Your summary of benefits

Anthem® Health Plans of NH, INC. (DBA Anthem® Blue Cross and Blue Shield)

Your Plan: Student Advantage Health Insurance Plan

Your School: SOUTHERN NH UNIVERSITY - SHIP

Your Network: Blue Choice POS

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$150 student person	$450 student person
Overall Out-of-Pocket Limit	$6,600 person / $13,200 family	$13,200 person / $26,400 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. All medical and prescription drugs deductibles, copayments and coinsurance apply toward the out-of-pocket maximum. In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Virtual Visits from online provider LiveHealth Online *via www.livehealthonline.com: Visits for urgent/acute medical care are covered at 20% coinsurance after medical deductible is met; visits for mental health and substance abuse care are covered at $20 copay per visit medical deductible does not apply.*		
Primary Care (PCP) *virtual and office*	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Mental Health and Substance Abuse Care *virtual and office*	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Care *virtual and office*	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care Prenatal *In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.*	No charge	40% coinsurance after medical deductible is met
Postnatal		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period. Benefit limit does not apply to Osteopathic manipulative treatment.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$20 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Urgent Care Doctor and Other Services	$20 copay per visit medical deductible does not apply	40%coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)		
Facility Fees *Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs is limited to 60 days per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Coverage includes acquisition and transplant procedures, collection and storage.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 120 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services *Coverage for rehabilitative physical therapy, occupational therapy and speech therapy is limited to 20 visits combined per benefit period. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Habilitation services *Coverage for habilitative physical therapy, occupational therapy and speech therapy is limited to 20 visits combined per benefit period. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 60 days per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospice	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

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 applicable
Pharmacy Out of Pocket Limit	Combined with medical out-of-pocket limit	Combined with medical out-of-pocket limit
Prescription Drug Coverage **Network*: Base Network*** **Drug List: *Traditional Open***		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (cost shares noted below)*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Home Delivery Pharmacy *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Tier 1 - Typically Generic *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.*	$20 copay per prescription (retail) and $50 copay per prescription (home delivery)	$20 copay per prescription (retail) then 40% coinsurance and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.*	$30 copay per prescription (retail) and $75 copay per prescription (home delivery)	$30 copay per prescription (retail) then 40% coinsurance and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.*	$60 copay per prescription (retail) and $150 copay per prescription (home delivery)	$60 copay per prescription (retail) then 40% coinsurance and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	$60 copay per prescription (retail) and $150 copay per prescription (home delivery)	$60 copay per prescription (retail) then 40% coinsurance and Not covered (home delivery)

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. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.		
Children's Vision Essential Health Benefits (up to age 19) **Vision exam** *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Frames *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45
Lenses *Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single* Reimbursed Up to $25*, Bifocal* Reimbursed Up to $40*, Trifocal* Reimbursed Up to $55*.*	No charge	Receives Reimbursement
Elective Contact Lenses *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $60
Non-Elective Contact Lenses *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $210

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. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Limited to 2 visits per 12 months.*	No charge	No charge
Basic services	20% coinsurance dental deductible does not apply	20% coinsurance dental deductible does not apply
Major services	50% coinsurance dental deductible does not apply	50% coinsurance dental deductible does not apply
Medically Necessary Orthodontia services	50% coinsurance dental deductible does not apply	50% coinsurance dental deductible does not apply
Cosmetic Orthodontia services	Not covered	Not covered
Adult Dental	Not covered	Not covered

Notes:

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- When using a non-network pharmacy, members are responsible for the stated copay & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=NH_SH_PPONH2000.

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 Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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Get help in your language

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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

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(TTY/TDD: 711)

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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՝ :

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Language Access Services:

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