telehealth) benefits available.     |
|   | <u>Specialist</u> visit   | Not Applicable  | \$40/visit,<br><u>deductible</u> does not apply                            | 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. |
| <b>If you have a test</b>                                     | <u>Diagnostic test</u> (x-ray, blood work)                      | Lab – Office<br>Not Applicable<br>X-Ray – Office<br>Not Applicable                | Lab – Office<br>No charge<br>X-Ray – Office<br>0% <u>coinsurance</u>       | Lab – Office<br>Not covered<br>X-Ray – Office<br>Not covered | -----none-----   |
|   | Imaging (CT/PET scans, MRIs)                                    | Not Applicable  | 0% <u>coinsurance</u>  | Not covered  | -----none-----   |
| <b>If you need drugs to treat your illness or condition</b>   | Typically Lower Cost Generic (Tier 1a)                          | \$2/prescription, Prescription Drug <u>deductible</u> does not apply (retail) and | \$12/prescription, Prescription Drug <u>deductible</u> does not            | Not covered (retail and home delivery)                       | For more information, refer to “Select Drug List” at <a href="http://www.anthem.com/pharm">http://www.anthem.com/pharm</a>   |

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/8NWRSMG01012025>.

| 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) |  |
| More information about <b>prescription drug coverage</b> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> |   | \$4/prescription, Prescription Drug <u>deductible</u> does not apply (home delivery)   | apply (retail only)  |   | <a href="#">acyinformation/</a><br>*See Prescription Drug section. |
|  | Typically Generic (Tier 1b)                                       | \$20/prescription, Prescription Drug <u>deductible</u> does not apply (retail) and \$40/prescription, Prescription Drug <u>deductible</u> does not apply (home delivery)   | \$30/prescription, Prescription Drug <u>deductible</u> does not apply (retail only)                        | Not covered (retail and home delivery)          |  |
|  | Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)  | \$60/prescription, Prescription Drug <u>deductible</u> applies (retail) and \$120/prescription, Prescription Drug <u>deductible</u> applies (home delivery)  | \$70/prescription, Prescription Drug <u>deductible</u> applies (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, Prescription Drug <u>deductible</u> applies (retail) and 30% <u>coinsurance</u> up to \$800/prescription, Prescription Drug <u>deductible</u> applies (home delivery) | 40% <u>coinsurance</u> up to \$500/prescription, Prescription Drug <u>deductible</u> applies (retail only) | Not covered (retail and home delivery)          |  |
|  | Typically Preferred <u>Specialty</u> (brand and generic) (Tier 4) | 40% <u>coinsurance</u> up to   | 50% <u>coinsurance</u> up to   | Not covered (retail and home delivery)          |  |

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| 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)          |  |
|   |  | \$550/prescription, Prescription Drug <u>deductible</u> applies (retail and home delivery) | \$650/prescription, Prescription Drug <u>deductible</u> applies (retail only)                       |  |  |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center) | Not Applicable   | \$500/visit   | Not covered  | \$250/visit, <u>deductible</u> does not apply for Ambulatory Surgical Center.  |
|   | Physician/surgeon fees                         | Not Applicable   | 0% <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   | 0% <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, <u>deductible</u> does not apply   | 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   | 0% <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> .                       |
|   | Physician/surgeon fees                         | Not Applicable   | 0% <u>coinsurance</u>   | Not covered  | -----none-----   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | Not Applicable   | Office Visit \$20/visit, <u>deductible</u> does not apply<br>Other Outpatient 0% <u>coinsurance</u> | Office Visit Not covered<br>Other Outpatient Not covered | Office Visit <u>Copayment</u> waived for members under 19 years old. Virtual visits (Telehealth) benefits available.<br>Other Outpatient<br>-----none----- |
|   | Inpatient services                             | Not Applicable   | 0% <u>coinsurance</u>   | Not covered  | -----none-----   |
| If you are pregnant   | Office visits                                  | Not Applicable   | 0% <u>coinsurance</u>   | Not covered  | <u>Cost sharing</u> does not apply for In- <u>Network</u> <u>preventive services</u> . Depending on the type of  |
|   | Childbirth/delivery professional services      | Not Applicable   | 0% <u>coinsurance</u>   | Not covered  |  |

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/8NWRSMG01012025>.

| 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) |  |
|  | Childbirth/delivery facility services | Not Applicable                                     | 0% <u>coinsurance</u>                        | Not covered                                     | 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. |
| If you need help recovering or have other special health needs | <u>Home health care</u>               | Not Applicable                                     | 0% <u>coinsurance</u>                        | Not covered                                     | -----none-----   |
|  | <u>Rehabilitation services</u>        | Not Applicable                                     | \$20/visit, <u>deductible</u> does not apply | Not covered                                     | *See Therapy Services section.   |
|  | <u>Habilitation services</u>          | Not Applicable                                     | \$20/visit, <u>deductible</u> does not apply | Not covered                                     |  |
|  | <u>Skilled nursing care</u>           | Not Applicable                                     | 0% <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                                     | 0% <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.  |

**Excluded Services & Other Covered Services:**

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other excluded services.) |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>                             | <ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Routine foot care unless <u>medically necessary</u></li> </ul> |

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/8NWRSMG01012025>.

- 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
- 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](http://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](http://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](http://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](mailto:consumerservices@ins.nh.gov)

**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)

|   |         |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,000 |
| ■ <u>Specialist copayment</u>                 | \$40    |
| ■ <u>Hospital (facility) coinsurance</u>      | 0%      |
| ■ <u>Other coinsurance</u>                    | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,000        |
| <u>Copayments</u>                 | \$10           |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,070</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|   |         |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,000 |
| ■ <u>Specialist copayment</u>                 | \$40    |
| ■ <u>Hospital (facility) coinsurance</u>      | 0%      |
| ■ <u>Other coinsurance</u>                    | 0%      |

This **EXAMPLE** event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$250          |
| <u>Copayments</u>                 | \$1,600        |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,870</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|   |         |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,000 |
| ■ <u>Specialist copayment</u>                 | \$40    |
| ■ <u>Hospital (facility) coinsurance</u>      | 0%      |
| ■ <u>Other coinsurance</u>                    | 0%      |

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,000        |
| <u>Copayments</u>                 | \$200          |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,200</b> |

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 dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄èdjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̀ bídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-ziiin-nyò d̀ò gbo wùdù ke, d̀á (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 nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (855) 748-1805.

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## Language Access Services:

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ເພື່ອໂອ້ນລັບກ່ຽວກັບພາສາ, ໃຫ້ໂທຫາ (855) 748-1805.

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## Language Access Services:

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