Proposal for Health and Dental Coverage

Suncook Valley Regional Towns Association

June 13, 2016

HealthTrust

TABLE OF CONTENTS

Suncook Valley Regional Towns Association

Cover Letter

1. Letter of Transmittal

2. Executive Summary

3. Organizational Profile

4. Client Summaries and References

5. Proposed Rates and Benefit Options
   a. Medical
   b. Dental
   c. Flexible Spending Accounts (FSA)

6. Cost Sharing Schedules/Benefit Summaries/Outline of Benefits
   a. BlueChoice (BC)
   b. Access Blue New England (AB)
   c. Lumenos
   d. Medicomp Three
   e. Prescription
   f. Dental

7. Exhibits/Additional Information
   a. HealthTrust Overview
   b. Medical Summary of Benefits and Coverage
   c. Dental Plan Document and Description
   d. Application and Membership Agreements
   e. Staff Biographies
   f. Brochures

June 13, 2016

Mr. Shaun Mulholland
Town Administrator
Town of Allenstown
16 School Street
Allenstown, NH 03275

Dear Mr. Mulholland:

HealthTrust, Inc. is pleased to provide the Suncook Valley Regional Towns Association ("SVRTA") with a proposal for health and dental coverage effective for the period January 1, 2016 through December 31, 2016. Following the HealthTrust Board of Directors meeting in October 2016, we will provide an updated proposal for the period of January 1, 2017 through December 31, 2017. Rates for the calendar year 2018 will be approved by the Board in October of 2017.

Several health plan options have been provided for the SVRTA to consider, including our Site of Service medical plans and a two-tier prescription drug program. Medicomp rates for retirees over the age of 65 have also been provided.

By combining the benefits of long-term cost efficiency, comprehensive coverage, extensive wellness and health management programming, and employee health awareness, HealthTrust offers the best in service and competitive pricing.

HealthTrust is pleased to enclose fully-insured monthly rates and benefit information for the five dental plan options currently offered by SVRTA Member Towns to consider. HealthTrust's dental program is administered by Northeast Delta Dental (Delta), the largest, most experienced dental benefits carrier in the nation. Delta has been HealthTrust's partner for 26 years and is locally based in Concord, NH. Delta provides our members with an extensive local and national network of participating dentists, comprehensive benefits and exemplary customer service. Our members receive the most value by accessing care from a Delta participating dentist through their ease of administration, automatic claim filing and direct-to-dentist payment plans. Our members also have the freedom to receive services from any dentist they choose.

This proposal meets all terms and conditions requested by the SVRTA in its request for a proposal, except as otherwise noted.

As you consider this proposal, please note the following:

- This proposal was based on 146 contracts for actives and retirees. The SVRTA Member Towns are currently rated as a combination of entities for medical rating purposes with HealthTrust. HealthTrust reserves the right to revisit these rates if there is an adjustment of 10% in enrollment.

- HealthTrust did not include the Town of Northwood in this proposal as directed and confirmed. The Town currently does not participate in the SVRTA medical rating combination, however, is important to note that they are currently a participating Member group with HealthTrust for medical and dental coverage, and rated as part of the July 50 and

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Email: info@healthtrustnh.org • Website: *www.healthtrustnh.org*

Under Pool. HealthTrust would be pleased to include the Town as part of the rating combination beginning in 2017.

- Rating for this proposal and for each subsequent renewal will be developed utilizing the claims experience for your group coupled with the experience of HealthTrust's entire January rating pool. Included will be the added value of low pool-wide administrative costs. This approach will provide a fair and reasonable quote each year that has the advantage of continued, longer-term rate stability.

- **Enhanced Network for Matthew Thornton Blue HMO Coverages:**
  Effective January 1, 2016, Matthew Thornton Blue (MTB) became Access Blue New England (AB) which provides a broader network and no in-network referrals needed. HealthTrust believes that having access to a New England-wide network will provide greater value to our Members and their enrollees. With the Access Blue New England network, HMO enrollees can choose and use any Blue Cross and Blue Shield network doctor or hospital in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island or Vermont. This will allow HMO enrollees access to in-network primary care, specialist care, and urgent care anywhere in New England **without a referral.** While this network enhancement resulted in the Matthew Thornton Blue HMO (MTB) medical plan name changing to Access Blue New England HMO (AB), the AB plans are otherwise identical to the comparable MTB plans.

- Along with HealthTrust's partners, Anthem Blue Cross and Blue Shield and CVS/caremark, we have provided a number of benefit options, including plans which offer our most popular and competitively priced $10/20/45 prescription drug benefit. HealthTrust has a variety of additional plan options that are available and we will be pleased to discuss those options at any time.

Selecting a medical coverage provider is more than just comparing rates and there are several key advantages to choosing HealthTrust.

Programs designed to address the rising cost of healthcare:

At no additional cost, the SVRTA will enjoy the benefits of HealthTrust's award-winning ***Slice of Life*** health management program, recognized as one of the most successful and innovative wellness initiatives in the country.

SmartShopper is an exciting new addition to our Slice of Life program. HealthTrust enrollees and their eligible family members (with the exception of Medicomp Three enrollees) can earn cash rewards by shopping for cost-effective, high quality medical services online or by telephone. The program raises awareness about healthcare costs and options, and can reduce medical expenses.

HealthTrust partners with **Onlife Health** to provide and administer online ***Health Assessments, Personal Wellness Reports and Dedicated Health Coaching*** programs. In 2014, a broader range of personalized health coaching options became available through **Onlife Health's *Live on* Web Portal**. Detailed information about the program, its various financial incentives and the new ***Biometric Health Screening Reward*** is provided with this proposal.

In addition, HealthTrust's newest program, **LiveHealth Online** provides a convenient, cost-effective way for enrollees to seek medical care. HealthTrust medical plan enrollees can visit a doctor online anytime of the day from home or work – all for the cost of a typical copay.

Benefits Advisors are available to schedule regular onsite meetings to review program questions, rate setting process, claims utilization and ongoing benefit needs.

Wellness Advisors deliver workplace health and safety programs and trainings onsite for employees at no additional cost. The ***Wellness Coordinator Academy***, ***Health Awareness Program, Flu Vaccine Reimbursement Program*** and the ***Life Resources – Employee Assistance Program*** are just a few examples of HealthTrust's health management programs available. More detailed information is included as part of this proposal.

Services designed exclusively to ease the administrative burden associated with employee benefit management:

HealthTrust's courteous and knowledgeable **Enrollee Services Representatives** are readily available to answer questions on enrollment, benefits, claims processing, wellness programs and other important coverage issues.

Claims Advocates are available to assist your employees with claim issues and payments.

Retiree Advocates are available to assist retirees with questions related to the New Hampshire Retirement System (NHRS) subsidies, healthcare, Medicare, and prescription drug coverage.

Individual COBRA administration and retiree billing services are available at no additional cost. Please note that individual billing for all your retirees, administration of New Hampshire Retirement System (NHRS) payments and retiree advocate services are available.

Flexible Spending Account administration is available for eligible healthcare and dependent care expenses for all your employees choosing to participate. Rates effective beginning January 1, 2017 are included as part of this proposal.

As this proposal and its many features are reviewed, it will become evident that HealthTrust's combination of pricing, service, support, and coverage will offer the best value for the SVRTA, its member Towns, their employees, and local taxpayers.

Please let us know if you have any questions related to the proposal. Member Relations Advisor Kevin Flanagan will be glad to meet with you at any time to discuss it in further detail. Kevin can be reached directly at 603.226.1326.

Sincerely,

Scott Weden
Manager, Benefits and Wellness

Section 1

Suncook Valley Regional Towns Association

Date: June 13, 2016

Company Name: **HealthTrust, Inc.**
Address: **25 Triangle Park Drive**
P.O. Box 617
Concord, NH 03302

To: Mr. Shaun Mulholland
Town Administrator
Town of Allenstown
16 School Street
Allenstown, NH 03275

RE: Proposal for: Health and Dental Insurance Plans
Proposal Due Date: June 13, 2016 at **5:00 PM**

Dear Mr. Mulholland:

HealthTrust, Inc. (HealthTrust) hereby submits an offer to the Suncook Valley Regional Towns Association as indicated in its Health and Dental Insurance Plans Proposal at the price(s) quoted in the Proposed Rates and Benefit Options section of our proposal. This proposal is in complete accordance with all conditions of this RFP and all specifications set forth in the RFP except as otherwise noted.

HealthTrust was established in 1984 to provide a full spectrum of employee benefits for local government units in New Hampshire. It operates under New Hampshire RSA 5-B and as such is a non-profit corporation.

Company Signer: **Scott Weden** is authorized to legally obligate **HealthTrust, Inc.**

We attest to the fact that:

1. HealthTrust has reviewed and agrees to be bound by all RFP terms and conditions, except as otherwise noted.

2. The proposal is effective for the period of January 1, 2016 through December 31, 2016. Following the HealthTrust Board of Directors Meeting in October 2016, we will provide an updated proposal for the period of January 1, 2017 through December 31, 2017. Rates for calendar year 2018 will be approved by the Board in October of 2017.

3. That the prices quoted in the proposal were established without collusion with other eligible vendors.

4. That HealthTrust is committed to a successful program implementation within the time period specified.

5. The enclosed cover letter provides a proposal summary and basis upon which we are submitting this proposal.

Our official point of contact is: **Scott Weden, Manager, Benefits and Wellness**

Telephone: **603.230.3388**, Email: **sweden@healthtrustnh.org**

Authorized Signature Printed: **Scott Weden**

Authorized Signature: _____

Section 2

HealthTrust

Suncook Valley Regional Towns Association
Proposal for Health and Dental Plans
Executive Summary

HealthTrust understands the requirements of this proposal and is pleased to present a proposal that includes high quality, cost-effective medical, dental and prescription plan options combined with outstanding services and staff dedicated to an ongoing relationship with the Suncook Valley Regional Towns Association.

In this proposal response, we understand the project and scope of work and have provided the following:

- Medical (including Medicare Supplemental Plans) and prescription plan options – both current and proposed alternatives for consideration. HealthTrust partners with Anthem Blue Cross and Blue Shield for medical coverage and CVS/caremark for prescription drug coverage.
- Dental plan options – both current and alternatives for consideration. HealthTrust partners with Northeast Delta Dental for dental coverage.
- All plans comply with the provisions of the Patient Affordable Care Act as applicable.
- Plan cost sharing schedules and benefit summaries that include the details of coverage for each medical, dental and prescription benefit plan proposed.
- The SVRTA Member Towns are currently rated as a combination of entities for medical rating purposes with HealthTrust. The proposed medical rates included in this proposal are effective for the period of January 1, 2016 through December 31, 2016. Following the HealthTrust Board of Directors meeting in October 2016, we will provide an updated proposal for the period of January 1, 2017 through December 31, 2017. Rates for the calendar year 2018 will be approved by the Board in October of 2017.
- Dental plan information and rates effective for the period of January 1, 2016 through December 31, 2016.
- Information regarding HealthTrust's award-winning Slice of Life wellness program, LifeResources Employee Assistance Program and SmartShopper. These programs are all provided at no additional cost.
- Flexible Spending Accounts (FSAs) program information and rates effective for the period of January 1, 2017 through December 31, 2017. FSAs are administered directly by HealthTrust with low participant fees and free Prepaid Benefits Card. No set up or plan document fees are required.
- Individual COBRA administration and retiree billing services are available at no additional cost.
- Anthem, CVS/caremark and Northeast Delta Dental network directories may be accessed on HealthTrust's website at www.healthtrustnh.org under the "*Resources*" tab.

Section 3

HealthTrust

Suncook Valley Regional Towns Association
Proposal for Health and Dental Plans
Organizational Profile

HealthTrust is a member-driven, nonprofit risk pool that was established in 1984 to provide high-quality, cost-effective employee benefits and services to the public sector exclusively. HealthTrust serves more than 70,000 New Hampshire employees, retirees and their family members while reducing costs through pooling strategies with a commitment to education, health promotion and disease prevention. HealthTrust's more than 350 Member Groups include municipalities, counties, school districts, and quasi-governmental entities. HealthTrust provides employee benefit programs and services to school teachers and principals, firefighters, police officers, public works employees, office workers and many other public sector professionals in New Hampshire. We are proud to insure over 77% of New Hampshire's public sector, and have a unique understanding of the needs of this market.

HealthTrust is the largest public entity pool in the nation as ranked by *Business Insurance* magazine. Since 1984, the goal of HealthTrust has been to provide Member Groups with the programs and services they need to effectively manage long-term costs, while helping to keep employees healthy and productive. HealthTrust is committed to mitigating the rising cost of healthcare by providing population health management programs, educating local government employees on how to be better healthcare consumers, and by assigning dedicated Benefits Advisors and Wellness Advisors to every Member Group for assistance with worksite and individual wellness programming.

HealthTrust's Benefits and Wellness Department assists Member Groups in understanding the benefit choices available and designing a mix of programs that can be tailored to meet each Member's unique medical coverage needs. Scott Weden leads the Benefits and Wellness Department. Bill Byron leads the Wellness team's efforts, and Melisa Briggs leads the Benefits team's efforts. Candace Schaefer, Benefits Advisor, and Ashley Brigham, Wellness Advisor, will serve as Suncook Valley Regional Towns Association's ("SVRTA's") primary contacts for benefits and wellness. Kevin Flanagan is SVRTA's Member Relations Advisor.

HealthTrust does not offset healthcare increases with reductions in benefits. Instead, HealthTrust offers a variety of plan options at various prices and benefit levels. Regular communication is important at a time when the healthcare industry is undergoing rapid change and innovative new programs are being introduced almost daily. In this regard, every newly covered enrollee receives an education packet, which contains comprehensive information about the program, including plan summaries and information about the myriad of wellness and health management program options, health-related newsletters and other educational materials.

In order to provide the best possible service to Member Groups, employees, retirees, and eligible family members, Enrollee Services is there to help. HealthTrust's acclaimed Enrollee Services Team, under the direction of Martha Swasey, also includes retiree specialists and claims advocates. All Enrollee Services Representatives are cross-trained to answer enrollment, eligibility, benefit, and wellness program questions. HealthTrust regularly monitors its claims administration processes for speed, effectiveness of claims processing and problem resolution.

The proposal includes Health Plan option sheets with rates for current SVRTA medical and prescription plans. Several alternative plan options with rates are presented for consideration, including the new Site of Service medical plans, a two-tier prescription drug program and the Lumenos High Deductible Health Plan. Medicomp rates for retirees over the age of 65 have also been provided. Anthem Cost Sharing Schedules and CVS/caremark prescription benefit summaries are provided for information about coverage and plan limitations. Plan Subscriber Certificates are available upon request.

HealthTrust understands the requirements of this proposal and is pleased to present a proposal that includes high quality, cost-effective medical and prescription plan options combined with outstanding services and staff dedicated to an ongoing relationship with the Suncook Valley Regional Towns Association.

HealthTrust staff is talented and highly experienced servicing cities, towns, school districts, and county Members in all matters concerning public entity risk pooling and risk management. Staff is proactive and able to focus its efforts to maximize each Member's efforts to control risk and provide the best and most affordable employee benefits. Candace Schaefer, Benefits Advisor, will assist SVRTA Member Towns with an implementation plan for any plan changes. Candace Schaefer and Ashley Brigham, Wellness Advisor, will also work closely with the SVRTA Member Towns to schedule employee education meetings to ensure a smooth transition.

In partnership with Anthem Blue Cross and Blue Shield, CVS/caremark and Northeast Delta Dental, HealthTrust products are designed to meet the needs of New Hampshire's public sector through flexible product design, strong provider networks and discounts, state-of-the-art medical, dental and pharmacy management programs, dedicated customer service teams, timely and accurate claims processing, interactive and proactive disease management programs.

These combined strengths make HealthTrust uniquely positioned to meet the needs of our Member groups.

Section 4

HealthTrust

REFERENCES – HEALTHTRUST MEMBERS

Town of Bow

Contact Person: ***Robert Blanchette, Finance Director***
Address: ***10 Grandview Road***
Bow, NH 03304
Phone: ***603.228.1187***

School Administrative Unit #44

Contact Person: ***Linda Osburn, Benefits Administrator***
Address: ***23A Mountain Avenue***
Northwood, NH 03261
Phone: ***603.942.1290***

Merrimack County

Contact Person: ***Sara Lewko, Human Resources Director***
Address: ***333 Daniel Webster Highway Suite 2***
Boscawen, NH 03303
Phone: ***603.796.6800***

HealthTrust

HealthTrust Medical Groups

Abbie Greenleaf Library
Androscoggin Valley Regional RDD
BCEP Solid Waste
Belknap County Conservation District
Berlin Housing Authority
Berlin Water Works
Bethlehem Village District
Brookline Public Library
Campton Thornton Fire Dept
Capital Area Fire Mutual Aid
Chamberlin Free Public Library
City of Berlin
City of Claremont
City of Dover
City of Franklin
City of Lebanon
City of Portsmouth
City of Rochester
City of Somersworth
Claremont Housing Authority
Concord Regional Solid Waste
Conway Village Fire District
Coop Alliance for Seacoast Transp
Derry Housing Authority
Derry Public Library
Dover Housing Authority
Exeter Housing Authority
Goffstown Village Precinct
Grafton County
Great Bay eLearning Charter School
HealthTrust, Inc.
Housing Auth Town of Salem
Laconia Housing Authority
Laconia Water Works
Lakes Region Mutual Fire Aid
Lakes Region Planning Commission
Lebanon Housing Authority
Littleton Water and Light
Londonderry School District
Lower Bartlett Water Precinct
Making Community Connections Charter School
Manchester Employee Contrib Ret Sys
Manchester Housing Authority
Meriden Village Water District
Merrimack County
Merrimack Public Library
Merrimack School District
Merrimack Village District
Milford Area Communications
Mountain Lakes Village District
Nashua Housing Authority
New London Springfield Water Precinct
NEXT Charter School
NH Association of Counties
NH Municipal Association, Inc.
NH Municipal Bond Bank
NH School Boards Association
North Conway Water Precinct
North Country Charter Academy
North Country Council
Pelham School District
Pembroke Water Works
Penacook Boscawen Water Precinct
Plaistow Public Library
Plymouth Village Water & Sewer
Property-Liability Trust, Inc.
Regional Services & Education
Rochester Housing Authority
Rochester School District
Rockingham County Conservation District
Rollinsford Water & Sewer District
Rye Water District
School Administrative Unit #01
School Administrative Unit #02
School Administrative Unit #04
School Administrative Unit #05
School Administrative Unit #06
School Administrative Unit #07
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School Administrative Unit #84
School Administrative Unit #85
School Administrative Unit #86
School Administrative Unit #88
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School Administrative Unit #94
School Administrative Unit #95
Seacoast Learning Collaborative
Somersworth Housing Authority
Southern NH Planning Commission
Southwest Region Planning
Strafford County
Strafford Regional Planning
Sullivan County
SWNH Fire Mutual Aid
Taylor Library
The Frost Place
Tilton-Northfield Water District
Town of Acworth
Town of Allenstown
Town of Alstead
Town of Alton
Town of Antrim
Town of Ashland
Town of Atkinson
Town of Barnstead
Town of Barrington
Town of Bartlett
Town of Bath
Town of Bedford
Town of Belmont
Town of Boscawen
Town of Bow
Town of Bradford
Town of Brentwood
Town of Bristol
Town of Brookline
Town of Canterbury
Town of Carroll
Town of Center Harbor
Town of Chester
Town of Chesterfield
Town of Chichester
Town of Conway
Town of Cornish
Town of Croydon
Town of Dalton
Town of Danbury
Town of Danville
Town of Deering
Town of Derry
Town of Dorchester
Town of Dublin
Town of Dummer
Town of Dunbarton
Town of Durham
Town of East Kingston
Town of Eaton
Town of Effingham
Town of Enfield
Town of Epping
Town of Epsom
Town of Exeter
Town of Farmington
Town of Fitzwilliam
Town of Francestown
Town of Franconia
Town of Freedom
Town of Fremont
Town of Gilford

Town of Gilsum
Town of Goffstown
Town of Gorham
Town of Goshen
Town of Grafton
Town of Greenland
Town of Greenville
Town of Groton
Town of Hampstead
Town of Hampton
Town of Hampton Falls
Town of Hancock
Town of Hanover
Town of Harrisville
Town of Haverhill
Town of Hebron
Town of Hill
Town of Hillsborough
Town of Hinsdale
Town of Holderness
Town of Hollis
Town of Hopkinton
Town of Hudson
Town of Kensington
Town of Kingston
Town of Landaff
Town of Langdon
Town of Lee
Town of Lempster
Town of Lincoln
Town of Lisbon
Town of Littleton
Town of Londonderry
Town of Loudon
Town of Lyman
Town of Lyme
Town of Madbury
Town of Madison
Town of Marlborough
Town of Marlow
Town of Mason
Town of Merrimack
Town of Middleton
Town of Milan
Town of Milford
Town of Nelson
Town of New Castle
Town of New London
Town of Newbury
Town of Newington
Town of Newmarket
Town of Newport
Town of Newton
Town of North Hampton
Town of Northumberland
Town of Northwood
Town of Nottingham
Town of Ossipee
Town of Pelham
Town of Pembroke
Town of Piermont
Town of Pittsfield
Town of Plaistow
Town of Plymouth
Town of Rollinsford
Town of Rumney
Town of Rye
Town of Salisbury
Town of Seabrook
Town of Seabrook Library
Town of Shelburne
Town of Springfield
Town of Stark
Town of Stewartstown
Town of Strafford
Town of Stratham
Town of Sugar Hill
Town of Sullivan
Town of Sunapee
Town of Sutton
Town of Swanzey
Town of Thornton
Town of Tilton
Town of Troy
Town of Unity
Town of Wakefield
Town of Walpole
Town of Warren
Town of Washington
Town of Waterville Valley
Town of Weare
Town of Webster
Town of Wentworth

Town of Westmoreland
Town of Wilmot
Town of Wilton
Town of Winchester
Town of Windham
Town of Windsor
Town of Woodstock
Troy Water & Sewer
Upper Valley Lake Sunapee RPC
Village District of Eastman
Village District of Eidelweiss
Virtual Learning Academy Charter School
Warner Village Water District
Weeks Public Library
Woodsville Water & Light Dept

Section 5

Section 5a

Medical Rates and Options

HealthTrust

BCEP Solid Waste
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Current Medical Plans *Note: R$3/15M$1 and R$100M$1 will be discontinued 1/1/18.*

Medical Plan Code	BC3T5RDR	BC2T10	BC2T20	AB10	AB20	AB15IPDED
Prescription Plan Code	R$3/15M$1	R$3/15M$1	R$3/15M$1	R$3/15M$1	R$3/15M$1	R$3/15M$1
single	$921.01	N/A	N/A	N/A	N/A	N/A
2-person	$1,842.01					
family	$2,486.71					
Prescription Plan Code	RX10/20/45	RX10/20/45	RX10/20/45	RX10/20/45	RX10/20/45	RX10/20/45
single	$874.97	$856.85	$812.59	$790.29	$758.30	$745.22
2-person	$1,749.95	$1,713.70	$1,625.17	$1,580.58	$1,516.59	$1,490.45
family	$2,362.43	$2,313.50	$2,193.98	$2,133.79	$2,047.40	$2,012.11
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70
single	$846.43	$828.94	$786.12	$764.55	$733.60	$720.93
2-person	$1,692.85	$1,657.89	$1,572.24	$1,529.10	$1,467.19	$1,441.85
family	$2,285.35	$2,238.15	$2,122.53	$2,064.29	$1,980.71	$1,946.50
Office Visit Copay	$5	$10	$20	$10	$20	$15
ER Copay	$25	$50	$100	$50	$100	$100
Urgent Care Copay	$25	$50	$50	$50	$50	$50
Standard Deductible[1]	N/A	N/A	N/A	N/A	N/A	$500/$1,500
Self-Referred Deductible[2]	$150/$450	$250/$500	$250/$500	N/A	N/A	N/A
Chiro Visit Max/Copay (Y/N)	Unlimited/Y	35 visits/N	35 visits/N	12 visits/Y	12 visits/Y	12 visits/Y
PT, OT, ST Max/Copay (Y/N)	Unlimited/N	60 visits/N	60 visits/N[3]	60 visits/Y	60 visits/Y	60 visits/Y
Durable Medical Equipment	Covered at 100%	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	Covered at 80%	Covered at 80%	Covered at 80% after $100 deductible
$40 eyewear reimbursement	Benefit available once every 24 mos.	N/A	N/A	Benefit available once per year	Benefit available once per year	Benefit available once per year
Slice of Life & SmartShopper	Included	Included	Included	Included	Included	Included

1 - Deductible applies on certain services (per person/per family)
2 - Deductible on services accessed without a PCP referral (per person/per family)
3 - Effective 1/1/17, visits are unlimited

Medical Plan Code	MC3	MC3	MC3	MCNRX*
Prescription Plan Code	R$100M$1	RX10/20/45	R10/25/40 M10/40/70	N/A
single	$534.40	$507.70	$491.18	$203.05

*Medicare Supplemental Plan without RX Coverage

Prescription Plan Code	R$3/15M$1	RX10/20/45	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34-day supply)	$3 generic	$10 generic	$10 generic
	$15 brand	$20 preferred brand	$25 preferred brand
		$45 non-preferred brand	$40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$1 generic or brand	$10 generic	$10 generic
		$20 preferred brand	$40 preferred brand
		$45 non-preferred brand	$70 non-preferred brand

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

BCEP Solid Waste
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Medical Plan Code	AB15/40IPDED	ABSOS20/40 1KDED
Prescription Plan Code	RX10/20/45	RX10/20/45
single	$652.60	$611.22
2-person	$1,305.20	$1,222.45
family	$1,762.03	$1,650.30
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70
single	$631.35	$591.34
2-person	$1,262.70	$1,182.67
family	$1,704.65	$1,596.61
Office Visit Copay	$15	$20
Specialist Visit Copay	$40	$40
ER Copay	$250	$100
Urgent Care Copay	$125	$50
Standard Deductible[1]	$1,000/$3,000	$1,000/$3,000
Self-Referred Deductible[2]	N/A	N/A
Chiro Visit Max/Copay (Y/N)	12 visits/Y	12 visits/Y
PT, OT, ST Max/Copay (Y/N)	60 visits/Y	20 visits per therapy/Y
Durable Medical Equipment	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible
$40 eyewear reimbursement	N/A	N/A
Slice of Life & SmartShopper	Included	Included

1 - Deductible applies on certain services (per person/per family)

2 - Deductible on services accessed without a PCP referral (per person/per family)

Lumenos High Deductible Health Plan	
Medical Plan Code	Lumenos 2500
single	$618.04
2-person	$1,236.08
family	$1,668.71
Calendar Year Deductible	$2,500/$5,000
In-Network Coinsurance	Covered at 100% after deductible
Out-of-Network Coinsurance	Covered at 70% after deductible
In-Network Out-of-Pocket Maximum	$2,500/$5,000
Out-of-Network Out-of-Pocket Maximum	$5,000/$10,000
Chiro Visit Max	Unlimited
PT, OT, ST Max	60 visits
Anthem's Lumenos High Deductible Health Plans cover routine preventive care at 100% when received from a participating provider.	
Slice of Life & SmartShopper	Included

Prescription Plan Code	RX10/20/45	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34-day supply)	$10 generic	$10 generic
	$20 preferred brand	$25 preferred brand
	$45 non-preferred brand	$40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$10 generic	$10 generic
	$20 preferred brand	$40 preferred brand
	$45 non-preferred brand	$70 non-preferred brand

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

Town of Allenstown
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Current Medical Plans *Note: BC2T10+ changing to BC2T10 effective 1/1/17.*

Medical Plan Code	BC2T10+	BC2T10	BC2T20	AB20	AB15IPDED
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70
single	$819.80	$828.94	$786.12	$733.60	$720.93
2-person	$1,639.61	$1,657.89	$1,572.24	$1,467.19	$1,441.85
family	$2,213.47	$2,238.15	$2,122.53	$1,980.71	$1,946.50
Office Visit Copay	$10	$10	$20	$20	$15
ER Copay	$50	$50	$100	$100	$100
Urgent Care Copay	$50	$50	$50	$50	$50
Standard Deductible[1]	N/A	N/A	N/A	N/A	$500/$1,500
Self-Referred Deductible[2]	$500/$1,500	$250/$500	$250/$500	N/A	N/A
Chiro Visit Max/Copay (Y/N)	25 visits/N	35 visits/N	35 visits/N	12 visits/Y	12 visits/Y
PT, OT, ST Max/Copay (Y/N)	60 visits/N	60 visits/N	60 visits/N[3]	60 visits/Y	60 visits/Y
Durable Medical Equipment	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	Covered at 80%	Covered at 80% after $100 deductible
$40 eyewear reimbursement	N/A	N/A	N/A	Benefit available once per year	Benefit available once per year
Slice of Life & SmartShopper	Included	Included	Included	Included	Included

1 - Deductible applies on certain services (per person/per family)
2 - Deductible on services accessed without a PCP referral (per person/per family)
3 - Effective 1/1/17, visits are unlimited

Medical Plan Code	MC3	MCNRX*
Prescription Plan Code	R10/25/40 M10/40/70	N/A
single	$491.18	$203.05

*Medicare Supplemental Plan without RX Coverage

Prescription Plan Code	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34-day supply)	$10 generic
	$25 preferred brand
	$40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$10 generic
	$40 preferred brand
	$70 non-preferred brand

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

Town of Allenstown
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Medical Plan Code	AB15/40IPDED	ABSOS20/40 1KDED
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70
single	$631.35	$591.34
2-person	$1,262.70	$1,182.67
family	$1,704.65	$1,596.61
Office Visit Copay	$15	$20
Specialist Visit Copay	$40	$40
ER Copay	$250	$100
Urgent Care Copay	$125	$50
Standard Deductible[1]	$1,000/$3,000	$1,000/$3,000
Self-Referred Deductible[2]	N/A	N/A
Chiro Visit Max/Copay (Y/N)	12 visits/Y	12 visits/Y
PT, OT, ST Max/Copay (Y/N)	60 visits/Y	20 visits per therapy/Y
Durable Medical Equipment	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible
$40 eyewear reimbursement	N/A	N/A
Slice of Life & SmartShopper	Included	Included

1 - Deductible applies on certain services (per person/per family)

2 - Deductible on services accessed without a PCP referral (per person/per family)

Lumenos High Deductible Health Plan	
Medical Plan Code	Lumenos 2500
single	$618.04
2-person	$1,236.08
family	$1,668.71
Calendar Year Deductible	$2,500/$5,000
In-Network Coinsurance	Covered at 100% after deductible
Out-of-Network Coinsurance	Covered at 70% after deductible
In-Network Out-of-Pocket Maximum	$2,500/$5,000
Out-of-Network Out-of-Pocket Maximum	$5,000/$10,000
Chiro Visit Max	Unlimited
PT, OT, ST Max	60 visits
Anthem's Lumenos High Deductible Health Plans cover routine preventive care at 100% when received from a participating provider.	
Slice of Life & SmartShopper	Included

Prescription Plan Code	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34-day supply)	$10 generic
	$25 preferred brand
	$40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$10 generic
	$40 preferred brand
	$70 non-preferred brand

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

HealthTrust

Town of Barnstead
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Current Medical Plans

Medical Plan Code	BC2T20	ABSOS20/40 1KDED	ABSOS25/50 3KDED
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70
single	$786.12	$591.34	$429.43
2-person	$1,572.24	$1,182.67	$858.86
family	$2,122.53	$1,596.61	$1,159.46
Office Visit Copay	$20	$20	$25
Spefcialist Visit Copay	$20	$40	$50
ER Copay	$100	$100	$150
Urgent Care Copay	$50	$50	$75
Standard Deductible[1]	N/A	$1,000/$3,000	$3,000/$9,000
Self-Referred Deductible[2]	$250/$500	N/A	N/A
Chiro Visit Max/Copay (Y/N)	35 visits/N	12 visits/Y	12 visits/Y
PT, OT, ST Max/Copay (Y/N)	60 visits/N[3]	20 visits per therapy/Y	20 visits per therapy/Y
Durable Medical Equipment	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible
Slice of Life & SmartShopper	Included	Included	Included

1 - Deductible applies on certain services (per person/per family)
2 - Deductible on services accessed without a PCP referral (per person/per family)
3 - Effective 1/1/17, visits are unlimited

Medical Plan Code	MC3	MCNRX*
Prescription Plan Code	R10/25/40 M10/40/70	N/A
single	$491.18	$203.05

*Medicare Supplemental Plan without RX Coverage

Prescription Plan Code	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34-day supply)	$10 generic
	$25 preferred brand
	$40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$10 generic
	$40 preferred brand
	$70 non-preferred brand

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

Town of Barnstead
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Lumenos High Deductible Health Plan	
Medical Plan Code	Lumenos 2500
single	$618.04
2-person	$1,236.08
family	$1,668.71
Calendar Year Deductible	$2,500/$5,000
In-Network Coinsurance	Covered at 100% after deductible
Out-of-Network Coinsurance	Covered at 70% after deductible
In-Network Out-of-Pocket Maximum	$2,500/$5,000
Out-of-Network Out-of-Pocket Maximum	$5,000/$10,000
Chiro Visit Max	Unlimited
PT, OT, ST Max	60 visits
Slice of Life & SmartShopper	Included
Anthem's Lumenos High Deductible Health Plans cover routine preventive care at 100% when received from a participating provider.	

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate document which govern these plans.

