Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
 Coverage Period: 01/01/2024 - 12/31/2024

 Anthem Health Plans of NH, INC. (DBA Anthem Blue Cross and Blue Shield)
 Coverage for: Individual + Family | Plan Type: PPO +

 Anthem Silver Preferred Blue PPO 5000/20%/7250 w/HSA
 HSA



of coverage, <u>https://eoc.anthem.com/eocdps/9ZF9SMG01012024</u>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary/</u> or call (855) 330-1103 to request a copy.

Important Questions	Answers	Why This Matters:
· ·		
What is the overall <u>deductible</u> ?	\$5,000/person or \$10,000/family for In- <u>Network Providers</u> . \$10,000/person or \$20,000/family for Non- <u>Network</u> <u>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 <u>deductible?</u>	Yes. Preventive Care. 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</u> <u>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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-</u> <u>pocket limit</u> for this <u>plan</u> ?	 \$7,250/person or \$14,500/family for In-<u>Network Providers</u>. \$14,500/person or \$29,000/family for Non-<u>Network</u> <u>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 <u>out-of-pocket</u> <u>limit</u> ?	Premiums, balance-billing 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 <u>network</u> <u>provider</u> ?	Yes. See <u>www.anthem.com/find-</u> <u>care/?alphaprefix=YGR</u> or call (855) 330-1103 for a list of <u>network providers.</u> Benefits may be limited by Site of Service. Costs may vary by site of service	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</u> <u>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.

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NH/SG/Anthem Silver Preferred Blue PPO 5000/20%/7250 w/HSA/9ZF9/01-24

	and how the provider bills.	
Do you need a <u>referral</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
to see a specialist?		

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

			What You Will Pay			
Common Medical Event	Services You May Need	Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	Not Applicable	PPC 0% <u>coinsurance</u> PCP \$40/visit	40% <u>coinsurance</u>	Please see <u>http://www.anthem.com</u> for a list of <u>Preferred Primary Care</u> (PPC) <u>Providers</u> . Virtual visits (Telehealth) benefits available.	
If you visit a	<u>Specialist</u> visit	Not Applicable	\$60/visit	40% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.	
health care provider's office or clinic	Preventive care/screening/ immunization	Not Applicable	No charge	40% <u>coinsurance</u>	Prescribed FDA approved contraceptives are not subject to cost shares.You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office Not Applicable X-Ray – Office Not Applicable	Lab – Office 0% <u>coinsurance</u> X-Ray – Office 20% <u>coinsurance</u>	Lab – Office 40% <u>coinsurance</u> X-Ray – Office 40% <u>coinsurance</u>	none	
TC 1.1	Imaging (CT/PET scans, MRIs)	Not Applicable	20% coinsurance	40% <u>coinsurance</u>	none	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Typically Lower Cost Generic (Tier 1a)	\$3/prescription (retail) and \$6/prescription (home delivery)	\$13/prescription (retail only)	50% <u>coinsurance</u> (retail only)	For more information, refer to "Select Drug List" at http://www.anthem.com/pharm	
	Typically Generic (Tier 1b)	\$25/prescription (retail) and \$50/prescription (home delivery)	\$35/prescription (retail only)	50% <u>coinsurance</u> (retail only)	acyinformation/ *See Prescription Drug section	

* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>https://eoc.anthem.com/eocdps/9ZF9SMG01012024</u>.

			What You Will Pay		
Common Medical Event	Services You May Need	Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
http://www.anthe m.com/pharmacyi nformation/	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$80/prescription (retail) and \$160/prescription (home delivery)	\$90/prescription (retail only)	50% <u>coinsurance</u> (retail only)	
	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)	50% <u>coinsurance</u> (retail only)	
	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)	50% <u>coinsurance</u> (retail only)	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	Not Applicable	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$250/visit for Ambulatory Surgical Center for In- <u>Network</u> <u>Providers</u> .
surgery	Physician/surgeon fees	Not Applicable	20% <u>coinsurance</u>	40% coinsurance	none
	Emergency room care	Not Applicable	\$350/visit	Covered as In- <u>Network</u>	Copayment waived if admitted.
If you need immediate medical attention	Emergency medical transportation	Not Applicable	20% coinsurance	Covered as In- <u>Network</u>	Non-emergency Non- <u>Network</u> Ambulance Services are limited to \$50,000 per trip.
	Urgent care	Not Applicable	\$100/visit	40% <u>coinsurance</u>	In- <u>Network Urgent Care</u> benefit limited to preferred New Hampshire locations.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	20% <u>coinsurance</u>	40% <u>coinsurance</u>	100 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs for In- <u>Network</u> and Non- <u>Network</u> <u>Providers</u> combined.

* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>https://eoc.anthem.com/eocdps/9ZF9SMG01012024</u>.