Town of Chichester
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Current Medical Plans *Note: BC2T10+ changing to BC2T10 effective 1/1/17.*

Medical Plan Code	BC2T10+	BC2T10	BC2T20	AB20	AB15IPDED
Prescription Plan Code	RX10/20/45	RX10/20/45	RX10/20/45	RX10/20/45	RX10/20/45
single	$847.47	$856.85	$812.59	$758.30	$745.22
2-person	$1,694.94	$1,713.70	$1,625.17	$1,516.59	$1,490.45
family	$2,288.17	$2,313.50	$2,193.98	$2,047.40	$2,012.11
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70
single	$819.80	$828.94	$786.12	$733.60	$720.93
2-person	$1,639.61	$1,657.89	$1,572.24	$1,467.19	$1,441.85
family	$2,213.47	$2,238.15	$2,122.53	$1,980.71	$1,946.50
Office Visit Copay	$10	$10	$20	$20	$15
ER Copay	$50	$50	$100	$100	$100
Urgent Care Copay	$50	$50	$50	$50	$50
Standard Deductible[1]	N/A	N/A	N/A	N/A	$500/$1,500
Self-Referred Deductible[2]	$500/$1,500	$250/$500	$250/$500	N/A	N/A
Chiro Visit Max/Copay (Y/N)	25 visits/N	35 visits/N	35 visits/N	12 visits/Y	12 visits/Y
PT, OT, ST Max/Copay (Y/N)	60 visits/N	60 visits/N	60 visits/N[3]	60 visits/Y	60 visits/Y
Durable Medical Equipment	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	Covered at 80%	Covered at 80% after $100 deductible
$40 eyewear reimbursement	N/A	N/A	N/A	Benefit available once per year	Benefit available once per year
Slice of Life & SmartShopper	Included	Included	Included	Included	Included

1 - Deductible applies on certain services (per person/per family)

2 - Deductible on services accessed without a PCP referral (per person/per family)

3 - Effective 1/1/17, visits are unlimited

Medical Plan Code	MC3	MC3	MCNRX*
Prescription Plan Code	RX10/20/45	R10/25/40 M10/40/70	N/A
single	$507.70	$491.18	$203.05

*Medicare Supplemental Plan without RX Coverage

Prescription Plan Code	RX10/20/45	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34-day supply)	$10 generic	$10 generic
	$20 preferred brand	$25 preferred brand
	$45 non-preferred brand	$40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$10 generic	$10 generic
	$20 preferred brand	$40 preferred brand
	$45 non-preferred brand	$70 non-preferred brand

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

Town of Chichester
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Medical Plan Code	AB15/40IPDED	ABSOS20/40 1KDED
Prescription Plan Code	RX10/20/45	RX10/20/45
single	$652.60	$611.22
2-person	$1,305.20	$1,222.45
family	$1,762.03	$1,650.30
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70
single	$631.35	$591.34
2-person	$1,262.70	$1,182.67
family	$1,704.65	$1,596.61
Office Visit Copay	$15	$20
Specialist Visit Copay	$40	$40
ER Copay	$250	$100
Urgent Care Copay	$125	$50
Standard Deductible[1]	$1,000/$3,000	$1,000/$3,000
Self-Referred Deductible[2]	N/A	N/A
Chiro Visit Max/Copay (Y/N)	12 visits/Y	12 visits/Y
PT, OT, ST Max/Copay (Y/N)	60 visits/Y	20 visits per therapy/Y
Durable Medical Equipment	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible
$40 eyewear reimbursement	N/A	N/A
Slice of Life & SmartShopper	Included	Included

1 - Deductible applies on certain services (per person/per family)

2 - Deductible on services accessed without a PCP referral (per person/per family)

Lumenos High Deductible Health Plan	
Medical Plan Code	Lumenos 2500
single	$618.04
2-person	$1,236.08
family	$1,668.71
Calendar Year Deductible	$2,500/$5,000
In-Network Coinsurance	Covered at 100% after deductible
Out-of-Network Coinsurance	Covered at 70% after deductible
In-Network Out-of-Pocket Maximum	$2,500/$5,000
Out-of-Network Out-of-Pocket Maximum	$5,000/$10,000
Chiro Visit Max	Unlimited
PT, OT, ST Max	60 visits
Anthem's Lumenos High Deductible Health Plans cover routine preventive care at 100% when received from a participating provider.	
Slice of Life & SmartShopper	Included

Prescription Plan Code	RX10/20/45	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34-day supply)	$10 generic	$10 generic
	$20 preferred brand	$25 preferred brand
	$45 non-preferred brand	$40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$10 generic	$10 generic
	$20 preferred brand	$40 preferred brand
	$45 non-preferred brand	$70 non-preferred brand

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Town of Epsom
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Current Medical Plans

Medical Plan Code	BC3T10	BC2T20	AB20	AB15IPDED	ABSOS20/40 1KDED	ABSOS25/50 3KDED
Prescription Plan Code	RX10/20/45	RX10/20/45	RX10/20/45	RX10/20/45	RX10/20/45	RX10/20/45
single	$861.74	$812.59	N/A	N/A	N/A	N/A
2-person	$1,723.49	$1,625.17				
family	$2,326.71	$2,193.98				
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70
single	$833.68	$786.12	$733.60	$720.93	$591.34	$429.43
2-person	$1,667.35	$1,572.24	$1,467.19	$1,441.85	$1,182.67	$858.86
family	$2,250.93	$2,122.53	$1,980.71	$1,946.50	$1,596.61	$1,159.46
Office Visit Copay	$10	$20	$20	$15	$20	$25
Specialist Visit Copay	$10	$20	$20	$15	$40	$50
ER Copay	$50	$100	$100	$100	$100	$150
Urgent Care Copay	$50	$50	$50	$50	$50	$75
Standard Deductible[1]	N/A	N/A	N/A	$500/$1,500	$1,000/$3,000	$3,000/$9,000
Self-Referred Deductible[2]	$150/$450	$250/$500	N/A	N/A	N/A	N/A
Chiro Visit Max/Copay (Y/N)	Unlimited/Y	35 visits/N	12 visits/Y	12 visits/Y	12 visits/Y	12 visits/Y
PT, OT, ST Max/Copay (Y/N)	Unlimited/N	60 visits/N[3]	60 visits/Y	60 visits/Y	20 visits per therapy/Y	20 visits per therapy/Y
Durable Medical Equipment	Covered at 100%	Covered at 80% after $100 deductible	Covered at 80%	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible
$40 eyewear reimbursement	Benefit available once every 24 mos.	N/A	Benefit available once per year	Benefit available once per year	N/A	N/A
Slice of Life & SmartShopper	Included	Included	Included	Included	Included	Included

1 - Deductible applies on certain services (per person/per family)

2 - Deductible on services accessed without a PCP referral (per person/per family)

3 - Effective 1/1/17, visits are unlimited

Medical Plan Code	MC3	MC3	MCNRX*
Prescription Plan Code	RX10/20/45	R10/25/40 M10/40/70	N/A
single	$507.70	$491.18	$203.05

*Medicare Supplemental Plan without RX Coverage

Prescription Plan Code	RX10/20/45	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34-day supply)	$10 generic	$10 generic
	$20 preferred brand	$25 preferred brand
	$45 non-preferred brand	$40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$10 generic	$10 generic
	$20 preferred brand	$40 preferred brand
	$45 non-preferred brand	$70 non-preferred brand

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

Town of Epsom
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Lumenos High Deductible Health Plan	
Medical Plan Code	Lumenos 2500
single	$618.04
2-person	$1,236.08
family	$1,668.71
Calendar Year Deductible	$2,500/$5,000
In-Network Coinsurance	Covered at 100% after deductible
Out-of-Network Coinsurance	Covered at 70% after deductible
In-Network Out-of-Pocket Maximum	$2,500/$5,000
Out-of-Network Out-of-Pocket Maximum	$5,000/$10,000
Chiro Visit Max	Unlimited
PT, OT, ST Max	60 visits
Slice of Life & SmartShopper	Included
Anthem's Lumenos High Deductible Health Plans cover routine preventive care at 100% when received from a participating provider.	

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

HealthTrust

Town of Pembroke
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Current Medical Plans *Note: RX10/20/30 will be discontinued 1/1/18.*

Medical Plan Code	BC3T10	BC2T20	AB5	AB10	AB20	AB15IPDED
Prescription Plan Code	RX10/20/30	RX10/20/30	RX10/20/30	RX10/20/30	RX10/20/30	RX10/20/30
single	$886.20	N/A	$824.69	N/A	N/A	N/A
2-person	$1,772.40		$1,649.39			
family	$2,392.74		$2,226.68			
Prescription Plan Code	RX10/20/45	RX10/20/45	RX10/20/45	RX10/20/45	RX10/20/45	RX10/20/45
single	$861.74	$812.59	$801.92	$790.29	$758.30	$745.22
2-person	$1,723.49	$1,625.17	$1,603.84	$1,580.58	$1,516.59	$1,490.45
family	$2,326.71	$2,193.98	$2,165.18	$2,133.79	$2,047.40	$2,012.11
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70
single	$833.68	$786.12	$775.78	$764.55	$733.60	$720.93
2-person	$1,667.35	$1,572.24	$1,551.55	$1,529.10	$1,467.19	$1,441.85
family	$2,250.93	$2,122.53	$2,094.60	$2,064.29	$1,980.71	$1,946.50
Office Visit Copay	$10	$20	$5	$10	$20	$15
ER Copay	$50	$100	$25	$50	$100	$100
Urgent Care Copay	$50	$50	$25	$50	$50	$50
Standard Deductible[1]	N/A	N/A	N/A	N/A	N/A	$500/$1,500
Self-Referred Deductible[2]	$150/$450	$250/$500	N/A	N/A	N/A	N/A
Chiro Visit Max/Copay (Y/N)	Unlimited/Y	35 visits/N	12 visits/Y	12 visits/Y	12 visits/Y	12 visits/Y
PT, OT, ST Max/Copay (Y/N)	Unlimited/N	60 visits/N[3]	60 visits/Y	60 visits/Y	60 visits/Y	60 visits/Y
Durable Medical Equipment	Covered at 100%	Covered at 80% after $100 deductible	Covered at 80%	Covered at 80%	Covered at 80%	Covered at 80% after $100 deductible
$40 eyewear reimbursement	Benefit available once every 24 mos.	N/A	Benefit available once per year	Benefit available once per year	Benefit available once per year	Benefit available once per year
Slice of Life & SmartShopper	Included	Included	Included	Included	Included	Included

1 - Deductible applies on certain services (per person/per family)

2 - Deductible on services accessed without a PCP referral (per person/per family)

3 - Effective 1/1/17, visits are unlimited

Medical Plan Code	MC3	MC3	MC3	MCNRX*
Prescription Plan Code	RX10/20/30	RX10/20/45	R10/25/40 M10/40/70	N/A
single	$522.13	$507.70	$491.18	$203.05

*Medicare Supplemental Plan without RX Coverage

Prescription Plan Code	RX10/20/30	RX10/20/45	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34-day supply)	$10 generic	$10 generic	$10 generic
	$20 preferred brand	$20 preferred brand	$25 preferred brand
	$30 non-preferred brand	$45 non-preferred brand	$40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$10 generic	$10 generic	$10 generic
	$20 preferred brand	$20 preferred brand	$40 preferred brand
	$30 non-preferred brand	$45 non-preferred brand	$70 non-preferred brand

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

Town of Pembroke
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Medical Plan Code	AB15/40IPDED	ABSOS20/40 1KDED
Prescription Plan Code	RX10/20/45	RX10/20/45
single	$652.60	$611.22
2-person	$1,305.20	$1,222.45
family	$1,762.03	$1,650.30
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70
single	$631.35	$591.34
2-person	$1,262.70	$1,182.67
family	$1,704.65	$1,596.61
Office Visit Copay	$15	$20
Specialist Visit Copay	$40	$40
ER Copay	$250	$100
Urgent Care Copay	$125	$50
Standard Deductible[1]	$1,000/$3,000	$1,000/$3,000
Self-Referred Deductible[2]	N/A	N/A
Chiro Visit Max/Copay (Y/N)	12 visits/Y	12 visits/Y
PT, OT, ST Max/Copay (Y/N)	60 visits/Y	20 visits per therapy/Y
Durable Medical Equipment	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible
$40 eyewear reimbursement	N/A	N/A
Slice of Life & SmartShopper	Included	Included

1 - Deductible applies on certain services (per person/per family)

2 - Deductible on services accessed without a PCP referral (per person/per family)

Prescription Plan Code	RX10/20/45	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34-day supply)	$10 generic	$10 generic
	$20 preferred brand	$25 preferred brand
	$45 non-preferred brand	$40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$10 generic	$10 generic
	$20 preferred brand	$40 preferred brand
	$45 non-preferred brand	$70 non-preferred brand

Lumenos High Deductible Health Plan	
Medical Plan Code	Lumenos 2500
single	$618.04
2-person	$1,236.08
family	$1,668.71
Calendar Year Deductible	$2,500/$5,000
In-Network Coinsurance	Covered at 100% after deductible
Out-of-Network Coinsurance	Covered at 70% after deductible
In-Network Out-of-Pocket Maximum	$2,500/$5,000
Out-of-Network Out-of-Pocket Maximum	$5,000/$10,000
Chiro Visit Max	Unlimited
PT, OT, ST Max	60 visits
Anthem's Lumenos High Deductible Health Plans cover routine preventive care at 100% when received from a participating provider.	
Slice of Life & SmartShopper	Included

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

HealthTrust

Town of Pittsfield
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Current Medical Plans

Medical Plan Code	AB20	AB20IPDED	AB15IPDED	ABSOS20/40 1KDED	ABSOS25/50 3KDED
Prescription Plan Code	RX10/20/45	RX10/20/45	RX10/20/45	RX10/20/45	RX10/20/45
single	$758.30	$752.12	$745.22	$611.22	$443.86
2-person	$1,516.59	$1,504.24	$1,490.45	$1,222.45	$887.73
family	$2,047.40	$2,030.73	$2,012.11	$1,650.30	$1,198.43
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70
single	$733.60	$727.58	$720.93	$591.34	$429.43
2-person	$1,467.19	$1,455.16	$1,441.85	$1,182.67	$858.86
family	$1,980.71	$1,964.47	$1,946.50	$1,596.61	$1,159.46
Office Visit Copay	$20	$20	$15	$20	$25
Specialist Visit Copay	$20	$20	$15	$40	$50
ER Copay	$100	$150	$100	$100	$150
Urgent Care Copay	$50	$75	$50	$50	$75
Standard Deductible[1]	N/A	$250/$750	$500/$1,500	$1,000/$3,000	$3,000/$9,000
Self-Referred Deductible[2]	N/A	N/A	N/A	N/A	N/A
Chiro Visit Max/Copay (Y/N)	12 visits/Y	12 visits/Y	12 visits/Y	12 visits/Y	12 visits/Y
PT, OT, ST Max/Copay (Y/N)	60 visits/Y	60 visits/Y	60 visits/Y	20 visits per therapy/Y	20 visits per therapy/Y
Durable Medical Equipment	Covered at 80%	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible
$40 eyewear reimbursement	Benefit available once per year	Benefit available once per year	Benefit available once per year	N/A	N/A
Slice of Life & SmartShopper	Included	Included	Included	Included	Included

1 - Deductible applies on certain services (per person/per family)

2 - Deductible on services accessed without a PCP referral (per person/per family)

Medical Plan Code	MC3	MC3	MCNRX*
Prescription Plan Code	RX10/20/45	R10/25/40 M10/40/70	N/A
single	$507.70	$491.18	$203.05

*Medicare Supplemental Plan without RX Coverage

Prescription Plan Code	RX10/20/45	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34-day supply)	$10 generic	$10 generic
	$20 preferred brand	$25 preferred brand
	$45 non-preferred brand	$40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$10 generic	$10 generic
	$20 preferred brand	$40 preferred brand
	$45 non-preferred brand	$70 non-preferred brand

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

Town of Pittsfield
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Lumenos High Deductible Health Plan	
Medical Plan Code	Lumenos 2500
single 2-person family	$618.04 $1,236.08 $1,668.71
Calendar Year Deductible	$2,500/$5,000
In-Network Coinsurance	Covered at 100% after deductible
Out-of-Network Coinsurance	Covered at 70% after deductible
In-Network Out-of-Pocket Maximum	$2,500/$5,000
Out-of-Network Out-of-Pocket Maximum	$5,000/$10,000
Chiro Visit Max	Unlimited
PT, OT, ST Max	60 visits
Slice of Life & SmartShopper	Included
Anthem's Lumenos High Deductible Health Plans cover routine preventive care at 100% when received from a participating provider.	

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate document which govern these plans.

Town of Strafford
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Current Medical Plans

Medical Plan Code	AB20	AB15IPDED	AB15/40IPDED	ABSOS20/40 1KDED
Prescription Plan Code	RX10/20/45	RX10/20/45	RX10/20/45	RX10/20/45
single	$758.30	$745.22	$652.60	$611.22
2-person	$1,516.59	$1,490.45	$1,305.20	$1,222.45
family	$2,047.40	$2,012.11	$1,762.03	$1,650.30
Prescription Plan Code	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70	R10/25/40 M10/40/70
single	$733.60	$720.93	$631.35	$591.34
2-person	$1,467.19	$1,441.85	$1,262.70	$1,182.67
family	$1,980.71	$1,946.50	$1,704.65	$1,596.61
Office Visit Copay	$20	$15	$15	$20
Specialist Copay	$20	$15	$40	$40
ER Copay	$100	$100	$250	$100
Urgent Care Copay	$50	$50	$125	$50
Standard Deductible[1]	N/A	$500/$1,500	$1,000/$3,000	$1,000/$3,000
Self-Referred Deductible[2]	N/A	N/A	N/A	N/A
Chiro Visit Max/Copay (Y/N)	12 visits/Y	12 visits/Y	12 visits/Y	12 visits/Y
PT, OT, ST Max/Copay (Y/N)	60 visits/Y	60 visits/Y	60 visits/Y	20 visits per therapy/Y
Durable Medical Equipment	Covered at 80%	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible	Covered at 80% after $100 deductible
$40 eyewear reimbursement	Benefit available once per year	Benefit available once per year	N/A	N/A
Slice of Life & SmartShopper	Included	Included	Included	Included

1 - Deductible applies on certain services (per person/per family)

2 - Deductible on services accessed without a PCP referral (per person/per family)

Medical Plan Code	MC3	MC3	MCNRX*
Prescription Plan Code	RX10/20/45	R10/25/40 M10/40/70	N/A
single	$507.70	$491.18	$203.05

*Medicare Supplemental Plan without RX Coverage

Prescription Plan Code	RX10/20/45	R10/25/40 M10/40/70
Retail Pharmacy Copay (up to 34-day supply)	$10 generic	$10 generic
	$20 preferred brand	$25 preferred brand
	$45 non-preferred brand	$40 non-preferred brand
Mail Service Copay (up to 90-day supply)	$10 generic	$10 generic
	$20 preferred brand	$40 preferred brand
	$45 non-preferred brand	$70 non-preferred brand

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.

Town of Strafford
Proposed Rates and Benefit Options
Suncook Valley Regional Towns Combination
Valid 01/01/2016 through 12/31/2016

The proposed alternative plans provided on this comparison may not be available with your current plan offerings.
Please note plan changes and guidelines outlined in the proposal.

Lumenos High Deductible Health Plan	
Medical Plan Code	Lumenos 2500
single	$618.04
2-person	$1,236.08
family	$1,668.71
Calendar Year Deductible	$2,500/$5,000
In-Network Coinsurance	Covered at 100% after deductible
Out-of-Network Coinsurance	Covered at 70% after deductible
In-Network Out-of-Pocket Maximum	$2,500/$5,000
Out-of-Network Out-of-Pocket Maximum	$5,000/$10,000
Chiro Visit Max	Unlimited
PT, OT, ST Max	60 visits
Slice of Life & SmartShopper	Included
Anthem's Lumenos High Deductible Health Plans cover routine preventive care at 100% when received from a participating provider.	

DISCLAIMER: Monthly rates are based on a minimum of 75% participation of all eligible employees. HealthTrust's medical underwriting guidelines do not allow an employee to have the choice between medical plans that only differ by the accompanying RX plan. An employer is allowed to offer two plans to the same group of employees, one without a deductible and one with a deductible. Active employees and retirees must be offered the same prescription drug coverage. HealthTrust reserves the right to revisit these rates if there is a +/- 10% in enrollment. All deductibles and benefit limits shown are per calendar year. These charts are intended for summary purposes only. Details of coverage are set forth in separate document which govern these plans.

Section 5b

Dental Rates and Options

HealthTrust

Suncook Valley Regional Towns Association

	Dental Options				
Benefits	**2A**	**3**	**1**	**3A**	**1S**
Coverage A - Diagnostic & Preventive: Evaluations; X-rays; Cleanings; Fluoride; Space Maintainers; Sealants for Children	100%	100%	100%	100%	100%
Coverage B - Restorative: Fillings; Amalgam (Silver) or composite (White); Extractions; Root Canal Therapy; Periodontal Treatment; Repair of a removable denture; Emergency Treatment	80%	80%	80%	80%	80%
Coverage C - Prosthodontics: Removable and Fixed Partial Dentures (Bridges); Crowns; Dentures; Onlays; Implants	50%	50%	50%	50%	50%
Coverage D - Orthodontics: Correction of crooked teeth for dependent children to age 19	0%	0%	50%	0%	50%
Deductible Per Plan Year: (Person/Family) Not applied to Coverage A or D	$0	$25/$75	$25/$75	$0	$0
Maximum: Per Person/Per Plan Year	$750	$1,000	$1,000	$1,000	$2,000
Orthodontic Lifetime Maximum:	$0	$0	$1,000	$0	$1,000
Monthly Non-Flex Rates: (Apply when one option is offered to the same group of employees)					
Single	$39.43	$40.37	$40.37	$40.98	$44.35
2-Person	$75.84	$77.63	$78.14	$78.76	$85.68
Family	$132.97	$136.16	$142.16	$137.40	$153.26
Monthly Flex Rates: (Apply if two or three options are offered to the same group of employees)					
Single	$43.37	$44.41	$44.41	$45.07	$48.78
2-Person	$83.42	$85.39	$85.95	$86.64	$94.25
Family	$146.26	$149.78	$156.36	$151.14	$168.58

This chart is intended for summary purposes only.
Details of coverage are set forth in separate documents, which govern each benefit plan.
Monthly rates are guaranteed for the period of January 1, 2016 through December 31, 2016.

Section 5c

FSA Rates

HealthTrust

Flexible Spending Account Administration

A SERVICE OF HEALTHTRUST

- No Set-up or Renewal Fees
- Prepaid Benefits Card (at no cost)
- Plan Document Preparation
- Online Account Management
- Weekly Reimbursements
- Customizable Components
  - Over-the-Counter Reimbursement
  - Extended Reimbursement Deadline (Grace Period)
  - Carryover

Rates for July 1, 2016 to June 30, 2017:

$2.50 per employee per month

(Regardless of an employee's election to participate in Healthcare FSA, Dependent Care Reimbursement Account or both)

Rates for January 1, 2017 to December 31, 2017:

$2.50 per employee per month

(Regardless of an employee's election to participate in Healthcare FSA, Dependent Care Reimbursement Account or both)

For more information, visit the "Flexible Spending Account" section of *www.healthtrustnh.org*.

PO Box 617 • 25 Triangle Park Drive • Concord, NH 03302-0617
Toll Free: 800.527.5001 • Fax: 603.415.3099 • Email: fsa@healthtrustnh.org • *www.healthtrustnh.org*

Rev. 3/16

HealthTrust Health FSAs: Lower Costs, Same Benefits

HealthTrust recognizes how valuable a Healthcare Flexible Spending Account (Health FSA) can be to your employees. That's why we have made two key enhancements to our Health FSA program that start July 1, 2016 (for July plan groups) and January 1, 2017 (for January plan groups).

We have reduced our fees! The per-participant/per-month fee for HealthTrust Health FSAs and Dependent Care Reimbursement Accounts has been cut almost in half, from $4.75 to $2.50. If you paid for your employees' Benny™ Prepaid Benefits Card, the fee has been reduced from $6.25 to $2.50.

The Benny Prepaid Benefits Card is now free! (Previously $1.50/month per participant.) This convenient option means your employees don't have to pay up front and wait for reimbursement. The Benny Prepaid Benefits Card allows them to pay at the time of services with automatic debit.

Why Offer Your Employees a HealthTrust Health FSA?

Benefits of a Health FSA for Your Employees

- Tax savings of 20 to 35 percent for most people (depending on their particular tax situation)
- Health FSA fully funded on day one of plan year
- FSA specialists in HealthTrust Enrollee Services
- Grace period of 2½ months or $500 carryover option to avoid IRS "use-it-or-lose-it" penalty
- Pre-loaded Benny Prepaid Benefits Card

Benefits of a Health FSA for Your Group

- Matching FICA tax savings (7.65%)
- More robust benefits package
- Pre-funded on day one of plan year
- Administered directly by HealthTrust
- Exceptional service

TOP 10

Eligible Expenses Payable by Health FSA Funds

1. Medical deductibles/copays/coinsurance
2. Prescriptions
3. Dental services
4. Orthodontia
5. Vision services (including prescription glasses and contact lenses)
6. Over-the-counter products (including bandages and sunscreen – SPF 30 or higher)
7. Physical therapy
8. Chiropractic care
9. Acupuncture
10. Durable medical equipment (wheelchairs, hearing aids, CPAP, etc.)

For a more detailed list of eligible and ineligible health expenses, log on to *www.healthtrustnh.org* and click the "Forms and Documents" tab. Talk to your HealthTrust Benefits Advisor today about offering this valuable service to your employees. Your staff will thank you!

HealthTrust

PO Box 617 • Concord, NH 03302-0617 • Tel. 603.226.2861 • Toll Free 800.527.5001
Fax: 603.226.2988 • Email: fsa@healthtrustnh.org • Website: *www.healthtrustnh.org*

Section 6

Section 6a

BlueChoice Cost Sharing Schedules

HealthTrust

Anthem BlueCross BlueShield

BlueChoice®
Cost Sharing Schedule

This Cost Sharing Schedule is an important part of Your Subscriber Certificate and is an outline of Your coverage. Do not rely on this outline alone. Keep this schedule with Your Certificate because it contains important information about coverage and limitations. Please read Your Subscriber Certificate carefully as important terms and limitations apply.

Cost Sharing Summary	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$10 per visit	N/A
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Physician at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$10 per visit	
Emergency Room Copayment	$50 per visit	
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of an illness or injury.	$50 per visit	N/A
Standard Deductible	N/A	$250 per Member, per year $500 per family, per year
Standard Coinsurance	N/A	20%
Coinsurance Maximum	N/A	$900 per Member, per year $1,800 per family, per year
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 $100 per Member, per year 20%	 $100 per Member, per year 20%
Out-of-Pocket Limit** Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium, penalties, out-of-network expenses, amounts over the Maximum Allowed Amount or charges for noncovered services.	$5,000 per Member, per year $10,000 per family, per year	N/A
Inpatient Precertification Penalty	N/A	$500

*Benefits are limited to the Maximum Allowed Amount (MAA). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

**Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Medical/Surgical Care		
I. Inpatient Services		
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	You pay $0	Standard Deductible and Coinsurance, plus any balances
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year†		
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year†		
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests)† For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.		
II. Outpatient Services		
Preventive Care		
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older.† -Routine hearing exams - One exam each year.†	You pay $0	Standard Deductible and Coinsurance, plus any balances
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider		
Medical exams, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Injections (including allergy injections)	You pay $0	
Office surgery (including anesthesia)		
Laboratory tests (including allergy testing)		
X-ray tests (including ultrasound)		
MRA, MRI, PET, SPECT, CT Scan, CTA, chemotherapy, medical supplies and drugs		
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for more information about maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is indicated above under "Inpatient Services" or below under "Outpatient Facility Care."	

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Self-Referred Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Network or PCP-Referred Benefits and Out-of-Network or Self-Referred Benefits counts toward this limit.

	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center		
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Services of a surgeon, operating room for surgery and anesthesia	You pay $0	
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation		
Laboratory and x-ray tests (including ultrasounds)		
Emergency Room Visits and Urgent Care Facility Visits		
Use of the emergency room (The Copayment is waived if You are admitted)	Emergency Room Copayment	
Use of a licensed hospital's urgent care facility	Urgent Care Facility Copayment	Standard Deductible and Coinsurance, plus any balances
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You pay $0	
Laboratory and x-ray tests		
Ambulance Services Medically Necessary Emergency Transport	You pay $0	
III. Outpatient Physical Rehabilitation Services		
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year†	You pay $0	Standard Deductible and Coinsurance, plus any balances
Cardiac Rehabilitation Visits	Visit Copayment or Specialty Visit Copayment	
Chiropractic Care • **Office visit** - up to 35 visits per Member, per year	You pay $0	
• **X-ray tests** furnished by a chiropractor		
Early Intervention Services	Visit Copayment or Specialty Visit Copayment	
IV. Home Care		
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Home Health Agency services	You pay $0	
Hospice		
Infusion Therapy		
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance	Subject to the DME Deductible and Coinsurance, plus any balances

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Self-Referred Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Network or PCP-Referred Benefits and Out-of-Network or Self-Referred Benefits counts toward this limit.

	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)		
Outpatient/Office Visits		
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Partial Hospitalization and Intensive Outpatient Treatment Programs		
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	You pay $0	Standard Deductible and Coinsurance, plus any balances
Inpatient Care		
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions:** • Medical detoxification days - Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	You pay $0	Standard Deductible and Coinsurance, plus any balances
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	You pay $0	
VI. Prescription Eyewear		
N/A		

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Self-Referred Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

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Cost Sharing Schedule

This Cost Sharing Schedule is an important part of Your Subscriber Certificate and is an outline of Your coverage. Do not rely on this outline alone. Keep this schedule with Your Certificate because it contains important information about coverage and limitations. Please read Your Subscriber Certificate carefully as important terms and limitations apply.

Cost Sharing Summary	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$10 per visit	N/A
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Physician at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$10 per visit	
Emergency Room Copayment	$50 per visit	
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of an illness or injury.	$50 per visit	N/A
Standard Deductible	N/A	$500 per Member, per year $1,500 per family, per year
Standard Coinsurance	N/A	30%
Coinsurance Maximum	N/A	$1,000 per Member, per year $3,000 per family, per year
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 $100 per Member, per year 20%	 $100 per Member, per year 50%
Out-of-Pocket Limit** Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium, penalties, out-of-network expenses, amounts over the Maximum Allowed Amount or charges for noncovered services.	$5,000 per Member, per year $10,000 per family, per year	N/A
Inpatient Precertification Penalty	N/A	$500

*Benefits are limited to the Maximum Allowed Amount (MAA). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

**Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Medical/Surgical Care		
I. Inpatient Services		
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	You pay $0	Standard Deductible and Coinsurance, plus any balances
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year†		
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year†		
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests)† For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.		
II. Outpatient Services		
Preventive Care		
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older.† -Routine hearing exams - One exam each year.†	You pay $0	Standard Deductible and Coinsurance, plus any balances
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider		
Medical exams, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Injections (including allergy injections)	You pay $0	
Office surgery (including anesthesia)		
Laboratory tests (including allergy testing)		
X-ray tests (including ultrasound)		
MRA, MRI, PET, SPECT, CT Scan, CTA, chemotherapy, medical supplies and drugs		
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is indicated above under "Inpatient Services" or below under "Outpatient Facility Care."	

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Self-Referred Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Network or PCP-Referred Benefits and Out-of-Network or Self-Referred Benefits counts toward this limit.

	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center		
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Services of a surgeon, operating room for surgery and anesthesia	You pay $0	
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation		
Laboratory and x-ray tests (including ultrasounds)		
Emergency Room Visits and Urgent Care Facility Visits		
Use of the emergency room (The Copayment is waived if You are admitted)	Emergency Room Copayment	
Use of a licensed hospital's urgent care facility	Urgent Care Facility Copayment	Standard Deductible and Coinsurance, plus any balances
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You pay $0	
Laboratory and x-ray tests		
Ambulance Services Medically Necessary Emergency Transport	You pay $0	
III. Outpatient Physical Rehabilitation Services		
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year†	You pay $0	Standard Deductible and Coinsurance, plus any balances
Cardiac Rehabilitation Visits	Visit Copayment or Specialty Visit Copayment	
Chiropractic Care • **Office visit** - up to 25 visits per Member, per year	You pay $0	
• **X-ray tests** furnished by a chiropractor		
Early Intervention Services	Visit Copayment or Specialty Visit Copayment	
IV. Home Care		
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Home Health Agency services	You pay $0	
Hospice		
Infusion Therapy		
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance	Subject to the DME Deductible and Coinsurance, plus any balances

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† Any combination of Network or PCP-Referred Benefits and Out-of-Network or Self-Referred Benefits counts toward this limit.

	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)		
Outpatient/Office Visits		
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Partial Hospitalization and Intensive Outpatient Treatment Programs		
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	You pay $0	Standard Deductible and Coinsurance, plus any balances
Inpatient Care		
Mental Disorders: Unlimited Medically Necessary Inpatient days	You pay $0	Standard Deductible and Coinsurance, plus any balances
Substance Abuse Conditions: • Medical detoxification days - Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days		
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	You pay $0	
VI. Prescription Eyewear		
N/A		

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Self-Referred Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

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Cost Sharing Schedule

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Cost Sharing Summary	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$20 per visit	N/A
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Physician at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$20 per visit	
Emergency Room Copayment	$100 per visit	
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of an illness or injury.	$50 per visit	N/A
Standard Deductible	N/A	$250 per Member, per year $500 per family, per year
Standard Coinsurance	N/A	20%
Coinsurance Maximum	N/A	$900 per Member, per year $1,800 per family, per year
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	$100 per Member, per year 20%	$100 per Member, per year 20%
Out-of-Pocket Limit** Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium, penalties, out-of-network expenses, amounts over the Maximum Allowed Amount or charges for noncovered services.	$5,000 per Member, per year $10,000 per family, per year	N/A
Inpatient Precertification Penalty	N/A	$500

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Self-Referred Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

**Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Medical/Surgical Care		
I. Inpatient Services		
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	You pay $0	Standard Deductible and Coinsurance, plus any balances
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year†		
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year†		
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests)† For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.		
II. Outpatient Services		
Preventive Care		
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older.† -Routine hearing exams - One exam each year.†	You pay $0	Standard Deductible and Coinsurance, plus any balances
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider		
Medical exams, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Injections (including allergy injections)	You pay $0	
Office surgery (including anesthesia)		
Laboratory tests (including allergy testing)		
X-ray tests (including ultrasound)		
MRA, MRI, PET, SPECT, CT Scan, CTA, chemotherapy, medical supplies and drugs		
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is indicated above under "Inpatient Services" or below under "Outpatient Facility Care."	

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† Any combination of Network or PCP-Referred Benefits and Out-of-Network or Self-Referred Benefits counts toward this limit.

	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center		
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Services of a surgeon, operating room for surgery and anesthesia	You pay $0	
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation		
Laboratory and x-ray tests (including ultrasounds)		
Emergency Room Visits and Urgent Care Facility Visits		
Use of the emergency room (The Copayment is waived if You are admitted)	Emergency Room Copayment	
Use of a licensed hospital's urgent care facility	Urgent Care Facility Copayment	Standard Deductible and Coinsurance, plus any balances
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You pay $0	
Laboratory and x-ray tests		
Ambulance Services Medically Necessary Emergency Transport	You pay $0	
III. Outpatient Physical Rehabilitation Services		
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year†	You pay $0	Standard Deductible and Coinsurance, plus any balances
Cardiac Rehabilitation Visits	Visit Copayment or Specialty Visit Copayment	
Chiropractic Care • **Office visit** - up to 35 visits per Member, per year	You pay $0	
• **X-ray tests** furnished by a chiropractor		
Early Intervention Services	Visit Copayment or Specialty Visit Copayment	
IV. Home Care		
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Home Health Agency services	You pay $0	
Hospice		
Infusion Therapy		
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance	Subject to the DME Deductible and Coinsurance plus any balances

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† Any combination of Network or PCP-Referred Benefits and Out-of-Network or Self-Referred Benefits counts toward this limit.

	PCP-Referred Benefits	Self-Referred Benefits*
	YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)		
Outpatient/Office Visits		
Mental Health Visits - Unlimited Medically Necessary visits **Substance Abuse Visits -** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Partial Hospitalization and Intensive Outpatient Treatment Programs		
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	You pay $0	Standard Deductible and Coinsurance, plus any balances
Inpatient Care		
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions:** • Medical detoxification days - Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	You pay $0	Standard Deductible and Coinsurance, plus any balances
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	You pay $0	
VI. Prescription Eyewear		
N/A		

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Self-Referred Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

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Cost Sharing Schedule

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Cost Sharing Summary	**Option 1** *When Your PCP provides or refers Your care*	**Option 2** *When You seek care directly from a BlueChoice provider*	**Option 3*** *When You seek care from any out-of network provider*
	YOUR COST		
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$5 per visit	$15 per visit	N/A
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Physician at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$5 per visit	$15 per visit	N/A
Emergency Room Copayment	$25 per visit		
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of an illness or injury.	$25 per visit	$25 per visit	N/A
Standard Deductible	N/A	N/A	$150 per Member, per year $450 per family, per year
Standard Coinsurance	N/A	20%	20%
Coinsurance Maximum	N/A	$600 per Member, per year $1,800 per family, per year	$900 per Member, per year $2,700 per family, per year
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 N/A N/A	 N/A 20%	 N/A 20%
Out-of-Pocket Limit** Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium, penalties, out-of-network expenses, amounts over the Maximum Allowed Amount, or charges for noncovered services.	$5,000 per Member, per year $10,000 per family, per year		N/A
Inpatient Precertification Penalty	N/A	N/A	$500

Please note that throughout this schedule any reference to year means calendar year.

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Option 3 Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

**Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Coverage Outline	Option 1 *When Your PCP provides or refers Your care*	Option 2 *When You seek care directly from a BlueChoice provider*	Option 3* *When You seek care from any out-of network provider*
	YOUR COST		
Medical/Surgical Care			
I. Inpatient Services			
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	You pay $0	Standard Coinsurance	Standard Deductible and Coinsurance, plus any balances
In a Skilled Nursing Facility (Facility charges)			
In a Physical Rehabilitation Facility (Facility charges)			
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests)			
II. Outpatient Services			
Preventive Care			
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older.† -Routine hearing exams - One exam each year.†	You pay $0	You pay $0	Standard Deductible and Coinsurance, plus any balances
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider			
Medical exams, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Injections (including allergy injections)	You pay $0	You pay $0	
Office surgery (including anesthesia)			
Laboratory tests (including allergy testing)			
X-ray tests (including ultrasound)			
MRA, MRI, PET, SPECT, CT Scan, CTA, chemotherapy, medical supplies and drugs		Standard Coinsurance	
Maternity care (prenatal and postpartum visits) Please see your Subscriber Certificate for information about maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is indicated above under "Inpatient Services" or below under "Outpatient Facility Care."		

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Option 3 Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Option 1, 2 or 3 Benefits counts toward this limit.

	Option 1 *When Your PCP provides or refers Your care*	**Option 2** *When You seek care directly from a BlueChoice provider*	**Option 3*** *When You seek care from any out-of network provider*
	YOUR COST		
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center			
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Services of a surgeon, operating room for surgery and anesthesia	You pay $0	Standard Coinsurance	
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation			
Laboratory and x-ray tests (including ultrasounds)		You pay $0	
Emergency Room Visits and Urgent Care Facility Visits			
Use of the emergency room (The Copayment is waived if You are admitted)	Emergency Room Copayment		
Use of a licensed hospital's urgent care facility	Urgent Care Facility Copayment	Urgent Care Facility Copayment	Standard Deductible and Coinsurance, plus any balances
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You pay $0	You pay $0	
Laboratory and x-ray tests			
Ambulance Services Medically Necessary Emergency Transport	You pay $0		
III. Outpatient Physical Rehabilitation Services			
Physical Therapy and Occupational Therapy and Speech Therapy	You pay $0	Standard Coinsurance	Standard Deductible and Coinsurance, plus any balances
Cardiac Rehabilitation Visits	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	
Chiropractic Care • **Office visit** - unlimited		N/A	
• **X-ray tests** furnished by a chiropractor	You pay $0		
Early Intervention Services	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	
IV. Home Care			
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Home Health Agency services	You pay $0	Standard Coinsurance	
Hospice			
Infusion Therapy			
Durable Medical Equipment, Medical Supplies and Prosthetics			Standard Coinsurance, plus any balances

*Benefits are limited to the Maximum Allowed Amount (MAA). Under Option 3 Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification by Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Option 1, 2 or 3 Benefits counts toward this limit.

Option 2 Benefits are not available for Behavioral Health Care.	**Option 1** *When You obtain care from a Network Provider*	**Option 3*** *When You obtain care from any Eligible Mental Health or Substance Abuse Provider*
	YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)		
Outpatient/Office Visits		
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Partial Hospitalization and Intensive Outpatient Treatment Programs		
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	You pay $0	Standard Deductible and Coinsurance, plus any balances
Inpatient Care		
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions:** • Medical detoxification days - Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	You pay $0	Standard Deductible and Coinsurance, plus any balances
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	You pay $0	
VI. Prescription Eyewear		
Benefits are limited to a maximum of **$40** per Member, every two calendar years. Please refer to Your Prescription Eyewear Rider for more information.		

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Option 3 Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

HealthTrust

Anthem BlueCross BlueShield

BlueChoice®
Cost Sharing Schedule

This Cost Sharing Schedule is an important part of Your Subscriber Certificate and is an outline of Your coverage. Do not rely on this outline alone. Keep this schedule with Your Certificate because it contains important information about coverage and limitations. Please read Your Subscriber Certificate carefully as important terms and limitations apply.

Cost Sharing Summary	**Option 1** *When Your PCP provides or refers Your care*	**Option 2** *When You seek care directly from a BlueChoice provider*	**Option 3*** *When You seek care from any out-of-network provider*
	YOUR COST		
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$10 per visit	$30 per visit	N/A
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Physician at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$10 per visit	$30 per visit	N/A
Emergency Room Copayment	$50 per visit		
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of an illness or injury.	$50 per visit	$50 per visit	N/A
Standard Deductible	N/A	N/A	$150 per Member, per year $450 per family, per year
Standard Coinsurance	N/A	20%	20%
Coinsurance Maximum	N/A	$600 per Member, per year $1,800 per family, per year	$900 per Member, per year $2,700 per family, per year
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 N/A N/A	 N/A 20%	 N/A 20%
Out-of-Pocket Limit** Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium, penalties, out-of-network expenses, amounts over the Maximum Allowed Amount or charges for noncovered services.	$5,000 per Member, per year $10,000 per family, per year		N/A
Inpatient Precertification Penalty	N/A	N/A	$500

Please note that throughout this schedule any reference to year means calendar year.

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Option 3 Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

**Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Coverage Outline	Option 1 *When Your PCP provides or refers Your care*	Option 2 *When You seek care directly from a BlueChoice provider*	Option 3* *When You seek care from any out-of-network provider*
	YOUR COST		
Medical/Surgical Care			
I. Inpatient Services			
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	You pay $0	Standard Coinsurance	Standard Deductible and Coinsurance, plus any balances
In a Skilled Nursing Facility (Facility charges)			
In a Physical Rehabilitation Facility (Facility charges)			
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests)			
II. Outpatient Services			
Preventive Care			
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older.† -Routine hearing exams - One exam each year.†	You pay $0	You pay $0	Standard Deductible and Coinsurance, plus any balances
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider			
Medical exams, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Injections (including allergy injections)	You pay $0	You pay $0	
Office surgery (including anesthesia)			
Laboratory tests (including allergy testing)			
X-ray tests (including ultrasound)			
MRA, MRI, PET, SPECT, CT Scan, CTA, chemotherapy, medical supplies and drugs		Standard Coinsurance	
Maternity care (prenatal and postpartum visits) Please see your Subscriber Certificate for information about maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is indicated above under "Inpatient Services" or below under "Outpatient Facility Care."		

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Option 3 Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Option 1, 2 or 3 Benefits counts toward this limit.

	Option 1 *When Your PCP provides or refers Your care*	Option 2 *When You seek care directly from a BlueChoice provider*	Option 3* *When You seek care from any out-of-network provider*
	YOUR COST		
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center			
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Services of a surgeon, operating room for surgery and anesthesia	You pay $0	Standard Coinsurance	
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation			
Laboratory and x-ray tests (including ultrasounds)		You pay $0	
Emergency Room Visits and Urgent Care Facility Visits			
Use of the emergency room (The Copayment is waived if You are admitted)	Emergency Room Copayment		
Use of a licensed hospital's urgent care facility	Urgent Care Facility Copayment	Urgent Care Facility Copayment	Standard Deductible and Coinsurance, plus any balances
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You pay $0	You pay $0	
Laboratory and x-ray tests			
Ambulance Services Medically Necessary Emergency Transport	You pay $0		
III. Outpatient Physical Rehabilitation Services			
Physical Therapy and Occupational Therapy and Speech Therapy	You pay $0	Standard Coinsurance	Standard Deductible and Coinsurance, plus any balances
Cardiac Rehabilitation Visits	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	
Chiropractic Care • **Office visit** - unlimited		N/A	
• **X-ray tests** furnished by a chiropractor	You pay $0		
Early Intervention Services	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	
IV. Home Care			
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Home Health Agency services	You pay $0	Standard Coinsurance	
Hospice			
Infusion Therapy			
Durable Medical Equipment, Medical Supplies and Prosthetics			Standard Coinsurance, plus any balances

*Benefits are limited to the Maximum Allowed Amount (MAA). Under Option 3 Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification by Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Option 1, 2 or 3 Benefits counts toward this limit.

Option 2 Benefits are not available for Behavioral Health care.	**Option 1** *When You obtain care from a Network Provider*	**Option 3*** *When You obtain care from any Eligible Mental Health or Substance Abuse Provider*
	YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)		
Outpatient/Office Visits		
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment	Standard Deductible and Coinsurance, plus any balances
Partial Hospitalization and Intensive Outpatient Treatment Programs		
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	You pay $0	Standard Deductible and Coinsurance, plus any balances
Inpatient Care		
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions:** • Medical detoxification days - Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	You pay $0	Standard Deductible and Coinsurance, plus any balances
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	You pay $0	
VI. Prescription Eyewear		
Benefits are limited to a maximum of **$40** per Member, every two calendar years. Please refer to Your Prescription Eyewear Rider for more information.		

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Option 3 Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

Section 6b

Access Blue New England Cost Sharing Schedules

HealthTrust

Anthem BlueCross BlueShield

Access Blue New England SM
Cost Sharing Schedule

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Cost Sharing Summary	YOUR COST
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$5 per visit
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$5 per visit
Emergency Room Copayment	$25 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury.	$25 per visit
Standard Deductible	N/A
Standard Coinsurance	
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 N/A 20%
Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services.	$5,000 per Member, per year $10,000 per family, per year

***Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.**

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	YOUR COST
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	You pay $0
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.	
II. Outpatient Services	
Preventive Care	
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older. -Routine hearing exams - One exam each year.	You pay $0
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider	
Medical exams, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	You pay $0
Office surgery (including anesthesia)	
Laboratory tests (including allergy testing)	
X-ray tests (including ultrasound)	
MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).

	YOUR COST
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center	
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment
Services of a surgeon, operating room for surgery and anesthesia	You pay $0
Physician and professional services for the delivery of a baby or management of therapy. Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation	
Laboratory and x-ray tests (including ultrasounds)	
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room (The Copayment is waived if you are admitted)	Emergency Room Copayment
Use of a licensed hospital's urgent care facility in the Network	Urgent Care Facility Copayment
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You pay $0
Laboratory and x-ray tests	
Ambulance Services Medically Necessary Emergency Transport	
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year	Visit Copayment or Specialty Visit Copayment
Cardiac Rehabilitation Visits	
Chiropractic Care • **Office visits -** up to 12 visits per Member, per year	
• **X-ray tests** furnished by a chiropractor	You pay $0
Early Intervention Services	Visit Copayment or Specialty Visit Copayment
IV. Home Care	
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment
Home Health Agency services	You pay $0
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Coinsurance

	YOUR COST
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	You pay $0
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions**: • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	You pay $0
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	
VI. Prescription Eyewear	
Benefits are limited to a maximum of **$40** per Member, per year. Please refer to your Prescription Eyewear Rider for more information.	

HealthTrust

Anthem BlueCross BlueShield

Access Blue New England SM
Cost Sharing Schedule

This Cost Sharing Schedule is an important part of Your Subscriber Certificate and is an outline of Your coverage. Do not rely on this outline alone. Keep this schedule with Your Certificate because it contains important information about coverage and limitations. Please read Your Subscriber Certificate carefully as important terms and limitations apply.

Cost Sharing Summary	YOUR COST
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$10 per visit
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$10 per visit
Emergency Room Copayment	$50 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury.	$50 per visit
Standard Deductible	N/A
Standard Coinsurance	
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 N/A 20%
Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services.	$5,000 per Member, per year $10,000 per family, per year

*Once the Out-of-Pocket limit is satisfied, You will not have to pay additional Deductibles, Coinsurance or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	YOUR COST
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	You pay $0
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.	
II. Outpatient Services	
Preventive Care	
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older. -Routine hearing exams - One exam each year.	You pay $0
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider	
Medical exams, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	You pay $0
Office surgery (including anesthesia)	
Laboratory tests (including allergy testing)	
X-ray tests (including ultrasound)	
MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).

	YOUR COST
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center	
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment
Services of a surgeon, operating room for surgery and anesthesia	You pay $0
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation	
Laboratory and x-ray tests (including ultrasounds)	
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room (The Copayment is waived if you are admitted)	Emergency Room Copayment
Use of a licensed hospital's urgent care facility in the Network	Urgent Care Facility Copayment
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You pay $0
Laboratory and x-ray tests	
Ambulance Services Medically Necessary Emergency Transport	
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year	Visit Copayment or Specialty Visit Copayment
Cardiac Rehabilitation Visits	
Chiropractic Care • **Office visits -** up to 12 visits per Member, per year	
• **X-ray tests** furnished by a chiropractor	You pay $0
Early Intervention Services	Visit Copayment or Specialty Visit Copayment
IV. Home Care	
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment
Home Health Agency services	You pay $0
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Coinsurance

	YOUR COST
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	You pay $0
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions**: • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	You pay $0
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	
VI. Prescription Eyewear	
Benefits are limited to a maximum of **$40** per Member, per year. Please refer to your Prescription Eyewear Rider for more information.	

HealthTrust

Anthem BlueCross BlueShield

Access Blue New England SM
Cost Sharing Schedule

This Cost Sharing Schedule is an important part of Your Subscriber Certificate and is an outline of Your coverage. Do not rely on this outline alone. Keep this schedule with Your Certificate because it contains important information about coverage and limitations. Please read Your Subscriber Certificate carefully as important terms and limitations apply.

Cost Sharing Summary	YOUR COST
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$20 per visit
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$20 per visit
Emergency Room Copayment	$100 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury.	$50 per visit
Standard Deductible	N/A
Standard Coinsurance	
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 N/A 20%
Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services.	$5,000 per Member, per year $10,000 per family, per year

*Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	YOUR COST
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	You pay $0
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.	
II. Outpatient Services	
Preventive Care	
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older. -Routine hearing exams - One exam each year.	You pay $0
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider	
Medical exams, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	You pay $0
Office surgery (including anesthesia)	
Laboratory tests (including allergy testing)	
X-ray tests (including ultrasound)	
MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).

	YOUR COST
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center	
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment
Services of a surgeon, operating room for surgery and anesthesia	You pay $0
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation	
Laboratory and x-ray tests (including ultrasounds)	
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room (The Copayment is waived if you are admitted)	Emergency Room Copayment
Use of a licensed hospital's urgent care facility in the Network	Urgent Care Facility Copayment
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You pay $0
Laboratory and x-ray tests	
Ambulance Services Medically Necessary Emergency Transport	
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year	Visit Copayment or Specialty Visit Copayment
Cardiac Rehabilitation Visits	
Chiropractic Care • **Office visits -** up to 12 visits per Member, per year	
• **Laboratory and x-ray tests** furnished by a chiropractor	You pay $0
Early Intervention Services	Visit Copayment or Specialty Visit Copayment
IV. Home Care	
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment
Home Health Agency services	You pay $0
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Coinsurance

	YOUR COST
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	You pay $0
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions**: • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	You pay $0
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	
VI. Prescription Eyewear	
Benefits are limited to a maximum of **$40** per Member, per year. Please refer to your Prescription Eyewear Rider for more information.	

HealthTrust

Anthem BlueCross BlueShield

Access Blue New England SM
Cost Sharing Schedule

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Cost Sharing Summary	YOUR COST
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$15 per visit
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$15 per visit
Emergency Room Copayment	$100 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury.	$50 per visit
Standard Deductible	$500 per Member, per year $1,500 per family, per year
Standard Coinsurance	N/A
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 $100 per Member, per year 20%
Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services.	$5,000 per Member, per year $10,000 per family, per year

*Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	YOUR COST
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	Standard Deductible
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.	
II. Outpatient Services	
Preventive Care	
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older. -Routine hearing exams - One exam each year.	You pay $0
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider	
Medical exams, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	You pay $0
Office surgery (including anesthesia)	
Laboratory tests (including allergy testing)	
X-ray tests (including ultrasound)	
MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	Standard Deductible
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).

	YOUR COST
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center	
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment
Services of a surgeon, operating room for surgery and anesthesia	You pay $0
Physician and professional services for delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation	Standard Deductible
Laboratory and x-ray tests (including ultrasounds)	You pay $0
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room (The Copayment is waived if you are admitted)	Emergency Room Copayment
Use of a licensed hospital's urgent care facility in the Network	Urgent Care Facility Copayment
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	Standard Deductible
Laboratory and x-ray tests	You pay $0
Ambulance Services Medically Necessary Emergency Transport	Standard Deductible
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year	Visit Copayment or Specialty Visit Copayment
Cardiac Rehabilitation Visits	
Chiropractic Care • **Office visits -** up to 12 visits per Member, per year	
• **X-ray tests** furnished by a chiropractor	You pay $0
Early Intervention Services	Visit Copayment or Specialty Visit Copayment
IV. Home Care	
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment
Home Health Agency services	Standard Deductible
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance

	YOUR COST
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	Standard Deductible
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions**: • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	Standard Deductible
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	
VI. Prescription Eyewear	
Benefits are limited to a maximum of **$40** per Member, per year. Please refer to your Prescription Eyewear Rider for more information.	

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Access Blue New England SM
Cost Sharing Schedule

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Cost Sharing Summary	YOUR COST
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$20 per visit
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$20 per visit
Emergency Room Copayment	$150 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury.	$75 per visit
Standard Deductible	$250 per Member, per year $750 per family, per year
Standard Coinsurance	N/A
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 $100 per Member, per year 20%
Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services.	$5,000 per Member, per year $10,000 per family, per year

*Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	YOUR COST
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	Standard Deductible
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.	
II. Outpatient Services	
Preventive Care	
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older. -Routine hearing exams - One exam each year.	You pay $0
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider	
Medical exams, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	You pay $0
Office surgery (including anesthesia)	
Laboratory tests (including allergy testing)	
X-ray tests (including ultrasound)	
MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	Standard Deductible
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).

	YOUR COST
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center	
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment
Services of a surgeon, operating room for surgery and anesthesia	You pay $0
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation	Standard Deductible
Laboratory and x-ray tests (including ultrasounds)	You pay $0
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room (The Copayment is waived if you are admitted)	Emergency Room Copayment
Use of a licensed hospital's urgent care facility in the Network	Urgent Care Facility Copayment
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	Standard Deductible
Laboratory and x-ray tests	You pay $0
Ambulance Services Medically Necessary Emergency Transport	Standard Deductible
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year	Visit Copayment or Specialty Visit Copayment
Cardiac Rehabilitation Visits	
Chiropractic Care • **Office visits -** up to 12 visits per Member, per year	
• **X-ray tests** furnished by a chiropractor	You pay $0
Early Intervention Services	Visit Copayment or Specialty Visit Copayment
IV. Home Care	
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Copayment
Home Health Agency services	Standard Deductible
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance

	YOUR COST
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	Standard Deductible
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions**: • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	Standard Deductible
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	
VI. Prescription Eyewear	
Benefits are limited to a maximum of **$40** per Member, per year. Please refer to your Prescription Eyewear Rider for more information.	

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Access Blue New England SM
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Cost Sharing Summary	YOUR COST
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$15 per visit
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$40 per visit
Emergency Room Copayment	$250 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury.	$125 per visit
Standard Deductible	$1,000 per Member, per year $3,000 per family, per year
Standard Coinsurance	N/A
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 $100 per Member, per year 20%
Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services.	$5,000 per Member, per year $10,000 per family, per year

*Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	YOUR COST
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	Standard Deductible
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.	
II. Outpatient Services	
Preventive Care	
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older. -Routine hearing exams - One exam each year.	You pay $0
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider	
Medical exams, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	You pay $0
Office surgery (including anesthesia)	
Laboratory tests (including allergy testing)	
X-ray tests (including ultrasound)	
MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	Standard Deductible
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).

	YOUR COST
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center	
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment
Services of a surgeon, operating room for surgery and anesthesia	Standard Deductible
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation	Standard Deductible
Laboratory and x-ray tests (including ultrasounds)	You pay $0
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room (The Copayment is waived if you are admitted)	Emergency Room Copayment
Use of a licensed hospital's urgent care facility in the Network	Urgent Care Facility Copayment
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	Standard Deductible
Laboratory and x-ray tests	You pay $0
Ambulance Services Medically Necessary Emergency Transport	Standard Deductible
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year	Specialty Visit Copayment
Cardiac Rehabilitation Visits	
Chiropractic Care • **Office visits -** up to 12 visits per Member, per year	
• **X-ray tests** furnished by a chiropractor	You pay $0
Early Intervention Services	Specialty Visit Copayment
IV. Home Care	
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Copayment
Home Health Agency services	Standard Deductible
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance

	YOUR COST
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	Standard Deductible
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions**: • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	Standard Deductible
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	
VI. Prescription Eyewear	
N/A	

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Access Blue New England SM
Site of Service Plan
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Cost Sharing Summary	YOUR COST
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$20 per visit
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$40 per visit
Emergency Room Copayment	$100 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury.	$50 per visit
Standard Deductible	$1,000 per Member, per year $3,000 per family, per year
Standard Coinsurance	N/A
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 $100 per Member, per year 20%
Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services.	$5,000 per Member, per year $10,000 per family, per year

*Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	YOUR COST
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	Standard Deductible
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.	
II. Outpatient Services	
Preventive Care	
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older. -Routine hearing exams - One exam each year.	You pay $0
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider	
Medical exams, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	
Office surgery (including anesthesia)	
Surgery and anesthesia in an independent ambulatory surgical center in the Network	$75 per admission
Laboratory tests (including allergy testing) provided by an Independent Laboratory Provider in the Network	You pay $0
X-ray tests (including ultrasound)	Standard Deductible
MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).

	YOUR COST
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center	
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment
Services of a surgeon, operating room for surgery and anesthesia	Standard Deductible
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation	
Laboratory and x-ray tests (including ultrasounds)	
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room (The Copayment is waived if you are admitted)	Emergency Room Copayment
Use of a licensed hospital's urgent care facility in the Network	Urgent Care Facility Copayment
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	Standard Deductible
Laboratory and x-ray tests	
Ambulance Services Medically Necessary Emergency Transport	
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy Up 20 visits per therapy per Member, per year	Specialty Visit Copayment
Cardiac Rehabilitation Visits	
Chiropractic Care • **Office visits -** up to 12 visits per Member, per year	
• **X-ray tests** furnished by a chiropractor	Standard Deductible
Early Intervention Services	Specialty Visit Copayment
IV. Home Care	
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Copayment
Home Health Agency services	Standard Deductible
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance

	YOUR COST
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	Standard Deductible
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions**: • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	Standard Deductible
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	
VI. Prescription Eyewear	
N/A	

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Access Blue New England SM
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Cost Sharing Summary	YOUR COST
Visit Copayment Applies each time You visit Your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.	$25 per visit
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$50 per visit
Emergency Room Copayment	$150 per visit
Urgent Care Facility Copayment Applies each time You visit a licensed hospital's Network urgent care facility for diagnosis, care and treatment of illness or injury.	$75 per visit
Standard Deductible	$3,000 per Member, per year $9,000 per family, per year
Standard Coinsurance	N/A
Coinsurance Maximum	
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 $100 per Member, per year 20%
Out-of-Pocket Limit* Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium or charges for noncovered services.	$5,000 per Member, per year $10,000 per family, per year

*Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	YOUR COST
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	Standard Deductible
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year	
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.	
II. Outpatient Services	
Preventive Care	
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams - One exam each year for Members 18 years old and younger; one exam every two years for Members 19 years old and older. -Routine hearing exams - One exam each year.	You pay $0
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider	
Medical exams, consultations, medical treatments, and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	
Office surgery (including anesthesia)	
Surgery and anesthesia in an independent ambulatory surgical center in the Network	$75 per admission
Laboratory tests (including allergy testing) provided by an Independent Laboratory Provider in the Network	You pay $0
X-ray tests (including ultrasound)	Standard Deductible
MRA, MRI, PET, SPECT, CT Scan, CTA, Chemotherapy, medical supplies and drugs	
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about maternity care.	You pay no Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).

	YOUR COST
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center	
Medical exams and consultations by a physician	Visit Copayment or Specialty Visit Copayment
Services of a surgeon, operating room for surgery and anesthesia	Standard Deductible
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation	
Laboratory and x-ray tests (including ultrasounds)	
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room (The Copayment is waived if you are admitted)	Emergency Room Copayment
Use of a licensed hospital's urgent care facility in the Network	Urgent Care Facility Copayment
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	Standard Deductible
Laboratory and x-ray tests	
Ambulance Services Medically Necessary Emergency Transport	
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy Up 20 visits per therapy per Member, per year	Specialty Visit Copayment
Cardiac Rehabilitation Visits	
Chiropractic Care • **Office visits -** up to 12 visits per Member, per year	
• **X-ray tests** furnished by a chiropractor	Standard Deductible
Early Intervention Services	Specialty Visit Copayment
IV. Home Care	
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Copayment
Home Health Agency services	Standard Deductible
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	Subject to the DME Deductible and Coinsurance

	YOUR COST
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits	
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Visit Copayment or Specialty Visit Copayment
Partial Hospitalization and Intensive Outpatient Treatment Programs	
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Unlimited Medically Necessary care for rehabilitation and detoxification	Standard Deductible
Inpatient Care	
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions**: • Medical detoxification days – Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	Standard Deductible
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	
VI. Prescription Eyewear	
N/A	

Section 6c

Lumenos Cost Sharing Schedule

HealthTrust

Anthem BlueCross BlueShield

Lumenos Preferred Blue®
Cost Sharing Schedule

This Cost Sharing Schedule is an important part of Your Subscriber Certificate and is an outline of Your coverage. Do not rely on this outline alone. Keep this schedule with Your Certificate because it contains important information about coverage and limitations. Please read Your Subscriber Certificate carefully as important terms and limitations apply.

Cost Sharing Summary	Network Benefits	Out-of-Network Benefits*
	YOUR COST	
Visit Copayment Applies each time You visit a Preferred Provider or Preferred obstetrical/gynecological specialist.	N/A	N/A
Specialty Visit Copayment Applies each time You visit a specialist. This Copayment also applies each time You visit a Preferred Physician at a Preferred Walk-In Center for diagnosis, care and treatment of an illness or injury.	N/A	
Emergency Room Copayment	N/A	
Urgent Care Facility Copayment Applies each time You visit a Preferred licensed hospital's urgent care facility for diagnosis, care and treatment of an illness or injury.	N/A	N/A
Standard Deductible+	$2,500 per Member, per year $5,000 per 2-person or family, per year	
Standard Coinsurance+	N/A	30%
Coinsurance Maximum	N/A	$2,500 per Member, per year $5,000 per 2-person or family, per year
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance**	 Standard Deductible N/A	 Standard Deductible Standard Coinsurance
Out-of-Pocket Limit** Includes all Deductibles, Coinsurance, and Copayments You pay during a year. It does not include Your premium, amounts over the Maximum Allowed Amount or charges for noncovered services.	$2,500 per Member, per year $5,000 per family, per year	$5,000 per Member, per year $10,000 per family, per year
Inpatient Precertification Penalty	N/A	N/A

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

**Once the Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

+If You are enrolled at the 2-person or family level, eligible expenses incurred by You or any of Your enrolled family members count toward satisfying the entire 2-person/family deductible and/or coinsurance.

Please note that throughout this schedule any reference to year means calendar year.

Coverage Outline	Network Benefits	Out-of-Network Benefits*
	YOUR COST	
Medical/Surgical Care		
I. Inpatient Services		
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
In a Skilled Nursing Facility (Facility charges) Up to 100 Inpatient days per Member, per year†		
In a Physical Rehabilitation Facility (Facility charges) Up to 100 Inpatient days per Member, per year†		
Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.		
II. Outpatient Services		
Preventive Care		
Preventive Care and screenings as required by law including, but not limited to: -Immunizations for babies, children and adults (including travel and rabies immunizations) -Cancer screenings such as; Mammograms, pap smears, prostatic specific antigen (PSA) screening, routine colonoscopy and sigmoidoscopy -Routine physical exams for babies, children and adults (including one annual gynecological exam) -Lead screening -Outpatient/office contraceptive services -Nutrition counseling -Routine vision exams -Routine hearing exams	You pay $0	Standard Deductible and Coinsurance, plus any balances
Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider		
Medical exams, consultations, medical treatments, and Preferred Provider services at a Network Walk-In Center	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Injections (including allergy injections)		
Office surgery (including anesthesia)		
Laboratory tests (including allergy testing)		
X-ray tests (including ultrasound)		
MRA,MRI, PET, SPECT, CT Scan, CTA, chemotherapy, medical supplies and drugs		
Maternity care (prenatal and postpartum visits) Please see Your Subscriber Certificate for information about maternity care.	Your share of the cost for delivery of a baby is indicated above under "Inpatient Services" or below under "Outpatient Facility Care."	

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Network Benefits and Out-of-Network Benefits counts toward this limit.

	Network Benefits	Out-of-Network Benefits*
	YOUR COST	
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center		
Medical exams and consultations by a physician	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Services of a surgeon, operating room for surgery and anesthesia		
Physician and professional services for the delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA Fees for use of a facility, medical supplies, drugs, other ancillaries, observation		
Laboratory and x-ray tests (including ultrasounds)		
Emergency Room Visits and Urgent Care Facility Visits		
Use of the emergency room	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Use of a licensed hospital's urgent care facility		
Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs		
Laboratory and x-ray tests		
Ambulance Services Medically Necessary Emergency Transport	Standard Deductible	
III. Outpatient Physical Rehabilitation Services		
Physical Therapy and Occupational Therapy and Speech Therapy Up to a combined maximum of 60 visits per Member, per year†	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Cardiac Rehabilitation Visits		
Chiropractic Care • **Office visit**		
• **X-ray tests** furnished by a chiropractor		
Early Intervention Services		
IV. Home Care		
Physician services Medical exams, injections, medical treatments, surgery and anesthesia	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Home Health Agency services – Up to 100 visits per Member, per year†		
Hospice		
Infusion Therapy		
Durable Medical Equipment, Medical Supplies and Prosthetics		

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

† Any combination of Network Benefits and Out-of-Network Benefits counts toward this limit.

	Network Benefits	Out-of-Network Benefits*
	YOUR COST	
V. Behavioral Health Care (Mental Health and Substance Abuse Care)		
Network Benefits are available when You obtain Covered Services from a Preferred Provider, as approved in advance. **Out-of-Network Benefits** are available when You obtain Covered Services from any Eligible Mental Health or Substance Abuse Provider, as approved in advance.		
Outpatient/Office Visits		
Mental Health Visits: Unlimited Medically Necessary visits **Substance Abuse Visits:** Unlimited Medically Necessary visits (including detoxification and substance abuse rehabilitation services)	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Partial Hospitalization and Intensive Outpatient Treatment Programs		
Mental Disorders: Unlimited Medically Necessary care **Substance Abuse Conditions**: Medically Necessary care for rehabilitation and detoxification	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Inpatient Care		
Mental Disorders: Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions:** • Medical detoxification days - Unlimited Medically Necessary Inpatient days • Substance abuse rehabilitation – Unlimited Medically Necessary Inpatient days	Standard Deductible	Standard Deductible and Coinsurance, plus any balances
Scheduled Ambulance Transport Limited to Medically Necessary transport from one facility to another	Standard Deductible	
VI. Prescription Eyewear		
N/A		
VII. Prescription Drugs		
Subject to any Standard Deductible and/or Standard Coinsurance shown on Page 1 of this Cost Sharing Schedule. Benefits and limitations are stated in Your Pharmacy Rider.		

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAA and charge. Please see Section 2 of Your Subscriber Certificate for details. Self-referred care may require preauthorization/precertification from Anthem. Please refer to Your Subscriber Certificate for details.

Section 6d

Medicomp Three

HealthTrust

MEDICOMP THREE

Medicare Supplemental Plan

MEDICOMP THREE FEATURES

Comprehensive Coverage

An important part of HealthTrust's Medicomp Three plan is its supplemental medical coverage. This portion of the plan pays the deductible and coinsurance required by Medicare Parts A and B—lowering your out-of-pocket costs for some types of care. Medicomp Three also provides Major Medical Benefits that may help pay for additional services that Medicare does not customarily pay.

Coverage No Matter Where You Are

With HealthTrust's Medicomp Three plan, there is no need to worry about traveling in the United States. You can choose to use a provider who accepts Medicare assignment and receive the maximum benefits, but you're covered even if you see a provider who doesn't.

Administered by Anthem Blue Cross and Blue Shield

Your Medicomp Three medical coverage is administered by Anthem Blue Cross and Blue Shield (Anthem), one of the most respected names in the business.

This brochure helps to explain how Medicomp Three coverage works by providing an overview of covered services. While this brochure is intended to describe your benefits as accurately as possible, the specific terms and conditions of eligibility and benefits are set forth in and governed by your Medicomp Three Subscriber Certificate, Prescription Benefit Program *summary (if you have elected prescription drug coverage) and any other separate documents relating to features of the plan.*

In the event of any discrepancy between this brochure and those documents, the terms of the Subscriber Certificate *or* Prescription Benefit Program *summary will govern. This brochure does not constitute a contract, or any offer to form a contract, and is not binding on any party. The benefits describe in this brochure may be changed at any time without prior notice.*

STRENGTHENING YOUR HEALTHCARE PLAN

Affordable, comprehensive healthcare is important to everyone—and it becomes even more important at retirement. That's why HealthTrust offers the Medicomp Three supplemental medical plan.