			What You Will Pay		
Common Medical Event	Services You May Need	Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	Not Applicable	20% <u>coinsurance</u>	40% <u>coinsurance</u>	none
If you need mental health, behavioral health, or substance	Outpatient services	Not Applicable	Office Visit \$25/visit Other Outpatient 20% <u>coinsurance</u>	Office Visit 40% <u>coinsurance</u> Other Outpatient 40% <u>coinsurance</u>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient none
abuse services	Inpatient services	Not Applicable	20% <u>coinsurance</u>	40% coinsurance	none
	Office visits	Not Applicable	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Cost sharing does not apply for
	Childbirth/delivery professional services	Not Applicable	20% coinsurance	40% <u>coinsurance</u>	In- <u>Network preventive services</u> . Depending on the type of
If you are pregnant	Childbirth/delivery facility services	Not Applicable	20% <u>coinsurance</u>	40% <u>coinsurance</u>	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.
	Home health care	Not Applicable	20% <u>coinsurance</u>	40% coinsurance	none
	Rehabilitation services	Not Applicable	\$40/visit	40% coinsurance	* C /Tl C
	Habilitation services	Not Applicable	\$40/visit	40% coinsurance	*See Therapy Services section.
If you need help recovering or have other special health needs	Skilled nursing care	Not Applicable	20% coinsurance	40% <u>coinsurance</u>	100 days/benefit period for skilled nursing services for In- <u>Network</u> and Non- <u>Network</u> <u>Providers</u> combined.
	Durable medical equipment	Not Applicable	20% coinsurance	40% <u>coinsurance</u>	*See <u>Durable Medical</u> <u>Equipment</u> Section
	Hospice services	Not Applicable	0% <u>coinsurance</u>	40% <u>coinsurance</u>	none
If your child needs dental or eye care	Children's eye exam	Not Applicable	No charge	\$0 <u>copayment</u> up to <u>plan</u> 's Maximum <u>Allowed Amount</u>	*See Vision Services section
	Children's glasses	Not Applicable	No charge	\$0 <u>copayment</u> up to <u>plan</u> 's Maximum <u>Allowed Amount</u>	See vision services section

* For more information about limitations and exceptions, see the **plan** or policy document at <u>https://eoc.anthem.com/eocdps/9ZF9SMG01012024</u>.

			What You Will Pay		
Common Medical Event	Services You May Need	Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Children's dental check-up	Not Applicable	0% <u>coinsurance</u>	30% coinsurance	*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 <u>excluded services</u> .)						
Cosmetic surgery	• Dental care (Adult)	• Long-term care				
Private-duty nursing	• Routine foot care unless <u>medically necessary</u>	Weight loss programs				
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)						
Abortion	• Acupuncture 20 visits/benefit period	Bariatric surgery				
Chiropractic care 36 visits/benefit period	Hearing aids	Infertility treatment				
• Most coverage provided outside the United	• Routine eye care (Adult) 1 exam/benefit					
States. See <u>www.bcbsglobalcore.com</u>	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), <u>www.dol.gov/ebsa/healthreform</u>, 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 <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 * For more information about limitations and exceptions, see the **plan** or policy document at https://eoc.anthem.com/eocdps/9ZF9SMG01012024.

Does this plan provide Minimum Essential Coverage? Yes.

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

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 <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost</u>-sharing amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal ca hospital delivery)	re and a	Managing Joe's Type 2 Diabe (a year of routine in-network care of controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$5,000 \$60 20% 0%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$5,000 \$60 20% 0%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$5,000 \$60 20% 0%
This EXAMPLE event includes servit like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Service Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i> <u>Specialist</u> visit (<i>anesthesia</i>)	es	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)		This EXAMPLE event includes services like: Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay: <u>Cost Sharing</u>		In this example, Joe would pay: <u>Cost Sharing</u>		In this example, Mia would pay: <u>Cost Sharing</u>	
Deductibles	\$5,000	Deductibles	\$5,000	Deductibles	\$2,800
<u>Copayments</u>	\$10	<u>Copayments</u>	\$200	Copayments	\$0
Coinsurance	\$1,500	Coinsurance	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$6,570	The total Joe would pay is	\$5,220	The total Mia would pay is	\$2,800

(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) 330-1103

Amharic (**አጣርኛ**): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማማኘት መብት አለዎት። አስተርዓሚ ለማናንር (855) 330-1103 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 1103-330 (855) .

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

Bassa (Băsóð Wùdù): À dyi dyi-diè-dè bě bédé bá céè-dè nìà kɛ dyí ní, ɔ mò nì dyí-bèdèìn-dè bé m ké gbo-kpá-kpá kè bỗ kpõ dé m bídí-wùdùǔn bó pídyi. Bé m ké wudu-ziìn-nyò dò gbo wùdù kɛ, dá (855) 330-1103.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, ভাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা ব্লার জন্য (855) 330-1103 –তে কল করুন।

Burmese **(မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 330-1103 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) 330-1103。

Dinka (Dinka): Na noŋ thiëëc në ke de yä thorë, ke yin noŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kor yin ba jam wënë ran ye thok geryic, ke yin col (855) 330-1103.

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) 330-1103.

Farsi (فارسي): 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 (853) 530-310 (855) تماس بگیرید.

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) 330-1103.

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) 330-1103.

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) 330-1103.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહતીિ મેળવવાનો તમને અધકાિર છે. દુભાષયાિ સાથે વાત કરવા માટે, કોલ કરો (855) 330-1103.

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.

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) 330-1103 ।

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Khmer (ខ្មែរ)៖ បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ(855) 330-1103 ។

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