Medicare Parts A and B provide valuable healthcare coverage to retirees. But this coverage is not complete. To help protect you from additional out-of-pocket costs, Medicomp Three pays the deductible and coinsurance required by Medicare Parts A and B—lowering your out-of-pocket costs for some types of care.

Medicomp Three consists of two parts:

- ***Medicare Complementary Benefits***, which picks up where Medicare leaves off, paying required deductibles and coinsurance for Medicare-approved services, and
- ***Major Medical Benefits***, which may cover services that Medicare does not. Major Medical Benefits are provided in addition to Medicare Complementary Benefits. Major Medical coverage is determined by HealthTrust and Anthem as set forth in the *Medicomp Three Subscriber Certificate*.

This brochure highlights how Medicare Complementary and Major Medical Benefits work with Medicare to provide you with a comprehensive healthcare plan.

Questions about Medicare Coverage? If you have questions about Medicare, call 800.MEDICARE (800.633.4227); TTY, call 877.486.2048. Representatives are available 24 hours a day, seven days a week. Be sure to have your Medicare ID card on hand when you call. You can also learn more by reviewing the current *Medicare & You* booklet, available at your local Medicare office or by visiting the Medicare website at *www.medicare.gov*.

UNDERSTANDING MEDICARE

Before we look at how Medicomp Three works, it's important that you understand the basics of Medicare. Medicare is a national health insurance program for people age 65 and older, as well as for those with qualifying disabilities. It consists of multiple parts:

- ***Part A—Hospital Insurance***. Part A provides limited coverage for inpatient care in hospitals, critical access hospitals and skilled nursing facilities. Part A also covers hospice care and some home healthcare. You do incur out-of-pocket costs, including deductibles and coinsurance.
- ***Part B—Medical Insurance***. Part B provides coverage for doctor visits, laboratory tests, emergency room and urgent care, durable medical equipment, outpatient hospital care, vaccinations (including flu, pneumonia and hepatitis B shots), mammograms, prostate cancer screenings and pap tests. It also covers other services that Part A does not, such as some occupational and physical therapy costs. As with Part A, you are subject to out-of-pocket costs, including deductibles and coinsurance.

To be eligible for Medicomp Three, you must be enrolled in both Medicare Parts A and B. While there is no premium for Medicare Part A, you do need to pay Medicare a monthly premium for Part B coverage. Check your Medicare identification card to see if you have Part A and/or Part B coverage.

Important Note – Medicare's required deductibles and coinsurance amounts may change each calendar year. For the most up-to-date deductible and coinsurance figures, review the current *Medicare & You* booklet available at your local Medicare office or by visiting the Medicare website at *www.medicare.gov,* or call 800.MEDICARE (800.633.4227).

Medicare Part D

Medicare offers prescription drug coverage known as Medicare Part D. This coverage is available to everyone with Medicare by enrolling in a Medicare Part D plan and paying a monthly premium. All Medicare Part D plans provide at least a standard level of prescription drug coverage set by Medicare.

If you are enrolled in a HealthTrust Medicomp Three with Prescription Drug Coverage Plan (MCRX), you do not need to also enroll in a Medicare Part D Plan. This is because the MCRX plan is considered "creditable" coverage which means that the prescription drug coverage is as good as or better than coverage available through a standard Medicare Part D plan. Please see the last page of this brochure for additional information regarding your prescription drug coverage.

HOW MEDICOMP THREE WORKS

Medicomp Three provides certain protections to help you get the highest level of benefits available. For example, your coverage cannot be denied or delayed due to any pre-existing condition. Also if your care is not covered by Medicare in whole or in part, you may submit a Major Medical claim. If your Major Medical claim is denied, you are responsible for paying 100 percent of the cost. For more information, see the *Major Medical Benefits* section on page 6.

Medicomp Three consists of two parts—Medicare Complementary Benefits and Major Medical Benefits. Now, let's look at each part.

Medicare Complementary Benefits

Medicare Parts A and B pay benefits after you have met certain deductibles and/or coinsurance. This means, if your only coverage is through Medicare, you will likely have to pay for some of your care.

However, the Medicomp Three Medicare Complementary Benefits cover 100 percent of Medicare Parts A and B required deductibles and coinsurance amounts. This means your out-of-pocket cost for care is lowered or eliminated.

The following pages look at how Medicare Complementary Benefits supplement your Medicare benefits.

Inpatient Hospital Stays

Medicare Part A provides limited coverage for inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. Part A also covers hospice care and some home healthcare.

Inpatient hospital coverage includes:

- A semiprivate room,
- Meals,
- General nursing care,
- Other hospital services and supplies,
- Care you receive at a critical access hospital, and
- Inpatient behavioral healthcare.

Coverage *does not* include:

- Private duty nursing,
- A television or telephone in your room, or
- A private room, unless medically necessary.

Medicare Part A requires payment of an annual deductible as well as coinsurance for some Part A services. But, Medicomp Three Complementary Benefits cover 100 percent of these costs.

This chart shows how Medicare Part A and Medicomp Three Complementary Benefits cover inpatient hospital care.

	Medicare Part A Pays	Medicomp Three Complementary Benefits Pay	You Pay*
Inpatient Hospital Benefits			
First 60 days	100% after calendar year Medicare Part A deductible	Medicare Part A deductible per calendar year	**$0**
Days 61 through 90	100% after Medicare Part A coinsurance per day	Medicare Part A coinsurance per day	**$0**
Days 91 through 150**	100% after Medicare Part A coinsurance per day	Medicare Part A coinsurance per day	**$0**
After 150 days of continuous confinement	$0	90% of covered services, up to a lifetime maximum of 365 days	10% of covered services, up to a lifetime maximum of 365 days Then 100% of charges. You may submit these charges for consideration for payment under Major Medical
Blood	100% after 3 pints	100% of first 3 pints	**$0**

** Any remaining balance for covered services may be eligible for coverage under Major Medical. For specific information about Major Medical Benefits, refer to Sections 3–5 of the* Medicomp Three Subscriber Certificate.
*** Note that Days 91 through 150 are one-time lifetime reserve days.*

Skilled Nursing Home Benefits

Skilled nursing home coverage includes:

- A semiprivate room,
- Meals,
- Skilled nursing and rehabilitative services, and
- Other services and supplies, generally after a related three-day inpatient hospital stay. Limited to up to 100 days per benefit period.

Please note that custodial care is *not* covered.

Medicare Part A covers 100 percent of Medicare-eligible expenses received in a semiprivate room in a skilled nursing facility during the first 20 days.

But, Part A requires payment of coinsurance from Days 21 through 100. Medicomp Three Complementary Benefits cover 100 percent of this cost.

This chart shows how Medicare Part A and Medicomp Three Complementary Benefits cover skilled nursing home care.

	Medicare Part A Pays	Medicomp Three Complementary Benefits Pay	You Pay*
Skilled Nursing Home Benefits**			
First 20 days	100%	$0	**$0**
Days 21 through 100	100% after calendar year Medicare Part A coinsurance per day	Medicare Part A coinsurance per day	**$0**
After 100 days of continuous confinement	$0	$0	100% of charges. You may submit these charges for consideration for payment under Major Medical

* *Any remaining balance for covered services may be eligible for coverage under Major Medical. For specific information about Major Medical Benefits, refer to Sections 3–5 of the* Medicomp Three Subscriber Certificate.
** *Before you receive skilled nursing home care, you are strongly advised to confirm that the facility qualifies for Medicare benefits.* Skilled nursing home confinement must follow a hospitalization and be medically necessary. Custodial care is not covered.

Medical Service Benefits

Medicare Part B covers Medicare-eligible expenses for services rendered by physicians and other Medicare-approved providers, including independent laboratories, ambulance services and independent physical therapists.

Some outpatient hospital services are also covered under Medicare Part B.

Medicare Part B requires payment of an annual deductible as well as coinsurance for certain services. Medicomp Three Complementary Benefits cover 100 percent of these costs.

This chart shows how Medicare Part B and Medicomp Three Complementary Benefits cover medical service care.

	Medicare Part B Pays	Medicomp Three Complementary Benefits Pay	You Pay*
Medical Service Benefits			
Physician services, hospital outpatient services, prosthetic devices, durable medical equipment, immunosuppressive drugs	80% of Medicare-approved charges after annual Medicare Part B deductible per calendar year	Remaining 20% of Medicare-approved charges and annual Medicare Part B deductible per calendar year	$0 for Medicare-eligible expenses 100% of non- Medicare-eligible expenses. You may submit these charges for consideration for payment under Major Medical
Blood	100% after 3 pints	100% of first 3 pints	**$0**
Non-inpatient psychiatric services (psychiatric maximums and exceptions may apply)**	80% of Medicare eligible expenses after psychiatric reduction, if applicable	Psychiatric reduction and 20% of Medicare-eligible expenses	$0 for Medicare-eligible expenses 100% of non-Medicare-eligible expenses. You may submit these charges for consideration for payment under Major Medical

** Any remaining balance for covered services may be eligible for coverage under Major Medical. For specific information about Major Medical Benefits, refer to Sections 3 through 5 of the* Medicomp Three Subscriber Certificate.
*** For psychiatric maximums and exceptions, refer to the Medicare & You handbook available from your local Medicare office by calling 800.633.4227 or at* www.medicare.gov.

MAJOR MEDICAL BENEFITS

Major Medical Benefits are an important component of your Medicomp Three plan.

Please Note: Major Medical Benefits are in addition to your Medicare Complementary Benefits. Major Medical Benefits do not duplicate coverage that is available under Medicare Part A, Medicare Part B or Medicare Complementary Benefits.

If you receive care or services that Medicare does not cover, or if Medicare covers some but not all of your care, you may submit these charges not covered by Medicare to be considered for coverage under Major Medical.

How Major Medical Benefits Are Paid

HealthTrust's Medicomp Three plan pays 100 percent of the cost of eligible Major Medical covered services; *you pay nothing out-of-pocket*.

Please note that Major Medical covers approved care at 100 percent of the *maximum allowable benefit*. The *maximum allowable benefit* is the amount the plan allows for a particular service in your geographical area. Amounts that exceed the *maximum allowable benefit* are not eligible for payment and are considered out-of-pocket expenses to you.

With Major Medical, covered medical services are reimbursable regardless of your choice of physician or hospital.

Maximum Lifetime Benefit

Major Medical carries a lifetime benefit maximum of $1 million. You are responsible for 100 percent of any costs in excess of this maximum.

Any Major Medical Benefits count toward this maximum, as do any benefits previously paid by Anthem while you were covered by any Anthem and/or HealthTrust-sponsored Anthem plan.

Eligible Services

While there is no guarantee that the services listed below will always be accepted for Major Medical payment, we encourage you to submit claims for:

- Ambulance services,
- Chiropractic care received from a participating provider,
- Diabetes management programs,
- Emergency care, which is defined as care required to prevent serious jeopardy to your health, impairment of bodily functions or dysfunction of a bodily organ or part. This includes heart attacks, broken bones, stroke, uncontrolled bleeding and unconsciousness,
- Hospice care received from a participating provider,
- Immunizations,
- Laboratory and x-ray tests.

For a list of services eligible for submission under Major Medical—as well as a list of limitations and exclusions—see your *Medicomp Three Subscriber Certificate*, available from Anthem by calling 800.225.2666.

Determining Claims

When determining whether your claim qualifies for Major Medical Benefits, Anthem considers the following:

1. Were the services and supplies medically necessary?
2. Were the services and supplies ordered, performed, prescribed, or supervised by a qualifying physician?
3. Are the charges consistent with the maximum allowable benefit determination?
4. If the claim is in connection with a hospital stay, are the charges within the hospital's semiprivate room rate?

Anthem will notify you if your Major Medical claim is approved or denied. *If coverage is denied, you are responsible for paying 100 percent of any remaining balance*.

In addition, benefits are subject to any applicable deductible, coinsurance, benefit period restrictions, and lifetime maximums that may apply.

PRESCRIPTION DRUG BENEFITS

With Medicomp Three with Prescription Drug Coverage Plan, you receive comprehensive prescription drug benefits administered by CVS Caremark – as soon as your coverage becomes effective with HealthTrust. Please refer to your CVS Caremark "Your Personal Prescription Drug Benefit Program" summary for information regarding your prescription drug coverage.

HealthTrust's MCRX coverage is considered "creditable" coverage which means that the prescription drug coverage is as good as or better than coverage available through a standard Medicare Part D plan. Being enrolled in a creditable coverage plan also allows you to avoid late-enrollment fees if you later switch to a Medicare Part D plan. However, you will not be able to enroll in a Medicare Part D plan until your prescription drug coverage with MCRX ends.

If your group offers a HealthTrust Medicomp Three without Prescription Drug Coverage Plan (MCNRX) and you elect the MCNRX coverage, you will need to enroll in a Medicare Part D plan for your prescription drug coverage.

CONTACT INFORMATION

Organization	Services
HealthTrust **800.527.5001** ***www.healthtrustnh.org***	Provides answers to questions about your enrollment plan materials and the *Slice of Life* health management programs
Medicare **800.MEDICARE (800.633.4227)** ***www.medicare.gov***	Provides answers to questions about Part A, Part B, and Part D coverage, and other Medicare programs
Anthem Blue Cross and Blue Shield **800.225.2666** ***www.anthem.com***	Provides answers about your benefits, covered services, plan materials, *Subscriber Certificate* and participating providers
LifeResources—Employee Assistance Program* **800.759.8122** ****Link to their organization is available at www.healthtrustnh.org.***	Provides counseling and resources for a variety of member needs
CVS Caremark **888.726.1631** ***www.caremark.com***	Provides answers about your prescription drug program benefits and services

HealthTrust

PO Box 617 • Concord, NH 03302-0617

Tel: 603.226.2861 • 800.527.5001 (NH Toll Free) • Fax: 603.415.3099

Website: *www.healthtrustnh.org*

Section 6e

Prescription Benefit Summaries

HealthTrust

Your Personal Prescription Benefit Program

CVS/caremark™

	RETAIL PHARMACY	MAIL SERVICE PHARMACY
	For immediate or short-term medication needs*	For maintenance or long-term medication needs*
YOU WILL PAY	• **$3** for each generic medication • **$15** for each preferred/non-preferred brand-name medication**	• **$1** for each generic medication • **$1** for each preferred/non-preferred brand-name medication**
	• **$0** for contraceptives, contraception devices, emergency contraception and certain preventative medications. (Brand-name medications with direct generic equivalents will require an applicable copayment.)	
MAXIMUM OUT-OF-POCKET	**$1,600** per individual / **$3,200** per family***	
DAY SUPPLY LIMIT	Up to a **34**-day supply	Up to a **90**-day supply
REFILL LIMIT	One initial fill plus two refills for maintenance or long-term medications. For each additional fill you will pay 100% of the prescription cost.	None
PRIOR AUTHORIZATION REQUIRED	Botox and Myobloc for non-cosmetic purposes only; Wellbutrin and its generics **(all forms of Wellbutrin and its generics are not covered for use as a smoking deterrent);** Specialty Medications; Compound Medications	
TOBACCO CESSATION	Your plan covers prescription medication and some over-the-counter products designed to eliminate tobacco use. Coverage is available through your retail and mail service benefit subject to the cost sharing components and dispensing limitations of your plan. To be eligible for the coverage you must be age 18 or older. Contact Customer Care or log on to www.caremark.com to find out more about which prescription medications and over-the-counter products are covered under your plan.	

*Your plan may have coverage limits, be subject to dispensing limitations and may not cover certain medications. Please contact CVS/caremark at 1-888-726-1631 or log on to www.caremark.com for the most up-to-date plan information.

**When a generic equivalent is available but the pharmacy dispenses the brand-name medication for any reason other than a doctor's "dispense as written" or equivalent instructions, you will pay the generic copayment plus the difference in cost between the brand-name and the generic.

***Maximum Out-of-Pocket applies per plan year (January Plans: 1/1 through 12/31; July Plans: 7/1 through 6/30)

Where to Fill Your Prescriptions

Choosing where to fill your prescription depends on whether you are ordering a short-term or long-term medication:

Short-term medications are generally taken for a limited amount of time and have a limited amount of refills, such as an antibiotic. You can fill prescriptions for these medications at any pharmacy in the CVS/caremark retail network.

- Choose from more than 64,000 network pharmacies nationwide, including over 20,000 independent community pharmacies
- Find a participating pharmacy at www.caremark.com

Tip: To avoid filling out claims paperwork, bring your Prescription Card with you when you pick up your prescription and use a pharmacy in the CVS/caremark retail network. Additional Prescription Cards may be obtained by calling Customer Care toll-free at 1-888-726-1631.

Long-term medications are taken regularly for chronic conditions such as high blood pressure, asthma, diabetes or high cholesterol. You will generally save money by using mail service for these prescriptions. Choose **one** of four easy ways to start using the CVS Caremark Mail Service Pharmacy:

1. Fill out and send in a mail service order from - use the one included with your welcome kit or print one at www.caremark.com
2. Use the FastStart® tool found on www.caremark.com
3. Call FastStart® toll-free at 1-800-875-0867
4. Ask your doctor to call in the prescription through the toll-free FastStart® physician number at 1-800-378-5697

Customer Care

If you have questions about your prescriptions or benefits, you can contact Customer Care 24 hours a day, seven days a week, toll-free at **1-888-726-1631** or by e-mail at **customerservice@caremark.com**. For Telecommunication Device assistance, please call toll-free **1-800-863-5488**. **Caremark.com** is also available to help you manage your prescription drug benefits. By registering online, you can order mail service refills, check order status, price medications, and much more.

Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-726-1631.
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

To contact HealthTrust, please call toll-free at **1-800-527-5001** between the hours of 8:30 a.m. and 4:30 p.m. (EST) Monday through Friday or visit **www.healthtrustnh.org**. HealthTrust Enrollee Services Representatives are available for issues or concerns with enrollment or eligibility, and any other prescription benefit-related inquiry.
For further information or questions, you may also e-mail Enrollee Services at **enrolleeservices@healthtrustnh.org**.

1469-2PPDF-0115
R$3/15M$1

Getting Your Prescription Filled at a Retail Pharmacy

CVS/caremark Participating Retail Pharmacies
Participating retail pharmacies can easily access information about your prescription benefit plan and the appropriate payment. You will not need to file any additional paperwork when you use a pharmacy in the CVS/caremark retail network. If you use a pharmacy outside the CVS/caremark retail network, you will pay more for your prescription(s) in most cases. Non-participating retail pharmacies will ask you to pay 100 percent of the prescription price. Then, you will need to submit a paper claim form along with the original prescription receipt(s) for reimbursement of covered expenses.

Day Supply Limit
You can get up to a 34-day supply of medication each time you have a prescription filled at a participating retail pharmacy. Ask your doctor to write a prescription for up to a 34-day supply, when clinically appropriate.

Refill Limit
You may obtain one initial fill plus two refills for maintenance or long-term medications at a retail pharmacy. It will then be necessary for you to utilize CVS Caremark Mail Service Pharmacy for additional supplies. Otherwise, you will be responsible for 100 percent of the cost of the medication when filled at a retail pharmacy. To determine if your prescription medication is classified as maintenance or long-term, please call Customer Care toll-free at 1-888-726-1631.

Getting Your Prescription Filled Through the CVS Caremark Mail Service Pharmacy

CVS/caremark operates two mail service pharmacies across the United States to provide quick service to plan participants wherever they live. To ensure your safety, our mail service pharmacies are staffed by registered pharmacists. Just like your neighborhood pharmacist, our pharmacists check each prescription to make sure it is filled correctly. In addition, your prescription history is reviewed to identify any possible problems with new medications you may be prescribed.

Day Supply Limit
You can get up to a 90-day supply of medication when you get a prescription filled through the CVS Caremark Mail Service Pharmacy. Ask your doctor to write a prescription for up to a 90-day supply plus three refills for up to one year when clinically appropriate. **Please Note:** *By law, CVS/caremark must fill your prescription for the exact quantity of medication prescribed by your doctor, up to the 90-day supply limit.*

Payment Options
While checks and money orders are accepted, the preferred method of payment is by credit card. For credit card payments, simply include your VISA®, Discover®, MasterCard® or American Express® number and expiration date in the space provided on the mail service order form.

Convenient Home Delivery
Please allow 10-14 days for delivery from the time your order is placed. Refills are delivered within seven days following CVS/caremark's receipt of your refill request by phone or online. Your package will include a new mail service order form and an invoice, if applicable. You will also receive the same type of information about your prescribed medication that you would receive from a retail pharmacy.

Other Important Plan Information

Drug List
Your plan is subject to a list of prescription drugs that are preferred by the plan because of their safety, clinical effectiveness and ability to help control prescription drug costs. The drug list is updated on a regular basis. Log on to www.caremark.com or call Customer Care toll-free at 1-888-726-1631 to access the most current drug list for your plan.

Prior Authorization
Some medications may require approval before the prescription can be filled. Your retail pharmacist will give you or your doctor a toll-free number to call in order to obtain approval. The CVS Caremark Mail Service Pharmacy will contact your doctor directly for approval.

Specialty Medications
Specialty medications are used for the treatment of chronic and/or genetic conditions, such as multiple sclerosis, rheumatoid arthritis or hepatitis C, and are often injected or infused. All specialty medications will be provided by CVS Caremark's Specialty Pharmacy and require Prior Authorization before the prescription can be filled. CVS Caremark's Specialty Pharmacy is a mail order facility dedicated to dispensing specialty medications. Questions? Call CVS Caremark Specialty Pharmacy toll-free at 1-800-237-2767.

HealthTrust

Your Personal Prescription Benefit Program

CVS/caremark™

	RETAIL PHARMACY	MAIL SERVICE PHARMACY
	For immediate or short-term medication needs*	For maintenance or long-term medication needs*
YOU WILL PAY	• **$100** calendar year deductible, then 20% for each generic or preferred/non-preferred brand-name medication**	• **$1** for each generic medication • **$1** for each preferred/non-preferred brand-name medication**
	• **$0** for contraceptives, contraception devices, emergency contraception and certain preventative medications. (Brand-name medications with direct generic equivalents will require an applicable copayment.)	
MAXIMUM OUT-OF-POCKET	**$500** per individual per calendar year	None
DAY SUPPLY LIMIT	Up to a **34**-day supply	Up to a **90**-day supply
REFILL LIMIT	One initial fill plus two refills for maintenance or long-term medications. For each additional fill you will pay 100% of the prescription cost.	None
PRIOR AUTHORIZATION REQUIRED	Botox and Myobloc for non-cosmetic purposes only; Wellbutrin and its generics **(all forms of Wellbutrin and its generics are not covered for use as a smoking deterrent);** Specialty Medications; Compound Medications	
TOBACCO CESSATION	Your plan covers prescription medication and some over-the-counter products designed to eliminate tobacco use. Coverage is available through your retail and mail service benefit subject to the cost sharing components and dispensing limitations of your plan. To be eligible for the coverage you must be age 18 or older. Contact Customer Care or log on to www.caremark.com to find out more about which prescription medications and over-the-counter products are covered under your plan.	

*Your plan may have coverage limits, be subject to dispensing limitations and may not cover certain medications. Please contact CVS/caremark at 1-888-726-1631 or log on to www.caremark.com for the most up-to-date plan information.

**When a generic equivalent is available but the pharmacy dispenses the brand-name medication for any reason other than a doctor's "dispense as written" or equivalent instructions, you will pay the generic copayment plus the difference in cost between the brand-name and the generic.

Where to Fill Your Prescriptions

Choosing where to fill your prescription depends on whether you are ordering a short-term or long-term medication:

Short-term medications are generally taken for a limited amount of time and have a limited amount of refills, such as an antibiotic. You can fill prescriptions for these medications at any pharmacy in the CVS/caremark retail network.

- Choose from more than 64,000 network pharmacies nationwide, including over 20,000 independent community pharmacies
- Find a participating pharmacy at www.caremark.com

Tip: To avoid filling out claims paperwork, bring your Prescription Card with you when you pick up your prescription and use a pharmacy in the CVS/caremark retail network. Additional Prescription Cards may be obtained by calling Customer Care toll-free at 1-888-726-1631.

Long-term medications are taken regularly for chronic conditions such as high blood pressure, asthma, diabetes or high cholesterol. You will generally save money by using mail service for these prescriptions. Choose **one** of four easy ways to start using the CVS Caremark Mail Service Pharmacy:

1. Fill out and send in a mail service order from - use the one included with your welcome kit or print one at www.caremark.com
2. Use the FastStart® tool found on www.caremark.com
3. Call FastStart® toll-free at 1-800-875-0867
4. Ask your doctor to call in the prescription through the toll-free FastStart® physician number at 1-800-378-5697

Customer Care

If you have questions about your prescriptions or benefits, you can contact Customer Care 24 hours a day, seven days a week, toll-free at **1-888-726-1631** or by e-mail at **customerservice@caremark.com**. For Telecommunication Device assistance, please call toll-free **1-800-863-5488**. **Caremark.com** is also available to help you manage your prescription drug benefits. By registering online, you can order mail service refills, check order status, price medications, and much more.

Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-726-1631.
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

To contact HealthTrust, please call toll-free at **1-800-527-5001** between the hours of 8:30 a.m. and 4:30 p.m. (EST) Monday through Friday or visit **www.healthtrustnh.org**. HealthTrust Enrollee Services Representatives are available for issues or concerns with enrollment or eligibility, and any other prescription benefit-related inquiry.
For further information or questions, you may also e-mail Enrollee Services at **enrolleeservices@healthtrustnh.org**.

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Payment Options
While checks and money orders are accepted, the preferred method of payment is by credit card. For credit card payments, simply include your VISA®, Discover®, MasterCard® or American Express® number and expiration date in the space provided on the mail service order form.

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HealthTrust

Your Personal Prescription Benefit Program

CVS/caremark™

	RETAIL PHARMACY	MAIL SERVICE PHARMACY
	For immediate or short-term medication needs*	For maintenance or long-term medication needs*
YOU WILL PAY	• **$10** for each generic medication • **$20** for each preferred brand-name medication** • **$30** for each non-preferred brand-name medication**	• **$10** for each generic medication • **$20** for each preferred brand-name medication** • **$30** for each non-preferred brand-name medication**
	• **$0** for contraceptives, contraception devices, emergency contraception and certain preventative medications. (Brand-name medications with direct generic equivalents will require an applicable copayment.)	
MAXIMUM OUT-OF-POCKET	**$1,600** per individual / **$3,200** per family***	
DAY SUPPLY LIMIT	Up to a **34**-day supply	Up to a **90**-day supply
REFILL LIMIT	One initial fill plus two refills for maintenance or long-term medications. For each additional fill you will pay 100% of the prescription cost.	None
PRIOR AUTHORIZATION REQUIRED	Botox and Myobloc for non-cosmetic purposes only; Wellbutrin and its generics **(all forms of Wellbutrin and its generics are not covered for use as a smoking deterrent);** Specialty Medications; Compound Medications	
TOBACCO CESSATION	Your plan covers prescription medication and some over-the-counter products designed to eliminate tobacco use. Coverage is available through your retail and mail service benefit subject to the cost sharing components and dispensing limitations of your plan. To be eligible for the coverage you must be age 18 or older. Contact Customer Care or log on to www.caremark.com to find out more about which prescription medications and over-the-counter products are covered under your plan.	

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***Maximum Out-of-Pocket applies per plan year (January Plans: 1/1 through 12/31; July Plans: 7/1 through 6/30)

Where to Fill Your Prescriptions

Choosing where to fill your prescription depends on whether you are ordering a short-term or long-term medication:

Short-term medications are generally taken for a limited amount of time and have a limited amount of refills, such as an antibiotic. You can fill prescriptions for these medications at any pharmacy in the CVS/caremark retail network.

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2. Use the FastStart® tool found on www.caremark.com
3. Call FastStart® toll-free at 1-800-875-0867
4. Ask your doctor to call in the prescription through the toll-free FastStart® physician number at 1-800-378-5697

Customer Care

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HealthTrust

Your Personal Prescription Benefit Program

CVS/caremark

	RETAIL PHARMACY	MAIL SERVICE PHARMACY
	For immediate or short-term medication needs*	For maintenance or long-term medication needs*
YOU WILL PAY	• **$10** for each generic medication • **$20** for each preferred brand-name medication** • **$45** for each non-preferred brand-name medication**	• **$10** for each generic medication • **$20** for each preferred brand-name medication** • **$45** for each non-preferred brand-name medication**
	• **$0** for contraceptives, contraception devices, emergency contraception and certain preventative medications. (Brand-name medications with direct generic equivalents will require an applicable copayment.)	
MAXIMUM OUT-OF-POCKET	**$1,600** per individual / **$3,200** per family***	
DAY SUPPLY LIMIT	Up to a **34**-day supply	Up to a **90**-day supply
REFILL LIMIT	One initial fill plus two refills for maintenance or long-term medications. For each additional fill you will pay 100% of the prescription cost.	None
PRIOR AUTHORIZATION REQUIRED	Botox and Myobloc for non-cosmetic purposes only; Wellbutrin and its generics **(all forms of Wellbutrin and its generics are not covered for use as a smoking deterrent);** Specialty Medications; Compound Medications	
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***Maximum Out-of-Pocket applies per plan year (January Plans: 1/1 through 12/31; July Plans: 7/1 through 6/30)

Where to Fill Your Prescriptions

Choosing where to fill your prescription depends on whether you are ordering a short-term or long-term medication:

Short-term medications are generally taken for a limited amount of time and have a limited amount of refills, such as an antibiotic. You can fill prescriptions for these medications at any pharmacy in the CVS/caremark retail network.

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YOU WILL PAY	• **$10** for each generic medication • **$25** for each preferred brand-name medication** • **$40** for each non-preferred brand-name medication**	• **$10** for each generic medication • **$40** for each preferred brand-name medication** • **$70** for each non-preferred brand-name medication**
	• **$0** for contraceptives, contraception devices, emergency contraception and certain preventative medications. (Brand-name medications with direct generic equivalents will require an applicable copayment.)	
MAXIMUM OUT-OF-POCKET	**$1,600** per individual / **$3,200** per family***	
DAY SUPPLY LIMIT	Up to a **34**-day supply	Up to a **90**-day supply
REFILL LIMIT	One initial fill plus two refills for maintenance or long-term medications. For each additional fill you will pay 100% of the prescription cost.	None
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- Choose from more than 64,000 network pharmacies nationwide, including over 20,000 independent community pharmacies
- Find a participating pharmacy at www.caremark.com

Tip: To avoid filling out claims paperwork, bring your Prescription Card with you when you pick up your prescription and use a pharmacy in the CVS/caremark retail network. Additional Prescription Cards may be obtained by calling Customer Care toll-free at 1-888-726-1631.

Long-term medications are taken regularly for chronic conditions such as high blood pressure, asthma, diabetes or high cholesterol. You will generally save money by using mail service for these prescriptions. Choose **one** of four easy ways to start using the CVS Caremark Mail Service Pharmacy:

1. Fill out and send in a mail service order from - use the one included with your welcome kit or print one at www.caremark.com
2. Use the FastStart® tool found on www.caremark.com
3. Call FastStart® toll-free at 1-800-875-0867
4. Ask your doctor to call in the prescription through the toll-free FastStart® physician number at 1-800-378-5697

Customer Care

If you have questions about your prescriptions or benefits, you can contact Customer Care 24 hours a day, seven days a week, toll-free at **1-888-726-1631** or by e-mail at **customerservice@caremark.com**. For Telecommunication Device assistance, please call toll-free **1-800-863-5488**. **Caremark.com** is also available to help you manage your prescription drug benefits. By registering online, you can order mail service refills, check order status, price medications, and much more.

Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-726-1631.
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

To contact HealthTrust, please call toll-free at **1-800-527-5001** between the hours of 8:30 a.m. and 4:30 p.m. (EST) Monday through Friday or visit **www.healthtrustnh.org**. HealthTrust Enrollee Services Representatives are available for issues or concerns with enrollment or eligibility, and any other prescription benefit-related inquiry.
For further information or questions, you may also e-mail Enrollee Services at **enrolleeservices@healthtrustnh.org**.

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Getting Your Prescription Filled at a Retail Pharmacy

CVS/caremark Participating Retail Pharmacies
Participating retail pharmacies can easily access information about your prescription benefit plan and the appropriate payment. You will not need to file any additional paperwork when you use a pharmacy in the CVS/caremark retail network. If you use a pharmacy outside the CVS/caremark retail network, you will pay more for your prescription(s) in most cases. Non-participating retail pharmacies will ask you to pay 100 percent of the prescription price. Then, you will need to submit a paper claim form along with the original prescription receipt(s) for reimbursement of covered expenses.

Day Supply Limit
You can get up to a 34-day supply of medication each time you have a prescription filled at a participating retail pharmacy. Ask your doctor to write a prescription for up to a 34-day supply, when clinically appropriate.

Refill Limit
You may obtain one initial fill plus two refills for maintenance or long-term medications at a retail pharmacy. It will then be necessary for you to utilize CVS Caremark Mail Service Pharmacy for additional supplies. Otherwise, you will be responsible for 100 percent of the cost of the medication when filled at a retail pharmacy. To determine if your prescription medication is classified as maintenance or long-term, please call Customer Care toll-free at 1-888-726-1631.

Getting Your Prescription Filled Through the CVS Caremark Mail Service Pharmacy

CVS/caremark operates two mail service pharmacies across the United States to provide quick service to plan participants wherever they live. To ensure your safety, our mail service pharmacies are staffed by registered pharmacists. Just like your neighborhood pharmacist, our pharmacists check each prescription to make sure it is filled correctly. In addition, your prescription history is reviewed to identify any possible problems with new medications you may be prescribed.

Day Supply Limit
You can get up to a 90-day supply of medication when you get a prescription filled through the CVS Caremark Mail Service Pharmacy. Ask your doctor to write a prescription for up to a 90-day supply plus three refills for up to one year when clinically appropriate. **Please Note:** *By law, CVS/caremark must fill your prescription for the exact quantity of medication prescribed by your doctor, up to the 90-day supply limit.*

Payment Options
While checks and money orders are accepted, the preferred method of payment is by credit card. For credit card payments, simply include your VISA®, Discover®, MasterCard® or American Express® number and expiration date in the space provided on the mail service order form.

Convenient Home Delivery
Please allow 10-14 days for delivery from the time your order is placed. Refills are delivered within seven days following CVS/caremark's receipt of your refill request by phone or online. Your package will include a new mail service order form and an invoice, if applicable. You will also receive the same type of information about your prescribed medication that you would receive from a retail pharmacy.

Other Important Plan Information

Drug List
Your plan is subject to a list of prescription drugs that are preferred by the plan because of their safety, clinical effectiveness and ability to help control prescription drug costs. The drug list is updated on a regular basis. Log on to www.caremark.com or call Customer Care toll-free at 1-888-726-1631 to access the most current drug list for your plan.

Prior Authorization
Some medications may require approval before the prescription can be filled. Your retail pharmacist will give you or your doctor a toll-free number to call in order to obtain approval. The CVS Caremark Mail Service Pharmacy will contact your doctor directly for approval.

Specialty Medications
Specialty medications are used for the treatment of chronic and/or genetic conditions, such as multiple sclerosis, rheumatoid arthritis or hepatitis C, and are often injected or infused. All specialty medications will be provided by CVS Caremark's Specialty Pharmacy and require Prior Authorization before the prescription can be filled. CVS Caremark's Specialty Pharmacy is a mail order facility dedicated to dispensing specialty medications. Questions? Call CVS Caremark Specialty Pharmacy toll-free at 1-800-237-2767.

Section 6f

Dental Outline of Benefits

HealthTrust

DELTA DENTAL

Outline of Benefits

This Outline of Benefits describes the level of coverage under your employer's HealthTrust Dental Plan for services performed by dentists who participate in the Delta Dental PPO and Delta Dental Premier networks. Employees and their eligible dependents are free to visit *any* dentist, participating or nonparticipating. Visit Northeast Delta Dental's Web site at *www.nedelta.com* for an updated list of participating dentists.

Your employer's HealthTrust Dental Plan includes the following coverage categories. This information is provided for summary purposes only; certain benefit limitations and exclusions may apply. For further details, please refer to your Dental Plan Description available at *www.healthtrustnh.org*.

Dental Plan Option 2A

Coverage A Diagnostic/Preventive	Coverage B Basic	Coverage C Major
Deductible: $0 There is no deductible on this plan		
Covered at 100%*	**Covered at 80%***	**Covered at 50%***
Diagnostic: Evaluations - twice in a calendar year: this includes periodic, limited, problem-focused, and comprehensive evaluations X-rays - complete series or panoramic film - once in a 5-year period; Bitewing x-rays - once in a calendar year; X-rays of individual teeth - as necessary Brush biopsy - once in a calendar year, no age limit **Preventive:** Cleanings - four per calendar year Fluoride - twice in a calendar year through age 18 Space maintainers - through age 15 Sealant application to permanent molars - once in a 3-year period per tooth, for children through age 18	**Restorative:** Amalgam (silver) fillings and/or Composite (white) fillings (anterior and posterior teeth) **Oral Surgery:** Surgical and routine extractions **Endodontics:** Root canal therapy **Periodontics:** Periodontal cleaning - four cleanings per calendar year; these may be routine (Coverage A) or periodontal (Coverage B) Treatment of gum disease Clinical crown lengthening - once in a lifetime per site **Denture Repair:** Repair of a removable denture to its original condition **Emergency Palliative Treatment**	**Prosthodontics:** Removable and fixed partial dentures (bridge); complete dentures Rebase and reline (dentures) Crowns Onlays Implants

Plan Year Maximum: $750 per person (Coverages A, B and C combined) beginning each January 1st

***Benefit percentages shown are based upon the lesser of the actual submitted charge or Delta Dental's allowance under the Plan.**

Rev. 01/16

Delta Dental PPO and Premier Networks

You'll get the best value from your Plan when you receive your dental care from one of Delta Dental's PPO or Premier network participating dentists, including:

▲ **No Balance Billing:** Participating dentists agree not to charge any difference between their fees and Delta Dental's allowed fees. Because participating dentists accept Delta Dental's allowed fees for services, you will typically pay less when you visit a participating dentist.

▲ **No Claims Paperwork:** Participating dentists will prepare and submit claim forms for you.

▲ **Direct Payment:** Northeast Delta Dental pays participating dentists directly, so you don't have to pay the covered amount up front and wait for a reimbursement check.

To find out if your dentist participates, you can: call your dentist, visit Northeast Delta Dental's website at ***www.nedelta.com*** or call Northeast Delta Dental's Customer Service at 800.832.5700.

Claim Process for Participating Dentists

Your participating dentist will submit your claim to Northeast Delta Dental (claims for any of your covered dependents should be submitted under *your* Subscriber ID number). Northeast Delta Dental will produce an Explanation of Benefits (available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***) detailing what has been processed under your Plan's coverage. You are responsible to pay any outstanding balance directly to the dentist.

Claim Process for Nonparticipating Dentists

Your Plan provides coverage regardless of your choice of dentist, participating or not. If you visit a nonparticipating dentist, you may be required to submit your own claim and pay for services at the time they are provided. Claim forms are available by calling Northeast Delta Dental or visiting ***www.nedelta.com***. Payment will be made to you, the Subscriber, unless the state in which the services are rendered requires that assignment of benefits (directing that payment be sent to the dentist) be honored and Northeast Delta Dental receives written notice of such assignment. Payment for treatment performed by a nonparticipating dentist will be limited to the lesser of the dentist's actual submitted charge or Delta Dental's allowance for nonparticipating dentists in the geographic area in which services are provided. It is your responsibility to ensure that full payment is made to the dentist. Northeast Delta Dental will produce an Explanation of Benefits (available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***) detailing what has been processed under your Plan's coverage.

Predetermination of Benefits

HealthTrust and Northeast Delta Dental strongly encourage predetermination of cases involving costly or extensive treatment plans. Although it's not required, predetermination helps avoid any potential confusion regarding your Plan's payment and your financial obligation to the dentist.

Coordination of Benefits

When an individual covered under this Plan has additional dental coverage, the Coordination of Benefits provision described in your Dental Plan Description will determine the sequence and extent of payment. If you have any questions, please contact Northeast Delta Dental's Customer Service at 800.832.5700 or 603.223.1234.

Identification Card

Upon your initial enrollment in a HealthTrust Dental Plan, two identification cards from Northeast Delta Dental will be produced and distributed. Both cards are issued in the subscriber's name, but can be used by everyone covered under the Plan. Any additional or replacement cards will be available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***.

Dental Plan Description

The Dental Plan Description describes the benefits of your Plan and tells you how to use your Plan. You can access your Dental Plan Description by going to ***www.healthtrustnh.org***. Please review this document in order to understand the benefits and provisions of your employer's HealthTrust Dental Plan.

Who is Eligible

All eligible employees and their eligible dependents, generally defined as:

- Spouse;
- Dependent children from age 2 to age 26;
- Unmarried, incapacitated dependent children age 26 or older.

Please refer to the Dental Plan Description for additional information regarding dependent eligibility.

Eligibility or Benefits Questions

If you have questions regarding eligibility or benefits, please contact your employer or HealthTrust's Enrollee Services at 800.527.5001.

Claims Questions

If you have further questions, please contact Northeast Delta Dental's Customer Service at 800.832.5700 or 603.223.1234.

Further Information

This Outline of Benefits should be used only as a guideline for your dental plan coverage. For detailed information on your Plan's terms, conditions, limitations and exclusions, please refer to your Dental Plan Description or consult your employer. In the event of a conflict or discrepancy between this Outline of Benefits and either the Dental Plan Description or Plan Document, the Dental Plan Description or the Plan Document will control.

To obtain a hard copy of the Dental Plan Description or Plan Document, contact your employer or HealthTrust's Enrollee Services at 800.527.5001.

HealthTrust

DELTA DENTAL

Outline of Benefits

This Outline of Benefits describes the level of coverage under your employer's HealthTrust Dental Plan for services performed by dentists who participate in the Delta Dental PPO and Delta Dental Premier networks. Employees and their eligible dependents are free to visit *any* dentist, participating or nonparticipating. Visit Northeast Delta Dental's Web site at *www.nedelta.com* for an updated list of participating dentists.

Your employer's HealthTrust Dental Plan includes the following coverage categories. This information is provided for summary purposes only; certain benefit limitations and exclusions may apply. For further details, please refer to your Dental Plan Description available at *www.healthtrustnh.org*.

Dental Plan Option 3

Coverage A Diagnostic/Preventive	Coverage B Basic	Coverage C Major
Deductible: None	**Deductible**: $25 Per Person, Per Year ($75 Per Family)	
Covered at 100%*	**Covered at 80%***	**Covered at 50%***
Diagnostic: Evaluations - twice in a calendar year: this includes periodic, limited, problem-focused, and comprehensive evaluations X-rays - complete series or panoramic film - once in a 5-year period; Bitewing x-rays - once in a calendar year; X-rays of individual teeth - as necessary Brush biopsy - once in a calendar year, no age limit **Preventive:** Cleanings - four per calendar year Fluoride - twice in a calendar year through age 18 Space maintainers - through age 15 Sealant application to permanent molars - once in a 3-year period per tooth, for children through age 18	**Restorative:** Amalgam (silver) fillings and/or Composite (white) fillings (anterior and posterior teeth) **Oral Surgery:** Surgical and routine extractions **Endodontics:** Root canal therapy **Periodontics:** Periodontal cleaning - four cleanings per calendar year; these may be routine (Coverage A) or periodontal (Coverage B) Treatment of gum disease Clinical crown lengthening - once in a lifetime per site **Denture Repair:** Repair of a removable denture to its original condition **Emergency Palliative Treatment**	**Prosthodontics:** Removable and fixed partial dentures (bridge); complete dentures Rebase and reline (dentures) Crowns Onlays Implants

Plan Year Maximum: $1,000 per person (Coverages A, B and C combined) beginning each January 1st

***Benefit percentages shown are based upon the lesser of the actual submitted charge or Delta Dental's allowance under the Plan.**

Rev. 01/16

Delta Dental PPO and Premier Networks

You'll get the best value from your Plan when you receive your dental care from one of Delta Dental's PPO or Premier network participating dentists, including:

▲ **No Balance Billing:** Participating dentists agree not to charge any difference between their fees and Delta Dental's allowed fees. Because participating dentists accept Delta Dental's allowed fees for services, you will typically pay less when you visit a participating dentist.

▲ **No Claims Paperwork:** Participating dentists will prepare and submit claim forms for you.

▲ **Direct Payment:** Northeast Delta Dental pays participating dentists directly, so you don't have to pay the covered amount up front and wait for a reimbursement check.

To find out if your dentist participates, you can: call your dentist, visit Northeast Delta Dental's website at ***www.nedelta.com*** or call Northeast Delta Dental's Customer Service at 800.832.5700.

Claim Process for Participating Dentists

Your participating dentist will submit your claim to Northeast Delta Dental (claims for any of your covered dependents should be submitted under *your* Subscriber ID number). Northeast Delta Dental will produce an Explanation of Benefits (available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***) detailing what has been processed under your Plan's coverage. You are responsible to pay any outstanding balance directly to the dentist.

Claim Process for Nonparticipating Dentists

Your Plan provides coverage regardless of your choice of dentist, participating or not. If you visit a nonparticipating dentist, you may be required to submit your own claim and pay for services at the time they are provided. Claim forms are available by calling Northeast Delta Dental or visiting ***www.nedelta.com***. Payment will be made to you, the Subscriber, unless the state in which the services are rendered requires that assignment of benefits (directing that payment be sent to the dentist) be honored and Northeast Delta Dental receives written notice of such assignment. Payment for treatment performed by a nonparticipating dentist will be limited to the lesser of the dentist's actual submitted charge or Delta Dental's allowance for nonparticipating dentists in the geographic area in which services are provided. It is your responsibility to ensure that full payment is made to the dentist. Northeast Delta Dental will produce an Explanation of Benefits (available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***) detailing what has been processed under your Plan's coverage.

Predetermination of Benefits

HealthTrust and Northeast Delta Dental strongly encourage predetermination of cases involving costly or extensive treatment plans. Although it's not required, predetermination helps avoid any potential confusion regarding your Plan's payment and your financial obligation to the dentist.

Coordination of Benefits

When an individual covered under this Plan has additional dental coverage, the Coordination of Benefits provision described in your Dental Plan Description will determine the sequence and extent of payment. If you have any questions, please contact Northeast Delta Dental's Customer Service at 800.832.5700 or 603.223.1234.

Identification Card

Upon your initial enrollment in a HealthTrust Dental Plan, two identification cards from Northeast Delta Dental will be produced and distributed. Both cards are issued in the subscriber's name, but can be used by everyone covered under the Plan. Any additional or replacement cards will be available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***.

Dental Plan Description

The Dental Plan Description describes the benefits of your Plan and tells you how to use your Plan. You can access your Dental Plan Description by going to ***www.healthtrustnh.org***. Please review this document in order to understand the benefits and provisions of your employer's HealthTrust Dental Plan.

Who is Eligible

All eligible employees and their eligible dependents, generally defined as:

- Spouse;
- Dependent children from age 2 to age 26;
- Unmarried, incapacitated dependent children age 26 or older.

Please refer to the Dental Plan Description for additional information regarding dependent eligibility.

Eligibility or Benefits Questions

If you have questions regarding eligibility or benefits, please contact your employer or HealthTrust's Enrollee Services at 800.527.5001.

Claims Questions

If you have further questions, please contact Northeast Delta Dental's Customer Service at 800.832.5700 or 603.223.1234.

Further Information

This Outline of Benefits should be used only as a guideline for your dental plan coverage. For detailed information on your Plan's terms, conditions, limitations and exclusions, please refer to your Dental Plan Description or consult your employer. In the event of a conflict or discrepancy between this Outline of Benefits and either the Dental Plan Description or Plan Document, the Dental Plan Description or the Plan Document will control.

To obtain a hard copy of the Dental Plan Description or Plan Document, contact your employer or HealthTrust's Enrollee Services at 800.527.5001.

HealthTrust

DELTA DENTAL

Outline of Benefits

This Outline of Benefits describes the level of coverage under your employer's HealthTrust Dental Plan for services performed by dentists who participate in the Delta Dental PPO and Delta Dental Premier networks. Employees and their eligible dependents are free to visit *any* dentist, participating or nonparticipating. Visit Northeast Delta Dental's Web site at *www.nedelta.com* for an updated list of participating dentists.

Your employer's HealthTrust Dental Plan includes the following coverage categories. This information is provided for summary purposes only; certain benefit limitations and exclusions may apply. For further details, please refer to your Dental Plan Description available at *www.healthtrustnh.org*.

Dental Plan Option 1

Coverage A Diagnostic/Preventive	Coverage B Basic	Coverage C Major	Coverage D Orthodontics
Deductible: None	**Deductible**: $25 Per Person, Per Year ($75 Per Family)		**Deductible: None**
Covered at 100%*	**Covered at 80%***	**Covered at 50%***	**Covered at 50%***
Diagnostic: Evaluations - twice in a calendar year: this includes periodic, limited, problem-focused, and comprehensive evaluations X-rays - complete series or panoramic film - once in a 5-year period; Bitewing x-rays - once in a calendar year; X-rays of individual teeth - as necessary Brush biopsy - once in a calendar year, no age limit **Preventive:** Cleanings - four per calendar year Fluoride - twice in a calendar year through age 18 Space maintainers - through age 15 Sealant application to permanent molars - once in a 3-year period per tooth, for children through age 18	**Restorative:** Amalgam (silver) fillings and/or Composite (white) fillings (anterior and posterior teeth) **Oral Surgery:** Surgical and routine extractions **Endodontics:** Root canal therapy **Periodontics:** Periodontal cleaning - four cleanings per calendar year; these may be routine (Coverage A) or periodontal (Coverage B) Treatment of gum disease Clinical crown lengthening - once in a lifetime per site **Denture Repair:** Repair of a removable denture to its original condition **Emergency Palliative Treatment**	**Prosthodontics:** Removable and fixed partial dentures (bridge); complete dentures Rebase and reline (dentures) Crowns Onlays Implants	**Orthodontics:** Correction of crooked teeth for dependent children through the end of the month in which the child turns 19
Plan Year Maximum: $1,000 per person (Coverages A, B and C combined) beginning each January 1st			**Orthodontic Lifetime Maximum:** $1,000 Per Person

***Benefit percentages shown are based upon the lesser of the actual submitted charge or Delta Dental's allowance under the Plan.**

Delta Dental PPO and Premier Networks

You'll get the best value from your Plan when you receive your dental care from one of Delta Dental's PPO or Premier network participating dentists, including:

▲ **No Balance Billing:** Participating dentists agree not to charge any difference between their fees and Delta Dental's allowed fees. Because participating dentists accept Delta Dental's allowed fees for services, you will typically pay less when you visit a participating dentist.

▲ **No Claims Paperwork:** Participating dentists will prepare and submit claim forms for you.

▲ **Direct Payment:** Northeast Delta Dental pays participating dentists directly, so you don't have to pay the covered amount up-front and wait for a reimbursement check.

To find out if your dentist participates, you can: call your dentist, visit Northeast Delta Dental's website at ***www.nedelta.com*** or call Northeast Delta Dental's Customer Service at 800.832.5700.

Claim Process for Participating Dentists

Your participating dentist will submit your claim to Northeast Delta Dental (claims for any of your covered dependents should be submitted under *your* Subscriber ID number). Northeast Delta Dental will produce an Explanation of Benefits (available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***) detailing what has been processed under your Plan's coverage. You are responsible to pay any outstanding balance directly to the dentist.

Claim Process for Nonparticipating Dentists

Your Plan provides coverage regardless of your choice of dentist, participating or not. If you visit a nonparticipating dentist, you may be required to submit your own claim and pay for services at the time they are provided. Claim forms are available by calling Northeast Delta Dental or visiting ***www.nedelta.com***. Payment will be made to you, the Subscriber, unless the state in which the services are rendered requires that assignment of benefits (directing that payment be sent to the dentist) be honored and Northeast Delta Dental receives written notice of such assignment. Payment for treatment performed by a nonparticipating dentist will be limited to the lesser of the dentist's actual submitted charge or Delta Dental's allowance for nonparticipating dentists in the geographic area in which services are provided. It is your responsibility to ensure that full payment is made to the dentist. Northeast Delta Dental will produce an Explanation of Benefits (available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***) detailing what has been processed under your Plan's coverage.

Predetermination of Benefits

HealthTrust and Northeast Delta Dental strongly encourage predetermination of cases involving costly or extensive treatment plans. Although it's not required, predetermination helps avoid any potential confusion regarding your Plan's payment and your financial obligation to the dentist.

Coordination of Benefits

When an individual covered under this Plan has additional dental coverage, the Coordination of Benefits provision described in your Dental Plan Description will determine the sequence and extent of payment. If you have any questions, please contact Northeast Delta Dental's Customer Service at 800.832.5700 or 603.223.1234.

Identification Card

Upon your initial enrollment in a HealthTrust Dental Plan, two identification cards from Northeast Delta Dental will be produced and distributed. Both cards are issued in the subscriber's name, but can be used by everyone covered under the Plan. Any additional or replacement cards will be available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***.

Dental Plan Description

The Dental Plan Description describes the benefits of your Plan and tells you how to use your Plan. You can access your Dental Plan Description by going to ***www.healthtrustnh.org***. Please review this document in order to understand the benefits and provisions of your employer's HealthTrust Dental Plan.

Who is Eligible

All eligible employees and their eligible dependents, generally defined as:

- Spouse;
- Dependent children from age 2 to age 26;
- Unmarried, incapacitated dependent children age 26 or older.

Please refer to the Dental Plan Description for additional information regarding dependent eligibility.

Eligibility or Benefits Questions

If you have questions regarding eligibility or benefits, please contact your employer or HealthTrust's Enrollee Services at 800.527.5001.

Claims Questions

If you have further questions, please contact Northeast Delta Dental's Customer Service at 800.832.5700 or 603.223.1234.

Further Information

This Outline of Benefits should be used only as a guideline for your dental plan coverage. For detailed information on your Plan's terms, conditions, limitations and exclusions, please refer to your Dental Plan Description or consult your employer. In the event of a conflict or discrepancy between this Outline of Benefits and either the Dental Plan Description or Plan Document, the Dental Plan Description or the Plan Document will control.

To obtain a hard copy of the Dental Plan Description or Plan Document, contact your employer or HealthTrust's Enrollee Services at 800.527.5001.

HealthTrust

DELTA DENTAL

Outline of Benefits

This Outline of Benefits describes the level of coverage under your employer's HealthTrust Dental Plan for services performed by dentists who participate in the Delta Dental PPO and Delta Dental Premier networks. Employees and their eligible dependents are free to visit *any* dentist, participating or nonparticipating. Visit Northeast Delta Dental's Web site at *www.nedelta.com* for an updated list of participating dentists.

Your employer's HealthTrust Dental Plan includes the following coverage categories. This information is provided for summary purposes only; certain benefit limitations and exclusions may apply. For further details, please refer to your Dental Plan Description available at *www.healthtrustnh.org*.

Dental Plan Option 3A

Coverage A Diagnostic/Preventive	Coverage B Basic	Coverage C Major
Deductible: $0 There is no deductible on this plan		
Covered at 100%*	**Covered at 80%***	**Covered at 50%***
Diagnostic: Evaluations - twice in a calendar year: this includes periodic, limited, problem-focused, and comprehensive evaluations X-rays - complete series or panoramic film - once in a 5-year period; Bitewing x-rays - once in a calendar year; X-rays of individual teeth - as necessary Brush biopsy - once in a calendar year, no age limit **Preventive:** Cleanings - four per calendar year Fluoride - twice in a calendar year through age 18 Space maintainers - through age 15 Sealant application to permanent molars - once in a 3-year period per tooth, for children through age 18	**Restorative:** Amalgam (silver) fillings and/or Composite (white) fillings (anterior and posterior teeth) **Oral Surgery:** Surgical and routine extractions **Endodontics:** Root canal therapy **Periodontics:** Periodontal cleaning - four cleanings per calendar year; these may be routine (Coverage A) or periodontal (Coverage B) Treatment of gum disease Clinical crown lengthening - once in a lifetime per site **Denture Repair:** Repair of a removable denture to its original condition **Emergency Palliative Treatment**	**Prosthodontics:** Removable and fixed partial dentures (bridge); complete dentures Rebase and reline (dentures) Crowns Onlays Implants

Plan Year Maximum: $1,000 per person (Coverages A, B and C combined) beginning each January 1st

***Benefit percentages shown are based upon the lesser of the actual submitted charge or Delta Dental's allowance under the Plan.**

Rev. 01/16

Delta Dental PPO and Premier Networks

You'll get the best value from your Plan when you receive your dental care from one of Delta Dental's PPO or Premier network participating dentists, including:

▲ **No Balance Billing:** Participating dentists agree not to charge any difference between their fees and Delta Dental's allowed fees. Because participating dentists accept Delta Dental's allowed fees for services, you will typically pay less when you visit a participating dentist.

▲ **No Claims Paperwork:** Participating dentists will prepare and submit claim forms for you.

▲ **Direct Payment:** Northeast Delta Dental pays participating dentists directly, so you don't have to pay the covered amount up front and wait for a reimbursement check.

To find out if your dentist participates, you can: call your dentist, visit Northeast Delta Dental's website at ***www.nedelta.com*** or call Northeast Delta Dental's Customer Service at 800.832.5700.

Claim Process for Participating Dentists

Your participating dentist will submit your claim to Northeast Delta Dental (claims for any of your covered dependents should be submitted under *your* Subscriber ID number). Northeast Delta Dental will produce an Explanation of Benefits (available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***) detailing what has been processed under your Plan's coverage. You are responsible to pay any outstanding balance directly to the dentist.

Claim Process for Nonparticipating Dentists

Your Plan provides coverage regardless of your choice of dentist, participating or not. If you visit a nonparticipating dentist, you may be required to submit your own claim and pay for services at the time they are provided. Claim forms are available by calling Northeast Delta Dental or visiting ***www.nedelta.com***. Payment will be made to you, the Subscriber, unless the state in which the services are rendered requires that assignment of benefits (directing that payment be sent to the dentist) be honored and Northeast Delta Dental receives written notice of such assignment. Payment for treatment performed by a nonparticipating dentist will be limited to the lesser of the dentist's actual submitted charge or Delta Dental's allowance for nonparticipating dentists in the geographic area in which services are provided. It is your responsibility to ensure that full payment is made to the dentist. Northeast Delta Dental will produce an Explanation of Benefits (available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***) detailing what has been processed under your Plan's coverage.

Predetermination of Benefits

HealthTrust and Northeast Delta Dental strongly encourage predetermination of cases involving costly or extensive treatment plans. Although it's not required, predetermination helps avoid any potential confusion regarding your Plan's payment and your financial obligation to the dentist.

Coordination of Benefits

When an individual covered under this Plan has additional dental coverage, the Coordination of Benefits provision described in your Dental Plan Description will determine the sequence and extent of payment. If you have any questions, please contact Northeast Delta Dental's Customer Service at 800.832.5700 or 603.223.1234.

Identification Card

Upon your initial enrollment in a HealthTrust Dental Plan, two identification cards from Northeast Delta Dental will be produced and distributed. Both cards are issued in the subscriber's name, but can be used by everyone covered under the Plan. Any additional or replacement cards will be available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***.

Dental Plan Description

The Dental Plan Description describes the benefits of your Plan and tells you how to use your Plan. You can access your Dental Plan Description by going to ***www.healthtrustnh.org***. Please review this document in order to understand the benefits and provisions of your employer's HealthTrust Dental Plan.

Who is Eligible

All eligible employees and their eligible dependents, generally defined as:

- Spouse;
- Dependent children from age 2 to age 26;
- Unmarried, incapacitated dependent children age 26 or older.

Please refer to the Dental Plan Description for additional information regarding dependent eligibility.

Eligibility or Benefits Questions

If you have questions regarding eligibility or benefits, please contact your employer or HealthTrust's Enrollee Services at 800.527.5001.

Claims Questions

If you have further questions, please contact Northeast Delta Dental's Customer Service at 800.832.5700 or 603.223.1234.

Further Information

This Outline of Benefits should be used only as a guideline for your dental plan coverage. For detailed information on your Plan's terms, conditions, limitations and exclusions, please refer to your Dental Plan Description or consult your employer. In the event of a conflict or discrepancy between this Outline of Benefits and either the Dental Plan Description or Plan Document, the Dental Plan Description or the Plan Document will control.

To obtain a hard copy of the Dental Plan Description or Plan Document, contact your employer or HealthTrust's Enrollee Services at 800.527.5001.

HealthTrust

DELTA DENTAL

Outline of Benefits

This Outline of Benefits describes the level of coverage under your employer's HealthTrust Dental Plan for services performed by dentists who participate in the Delta Dental PPO and Delta Dental Premier networks. Employees and their eligible dependents are free to visit *any* dentist, participating or nonparticipating. Visit Northeast Delta Dental's Web site at *www.nedelta.com* for an updated list of participating dentists.

Your employer's HealthTrust Dental Plan includes the following coverage categories. This information is provided for summary purposes only; certain benefit limitations and exclusions may apply. For further details, please refer to your Dental Plan Description available at *www.healthtrustnh.org*.

Dental Plan Option 1S

Coverage A Diagnostic/Preventive	Coverage B Basic	Coverage C Major	Coverage D Orthodontics
Deductible: $0 There is no deductible on this plan			
Covered at 100%*	**Covered at 80%***	**Covered at 50%***	**Covered at 50%***
Diagnostic: Evaluations - twice in a calendar year: this includes periodic, limited, problem-focused, and comprehensive evaluations X-rays - complete series or panoramic film - once in a 5-year period; Bitewing x-rays - once in a calendar year; X-rays of individual teeth - as necessary Brush biopsy - once in a calendar year, no age limit **Preventive:** Cleanings - four per calendar year Fluoride - twice in a calendar year through age 18 Space maintainers - through age 15 Sealant application to permanent molars - once in a 3-year period per tooth, for children through age 18	**Restorative:** Amalgam (silver) fillings and/or Composite (white) fillings (anterior and posterior teeth) **Oral Surgery:** Surgical and routine extractions **Endodontics:** Root canal therapy **Periodontics:** Periodontal cleaning - four cleanings per calendar year; these may be routine (Coverage A) or periodontal (Coverage B) Treatment of gum disease Clinical crown lengthening - once in a lifetime per site **Denture Repair:** Repair of a removable denture to its original condition **Emergency Palliative Treatment**	**Prosthodontics:** Removable and fixed partial dentures (bridge); complete dentures Rebase and reline (dentures) Crowns Onlays Implants	**Orthodontics:** Correction of crooked teeth for dependent children through the end of the month in which the child turns 19
Plan Year Maximum: $2,000 per person (Coverages A, B and C combined) beginning each January 1st			**Orthodontic Lifetime Maximum:** $1,000 Per Person

***Benefit percentages shown are based upon the lesser of the actual submitted charge or Delta Dental's allowance under the Plan.**

Delta Dental PPO and Premier Networks

You'll get the best value from your Plan when you receive your dental care from one of Delta Dental's PPO or Premier network participating dentists, including:

▲ **No Balance Billing:** Participating dentists agree not to charge any difference between their fees and Delta Dental's allowed fees. Because participating dentists accept Delta Dental's allowed fees for services, you will typically pay less when you visit a participating dentist.

▲ **No Claims Paperwork:** Participating dentists will prepare and submit claim forms for you.

▲ **Direct Payment:** Northeast Delta Dental pays participating dentists directly, so you don't have to pay the covered amount up-front and wait for a reimbursement check.

To find out if your dentist participates, you can: call your dentist, visit Northeast Delta Dental's website at ***www.nedelta.com*** or call Northeast Delta Dental's Customer Service at 800.832.5700.

Claim Process for Participating Dentists

Your participating dentist will submit your claim to Northeast Delta Dental (claims for any of your covered dependents should be submitted under *your* Subscriber ID number). Northeast Delta Dental will produce an Explanation of Benefits (available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***) detailing what has been processed under your Plan's coverage. You are responsible to pay any outstanding balance directly to the dentist.

Claim Process for Nonparticipating Dentists

Your Plan provides coverage regardless of your choice of dentist, participating or not. If you visit a nonparticipating dentist, you may be required to submit your own claim and pay for services at the time they are provided. Claim forms are available by calling Northeast Delta Dental or visiting ***www.nedelta.com***. Payment will be made to you, the Subscriber, unless the state in which the services are rendered requires that assignment of benefits (directing that payment be sent to the dentist) be honored and Northeast Delta Dental receives written notice of such assignment. Payment for treatment performed by a nonparticipating dentist will be limited to the lesser of the dentist's actual submitted charge or Delta Dental's allowance for nonparticipating dentists in the geographic area in which services are provided. It is your responsibility to ensure that full payment is made to the dentist. Northeast Delta Dental will produce an Explanation of Benefits (available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***) detailing what has been processed under your Plan's coverage.

Predetermination of Benefits

HealthTrust and Northeast Delta Dental strongly encourage predetermination of cases involving costly or extensive treatment plans. Although it's not required, predetermination helps avoid any potential confusion regarding your Plan's payment and your financial obligation to the dentist.

Coordination of Benefits

When an individual covered under this Plan has additional dental coverage, the Coordination of Benefits provision described in your Dental Plan Description will determine the sequence and extent of payment. If you have any questions, please contact Northeast Delta Dental's Customer Service at 800.832.5700 or 603.223.1234.

Identification Card

Upon your initial enrollment in a HealthTrust Dental Plan, two identification cards from Northeast Delta Dental will be produced and distributed. Both cards are issued in the subscriber's name, but can be used by everyone covered under the Plan. Any additional or replacement cards will be available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***.

Dental Plan Description

The Dental Plan Description describes the benefits of your Plan and tells you how to use your Plan. You can access your Dental Plan Description by going to ***www.healthtrustnh.org***. Please review this document in order to understand the benefits and provisions of your employer's HealthTrust Dental Plan.

Who is Eligible

All eligible employees and their eligible dependents, generally defined as:

- Spouse;
- Dependent children from age 2 to age 26;
- Unmarried, incapacitated dependent children age 26 or older.

Please refer to the Dental Plan Description for additional information regarding dependent eligibility.

Eligibility or Benefits Questions

If you have questions regarding eligibility or benefits, please contact your employer or HealthTrust's Enrollee Services at 800.527.5001.

Claims Questions

If you have further questions, please contact Northeast Delta Dental's Customer Service at 800.832.5700 or 603.223.1234.

Further Information

This Outline of Benefits should be used only as a guideline for your dental plan coverage. For detailed information on your Plan's terms, conditions, limitations and exclusions, please refer to your Dental Plan Description or consult your employer. In the event of a conflict or discrepancy between this Outline of Benefits and either the Dental Plan Description or Plan Document, the Dental Plan Description or the Plan Document will control.

To obtain a hard copy of the Dental Plan Description or Plan Document, contact your employer or HealthTrust's Enrollee Services at 800.527.5001.

Section 7

Section 7a

HealthTrust Overview

OUR VISION

New Hampshire communities' most trusted partner in achieving optimum health through a culture of wellness

OUR MISSION

To provide high quality, cost-effective employee benefit products and services for public employers and employees in New Hampshire in order to reduce costs through pooling strategies with a commitment to education, health promotion and disease prevention.

OUR VALUES

Integrity
Service
Collaboration
Innovation

HealthTrust

PO Box 617 • Concord, NH 03302-0617 • Tel. 603.226.2861 • Toll Free 800.527.5001
Fax: 603.226.2988 • Email: info@healthtrustnh.org • Website: *www.healthtrustnh.org*

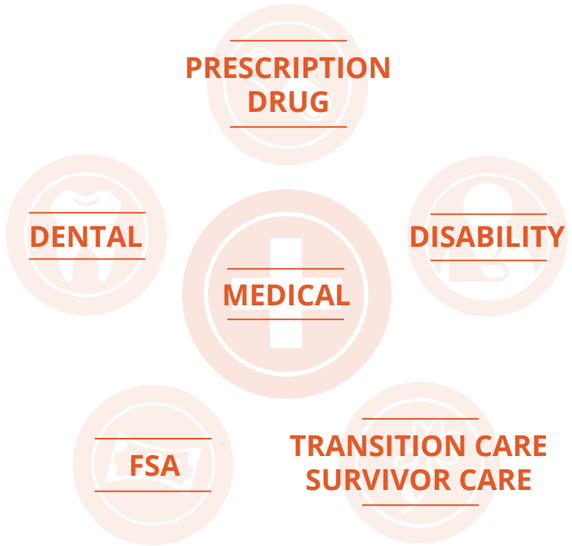
HealthTrust

Providing healthcare coverage to New Hampshire public sector employers for their employees, retirees and families

Who *is* HealthTrust?

HealthTrust is a nonprofit provider of high quality, cost-effective medical, dental, prescription drug and ancillary benefit plans exclusively for public sector employers and their employees in New Hampshire.

We are a risk pool. Our Members include schools, towns, cities, counties and quasi-governmental entities in New Hampshire who have pooled their insurance dollars to create, in effect, their own insurance coverage, or to "self-insure."



The Risk Pool Advantage

- Comprehensive employee benefit programs and services that meet public sector needs specifically
- A greater pool of resources
- Exceptional value
- Lower premiums and more stable pricing
- Coverage for groups of all sizes

We specialize in you. For more than 30 years, HealthTrust has served New Hampshire's public sector employers and their employees. Coverage is administered from our office in Concord. We are a New Hampshire organization serving New Hampshire's workers.

Our Board represents you.

The 11 dedicated members of our Board of Directors include municipal, school and county officials and employees. They understand and share the unique needs of New Hampshire's public employers and employees.

What sets *us* apart?

1 Our plan options

HealthTrust teams with the best partners to offer high quality, cost-effective, comprehensive benefit plans.

- **Medical and Prescription coverage** provided in partnership with Anthem Blue Cross and Blue Shield and CVS/caremark
  - Discounts on hospitals and medical providers, reflected in our rates, provided through partnership with Anthem
  - An HMO network of providers that spans all six New England states, and access to in-network specialists without a referral
  - Coverage for preventive services at no cost
  - Worldwide coverage for emergency and urgent care
  - 24/7 NurseLine, Future Moms and a suite of other health management programs to keep employees healthy
  - Access to more than 64,000 network retail pharmacies nationwide
  - CVS/caremark mail service for stress-free, cost-saving prescriptions and refills
- **Dental coverage** provided in partnership with Northeast Delta Dental
  - Most dental plans cover 100 percent of preventive care
  - Nationwide network of dentists, the most extensive of any provider
  - Direct billing through most New Hampshire dental offices
- **Disability and Life coverage** – Short-Term Disability (provided by HealthTrust directly); Long-Term Disability and Life (provided in partnership with National Insurance Services and Madison National Life Insurance Company)
- **Transition Care and Survivor Care** – Transition Care (coverage for an enrollee's family for up to one year after the enrollee's death) and Survivor Care (continuous coverage for an enrollee's eligible family members if the enrollee dies while performing job duties)
- **Flexible Spending Accounts** (FSAs) administered directly by HealthTrust with low participant fees and free Benny Prepaid Benefits Card. No setup or plan document fees.

3 Our services

At HealthTrust, exceptional service isn't the exception – it's the rule. Our personal, local services save you time and money and provide your employees stress-reducing support.

93% INQUIRIES RESOLVED SAME DAY AS CALL OR VISIT

CALLS ANSWERED **WITHIN 13 SEC.** ON AVERAGE

- **We answer the phone.** No electronic voices or computer directories! Our Enrollee Services Representatives include specialists in retiree services, enrollment, ancillary coverage, and more who answer your questions personally and professionally.
  - About 24,000 calls handled annually
  - Calls answered within 13 seconds on average
  - 93 percent of inquiries resolved on the same day as call or visit
  - Claims specialists available to advocate for enrollees when needed
- **We come to you.** Each Member Group is assigned their own HealthTrust Benefits Advisor and Wellness Advisor.
  - Our Benefits Advisors will come to your workplace to review your group's plan options with you.
  - Our Wellness Advisors will provide interactive presentations customized to your group at your workplace.
  - HealthTrust advisors make more than 1,400 visits to Member Groups' workplaces annually.
  - Many advisors serve the same Members for years.
- **We make administration easier.**
  - Benefits Administrator workshops and one-on-one trainings let Member Groups spend a few hours with HealthTrust to save time all year long
  - Secure portal for Benefits Administrators makes it easy to update enrollment information, order supplies, access forms, and more.
  - Secure portal for enrollees and retirees offers detailed plan and program information and direct access to partner websites.
  - Affordable Care Act trainings – identifying what's next in healthcare and making sure Member Groups are prepared
  - Retiree advocacy and workshops for enrollees turning 65
  - In-house COBRA and retiree billing
  - FSA administration
  - Short-term disability claims processing and advocacy

2 Our programs

HealthTrust's programs help employees be more informed, healthier medical consumers.

Slice of Life – Your Way to Better Health

The **Slice of Life** health management program, provided in partnership with Onlife Health
- Cash rewards for making healthy choices
- Regional Biometric Health Screenings
- Worksite flu vaccine clinics
- Wellness Coordinator Academy to promote **Slice of Life** and offer wellness programs on-site

SmartShopper

SmartShopper, provided in partnership with Vitals
- Cash rewards to enrollees who choose cost-effective healthcare options
- Raises awareness of wide-ranging healthcare costs and promotes medical consumerism
- Saved more than $1 million in claims the first year (2015) alone

LiveHealth® ONLINE

LiveHealth Online, affordable care at enrollees' fingertips, anytime, anywhere
- Virtual appointments with board-certified doctors and licensed therapists and psychologists
- Cost is comparable to plan copay (and no more than $49 for a medical visit or $89 for a behavioral health visit)
- Covered by all HealthTrust medical plans (except Medicomp Three)

LifeResources

LifeResources Employee Assistance Program (EAP) provided in partnership with AllOne Health
- Referrals to free consultations with legal, financial and social services experts
- Caregiver support
- Educational resources through online and in-person trainings

Section 7b

Summary of Benefits and Coverage

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-438-9672.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PCP-referred benefits: **$0** individual/**$0** family. For self-referred benefits: **$250** individual/**$500** family. **Deductible** does not apply to in-network preventive care, in-network office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** for Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses: $5,000** individual/**$10,000** family. **For prescriptions: $1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network expenses, precertification penalty and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-438-9672.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I 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 the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-438-9672** or visit us at **www.anthem.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.anthem.com** or call **1-800-438-9672** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per visit	20% coinsurance	——none——
	Specialist visit	$10 copay per visit	20% coinsurance	——none——
	Other practitioner office visit	$10 copay per visit	20% coinsurance	Chiropractic care limited to 35 visits per member per calendar year.
	Preventive care/screening/immunization	No charge	Balance billing	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$45/Rx for retail; $45/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	——————none——————
	Physician/surgeon fees	No charge	20% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$50 copay per visit	$50 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$50 copay per visit	20% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
	Physician/surgeon fee	No charge	20% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay per visit	20% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
	Substance use disorder outpatient services	$10 copay per visit	20% coinsurance	——————none——————
	Substance use disorder inpatient services	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	Copay applies to initial visit.
	Delivery and all inpatient services	No charge	20% coinsurance	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	——————none——————
	Rehabilitation services	$10 copay per visit	20% coinsurance	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year. PCP-referred and self-referred visits count towards your limit.
	Habilitation services	$10 copay per visit	20% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No charge	20% coinsurance	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	20% coinsurance	——————none——————
	Hospice service	No charge	20% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance	Limited to one exam per calendar year.
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-438-9672. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim Appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,490
- **Patient pays** $910

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$500
Coinsurance	$230
Limits or exclusions	$80
Total	**$910**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-438-9672.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PCP-referred benefits: **$0** individual/**$0** family. For self-referred benefits: **$250** individual/**$500** family. **Deductible** does not apply to in-network preventive care, in-network office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** for Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses: $5,000** individual/**$10,000** family. **For prescriptions: $1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network expenses, precertification penalty and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-438-9672.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I 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 the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per visit	20% coinsurance	——none——
	Specialist visit	$10 copay per visit	20% coinsurance	——none——
	Other practitioner office visit	$10 copay per visit	20% coinsurance	Chiropractic care limited to 35 visits per member per calendar year.
	Preventive care/screening/immunization	No charge	Balance billing	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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.
	Preferred brand drugs	$25/Rx for retail; $40/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$40/Rx for retail; $70/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	——————none——————
	Physician/surgeon fees	No charge	20% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$50 copay per visit	$50 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$50 copay per visit	20% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
	Physician/surgeon fee	No charge	20% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay per visit	20% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
	Substance use disorder outpatient services	$10 copay per visit	20% coinsurance	——————none——————
	Substance use disorder inpatient services	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	Copay applies to initial visit.
	Delivery and all inpatient services	No charge	20% coinsurance	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	——————none——————
	Rehabilitation services	$10 copay per visit	20% coinsurance	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year. PCP-referred and self-referred visits count towards your limit.
	Habilitation services	$10 copay per visit	20% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No charge	20% coinsurance	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	20% coinsurance	——————none——————
	Hospice service	No charge	20% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance	Limited to one exam per calendar year.
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-438-9672. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim Appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,490
- **Patient pays** $910

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$500
Coinsurance	$230
Limits or exclusions	$80
Total	**$910**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-438-9672.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PCP-referred benefits: **$0** individual/**$0** family. For self-referred benefits: **$500** individual/**$1,500** family. **Deductible** does not apply to in-network preventive care, in-network office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** for Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses: $5,000** individual/**$10,000** family. **For prescriptions: $1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network expenses, precertification penalty and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-438-9672	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I 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 the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-438-9672** or visit us at **www.anthem.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.anthem.com** or call **1-800-438-9672** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per visit	30% coinsurance	——none——
	Specialist visit	$10 copay per visit	30% coinsurance	——none——
	Other practitioner office visit	$10 copay per visit	30% coinsurance	Chiropractic care limited to 25 visits per member per calendar year.
	Preventive care/screening/immunization	No charge	Balance billing	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$45/Rx for retail; $45/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	——————none——————
	Physician/surgeon fees	No charge	30% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$50 copay per visit	$50 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$50 copay per visit	30% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply)
	Physician/surgeon fee	No charge	30% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay per visit	30% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	No charge	30% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply)
	Substance use disorder outpatient services	$10 copay per visit	30% coinsurance	——————none——————
	Substance use disorder inpatient services	No charge	30% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply)
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	Copay applies to initial visit.
	Delivery and all inpatient services	No charge	30% coinsurance	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	——————none——————
	Rehabilitation services	$10 copay per visit	30% coinsurance	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year. PCP-referred and self-referred visits count towards your limit.
	Habilitation services	$10 copay per visit	30% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No charge	30% coinsurance	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	50% coinsurance	——————none——————
	Hospice service	No charge	30% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	30% coinsurance	Limited to one exam per calendar year.
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
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If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-438-9672. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim Appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

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Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,490
- **Patient pays** $910

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$500
Coinsurance	$230
Limits or exclusions	$80
Total	**$910**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
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What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PCP-referred benefits: **$0** individual/**$0** family. For self-referred benefits: **$500** individual/**$1,500** family. **Deductible** does not apply to in-network preventive care, in-network office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** for Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses: $5,000** individual/**$10,000** family. **For prescriptions: $1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network expenses, precertification penalty and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-438-9672.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I 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 the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per visit	30% coinsurance	——none——
	Specialist visit	$10 copay per visit	30% coinsurance	——none——
	Other practitioner office visit	$10 copay per visit	30% coinsurance	Chiropractic care limited to 25 visits per member per calendar year.
	Preventive care/screening/immunization	No charge	Balance billing	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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.
	Preferred brand drugs	$25/Rx for retail; $40/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$40/Rx for retail; $70/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	——————none——————
	Physician/surgeon fees	No charge	30% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$50 copay per visit	$50 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$50 copay per visit	30% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
	Physician/surgeon fee	No charge	30% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay per visit	30% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	No charge	30% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
	Substance use disorder outpatient services	$10 copay per visit	30% coinsurance	——————none——————
	Substance use disorder inpatient services	No charge	30% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	Copay applies to initial visit.
	Delivery and all inpatient services	No charge	30% coinsurance	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	——————none——————
	Rehabilitation services	$10 copay per visit	30% coinsurance	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year. PCP-referred and self-referred visits count towards your limit.
	Habilitation services	$10 copay per visit	30% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No charge	30% coinsurance	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	50% coinsurance	——————none——————
	Hospice service	No charge	30% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	30% coinsurance	Limited to one exam per calendar year.
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-438-9672. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim Appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,490
- **Patient pays** $910

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$500
Coinsurance	$230
Limits or exclusions	$80
Total	**$910**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-438-9672.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PCP-referred benefits: **$0** individual/**$0** family. For self-referred benefits: **$250** individual/**$500** family. **Deductible** does not apply to in-network preventive care, in-network office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** for Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses: $5,000** individual/**$10,000** family. **For prescriptions: $1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network expenses, precertification penalty and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-438-9672.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I 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 the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-438-9672** or visit us at **www.anthem.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.anthem.com** or call **1-800-438-9672** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	20% coinsurance	——none——
	Specialist visit	$20 copay per visit	20% coinsurance	——none——
	Other practitioner office visit	$20 copay per visit	20% coinsurance	Chiropractic care limited to 35 visits per member per calendar year.
	Preventive care/screening/immunization	No charge	Balance billing	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$30/Rx for retail; $30/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	——————none——————
	Physician/surgeon fees	No charge	20% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$100 copay per visit	$100 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$50 copay per visit	20% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
	Physician/surgeon fee	No charge	20% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay per visit	20% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
	Substance use disorder outpatient services	$20 copay per visit	20% coinsurance	——————none——————
	Substance use disorder inpatient services	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	Copay applies to initial visit.
	Delivery and all inpatient services	No charge	20% coinsurance	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	——————none——————
	Rehabilitation services	$20 copay per visit	20% coinsurance	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year. PCP-referred and self-referred visits count towards your limit.
	Habilitation services	$20 copay per visit	20% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No charge	20% coinsurance	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	20% coinsurance	——————none——————
	Hospice service	No charge	20% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance	Limited to one exam per calendar year.
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (limit of one exam every two years)

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If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim Appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

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Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,390
- **Patient pays** $1,010

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$600
Coinsurance	$230
Limits or exclusions	$80
Total	**$1,010**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PCP-referred benefits: **$0** individual/**$0** family. For self-referred benefits: **$250** individual/**$500** family. **Deductible** does not apply to in-network preventive care, in-network office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** for Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses: $5,000** individual/**$10,000** family. **For prescriptions: $1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network expenses, precertification penalty and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-438-9672.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I 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 the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	20% coinsurance	——none——
	Specialist visit	$20 copay per visit	20% coinsurance	——none——
	Other practitioner office visit	$20 copay per visit	20% coinsurance	Chiropractic care limited to 35 visits per member per calendar year.
	Preventive care/screening/immunization	No charge	Balance billing	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$45/Rx for retail; $45/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	——————none——————
	Physician/surgeon fees	No charge	20% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$100 copay per visit	$100 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$50 copay per visit	20% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
	Physician/surgeon fee	No charge	20% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay per visit	20% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
	Substance use disorder outpatient services	$20 copay per visit	20% coinsurance	——————none——————
	Substance use disorder inpatient services	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	Copay applies to initial visit.
	Delivery and all inpatient services	No charge	20% coinsurance	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	——————none——————
	Rehabilitation services	$20 copay per visit	20% coinsurance	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year. PCP-referred and self-referred visits count towards your limit.
	Habilitation services	$20 copay per visit	20% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No charge	20% coinsurance	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	20% coinsurance	——————none——————
	Hospice service	No charge	20% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance	Limited to one exam per calendar year.
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-438-9672. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim Appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,390
- **Patient pays** $1,010

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$600
Coinsurance	$230
Limits or exclusions	$80
Total	**$1,010**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-438-9672.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PCP-referred benefits: **$0** individual/**$0** family. For self-referred benefits: **$250** individual/**$500** family. **Deductible** does not apply to in-network preventive care, in-network office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** for Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses: $5,000** individual/**$10,000** family. **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network expenses, precertification penalty and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-438-9672.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I 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 the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	20% coinsurance	——none——
	Specialist visit	$20 copay per visit	20% coinsurance	——none——
	Other practitioner office visit	$20 copay per visit	20% coinsurance	Chiropractic care limited to 35 visits per member per calendar year.
	Preventive care/screening/immunization	No charge	Balance billing	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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.
	Preferred brand drugs	$25/Rx for retail; $40/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$40/Rx for retail; $70/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	——————none——————
	Physician/surgeon fees	No charge	20% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$100 copay per visit	$100 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$50 copay per visit	20% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
	Physician/surgeon fee	No charge	20% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay per visit	20% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
	Substance use disorder outpatient services	$20 copay per visit	20% coinsurance	——————none——————
	Substance use disorder inpatient services	No charge	20% coinsurance	Precertification required for self-referred hospital stay (or $500 penalty may apply).
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	Copay applies to initial visit.
	Delivery and all inpatient services	No charge	20% coinsurance	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Benefits	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	——————none——————
	Rehabilitation services	$20 copay per visit	20% coinsurance	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year. PCP-referred and self-referred visits count towards your limit.
	Habilitation services	$20 copay per visit	20% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No charge	20% coinsurance	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	20% coinsurance	——————none——————
	Hospice service	No charge	20% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance	Limited to one exam per calendar year.
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

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- Acupuncture
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- Long-term care
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- Routine foot care
- Weight loss programs

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- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
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For Medical Claims:
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim Appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

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(normal delivery)

- **Amount owed to providers:** $7,540
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Sample care costs:

Hospital charges (mother)	$2,700
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Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,390
- **Patient pays** $1,010

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$600
Coinsurance	$230
Limits or exclusions	$80
Total	**$1,010**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
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- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
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Does the Coverage Example predict my own care needs?

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PCP-referred benefits: **$0** individual/**$0** family. For self-referred **network** providers: **$0** individual/**$0** family. For self-referred **out-of-network** providers: $**150** individual/**$450** family. **Deductible** does not apply to in-network preventive care, in-network office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses: $5,000** individual/**$10,000** family. **For prescriptions: $1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network expenses, precertification penalty and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call **1-800-438-9672**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call **1-800-438-9672** or visit us at **www.anthem.com.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.anthem.com** or call **1-800-438-9672** to request a copy.

Do I 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 **network** or **out-of-network specialist**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay per visit	$15 copay per visit	20% coinsurance	——none——
	Specialist visit	$5 copay per visit	$15 copay per visit	20% coinsurance	——none——
	Other practitioner office visit	$5 copay per visit	$15 copay per visit	20% coinsurance	——none——
	Preventive care/screening/ immunization	No charge	No charge	20% coinsurance	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	20% coinsurance	——none——

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$3/Rx for retail; $1/Rx for mail service		Your copay and any balance billing.	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 you use a CVS Caremark participating pharmacy.
	Preferred brand drugs	$15/Rx for retail; $1/Rx for mail service		Your copay and any balance billing.	
	Non-preferred brand drugs	$15/Rx for retail; $1/Rx for mail service		Your copay and any balance billing.	
	Specialty drugs	No retail coverage; $1/Rx for mail service		Not covered	Specialty medication available through preferred network only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	20% coinsurance	————none————
	Physician/surgeon fees	No charge	20% coinsurance	20% coinsurance	————none————
If you need immediate medical attention	Emergency room services	$25 copay	$25 copay before deductible, 20% coinsurance after.	$25 copay before deductible, 20% coinsurance after.	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	No charge	————none————
	Urgent care	$25 copay	$25 copay before deductible, 20% coinsurance after.	20% coinsurance	————none————

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
	Physician/surgeon fee	No charge	20% coinsurance	20% coinsurance	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$5 copay	$5 copay	20% coinsurance	————none————
	Mental/Behavioral health inpatient services	No charge	No charge	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
	Substance use disorder outpatient services	$5 copay	$5 copay	20% coinsurance	————none————
	Substance use disorder inpatient services	No charge	No charge	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	20% coinsurance	Copay applies to initial visit.
	Delivery and all inpatient services	No charge	20% coinsurance	20% coinsurance	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	20% coinsurance	————none————
	Rehabilitation services	No charge	20% coinsurance	20% coinsurance	————none————
	Habilitation services	No charge	20% coinsurance	20% coinsurance	Autism spectrum disorder is excluded.
	Skilled nursing care	No charge	20% coinsurance	20% coinsurance	————none————
	Durable medical equipment	No charge	20% coinsurance	20% coinsurance	————none————
	Hospice service	No charge	20% coinsurance	20% coinsurance	————none————
If your child needs dental or eye care	Eye exam	No charge	No charge	20% coinsurance	Limited to one exam per calendar year.
	Glasses	Not covered	Not covered	Not covered	$40 reimbursement per member every two years for frames and lenses.
	Dental check-up	Not covered	Not covered	Not covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-603-598-3320. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim Appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,380
- **Patient pays** $160

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$10
Coinsurance	$0
Limits or exclusions	$150
Total	**$160**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,150
- **Patient pays** $350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$170
Coinsurance	$0
Limits or exclusions	$80
Total	**$250**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-438-9672.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PCP-referred benefits: **$0** individual/**$0** family. For self-referred **network** providers: **$0** individual/**$0** family. For self-referred **out-of-network** providers: $**150** individual/**$450** family. **Deductible** does not apply to in-network preventive care, in-network office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses: $5,000** individual/**$10,000** family. **For prescriptions: $1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network expenses, precertification penalty and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call **1-800-438-9672**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

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Do I 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 **network** or **out-of-network specialist**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay per visit	$15 copay per visit	20% coinsurance	——none——
	Specialist visit	$5 copay per visit	$15 copay per visit	20% coinsurance	——none——
	Other practitioner office visit	$5 copay per visit	$15 copay per visit	20% coinsurance	——none——
	Preventive care/screening/ immunization	No charge	No charge	20% coinsurance	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	20% coinsurance	——none——

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service		Your copay and any balance billing.	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 you use a CVS Caremark participating pharmacy.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service		Your copay and any balance billing.	
	Non-preferred brand drugs	$45/Rx for retail; $45/Rx for mail service		Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service		Not covered	Specialty medication available through preferred network only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	20% coinsurance	————none————
	Physician/surgeon fees	No charge	20% coinsurance	20% coinsurance	————none————
If you need immediate medical attention	Emergency room services	$25 copay	$25 copay before deductible, 20% coinsurance after.	$25 copay before deductible, 20% coinsurance after.	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	No charge	————none————
	Urgent care	$25 copay	$25 copay before deductible, 20% coinsurance after.	20% coinsurance	————none————

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
	Physician/surgeon fee	No charge	20% coinsurance	20% coinsurance	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$5 copay	$5 copay	20% coinsurance	————none————
	Mental/Behavioral health inpatient services	No charge	No charge	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
	Substance use disorder outpatient services	$5 copay	$5 copay	20% coinsurance	————none————
	Substance use disorder inpatient services	No charge	No charge	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	20% coinsurance	Copay applies to initial visit.
	Delivery and all inpatient services	No charge	20% coinsurance	20% coinsurance	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	20% coinsurance	————none————
	Rehabilitation services	No charge	20% coinsurance	20% coinsurance	————none————
	Habilitation services	No charge	20% coinsurance	20% coinsurance	Autism spectrum disorder is excluded.
	Skilled nursing care	No charge	20% coinsurance	20% coinsurance	————none————
	Durable medical equipment	No charge	20% coinsurance	20% coinsurance	————none————
	Hospice service	No charge	20% coinsurance	20% coinsurance	————none————
If your child needs dental or eye care	Eye exam	No charge	No charge	20% coinsurance	Limited to one exam per calendar year.
	Glasses	Not covered	Not covered	Not covered	$40 reimbursement per member every two years for frames and lenses.
	Dental check-up	Not covered	Not covered	Not covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
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- Dental care (Children)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (limit of one exam every two years)

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For more information on your rights to continue coverage, contact the plan at 1-603-598-3320. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim Appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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About these Coverage Examples:

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,380
- **Patient pays** $160

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$10
Coinsurance	$0
Limits or exclusions	$150
Total	**$160**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,150
- **Patient pays** $350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$170
Coinsurance	$0
Limits or exclusions	$80
Total	**$250**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

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✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-438-9672.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PCP-referred benefits: **$0** individual/**$0** family. For self-referred **network** providers: **$0** individual/**$0** family. For self-referred **out-of-network** providers: $**150** individual/**$450** family. **Deductible** does not apply to in-network preventive care, in-network office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses: $5,000** individual/**$10,000** family. **For prescriptions: $1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network expenses, precertification penalty and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call **1-800-438-9672**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call **1-800-438-9672** or visit us at **www.anthem.com.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.anthem.com** or call **1-800-438-9672** to request a copy.

Do I 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 **network** or **out-of-network specialist**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay per visit	$15 copay per visit	20% coinsurance	——none——
	Specialist visit	$5 copay per visit	$15 copay per visit	20% coinsurance	——none——
	Other practitioner office visit	$5 copay per visit	$15 copay per visit	20% coinsurance	——none——
	Preventive care/screening/ immunization	No charge	No charge	20% coinsurance	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	20% coinsurance	——none——

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service		Your copay and any balance billing.	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 you use a CVS Caremark participating pharmacy.
	Preferred brand drugs	$25/Rx for retail; $40/Rx for mail service		Your copay and any balance billing.	
	Non-preferred brand drugs	$40/Rx for retail; $70/Rx for mail service		Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service		Not covered	Specialty medication available through preferred network only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	20% coinsurance	————none————
	Physician/surgeon fees	No charge	20% coinsurance	20% coinsurance	————none————
If you need immediate medical attention	Emergency room services	$25 copay	$25 copay before deductible, 20% coinsurance after.	$25 copay before deductible, 20% coinsurance after.	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	No charge	————none————
	Urgent care	$25 copay	$25 copay before deductible, 20% coinsurance after.	20% coinsurance	————none————

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
	Physician/surgeon fee	No charge	20% coinsurance	20% coinsurance	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$5 copay	$5 copay	20% coinsurance	————none————
	Mental/Behavioral health inpatient services	No charge	No charge	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
	Substance use disorder outpatient services	$5 copay	$5 copay	20% coinsurance	————none————
	Substance use disorder inpatient services	No charge	No charge	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	20% coinsurance	Copay applies to initial visit.
	Delivery and all inpatient services	No charge	20% coinsurance	20% coinsurance	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	20% coinsurance	————none————
	Rehabilitation services	No charge	20% coinsurance	20% coinsurance	————none————
	Habilitation services	No charge	20% coinsurance	20% coinsurance	Autism spectrum disorder is excluded.
	Skilled nursing care	No charge	20% coinsurance	20% coinsurance	————none————
	Durable medical equipment	No charge	20% coinsurance	20% coinsurance	————none————
	Hospice service	No charge	20% coinsurance	20% coinsurance	————none————
If your child needs dental or eye care	Eye exam	No charge	No charge	20% coinsurance	Limited to one exam per calendar year.
	Glasses	Not covered	Not covered	Not covered	$40 reimbursement per member every two years for frames and lenses.
	Dental check-up	Not covered	Not covered	Not covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-603-598-3320. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim Appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,380
- **Patient pays** $160

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$10
Coinsurance	$0
Limits or exclusions	$150
Total	**$160**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,150
- **Patient pays** $350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$170
Coinsurance	$0
Limits or exclusions	$80
Total	**$250**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-438-9672.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PCP-referred benefits: **$0** individual **/ $0** family For self-referred **network** providers: **$0** individual**/ $0** family For self-referred **out-of-network** providers: **$150** individual **/ $450** family **Deductible** does not apply to in-network preventive care, in-network office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses: $5,000** individual/**$10,000** family. **For prescriptions: $1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network expenses, precertification penalty and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call **1-800-438-9672**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call **1-800-438-9672** or visit us at **www.anthem.com.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.anthem.com** or call **1-800-438-9672** to request a copy.

Do I 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 **network** or **out-of-network specialist**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per visit	$30 copay per visit	20% coinsurance	——none——
	Specialist visit	$10 copay per visit	$30 copay per visit	20% coinsurance	——none——
	Other practitioner office visit	$10 copay per visit	$30 copay per visit	20% coinsurance	——none——
	Preventive care/screening/ immunization	No charge	No charge	20% coinsurance	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	20% coinsurance	——none——

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service		Your copay and any balance billing.	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 you use a CVS Caremark participating pharmacy.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service		Your copay and any balance billing.	
	Non-preferred brand drugs	$30/Rx for retail; $30/Rx for mail service		Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service		Not covered	Specialty medication available through preferred network only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	20% coinsurance	————none————
	Physician/surgeon fees	No charge	20% coinsurance	20% coinsurance	————none————
If you need immediate medical attention	Emergency room services	$50 copay	$50 copay, then 20% coinsurance	$50 copay before deductible, 20% coinsurance after	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	No charge	————none————
	Urgent care	$50 copay	$50 copay, then 20% coinsurance	$50 copay before deductible, 20% coinsurance after	————none————

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
	Physician/surgeon fee	No charge	20% coinsurance	20% coinsurance	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay	$10 copay	20% coinsurance	————none————
	Mental/Behavioral health inpatient services	No charge	No charge	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
	Substance use disorder outpatient services	$10 copay	$10 copay	20% coinsurance	————none————
	Substance use disorder inpatient services	No charge	No charge	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	20% coinsurance	Copay applies to initial visit.
	Delivery and all inpatient services	No charge	20% coinsurance	20% coinsurance	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	20% coinsurance	————none————
	Rehabilitation services	No charge	20% coinsurance	20% coinsurance	————none————
	Habilitation services	No charge	20% coinsurance	20% coinsurance	Autism spectrum disorder is excluded.
	Skilled nursing care	No charge	20% coinsurance	20% coinsurance	————none————
	Durable medical equipment	No charge	20% coinsurance	20% coinsurance	————none————
	Hospice service	No charge	20% coinsurance	20% coinsurance	————none————
If your child needs dental or eye care	Eye exam	No charge	No charge	20% coinsurance	Limited to one exam per calendar year.
	Glasses	Not covered	Not covered	Not covered	$40 reimbursement per member every two years for frames and lenses.
	Dental check-up	Not covered	Not covered	Not covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-603-598-3320. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim Appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,100
- **Patient pays** $300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$220
Coinsurance	$0
Limits or exclusions	$80
Total	**$300**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-438-9672.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PCP-referred benefits: **$0** individual **/ $0** family For self-referred **network** providers: **$0** individual**/ $0** family For self-referred **out-of-network** providers: **$150** individual **/ $450** family **Deductible** does not apply to in-network preventive care, in-network office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses: $5,000** individual/**$10,000** family. **For prescriptions: $1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network expenses, precertification penalty and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call **1-800-438-9672**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

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Do I 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 **network** or **out-of-network specialist**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per visit	$30 copay per visit	20% coinsurance	——none——
	Specialist visit	$10 copay per visit	$30 copay per visit	20% coinsurance	——none——
	Other practitioner office visit	$10 copay per visit	$30 copay per visit	20% coinsurance	——none——
	Preventive care/screening/ immunization	No charge	No charge	20% coinsurance	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	20% coinsurance	——none——

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Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service		Your copay and any balance billing.	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 you use a CVS Caremark participating pharmacy.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service		Your copay and any balance billing.	
	Non-preferred brand drugs	$45/Rx for retail; $45/Rx for mail service		Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service		Not covered	Specialty medication available through preferred network only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	20% coinsurance	————none————
	Physician/surgeon fees	No charge	20% coinsurance	20% coinsurance	————none————
If you need immediate medical attention	Emergency room services	$50 copay	$50 copay, then 20% coinsurance	$50 copay before deductible, 20% coinsurance after	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	No charge	————none————
	Urgent care	$50 copay	$50 copay, then 20% coinsurance	$50 copay before deductible, 20% coinsurance after	————none————

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
	Physician/surgeon fee	No charge	20% coinsurance	20% coinsurance	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay	$10 copay	20% coinsurance	————none————
	Mental/Behavioral health inpatient services	No charge	No charge	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
	Substance use disorder outpatient services	$10 copay	$10 copay	20% coinsurance	————none————
	Substance use disorder inpatient services	No charge	No charge	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	20% coinsurance	Copay applies to initial visit.
	Delivery and all inpatient services	No charge	20% coinsurance	20% coinsurance	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	20% coinsurance	————none————
	Rehabilitation services	No charge	20% coinsurance	20% coinsurance	————none————
	Habilitation services	No charge	20% coinsurance	20% coinsurance	Autism spectrum disorder is excluded.
	Skilled nursing care	No charge	20% coinsurance	20% coinsurance	————none————
	Durable medical equipment	No charge	20% coinsurance	20% coinsurance	————none————
	Hospice service	No charge	20% coinsurance	20% coinsurance	————none————
If your child needs dental or eye care	Eye exam	No charge	No charge	20% coinsurance	Limited to one exam per calendar year.
	Glasses	Not covered	Not covered	Not covered	$40 reimbursement per member every two years for frames and lenses.
	Dental check-up	Not covered	Not covered	Not covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-603-598-3320. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim Appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,100
- **Patient pays** $300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$220
Coinsurance	$0
Limits or exclusions	$80
Total	**$300**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PCP-referred benefits: **$0** individual **/ $0** family For self-referred **network** providers: **$0** individual**/ $0** family For self-referred **out-of-network** providers: **$150** individual **/ $450** family **Deductible** does not apply to in-network preventive care, in-network office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses: $5,000** individual/**$10,000** family. **For prescriptions: $1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network expenses, precertification penalty and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call **1-800-438-9672**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I 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 **network** or **out-of-network specialist**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per visit	$30 copay per visit	20% coinsurance	——none——
	Specialist visit	$10 copay per visit	$30 copay per visit	20% coinsurance	——none——
	Other practitioner office visit	$10 copay per visit	$30 copay per visit	20% coinsurance	——none——
	Preventive care/screening/ immunization	No charge	No charge	20% coinsurance	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	20% coinsurance	——none——

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Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service		Your copay and any balance billing.	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 you use a CVS Caremark participating pharmacy.
	Preferred brand drugs	$25/Rx for retail; $0/Rx for mail service		Your copay and any balance billing.	
	Non-preferred brand drugs	$40/Rx for retail; $70/Rx for mail service		Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service		Not covered	Specialty medication available through preferred network only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	20% coinsurance	————none————
	Physician/surgeon fees	No charge	20% coinsurance	20% coinsurance	————none————
If you need immediate medical attention	Emergency room services	$50 copay	$50 copay, then 20% coinsurance	$50 copay before deductible, 20% coinsurance after	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	No charge	————none————
	Urgent care	$50 copay	$50 copay, then 20% coinsurance	$50 copay before deductible, 20% coinsurance after	————none————

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
	Physician/surgeon fee	No charge	20% coinsurance	20% coinsurance	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay	$10 copay	20% coinsurance	————none————
	Mental/Behavioral health inpatient services	No charge	No charge	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
	Substance use disorder outpatient services	$10 copay	$10 copay	20% coinsurance	————none————
	Substance use disorder inpatient services	No charge	No charge	20% coinsurance	Precertification required for out-of-network hospital stay (or $500 penalty may apply).
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	20% coinsurance	Copay applies to initial visit.
	Delivery and all inpatient services	No charge	20% coinsurance	20% coinsurance	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost for PCP-Referred Benefits	Your Cost for Self-Referred Network Provider	Your Cost for Self-Referred Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	20% coinsurance	————none————
	Rehabilitation services	No charge	20% coinsurance	20% coinsurance	————none————
	Habilitation services	No charge	20% coinsurance	20% coinsurance	Autism spectrum disorder is excluded.
	Skilled nursing care	No charge	20% coinsurance	20% coinsurance	————none————
	Durable medical equipment	No charge	20% coinsurance	20% coinsurance	————none————
	Hospice service	No charge	20% coinsurance	20% coinsurance	————none————
If your child needs dental or eye care	Eye exam	No charge	No charge	20% coinsurance	Limited to one exam per calendar year.
	Glasses	Not covered	Not covered	Not covered	$40 reimbursement per member every two years for frames and lenses.
	Dental check-up	Not covered	Not covered	Not covered	————none————

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- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (limit of one exam every two years)

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If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim Appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

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Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,100
- **Patient pays** $300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$220
Coinsurance	$0
Limits or exclusions	$80
Total	**$300**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
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For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0.**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/ **$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year)for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay per visit	Not Covered	——none——
	Specialist visit	$5 copay per visit	Not Covered	——none——
	Other practitioner office visit	$5 copay per visit	Not Covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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 network copay when using a CVS Caremark participating pharmacy.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$30/Rx for retail; $30/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not Covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	——none——
	Physician/surgeon fees	No Charge	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$25 copay per visit	$25 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	——none——
	Urgent care	$25 copay per visit	$25 copay per visit	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	——none——
	Physician/surgeon fee	No Charge	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$5 copay per visit	Not Covered	——none——
	Mental/Behavioral health inpatient services	No Charge	Not Covered	
	Substance use disorder outpatient services	$5 copay per visit	Not Covered	
	Substance use disorder inpatient services	No Charge	Not Covered	
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Copay applies to initial visit.
	Delivery and all inpatient services	No Charge	Not Covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	——————none——————
	Rehabilitation services	$5 copay per visit	Not Covered	Coverage for physical, occupational and speech therapy services is limited to 60 visits combined per member per calendar year.
	Habilitation services	$5 copay per visit	Not Covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No Charge	Not Covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not Covered	——————none——————
	Hospice service	No Charge	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per calendar year.
	Glasses	Not Covered	Not Covered	$40 reimbursement per member per calendar year for frames and lenses.
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-527-5001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,620
- **Patient pays** $780

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$450
Coinsurance	$250
Limits or exclusions	$80
Total	**$780**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0.**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/ **$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year)for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay per visit	Not Covered	——none——
	Specialist visit	$5 copay per visit	Not Covered	——none——
	Other practitioner office visit	$5 copay per visit	Not Covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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 network copay when using a CVS Caremark participating pharmacy.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$45/Rx for retail; $45/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not Covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	——none——
	Physician/surgeon fees	No Charge	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$25 copay per visit	$25 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	——none——
	Urgent care	$25 copay per visit	$25 copay per visit	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	——none——
	Physician/surgeon fee	No Charge	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$5 copay per visit	Not Covered	——none——
	Mental/Behavioral health inpatient services	No Charge	Not Covered	
	Substance use disorder outpatient services	$5 copay per visit	Not Covered	
	Substance use disorder inpatient services	No Charge	Not Covered	
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Copay applies to initial visit.
	Delivery and all inpatient services	No Charge	Not Covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	——none——
	Rehabilitation services	$5 copay per visit	Not Covered	Coverage for physical, occupational and speech therapy services is limited to 60 visits combined per member per calendar year.
	Habilitation services	$5 copay per visit	Not Covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No Charge	Not Covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not Covered	——none——
	Hospice service	No Charge	Not Covered	——none——
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per calendar year.
	Glasses	Not Covered	Not Covered	$40 reimbursement per member per calendar year for frames and lenses.
	Dental check-up	Not Covered	Not Covered	——none——

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
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- Bariatric surgery
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- Infertility treatment (limitations apply)
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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

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Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,620
- **Patient pays** $780

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$450
Coinsurance	$250
Limits or exclusions	$80
Total	**$780**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

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Does the Coverage Example predict my own care needs?

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Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/ **$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year)for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay per visit	Not Covered	——none——
	Specialist visit	$5 copay per visit	Not Covered	——none——
	Other practitioner office visit	$5 copay per visit	Not Covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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 network copay when using a CVS Caremark participating pharmacy.
	Preferred brand drugs	$25/Rx for retail; $40/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$40/Rx for retail; $70/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not Covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	——none——
	Physician/surgeon fees	No Charge	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$25 copay per visit	$25 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	——none——
	Urgent care	$25 copay per visit	$25 copay per visit	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	——none——
	Physician/surgeon fee	No Charge	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$5 copay per visit	Not Covered	——none——
	Mental/Behavioral health inpatient services	No Charge	Not Covered	
	Substance use disorder outpatient services	$5 copay per visit	Not Covered	
	Substance use disorder inpatient services	No Charge	Not Covered	
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Copay applies to initial visit.
	Delivery and all inpatient services	No Charge	Not Covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	——————none——————
	Rehabilitation services	$5 copay per visit	Not Covered	Coverage for physical, occupational and speech therapy services is limited to 60 visits combined per member per calendar year.
	Habilitation services	$5 copay per visit	Not Covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No Charge	Not Covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not Covered	——————none——————
	Hospice service	No Charge	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per calendar year.
	Glasses	Not Covered	Not Covered	$40 reimbursement per member per calendar year for frames and lenses.
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-527-5001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,620
- **Patient pays** $780

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$450
Coinsurance	$250
Limits or exclusions	$80
Total	**$780**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year)for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per visit	Not Covered	——none——
	Specialist visit	$10 copay per visit	Not Covered	——none——
	Other practitioner office visit	$10 copay per visit	Not Covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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 network copay when using a CVS Caremark participating pharmacy.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$45/Rx for retail; $45/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not Covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	——none——
	Physician/surgeon fees	No Charge	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$50 copay per visit	$50 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	——none——
	Urgent care	$50 copay per visit	$50 copay per visit	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	——none——
	Physician/surgeon fee	No Charge	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay per visit	Not Covered	——none——
	Mental/Behavioral health inpatient services	No Charge	Not Covered	
	Substance use disorder outpatient services	$10 copay per visit	Not Covered	
	Substance use disorder inpatient services	No Charge	Not Covered	
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Copay applies to initial visit.
	Delivery and all inpatient services	No Charge	Not Covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	——none——
	Rehabilitation services	$10 copay per visit	Not Covered	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year.
	Habilitation services	$10 copay per visit	Not Covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No Charge	Not Covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not Covered	——none——
	Hospice service	No Charge	Not Covered	——none——
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per calendar year.
	Glasses	Not Covered	Not Covered	$40 reimbursement per member per calendar year for frames and lenses.
	Dental check-up	Not Covered	Not Covered	——none——

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,360
- **Patient pays** $180

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,570
- **Patient pays** $830

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$500
Coinsurance	$250
Limits or exclusions	$80
Total	**$830**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year)for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per visit	Not Covered	——none——
	Specialist visit	$10 copay per visit	Not Covered	——none——
	Other practitioner office visit	$10 copay per visit	Not Covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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 network copay when using a CVS Caremark participating pharmacy.
	Preferred brand drugs	$25/Rx for retail; $40/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$40/Rx for retail; $70/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not Covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	——none——
	Physician/surgeon fees	No Charge	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$50 copay per visit	$50 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	——none——
	Urgent care	$50 copay per visit	$50 copay per visit	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	——none——
	Physician/surgeon fee	No Charge	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay per visit	Not Covered	——none——
	Mental/Behavioral health inpatient services	No Charge	Not Covered	
	Substance use disorder outpatient services	$10 copay per visit	Not Covered	
	Substance use disorder inpatient services	No Charge	Not Covered	
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Copay applies to initial visit.
	Delivery and all inpatient services	No Charge	Not Covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	——————none——————
	Rehabilitation services	$10 copay per visit	Not Covered	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year.
	Habilitation services	$10 copay per visit	Not Covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No Charge	Not Covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not Covered	——————none——————
	Hospice service	No Charge	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per calendar year.
	Glasses	Not Covered	Not Covered	$40 reimbursement per member per calendar year for frames and lenses.
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-527-5001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,360
- **Patient pays** $180

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$30
Coinsurance	$0
Limits or exclusions	$150
Total	**$180**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,570
- **Patient pays** $830

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$500
Coinsurance	$250
Limits or exclusions	$80
Total	**$830**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	Not Covered	——none——
	Specialist visit	$20 copay per visit	Not Covered	——none——
	Other practitioner office visit	$20 copay per visit	Not Covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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 network copay when using a CVS Caremark participating pharmacy.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$45/Rx for retail; $45/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not Covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	——none——
	Physician/surgeon fees	No Charge	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$100 copay per visit	$100 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	——none——
	Urgent care	$50 copay per visit	$100 copay per visit	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	——none——
	Physician/surgeon fee	No Charge	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay per visit	Not Covered	——none——
	Mental/Behavioral health inpatient services	No Charge	Not Covered	
	Substance use disorder outpatient services	$20 copay per visit	Not Covered	
	Substance use disorder inpatient services	No Charge	Not Covered	
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Copay applies to initial visit.
	Delivery and all inpatient services	No Charge	Not Covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	——————none——————
	Rehabilitation services	$20 copay per visit	Not Covered	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year.
	Habilitation services	$20 copay per visit	Not Covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No Charge	Not Covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not Covered	——————none——————
	Hospice service	No Charge	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per calendar year.
	Glasses	Not Covered	Not Covered	$40 reimbursement per member per calendar year for frames and lenses.
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-527-5001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $ 7,350
- **Patient pays** $190

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$40
Coinsurance	$0
Limits or exclusions	$150
Total	**$190**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,470
- **Patient pays** $930

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$600
Coinsurance	$250
Limits or exclusions	$80
Total	**$930**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3057.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	Not Covered	——none——
	Specialist visit	$20 copay per visit	Not Covered	——none——
	Other practitioner office visit	$20 copay per visit	Not Covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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 network copay when using a CVS Caremark participating pharmacy.
	Preferred brand drugs	$25/Rx for retail; $40/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$40/Rx for retail; $70/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not Covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	——none——
	Physician/surgeon fees	No Charge	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$100 copay per visit	$100 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	——none——
	Urgent care	$50 copay per visit	$100 copay per visit	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	——none——
	Physician/surgeon fee	No Charge	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay per visit	Not Covered	——none——
	Mental/Behavioral health inpatient services	No Charge	Not Covered	
	Substance use disorder outpatient services	$20 copay per visit	Not Covered	
	Substance use disorder inpatient services	No Charge	Not Covered	
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Copay applies to initial visit.
	Delivery and all inpatient services	No Charge	Not Covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	——————none——————
	Rehabilitation services	$20 copay per visit	Not Covered	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year.
	Habilitation services	$20 copay per visit	Not Covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	No Charge	Not Covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not Covered	——————none——————
	Hospice service	No Charge	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per calendar year.
	Glasses	Not Covered	Not Covered	$40 reimbursement per member per calendar year for frames and lenses.
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-527-5001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $ 7,350
- **Patient pays** $190

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$40
Coinsurance	$0
Limits or exclusions	$150
Total	**$190**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,470
- **Patient pays** $930

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$600
Coinsurance	$250
Limits or exclusions	$80
Total	**$930**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** individual/**$1,500** family. **Deductible** does not apply to **network** preventive care, **network** office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** Durable Medical Equipment. There are no other specific **deductibles**.	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	Not Covered	——none——
	Specialist visit	$15 copay per visit	Not Covered	——none——
	Other practitioner office visit	$15 copay per visit	Not Covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not Covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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 network copay when using a CVS Caremark participating pharmacy.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$45/Rx for retail; $45/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not Covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	——none——
	Physician/surgeon fees	No Charge	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$100 copay before deductible and 0% coinsurance after deductible.	$100 copay before deductible and 0% coinsurance after deductible.	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance	0% coinsurance	——none——
	Urgent care	$50 copay before deductible and 0% coinsurance after deductible.	$100 copay before deductible and 0% coinsurance after deductible.	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not Covered	——none——
	Physician/surgeon fee	0% coinsurance	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay per visit	Not Covered	——none——
	Mental/Behavioral health inpatient services	0% coinsurance	Not Covered	
	Substance use disorder outpatient services	$15 copay per visit	Not Covered	
	Substance use disorder inpatient services	0% coinsurance	Not Covered	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not Covered	Copay applies to initial visit.
	Delivery and all inpatient services	0% coinsurance	Not Covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	——————none——————
	Rehabilitation services	$15 copay per visit	Not Covered	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year.
	Habilitation services	$15 copay per visit	Not Covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	0% coinsurance	Not Covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not Covered	——————none——————
	Hospice service	0% coinsurance	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per calendar year.
	Glasses	Not Covered	Not Covered	$40 reimbursement per member per calendar year for frames and lenses.
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-527-5001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,870
- **Patient pays** $670

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$670**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,440
- **Patient pays** $960

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$550
Coinsurance	$230
Limits or exclusions	$80
Total	**$960**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** individual/**$1,500** family. **Deductible** does not apply to **network** preventive care, **network** office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** Durable Medical Equipment. There are no other specific **deductibles**.	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year)for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-870-3122** or visit us at **www.anthem.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.anthem.com** or call **1-800-870-3122** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	Not Covered	——none——
	Specialist visit	$15 copay per visit	Not Covered	——none——
	Other practitioner office visit	$15 copay per visit	Not Covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not Covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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 network copay when using a CVS Caremark participating pharmacy.
	Preferred brand drugs	$25/Rx for retail; $40/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$40/Rx for retail; $70/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not Covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	——none——
	Physician/surgeon fees	No Charge	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$100 copay before deductible and 0% coinsurance after deductible.	$100 copay before deductible and 0% coinsurance after deductible.	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance	0% coinsurance	——none——
	Urgent care	$50 copay before deductible and 0% coinsurance after deductible.	$100 copay before deductible and 0% coinsurance after deductible.	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not Covered	——none——
	Physician/surgeon fee	0% coinsurance	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay per visit	Not Covered	——none——
	Mental/Behavioral health inpatient services	0% coinsurance	Not Covered	
	Substance use disorder outpatient services	$15 copay per visit	Not Covered	
	Substance use disorder inpatient services	0% coinsurance	Not Covered	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not Covered	Copay applies to initial visit.
	Delivery and all inpatient services	0% coinsurance	Not Covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	——————none——————
	Rehabilitation services	$15 copay per visit	Not Covered	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year.
	Habilitation services	$15 copay per visit	Not Covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	0% coinsurance	Not Covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not Covered	——————none——————
	Hospice service	0% coinsurance	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per calendar year.
	Glasses	Not Covered	Not Covered	$40 reimbursement per member per calendar year for frames and lenses.
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-527-5001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,870
- **Patient pays** $670

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$670**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,440
- **Patient pays** $960

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$550
Coinsurance	$230
Limits or exclusions	$80
Total	**$960**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** individual/**$750** family. **Deductible** does not apply to **network** preventive care, **network** office visits and prescription drugs. **Copayments** don't count toward the **deductible.**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-870-3122** or visit us at **www.anthem.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.anthem.com** or call **1-800-870-3122** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	Not Covered	——none——
	Specialist visit	$20 copay per visit	Not Covered	——none——
	Other practitioner office visit	$20 copay per visit	Not Covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not Covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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 network copay when using a CVS Caremark participating pharmacy.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$45/Rx for retail; $45/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not Covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	——none——
	Physician/surgeon fees	No Charge	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$150 copay before deductible and 0% coinsurance after deductible.	$150 copay before deductible and 0% coinsurance after deductible.	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance	0% coinsurance	——none——
	Urgent care	$75 copay before deductible and 0% coinsurance after deductible.	$150 copay before deductible and 0% coinsurance after deductible.	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not Covered	——none——
	Physician/surgeon fee	0% coinsurance	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay per visit	Not Covered	——none——
	Mental/Behavioral health inpatient services	0% coinsurance	Not Covered	
	Substance use disorder outpatient services	$20 copay per visit	Not Covered	
	Substance use disorder inpatient services	0% coinsurance	Not Covered	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not Covered	Copay applies to initial visit.
	Delivery and all inpatient services	0% coinsurance	Not Covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	——————none——————
	Rehabilitation services	$20 copay per visit	Not Covered	Coverage for physical, occupational and speech therapy services is limited to 60 visits combined per member per calendar year.
	Habilitation services	$20 copay per visit	Not Covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	0% coinsurance	Not Covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not Covered	——————none——————
	Hospice service	0% coinsurance	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per calendar year.
	Glasses	Not Covered	Not Covered	$40 reimbursement per member per calendar year for frames and lenses.
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

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- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

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For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

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Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

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Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,120
- **Patient pays** $420

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$420**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,390
- **Patient pays** $1,010

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$600
Coinsurance	$230
Limits or exclusions	$80
Total	**$1010**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

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Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** individual/**$750** family. **Deductible** does not apply to **network** preventive care, **network** office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-870-3122** or visit us at **www.anthem.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.anthem.com** or call **1-800-870-3122** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	Not Covered	——none——
	Specialist visit	$20 copay per visit	Not Covered	——none——
	Other practitioner office visit	$20 copay per visit	Not Covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not Covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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 network copay when using a CVS Caremark participating pharmacy.
	Preferred brand drugs	$25/Rx for retail; $40/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$40/Rx for retail; $70/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not Covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	——none——
	Physician/surgeon fees	No Charge	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$150 copay before deductible and 0% coinsurance after deductible.	$150 copay before deductible and 0% coinsurance after deductible.	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance	0% coinsurance	——none——
	Urgent care	$75 copay before deductible and 0% coinsurance after deductible.	$150 copay before deductible and 0% coinsurance after deductible.	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not Covered	——none——
	Physician/surgeon fee	0% coinsurance	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay per visit	Not Covered	——none——
	Mental/Behavioral health inpatient services	0% coinsurance	Not Covered	
	Substance use disorder outpatient services	$20 copay per visit	Not Covered	
	Substance use disorder inpatient services	0% coinsurance	Not Covered	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not Covered	Copay applies to initial visit.
	Delivery and all inpatient services	0% coinsurance	Not Covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	——————none——————
	Rehabilitation services	$20 copay per visit	Not Covered	Coverage for physical, occupational and speech therapy services is limited to 60 visits combined per member per calendar year.
	Habilitation services	$20 copay per visit	Not Covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	0% coinsurance	Not Covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not Covered	——————none——————
	Hospice service	0% coinsurance	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per calendar year.
	Glasses	Not Covered	Not Covered	$40 reimbursement per member per calendar year for frames and lenses.
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-527-5001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,120
- **Patient pays** $420

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$420**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,390
- **Patient pays** $1,010

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$600
Coinsurance	$230
Limits or exclusions	$80
Total	**$1010**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** individual/**$3,000** family. **Deductible** does not apply to **network** preventive care, **network** office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year)for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	Not Covered	——none——
	Specialist visit	$40 copay per visit	Not Covered	——none——
	Other practitioner office visit	$40 copay per visit	Not Covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not Covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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 network copay when using a CVS Caremark participating pharmacy.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$45/Rx for retail; $45/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not Covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not Covered	——none——
	Physician/surgeon fees	0% coinsurance	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$250 copay before deductible and 0% coinsurance after deductible.	$250 copay before deductible and 0% coinsurance after deductible.	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance	0% coinsurance	——none——
	Urgent care	$125 copay before deductible and 0% coinsurance after deductible.	$250 copay before deductible and 0% coinsurance after deductible.	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not Covered	——none——
	Physician/surgeon fee	0% coinsurance	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay per visit	Not Covered	——none——
	Mental/Behavioral health inpatient services	0% coinsurance	Not Covered	
	Substance use disorder outpatient services	$15 copay per visit	Not Covered	
	Substance use disorder inpatient services	0% coinsurance	Not Covered	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not Covered	Copay applies to initial visit.
	Delivery and all inpatient services	0% coinsurance	Not Covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	——————none——————
	Rehabilitation services	$40 copay per visit	Not Covered	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year.
	Habilitation services	$40 copay per visit	Not Covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	0% coinsurance	Not Covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not Covered	——————none——————
	Hospice service	0% coinsurance	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per calendar year.
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

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To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,320
- **Patient pays** $1,220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1000
Copays	$20
Coinsurance	$50
Limits or exclusions	$150
Total	**$1220**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,440
- **Patient pays** $960

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$550
Coinsurance	$230
Limits or exclusions	$80
Total	**$960**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

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✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** individual/**$3,000** family. **Deductible** does not apply to **network** preventive care, **network** office visits and prescription drugs. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year)for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-870-3122** or visit us at **www.anthem.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.anthem.com** or call **1-800-870-3122** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	Not Covered	——none——
	Specialist visit	$40 copay per visit	Not Covered	——none——
	Other practitioner office visit	$40 copay per visit	Not Covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not Covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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 network copay when using a CVS Caremark participating pharmacy.
	Preferred brand drugs	$25/Rx for retail; $40/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$40/Rx for retail; $70/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not Covered	Specialty medication available through preferred network only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not Covered	——none——
	Physician/surgeon fees	0% coinsurance	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$250 copay before deductible and 0% coinsurance after deductible.	$250 copay before deductible and 0% coinsurance after deductible.	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance	0% coinsurance	——none——
	Urgent care	$125 copay before deductible and 0% coinsurance after deductible.	$250 copay before deductible and 0% coinsurance after deductible.	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not Covered	——none——
	Physician/surgeon fee	0% coinsurance	Not Covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay per visit	Not Covered	——none——
	Mental/Behavioral health inpatient services	0% coinsurance	Not Covered	
	Substance use disorder outpatient services	$15 copay per visit	Not Covered	
	Substance use disorder inpatient services	0% coinsurance	Not Covered	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not Covered	Copay applies to initial visit.
	Delivery and all inpatient services	0% coinsurance	Not Covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	——————none——————
	Rehabilitation services	$40 copay per visit	Not Covered	Coverage for physical, occupational and speech therapy services is limited to 60 combined visits per member per calendar year.
	Habilitation services	$40 copay per visit	Not Covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	0% coinsurance	Not Covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not Covered	——————none——————
	Hospice service	0% coinsurance	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per calendar year.
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-527-5001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

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For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,320
- **Patient pays** $1,220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1000
Copays	$20
Coinsurance	$50
Limits or exclusions	$150
Total	**$1220**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,440
- **Patient pays** $960

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$550
Coinsurance	$230
Limits or exclusions	$80
Total	**$960**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** individual/**$3,000** family. **Deductible** does not apply to in-network preventive care, in-network office visits, prescription drugs and lab services provided in a preferred lab. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	Not covered	——none——
	Specialist visit	$40 copay per visit	Not covered	——none——
	Other practitioner office visit	$40 copay per visit	Not covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No charge	Not covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	Services in a preferred lab are covered at 100%.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	——none——

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$45/Rx for retail; $45/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not covered	Specialty medication available through preferred mail service only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay or 0% coinsurance	Not covered	$75 copay applies to preferred ambulatory surgery centers. Costs may vary by site of service.
	Physician/surgeon fees	$75 copay or 0% coinsurance	Not covered	
If you need immediate medical attention	Emergency room services	$100 copay before deductible.	$100 copay before deductible.	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance	0% coinsurance	——none——
	Urgent care	$50 copay before deductible.	$100 copay before deductible.	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	——none——
	Physician/surgeon fee	0% coinsurance	Not covered	——none——

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay per visit	Not covered	none
	Mental/Behavioral health inpatient services	0% coinsurance	Not covered	
	Substance use disorder outpatient services	$20 copay per visit	Not covered	
	Substance use disorder inpatient services	0% coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not covered	Copay applies to initial visit
	Delivery and all inpatient services	0% coinsurance	Not covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	——————none——————
	Rehabilitation services	$40 copay per visit	Not covered	Physical, occupational and speech therapy is limited to 20 visits per therapy per member per year.
	Habilitation services	$40 copay per visit	Not covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	0% coinsurance	Not covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not covered	——————none——————
	Hospice service	0% coinsurance	Not covered	——————none——————
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to one exam every calendar year.
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-527-5001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

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(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,370
- **Patient pays** $1,170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,390
- **Patient pays** $1,010

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$600
Coinsurance	$230
Limits or exclusions	$80
Total	**$1,010**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** individual/**$3,000** family. **Deductible** does not apply to in-network preventive care, in-network office visits, prescription drugs and lab services provided in a preferred lab. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	Not covered	——none——
	Specialist visit	$40 copay per visit	Not covered	——none——
	Other practitioner office visit	$40 copay per visit	Not covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No charge	Not covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	Services in a preferred lab are covered at 100%.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	——none——

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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.
	Preferred brand drugs	$25/Rx for retail; $40/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$40/Rx for retail; $70/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not covered	Specialty medication available through preferred mail service only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay or 0% coinsurance	Not covered	$75 copay applies to preferred ambulatory surgery centers. Costs may vary by site of service.
	Physician/surgeon fees	$75 copay or 0% coinsurance	Not covered	
If you need immediate medical attention	Emergency room services	$100 copay before deductible.	$100 copay before deductible.	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance	0% coinsurance	——none——
	Urgent care	$50 copay before deductible.	$100 copay before deductible.	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	——none——
	Physician/surgeon fee	0% coinsurance	Not covered	——none——

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay per visit	Not covered	——————none——————
	Mental/Behavioral health inpatient services	0% coinsurance	Not covered	
	Substance use disorder outpatient services	$20 copay per visit	Not covered	
	Substance use disorder inpatient services	0% coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not covered	Copay applies to initial visit
	Delivery and all inpatient services	0% coinsurance	Not covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	——none——
	Rehabilitation services	$40 copay per visit	Not covered	Physical, occupational and speech therapy is limited to 20 visits per therapy per member per year.
	Habilitation services	$40 copay per visit	Not covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	0% coinsurance	Not covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not covered	——none——
	Hospice service	0% coinsurance	Not covered	——none——
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to one exam every calendar year.
	Glasses	Not covered	Not covered	——none——
	Dental check-up	Not covered	Not covered	——none——

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,370
- **Patient pays** $1,170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,390
- **Patient pays** $1,010

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$600
Coinsurance	$230
Limits or exclusions	$80
Total	**$1,010**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** individual/**$9,000** family. **Deductible** does not apply to in-network preventive care, in-network office visits, prescription drugs and lab services provided in a preferred lab. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not covered	——none——
	Specialist visit	$50 copay per visit	Not covered	——none——
	Other practitioner office visit	$50 copay per visit	Not covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No charge	Not covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	Services in a preferred lab are covered at 100%.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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.
	Preferred brand drugs	$20/Rx for retail; $20/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$45/Rx for retail; $45/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not covered	Specialty medication available through preferred mail service only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay or 0% coinsurance	Not covered	$75 copay applies to preferred ambulatory surgery centers. Costs may vary by site of service.
	Physician/surgeon fees	$75 copay or 0% coinsurance	Not covered	
If you need immediate medical attention	Emergency room services	$150 copay before deductible.	$150 copay before deductible.	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance	0% coinsurance	——none——
	Urgent care	$75 copay before deductible.	$150 copay before deductible.	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	——none——
	Physician/surgeon fee	0% coinsurance	Not covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay per visit	Not covered	——none——
	Mental/Behavioral health inpatient services	0% coinsurance	Not covered	
	Substance use disorder outpatient services	$25 copay per visit	Not covered	
	Substance use disorder inpatient services	0% coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not covered	Copay applies to initial visit
	Delivery and all inpatient services	0% coinsurance	Not covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	——none——
	Rehabilitation services	$50 copay per visit	Not covered	Physical, occupational and speech therapy is limited to 20 visits per therapy per member per year.
	Habilitation services	$50 copay per visit	Not covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	0% coinsurance	Not covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not covered	——none——
	Hospice service	0% coinsurance	Not covered	——none——
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to one exam every calendar year.
	Glasses	Not covered	Not covered	——none——
	Dental check-up	Not covered	Not covered	——none——

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-527-5001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,370
- **Patient pays** $1,170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,390
- **Patient pays** $1,010

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$600
Coinsurance	$230
Limits or exclusions	$80
Total	**$1,010**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

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Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** individual/**$9,000** family. **Deductible** does not apply to in-network preventive care, in-network office visits, prescription drugs and lab services provided in a preferred lab. **Copayments** don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** Durable Medical Equipment. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **For medical expenses:** **$5,000** individual/**$10,000** family. **For prescriptions:** **$1,600** individual/**$3,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, out-of-network expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-800-870-3122.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You do not need a referral to see a **network specialist**. You do need a referral for all out-of-network **providers**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see an out-of-network **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not covered	——none——
	Specialist visit	$50 copay per visit	Not covered	——none——
	Other practitioner office visit	$50 copay per visit	Not covered	Chiropractic care limited to 12 visits per member per calendar year.
	Preventive care/screening/immunization	No charge	Not covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	Services in a preferred lab are covered at 100%.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-726-1631** or **www.caremark.com**.	Generic drugs	$10/Rx for retail; $10/Rx for mail service	Your copay and any balance billing.	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.
	Preferred brand drugs	$25/Rx for retail; $40/Rx for mail service	Your copay and any balance billing.	
	Non-preferred brand drugs	$40/Rx for retail; $70/Rx for mail service	Your copay and any balance billing.	
	Specialty drugs	No retail coverage; Rx copay for mail service	Not covered	Specialty medication available through preferred mail service only.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay or 0% coinsurance	Not covered	$75 copay applies to preferred ambulatory surgery centers. Costs may vary by site of service.
	Physician/surgeon fees	$75 copay or 0% coinsurance	Not covered	
If you need immediate medical attention	Emergency room services	$150 copay before deductible.	$150 copay before deductible.	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance	0% coinsurance	——none——
	Urgent care	$75 copay before deductible.	$150 copay before deductible.	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	——none——
	Physician/surgeon fee	0% coinsurance	Not covered	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay per visit	Not covered	——none——
	Mental/Behavioral health inpatient services	0% coinsurance	Not covered	
	Substance use disorder outpatient services	$25 copay per visit	Not covered	
	Substance use disorder inpatient services	0% coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not covered	Copay applies to initial visit
	Delivery and all inpatient services	0% coinsurance	Not covered	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider or Referred Care	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	——none——
	Rehabilitation services	$50 copay per visit	Not covered	Physical, occupational and speech therapy is limited to 20 visits per therapy per member per year.
	Habilitation services	$50 copay per visit	Not covered	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	0% coinsurance	Not covered	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	20% coinsurance	Not covered	——none——
	Hospice service	0% coinsurance	Not covered	——none——
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to one exam every calendar year.
	Glasses	Not covered	Not covered	——none——
	Dental check-up	Not covered	Not covered	——none——

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
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- Long-term care
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- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine eye care(Adult) (limit of one exam every two years)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-527-5001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For Medical Claims:
Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

For Prescription Drug Claims:
Prescription Claim appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 58072-2084

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,370
- **Patient pays** $1,170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,390
- **Patient pays** $1,010

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$600
Coinsurance	$230
Limits or exclusions	$80
Total	**$1,010**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-888-224-4896.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,500** individual/**$5,000** family. **Deductible** does not apply to in-network preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For **network** benefits: **$2,500** individual/**$5,000** family. For **out-of-network** benefits: **$5,000** individual/**$10,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call **1-800-438-9672**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	30% coinsurance	——none——
	Specialist visit	0% coinsurance	30% coinsurance	——none——
	Other practitioner office visit	0% coinsurance	30% coinsurance	——none——
	Preventive care/screening/immunization	No charge	30% coinsurance	——none——
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-888-224-4896 or www.anthem.com.	Generic drugs	0% coinsurance	30% coinsurance	Coinsurance after deductible applies to retail and mail service. Covers up to a 90 day supply retail and mail service.
	Preferred brand drugs	0% coinsurance	30% coinsurance	
	Non-preferred brand drugs	0% coinsurance	30% coinsurance	
	Specialty drugs	0% coinsurance	30% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	——none——
	Physician/surgeon fees	0% coinsurance	30% coinsurance	——none——

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	——none——
	Emergency medical transportation	0% coinsurance	0% coinsurance	——none——
	Urgent care	0% coinsurance	0% coinsurance	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Failure to obtain preauthorization may result in reduced or no coverage.
	Physician/surgeon fee	0% coinsurance	30% coinsurance	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance	30% coinsurance	Failure to obtain inpatient preauthorization may result in reduced or no coverage.
	Mental/Behavioral health inpatient services	0% coinsurance	30% coinsurance	
	Substance use disorder outpatient services	0% coinsurance	30% coinsurance	
	Substance use disorder inpatient services	0% coinsurance	30% coinsurance	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	30% coinsurance	——none——
	Delivery and all inpatient services	0% coinsurance	30% coinsurance	Other cost sharing may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	Coverage is limited to 100 visits per member per calendar year.
	Rehabilitation services	0% coinsurance	30% coinsurance	Coverage for physical, occupational and speech therapy services is limited to 60 visits combined per member per calendar year.
	Habilitation services	0% coinsurance	30% coinsurance	All rehabilitation and habilitation visits count towards your rehabilitation limit. Autism spectrum disorder is excluded.
	Skilled nursing care	0% coinsurance	30% coinsurance	Maximum of 100 days per member per calendar year. Separate maximum of 100 days per member per calendar year for inpatient physical rehabilitation.
	Durable medical equipment	0% coinsurance	30% coinsurance	——————none——————
	Hospice service	0% coinsurance	30% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	30% coinsurance	Limited to one exam per calendar year.
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-527-5001. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross and Blue Shield
PO BOX 518
North Haven, CT 06473-0518

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,890
- **Patient pays** $2,650

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2500
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$2,650**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,900
- **Patient pays** $2500

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,420
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,500**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Section 7c

Dental Plan Document and Description

Dental

Plan Document

for Benefits Provided by HealthTrust

HealthTrust

DELTA DENTAL®

Northeast Delta Dental

TABLE OF CONTENTS

INTRODUCTION AND GENERAL INFORMATION 1

(A) INTRODUCTION 1

(B) GENERAL INFORMATION 1

SECTION I. DEFINITIONS 2

SECTION II. ELIGIBILITY/ENROLLMENT/TERMINATION OF COVERAGE/CONTINUATION OF COVERAGE 4

(A) ELIGIBILITY 4

(B) ENROLLMENT 5

(C) TERMINATION OF COVERAGE 8

(D) CONTINUATION OF COVERAGE 8

SECTION III. BENEFITS 11

SECTION IV. CONDITIONS 11

SECTION V. COORDINATION OF BENEFITS (DUAL COVERAGE) 11

SECTION VI. GENERAL PROVISIONS 12

SECTION VII. AMENDMENT AND TERMINATION OF PLAN 13

APPENDIX A - DENTAL BENEFIT OPTIONS 14

APPENDIX B - DENTAL PLAN DESCRIPTION 15

INTRODUCTION AND GENERAL INFORMATION

(A) INTRODUCTION

This Plan Document provides Participating Groups offering a HealthTrust Dental Plan with a comprehensive description of the terms and conditions of Benefits coverage available to Eligible Persons. The actual coverage under the Plan is based upon the election made by the Participating Group and is set forth in the Dental Transmittal provided by HealthTrust to each Participating Group. This coverage is provided by HealthTrust, Inc. ("HealthTrust"), while Delta Dental Plan of New Hampshire ("Northeast Delta Dental") administers the Plan and pays the claims.

HealthTrust has sole and exclusive discretion in interpreting the Benefits covered under the Plan and the other terms, conditions, limitations, and exclusions set out in this Plan Document and in making factual determinations related to the Plan and its Benefits. HealthTrust may, from time to time, delegate discretionary authority to Northeast Delta Dental or other entities or individuals providing services in regard to the Plan. HealthTrust reserves the right to change, interpret, modify, withdraw, or add Benefits to the Plan without prior notice to, or approval by, Participating Groups or Eligible Persons. HealthTrust further reserves the right, at its discretion at any time, to terminate the Plan by giving advance notice of at least 30 days to the Participating Group.

The legal documents governing the Plan consist of this Plan Document and the Dental Plan Description attached hereto as Appendix B and incorporated herein by reference. Any change or amendment to the Plan shall be made in a written amendment approved by an authorized representative of HealthTrust, as described in Section VII. No individual or entity has any authority to make any oral changes or amendments to the Plan.

(B) GENERAL INFORMATION

Delta Dental PPO and Delta Dental Premier Dentist National Networks

Northeast Delta Dental is affiliated with a national association known as Delta Dental Plans Association and other Delta Dental companies which provide dental care programs in all states and U.S. territories.

A substantial majority of Dentists nationwide participate with Delta Dental through Participating Dentist agreements. The Participating Dentist networks under the Plan include both the Delta Dental PPO and Delta Dental Premier networks.

The Benefits described in this Plan Document will be available to Eligible Persons in accordance with the terms and conditions of eligibility and enrollment outlined in Section II.

Plan Year. Each Participating Group will select either a January (January 1 through December 31) or July (July 1 through June 30) Plan Year for its participation in the Plan. The initial Plan Year for each Participating Group will be the period commencing with the first of the month in which participation in the Plan begins and ending with the next December 31 or June 30, depending on whether the Participating Group selects a January or July Plan Year. Thereafter, the Plan Year will be each successive twelve (12) month period.

Selected Benefits. Selected Benefits will be the specific coverage option(s) selected by the Participating Group at the beginning of each Plan Year from the available Dental Benefit Options as set forth in Appendix A attached hereto and incorporated herein by reference. Selected Benefits for the Participating Group are set forth in the Dental Transmittal provided to the Participating Group by HealthTrust.

Name, business address, and telephone number of **HealthTrust:**

HealthTrust	603.226.2861
25 Triangle Park Drive	800.527.5001
P.O. Box 617	
Concord, NH 03302-0617	

Name, business address, and telephone number of **Northeast Delta Dental:**

Delta Dental Plan of New Hampshire	603.223.1000
One Delta Drive	800.537.1715
P.O. Box 2002	
Concord, NH 03302-2002	

For assistance in understanding this Plan Document, contact either HealthTrust or Northeast Delta Dental.

SECTION I. DEFINITIONS

(A) **Anniversary Date** means the first day of the Participating Group's Plan Year. This means that the Anniversary Date is January 1 for Participating Groups with a January Plan Year and July 1 for Participating Groups with a July Plan Year.

(B) **Benefits** means the categories of covered Dental Care available to Eligible Persons enrolled in the Plan as described in this Plan Document (including the Dental Transmittal) and the Dental Plan Description.

(C) **Claims Administrator** means Delta Dental Plan of New Hampshire, also known as Northeast Delta Dental, to whom claims administration of this Plan has been assigned.

(D) **Co-payment** means the amount of Dental Care cost that the Eligible Person is required to pay as specified in the Dental Transmittal.

(E) **Deductible** means the portion of the charge for covered Dental Care that the Eligible Person must pay before the Plan's payment responsibility begins as specified in the Dental Transmittal.

(F) **Delta Dental** means the dental service corporations and not-for-profit dental care companies, including Northeast Delta Dental, that comprise the members of Delta Dental Plans Association and which provide Dental Care programs in all states and U.S. territories.

(G) **Dental Benefit Options** means the coverage options available to Participating Groups (as set forth in Appendix A), which options include applicable coverage categories, Selected Percentages, Deductibles, and Maximum limitations.

(H) **Dental Care** means dental services ordinarily provided by Dentists or ODPs for diagnosis or treatment of dental disease, injury, or abnormality based on valid dental need in accordance with generally accepted standards of dental practice at the time the service is rendered.

(I) **Dental Enrollment Application (or Application)** means the form that must be completed, signed, and submitted to HealthTrust. An applicant is enrolled for Benefits under the Plan only upon acceptance of the Dental Enrollment Application by HealthTrust. This form is also used to notify HealthTrust of changes in enrollment information.

(J) **Dental Plan Description (or DPD)** means the document attached hereto as Appendix B and incorporated herein by reference.

(K) **Dental Transmittal** means the document signed by HealthTrust and the Participating Group, which describes the specific Dental Benefit Options and terms and conditions of the coverage selected by the Participating Group.

(L) **Dentist** means an individual duly licensed to practice dentistry in the state in which the Dental Care is provided.

(M) **Dependent** means an individual who may be enrolled for Benefits under the Plan pursuant to the provisions of Section II of this Plan Document.

(N) **Eligible Dependents** means those Dependents who meet the eligibility criteria and are properly enrolled for coverage under the Plan pursuant to the provisions of Section II of this Plan Document.

(O) **Eligible Persons** means the Subscriber and Eligible Dependent(s) who are enrolled for coverage under the Plan pursuant to the provisions of Section II of this Plan Document.

(P) **Employee** means any individual who is described as an employee in the governing documents applicable to HealthTrust other than an individual who is so described solely by reason of being a spouse or dependent. Generally, "Employee" will include, in whole or in part as each Participating Group may determine, any individual who is (i) actively engaged in employment with the Participating Group on a Full-Time or a Part-Time basis, (ii) a Retiree or on leave of absence, or (iii) a qualifying publicly elected or appointed official of the Participating Group. For purposes of this definition, an individual is employed (a) on a "Full-Time" basis if he or she is working 30 or more hours per week for the Participating Group or otherwise satisfies the definition of a "full-time employee" for purposes of eligibility for the Participating Group's medical plan, and (b) on a "Part-Time" basis if he or she is working a minimum of 15 hours per week for the Participating Group.

(Q) **HealthTrust** means HealthTrust, Inc., a New Hampshire voluntary corporation.

(R) **Maximum** means the maximum dollar amount the Plan will pay in any Plan Year (or lifetime for orthodontic Benefits) for covered Benefits as specified in the Dental Transmittal.

(S) **Non-Participating Dentist** means a Dentist who has not signed a participating agreement with Northeast Delta Dental or another Delta Dental company.

(T) **Northeast Delta Dental** means Delta Dental Plan of New Hampshire, also known as the Claims Administrator.

(U) **Other Dental Provider (ODP)** means an individual, other than a Dentist, who provides dental services and is authorized and licensed to provide such services by the state in which the services are rendered.

(V) **Participating Dentist** means a Dentist who has signed a participating agreement with Northeast Delta Dental or another Delta Dental company. A Participating Dentist agrees to abide by such uniform rules and regulations as are from time to time prescribed by Northeast Delta Dental or another Delta Dental company.

(W) **Participating Group** means a New Hampshire municipality, county, school district or other political subdivision or instrumentality thereof which is a participating member of HealthTrust and has elected to provide dental coverage under the Plan to Eligible Persons.

(X) **Plan** means the HealthTrust Dental Plan offered by the Participating Group as described in this Plan Document and the Dental Plan Description.

(Y) **Plan Document** means this document and all appendices and riders including without limitation the Dental Benefit Options, the Dental Plan Description and the Dental Transmittal, which documents are incorporated herein by this reference.

(Z) **Plan Year** means the twelve (12) month period selected by the Participating Group as described in the INTRODUCTION AND GENERAL INFORMATION section of this Plan Document and as set forth in the Dental Transmittal.

(AA) **Probationary Period** means the period of time as determined by each Participating Group (as set forth in the Dental Transmittal) before an Employee becomes eligible for Benefits under the Plan.

(BB) **Processing Policies** means the policies approved by Northeast Delta Dental, as may be amended from time to time, to be used in processing claims for payment and treatment plans for Predetermination of Benefits. Most frequently used Processing Policies are contained in the terms, conditions, limitations and exclusions described in the DPD.

(CC) **Rates** means the rates established by HealthTrust for coverage selected by a Participating Group as set forth in the Dental Transmittal.

(DD) **Retiree** means an individual who has retired from active employment with a Participating Group and whom the Participating Group determines is eligible to continue coverage under the Plan pursuant to NH RSA 100-A:50 and/or the applicable HealthTrust rules governing eligibility for retiree coverage.

(EE) **Selected Benefits** means the specific coverage options selected by the Participating Group at the beginning of each Plan Year from the available Dental Benefit Options. The Selected Benefits for the Participating Group are set forth in the Dental Transmittal.

(FF) **Selected Percentage** means the percentage amount of charges for Selected Benefits which the Plan will pay as set forth in the Dental Transmittal.

(GG) **Subscriber** means an Employee or Retiree who satisfies the eligibility criteria established by the Participating Group and HealthTrust, and who is properly enrolled for coverage under the Plan pursuant to the provisions of Section II of this Plan Document.

SECTION II. ELIGIBILITY/ENROLLMENT/TERMINATION OF COVERAGE/CONTINUATION OF COVERAGE

(A) ELIGIBILITY

Participating Groups may choose to have either Employee Only (no Dependent coverage), or Employee and Dependents coverage. In either case, at least 75% of all eligible Employees who do not otherwise have dental coverage must be enrolled. If Employee and Dependents coverage is offered, Employees who elect to cover Dependents must enroll all of their eligible Dependents (other than Dependent children age 19 and over) who do not otherwise have dental coverage and keep them enrolled for the term of each Plan Year unless there is a qualified family status change (as described later in this Section II). In addition, if there is an Employee contribution for Dependents, at least 50% of Subscribers with Dependents must enroll all of their eligible Dependents (other than Dependent children age 19 and over) who do not otherwise have dental coverage and keep them enrolled for the term of each Plan Year unless there is a qualified family status change (as described later in this Section II).

Employees and their Dependents are eligible for coverage under the Plan only if they meet all applicable eligibility requirements, including any Probationary Period established by the Participating Group. HealthTrust may require the Employee to furnish evidence satisfactory to HealthTrust of any Dependent's eligibility, such as a birth certificate, marriage license, or court decree.

1. Eligible Employee

An Employee who meets the definition of Employee as defined in Section I is eligible to enroll as a Subscriber on the first day of the calendar month following the date determined by the Participating Group and HealthTrust in accordance with applicable rules and procedures of HealthTrust, provided that the Employee:

(a) is certified as being an eligible Employee or Retiree by the Participating Group; and

(b) has satisfied any applicable Probationary Period.

2. Eligible Dependents (if Dependent Coverage is Offered by the Participating Group)

In addition to the Subscriber, the following individuals are also eligible for enrollment under the Plan as Dependents provided that Dependent coverage is offered by the Participating Group (as set forth in the Dental Transmittal):

(a) The Spouse of the Subscriber: A spouse is eligible to enroll unless he or she is legally separated from the Subscriber. Throughout this Plan Document, any reference to "spouse" means:

i. the individual to whom the Subscriber is lawfully married, as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same sex marriages; or

ii. the individual with whom the Subscriber has entered into a lawful civil union as recognized under laws that provide same gender couples in lawful civil unions with the same rights, responsibilities and obligations as afforded to lawfully married couples.

Throughout this Plan Document any reference to "marriage" means a lawful marriage or lawful civil union. References to legal separation apply to marriage and civil union legal separations. References to divorce apply to the termination of a marriage or civil union.

Coverage is available for same-sex or opposite-sex domestic partners (including "common law" type relationships and other unmarried couples) **only if** the Participating Group has purchased a Domestic Partner Rider and **only if** all of the criteria for domestic partner status and eligibility are met, as stated in the Domestic Partner Rider.

(b) A Child of the Subscriber or of the Subscriber's Spouse who is:

i. at least two (2) and under twenty-six (26) years of age whether married or unmarried; or

ii. an unmarried incapacitated dependent who is 26 years of age or older and physically or mentally incapable of self-support (as certified by a physician), when coverage would otherwise end because the child no longer meets any of the eligibility criteria outlined above. The physical or mental incapacity must have occurred before the child reached age 26 and must have occurred

while the Dependent was a covered Dependent child. Incapacitated Dependents may remain covered as long as their disability continues and as long as they are financially dependent on the Subscriber and are incapable of self-support. HealthTrust must receive an Application for the incapacitated Dependent child status and medical certification of the incapacity by a physician within 31 days of the date coverage would otherwise end for the child. HealthTrust must approve a Dependent child's incapacitated status and may periodically request that the incapacitated status of the child be recertified.

In addition, a newborn child will be covered for the initial 31-day period following birth at no additional premium. Coverage may resume on the first day of the month following the child's second birthday if the child is properly enrolled at that time.

The term "child" means:

i. a natural child or stepchild;

ii. a legally adopted child or a child who has been placed for adoption with the Subscriber or the Subscriber's spouse. For this purpose, "placed for adoption" means that the child has been placed in the custody of the Subscriber or the Subscriber's spouse pursuant to an adoption proceeding under the provisions of NH Revised Statutes Annotated 170-B before the adoption becomes final;

iii. a child for whom the Subscriber or the Subscriber's spouse has been appointed the permanent legal guardian by court order; or

iv. a child otherwise required to be enrolled under the Plan by federal or state law or by court order.

A foster child or grandchild is not eligible for coverage as a Dependent unless the child meets the definition of "child" above.

NOTE: By accepting coverage under the Plan, Subscribers represent that all statements made in their Dental Enrollment Application, or any other documentation provided with respect to eligibility and enrollment of the Subscriber and Eligible Dependents, are true to the best of the Subscriber's knowledge and belief. Subscribers must give HealthTrust information upon request that HealthTrust deems necessary to verify coverage eligibility. Examples of documentation that HealthTrust may need to decide coverage eligibility are information regarding: Dependent child status, incapacitated child status, marital status, divorce, legal separation, adoption or court orders regarding health care coverage for Eligible Dependent children.

HealthTrust reserves the right to retroactively cancel an Eligible Person's coverage under the Plan if a Subscriber fails to provide verification upon request or misrepresents the eligibility status of the Subscriber or any Dependents.

(B) ENROLLMENT

All eligible Employees and Dependents as set forth in the Dental Transmittal who have satisfied the eligibility requirements set forth in Section II (A) may be enrolled in the Plan. If the Employee does not submit a Dental Enrollment Application (for the Employee or his or her Dependents) when the employee first becomes eligible to enroll, such individual(s) will not be eligible to enroll at a later date, except during an open enrollment period or special enrollment period or as provided under "Changes in Enrollment upon Qualified Family Status Changes" in this section. See "Newly Eligible Employees and their Dependents – Initial Enrollment" later in this section for further details.

NOTE: If the Subscriber (and the Subscriber's Dependents) enroll, the Subscriber (and the Subscriber's Dependents) must remain enrolled throughout the Plan Year and may be removed only during an open enrollment period, except in the event of a qualified family status change.

1. **Open Enrollment Period.** There will be an annual open enrollment period during the 60 days prior to, and during the month which includes, the Participating Group's Anniversary Date each year. If the Dental Enrollment Application is received by HealthTrust on or before the last day of the annual open enrollment period, coverage will become effective on the Anniversary Date. If, however, the Dental Enrollment Application is not received by the end of the annual open enrollment period, the requested enrollment may

not be made until the next open enrollment period. Special open enrollment periods may be allowed for a Participating Group at the sole discretion of HealthTrust.

2. **Special Enrollment Period.** A special enrollment period will be offered to eligible Employees and/or their Dependents in the following circumstances:

   (a) Involuntary Loss of Other Insurance Coverage

   If an eligible Employee declines enrollment (for the Employee and/or his or her Dependents) when initially eligible or during an annual open enrollment because the individual(s) was covered under another group dental plan or other dental insurance, the Employee and/or his or her Dependents will be permitted to enroll in the Plan within 31 days after an involuntary loss of such other insurance coverage. For this purpose, an "involuntary loss" of other insurance coverage means (i) if the other coverage is COBRA continuation coverage, such COBRA coverage has been exhausted, or (ii) if the other coverage is not COBRA continuation coverage, the coverage has been terminated as a result of loss of eligibility (other than loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause), or employer contributions towards the other coverage have been terminated.

   (b) New Dependents

   If an Employee is eligible but not enrolled under the Plan because he or she previously declined enrollment upon initial eligibility or during an annual open enrollment period, and the Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee and his or her Dependents will be permitted to enroll in the Plan within 31 days after the marriage, birth, adoption, or placement for adoption. These special enrollment rights are in addition to a Subscriber's right to add Dependents to existing coverage as described in subsection 3(b) below.

   Employees and Dependents who become eligible for enrollment pursuant to Special Enrollment provisions (a or b above) may enroll in the Plan by submitting a completed Dental Enrollment Application in accordance with the above timeframes and the terms and conditions for enrollment set forth in the following subsection 3 below. Coverage of such individual(s) will become effective in accordance with that subsection and the applicable event allowing for special enrollment.

   (c) Loss of Coverage, or Becoming Eligible for Premium Assistance, under Medicaid or a State's Children's Health Insurance Program. If an Employee and/or Dependent(s) are eligible but not enrolled under the Plan, they may enroll during the Plan Year in either of the following situations:

   i. An Employee or Dependent loses coverage under a Medicaid plan (under title XIX of the Social Security Act) or under a state Children's Health Insurance Plan (under title XXI of the Social Security Act) due to loss of eligibility for such coverage; or

   ii. An Employee or Dependent becomes eligible for state funded group health plan premium assistance with respect to this Plan through a state Medicaid or Children's Health Insurance Program.

   The Subscriber must request enrollment under the Plan by submitting a completed Dental Enrollment Application within 60 days of the date the other coverage is lost or the date the Employee or Dependent is determined to be eligible for premium assistance (whichever is applicable). Coverage of such individual(s) will become effective as of the first of the month following the date coverage is lost or the Dependent's eligibility for premium assistance.

3. **Application and Effective Date of Coverage.** Employees and Dependents who meet the eligibility requirements in Section II (A) may enroll in the Plan by submitting a completed Dental Enrollment Application. An applicant is enrolled only upon acceptance of the Dental Enrollment Application by HealthTrust. The following subsections describe when Benefits become effective.

   (a) Newly Eligible Employees and their Dependents – Initial Enrollment

   An Employee who becomes eligible for Benefits under the Plan may enroll by submitting a Dental Enrollment Application to their Participating Group within 31 days from the date the Employee first satisfies any applicable Probationary Period. If the Employee elects to enroll all eligible Dependents,

they must be enrolled at the same time. Coverage of newly eligible Employees and their Dependents will become effective as of the first day of the month following the date the Employee became eligible, provided that HealthTrust receives the Dental Enrollment Application within 31 days. If a Dental Enrollment Application is received by HealthTrust after 31 days but within 60 days from the date the Employee first satisfies any applicable Probationary Period, coverage of the Employee and any eligible Dependents then being enrolled will become effective the first of the month following receipt of the Application. If the Employee does not submit a Dental Enrollment Application within 60 days of initial eligibility, the Employee and his or her Dependents will not be eligible to enroll at a later date, except during an open enrollment period, a special enrollment period, or as provided under "Changes in Enrollment upon Qualified Family Status Changes" immediately below.

(b) Changes in Enrollment upon Qualified Family Status Changes

A Subscriber may enroll or remove Dependents and/or change coverage type during a Plan Year provided that such change is due to and consistent with a qualified family status change. A "qualified family status change" will include:

i. marriage, divorce, or legal separation of the Subscriber;

ii. a change in a child's eligibility under Section II (A) 2 (b) due to age (turning age 2 or 26) or incapacity;

iii. adoption, placement for adoption or a change in legal custody of a child who is at least two (2) years of age;

iv. death of a spouse or a Dependent child;

v. a change in employment status of the Subscriber or spouse that affects dental benefits coverage (e.g., termination or commencement of employment, a change from part-time to full-time status or vice versa, an unpaid leave of absence, a strike or lockout);

vi. a significant change in the Subscriber's dental plan cost or coverage, or that of the Subscriber's spouse's, relating to that individual's employment status or coverage;

vii. the Subscriber's spouse's employer holds open enrollment at a time other than the Subscriber's employer and, as a result of its benefit offerings, the Subscriber would like to make a change and the Participating Group recognizes this as a qualified change in status; or

viii. the Subscriber's or a Dependent's involuntary loss of, or becoming newly eligible for, other dental insurance coverage.

HealthTrust is not responsible for automatically changing a Subscriber's coverage type or adding or removing Dependents upon a qualified family status change event. The Subscriber must request any desired change in coverage type and must promptly notify the Participating Group and HealthTrust of any Dependent(s) to be added to or removed from coverage under the Plan.

A Subscriber may enroll or remove Dependents and/or change coverage type by submitting a Dental Enrollment Application to their Participating Group within 31 days of the qualified family status change. The Application must include any requested change in coverage type. If a Dental Enrollment Application requesting to enroll Dependent(s) and/or to change coverage type is received by HealthTrust within 31 days of a qualified family status change, the requested change(s) will take effect on the first of the month following the date of the event. If the Dental Enrollment Application is not received by HealthTrust within the 31 days but is received within 60 days from the date of the qualified family status change event, the requested change will become effective the first of the month following receipt of the Dental Enrollment Application. If a request is not made within 60 days, coverage of Eligible Dependents and coverage type may not be changed until the next open enrollment or special enrollment period.

(c) Retroactivity Limit on Addition or Removal of Enrolled Dependents

Except as otherwise provided for in this Plan Document, addition or removal of enrolled Dependents or changes of coverage type may not be made more than 31 days retroactively.

(C) TERMINATION OF COVERAGE

This section describes circumstances under which an Eligible Person's coverage under the Plan will terminate. Whether or not the Eligible Person or the Participating Group contacts HealthTrust to effect any of the terminations in this section, HealthTrust will administer the terminations if HealthTrust has knowledge of the termination event. In no event are Benefits available for Dental Care rendered or delivered after the date coverage under the Plan terminates.

Subject to any right to continue coverage under the Plan as described in Section II (D), coverage of an Eligible Person will automatically terminate on the earliest of the following dates:

1. The date HealthTrust ceases to offer the Plan to Participating Groups;
2. The date as of which the Participating Group (or a subunit of the Participating Group) terminates its participation in the Plan;
3. The end of the month during which the Eligible Person ceases to be eligible as a Subscriber or Eligible Dependent, or such other date specified in written notice by the Participating Group to HealthTrust to terminate coverage of the Eligible Person(s) (in accordance with applicable rules and procedures of HealthTrust);
4. The date specified by HealthTrust that the Eligible Person's coverage will end because the Participating Group failed to pay any required contribution for coverage under the Plan;
5. The date of the Eligible Person's enrollment in the Plan if HealthTrust or the Claims Administrator determines that the Subscriber has omitted or made a material misrepresentation of fact on the Dental Enrollment Application (or other required documentation) or used fraud in obtaining or maintaining coverage under the Plan;
6. The date specified in a notice of cancellation or nonrenewal of the Participating Group's participation in the Plan or in HealthTrust, sent to the Participating Group by HealthTrust, due to the Participating Group's failure to meet HealthTrust's or the Plan's minimum Employee participation requirements or other requirements under the Participating Group's participation agreement with HealthTrust; or
7. The date established by HealthTrust for other causes as permitted by law. Cause may include failure to disclose other dental plan coverage, fraud committed by an Eligible Person in connection with any claim filed under the Plan, if an unauthorized individual is allowed to use any Eligible Person's identification card, or if an Eligible Person otherwise cooperates in the unauthorized use of such Eligible Person's identification card.

(D) CONTINUATION OF COVERAGE

1. Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) – COBRA is a federal law which requires the Participating Group to offer Eligible Persons ("qualified beneficiaries") the opportunity to continue group coverage under the Plan for a temporary period, at the Eligible Person's expense, when coverage would otherwise end because of certain "qualifying events." COBRA continuation rights under the Plan are available only through the Participating Group. HealthTrust assists the Participating Group with certain COBRA notice and other administrative requirements. Subscribers and covered spouses will receive a separate document, which describes the continuation rights in further detail, upon initial enrollment in the Plan.

2. Qualifying Events – Eligible Persons will become qualified beneficiaries if their coverage under the Plan would otherwise end due to one of the following qualifying events:

- The Subscriber's hours of employment are reduced; or
- The Subscriber's employment ends for any reason other than gross misconduct.

Additionally, Eligible Dependents will become qualified beneficiaries if their coverage would otherwise end due to one of the following qualifying events:

- The Subscriber dies;
- The Subscriber divorces or legally separates;
- The Subscriber becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- In the case of an Eligible Dependent, he or she no longer meets the eligibility requirements for coverage under the Plan.

3. **Notices and Election Rights** – COBRA coverage is available under the Plan to qualified beneficiaries only after the Participating Group and HealthTrust have been notified that a qualifying event has occurred. **The Subscriber or an Eligible Dependent who is a qualified beneficiary must notify the Participating Group within 60 days of the date coverage under the Plan would otherwise end due to divorce, legal separation or a child losing Dependent status.** If the Participating Group and HealthTrust are not notified of these qualifying events within this 60-day notice period, any Eligible Person who loses coverage will not be offered the right to elect continuation coverage.

   Once the Participating Group is notified of a qualifying event, the Participating Group must then notify HealthTrust. The Participating Group also must notify HealthTrust of other qualifying events including the Subscriber's death, termination of employment, reduction in hours of employment, or Medicare entitlement.

   After HealthTrust receives notice that a qualifying event has occurred, HealthTrust will provide notice to eligible qualified beneficiaries of their right to elect COBRA continuation coverage.

   Each qualified beneficiary will have an independent right to elect COBRA coverage and will have until the later of the following dates to make their election:

   - 60 days after the date their coverage would otherwise end due to the qualifying event; or
   - 60 days after the date the qualified beneficiary receives notice of the right to elect COBRA coverage.

   If COBRA coverage is not elected by the election deadline, all COBRA rights will be forfeited and no continuation coverage will be available to the qualified beneficiary.

4. **Nature and Duration of COBRA Coverage** – If a qualified beneficiary elects COBRA, the qualified beneficiary generally will receive the same coverage and enrollment rights as are provided to similarly situated active employees of the Participating Group and their family members.

   COBRA coverage is a temporary continuation of coverage under the Plan. The maximum period of COBRA coverage will depend on the nature of the qualifying event as follows:

   - ***18 months*** if the qualifying event is the Subscriber's termination of employment or reduction in hours of employment (the 18-month period may be extended to 29 months if a qualified beneficiary is determined to be disabled by the Social Security Administration at any time during the first 60 days of COBRA coverage); or
   - ***36 months*** if the qualifying event is the Subscriber's death, divorce or legal separation, Medicare entitlement, or a child losing Dependent status.

   Additional non-COBRA continuation period for former or surviving spouses – In addition to the maximum COBRA coverage period, the following continuation periods are available under the Plan:

   - If the qualifying event is divorce or legal separation and the former spouse is a qualified beneficiary age 55 or older at the time of the relevant court decree, the maximum continuation period will extend until the former spouse becomes eligible for coverage under another group dental plan or Medicare; or
   - If the qualifying event is the Subscriber's death and the Subscriber's surviving spouse is a qualified beneficiary age 55 or older at the time of the death, the maximum continuation period will extend until the surviving spouse becomes eligible for coverage under another group dental plan or Medicare.

   NOTE: The Plan does not provide additional continuation coverage rights to former spouses under NH RSA 415:18, VII-b.

   COBRA coverage will terminate prior to the maximum coverage period upon certain termination events which apply under the COBRA law. Eligibility for COBRA coverage under the Plan will end if the Participating Group terminates participation in the Plan for its active employees.

5. **Cost of Continuation Coverage** – Qualified beneficiaries will be obligated to pay the full cost for COBRA or other continuation coverage unless the Participating Group has other premium payment arrangements. An administrative fee as allowed by law may also apply. Specific information regarding the premium cost and payment terms for continuation coverage will be included in the COBRA election notice provided upon a qualifying event. The Participating Group will be responsible for collecting the applicable premium payment for continuation coverage from qualified beneficiaries and submitting the payment to HealthTrust unless the Participating Group has contracted with HealthTrust to administer COBRA billing services.

6. **Continuation of Coverage Due to Military Service (USERRA)** – In the event the Subscriber is no longer actively at work because he or she is called to military service in the Armed Forces of the United States, the Subscriber may elect to continue coverage for the Subscriber and Eligible Dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). "Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

   The Subscriber may elect to continue to cover the Subscriber and Eligible Dependents (if any) under the Plan. The Subscriber may be obligated to pay the full premium cost (and any applicable administrative fee) for continuation coverage under the Plan. This may include the amount the Participating Group normally pays on the Subscriber's behalf. If the Subscriber's military service is for a period of less than 31 days, the Subscriber may not be required to pay more than the active employee contribution, if any, for the continuation coverage. If continuation is elected under this provision, the maximum period of continuation coverage under the Plan shall be the lesser of:

   - 24 months; or
   - The Subscriber's period of military service (measured from the date the military service begins and ending on the day after the date on which the Subscriber fails to apply for re-employment or returns to employment with the Participating Group).

   Whether or not the Subscriber elects continuation coverage, if the Subscriber returns to employment with the Participating Group, the Subscriber and his or her eligible Dependents' coverage under the Plan will be reinstated. No Probationary Period or exclusions may be imposed on the Subscriber or the Subscriber's Eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, the performance of military service.

7. **Availability of Individual Coverage** – When an Eligible Person's group coverage under the Plan through a Participating Group terminates, including at the end of any continuation of coverage period, the Eligible Person may have access to an individual plan with Northeast Delta Dental. Individual policies will be subject to terms, conditions, and limitations set forth in the individual policy. Applications will be subject to Northeast Delta Dental's normal underwriting requirements. Application forms and information are available at ***www.deltadentalcoversme.com*** or at ***www.healthcare.gov***.

SECTION III. BENEFITS

HealthTrust Agrees:

To provide Benefits to Eligible Persons in accordance with the terms and conditions of this Plan Document and the Dental Plan Description (DPD), and in accordance with the rules, regulations and Processing Policies (including applicable American Dental Association (ADA) dental terminology and CDT codes) of the Claims Administrator, as amended from time to time.

The various coverage categories of dental benefits that may be selected under a HealthTrust Dental Plan, including applicable exclusions and limitations, are described in Sections IV and V of the DPD attached as Appendix B. **Eligible Persons will only be entitled under the Plan to those Benefit coverage categories selected by the Participating Group as set forth in the Dental Transmittal.**

SECTION IV. CONDITIONS

HealthTrust Agrees:

(A) Nothing herein will require the Claims Administrator to provide a recommendation of a Dentist to an Eligible Person.

(B) Subject to the provisions of this Plan Document and to such uniform requirements as are deemed proper by the Claims Administrator, to make payments through the Claims Administrator for Benefits in the following manner:

1. For Benefits provided to an Eligible Person by a Dentist participating in Delta Dental's PPO network, the Claims Administrator will pay to such Participating Dentist the applicable Selected Percentage of the lesser of either (a) the actual submitted charge, or (b) Northeast Delta Dental's allowance for Dentists participating in the Delta Dental PPO network in the geographic area in which the services were provided. Such payment, together with the Eligible Person's applicable Co-payment, will discharge in full the claim of such Participating Dentist for the Benefits provided.

2. For Benefits provided to an Eligible Person by a Dentist participating in Delta Dental's Premier network, the Claims Administrator will pay to such Participating Dentist the applicable Selected Percentage of the lesser of either (a) the actual submitted charge, or (b) Northeast Delta Dental's allowance for Dentists participating in the Delta Dental Premier network in the geographic area in which the services were provided. Such payment, together with the Eligible Person's applicable Co-payment, will discharge in full the claim of such Participating Dentist for the Benefits provided.

3. For Benefits provided to an Eligible Person by a Non-Participating Dentist or ODP, the Claims Administrator will pay the applicable Selected Percentage of the lesser of either (a) the actual submitted charge, or (b) Northeast Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which the services were provided. The Non-Participating Dentist or ODPs may balance bill up to their submitted charge. When there is not sufficient fee information available for a specific dental procedure, the Claims Administrator will determine an appropriate payment amount. An Eligible Person may be requested to bring a claim form for his or her visit. Claim forms are available at ***www.nedelta.com*** or by calling 800.832.5700.

   Payment will be made directly to the Subscriber unless the state in which the services are rendered requires that assignment of benefits be honored and the Claims Administrator receives written notice of an assignment on the claim form before payment of Benefits is made. Unless assignment of benefits applies, the Subscriber will be responsible for paying the Non-Participating Dentist or ODP both the amount received by the Subscriber from the Claims Administrator and also any portion of the Non-Participating Dentist's or ODP's fee which is not discharged by such payment from the Claims Administrator.

SECTION V. COORDINATION OF BENEFITS (DUAL COVERAGE)

In the event that any Eligible Person is entitled to benefits for Dental Care under any health care benefit program other than this Plan, the Coordination of Benefits provisions as set forth in Section VI of the DPD will determine the sequence and the extent of payment of Benefits under this Plan. Such other benefit programs may include any other group or individual plan providing benefits for Dental Care in which the Eligible Person is enrolled.

SECTION VI. GENERAL PROVISIONS

(A) Participating Dentists are independent contractors and neither HealthTrust nor the Claims Administrator will be liable for any act or omission of any Participating Dentist, his or her employees or agents, or any individual furnishing Dental Care or other professional services to Eligible Persons under the Plan.

(B) All Eligible Persons receiving Dental Care services under this Plan are bound by all the terms and conditions of this Plan Document.

(C) In consideration of waiving physical examination of an Eligible Person and as a condition precedent to the approval of claims hereunder, the Claims Administrator will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist's care is rendered, such information and records relating to attendance to, or examination of, or treatment rendered to such individual as may be required in the administration of such claim. The Claims Administrator may require that an Eligible Person be examined by a dental consultant retained by the Claims Administrator in or near his or her community. The Claims Administrator will, in every case, preserve the confidentiality of such information except when disclosure is necessary for the proper administration of the Plan or is permitted by law. Any disclosure of confidential information will be in compliance with applicable federal and state law requirements.

(D) Right of Recovery. HealthTrust and the Claims Administrator have the right to recover excess payments made for Benefits from the payee.

(E) Any notice required or permitted to be given by the Claims Administrator hereunder will be deemed to have been duly given if in writing and personally delivered, or if in writing and deposited in the United States mail with postage prepaid, addressed to a Subscriber or a Dentist at the last address of record at Northeast Delta Dental. Such notice will be deemed to be given when personally delivered or mailed.

(F) The Benefits to be provided under the Plan are for the personal benefit of Eligible Persons and cannot be transferred or assigned, except as otherwise required by law. Any attempt to so assign the Benefits will automatically terminate all rights hereunder. No rights of an Eligible Person to payment from, or claim or cause of action against, the Plan may be assigned to any Dentist. All payments made by the Plan will be subject to this provision.

(G) In the event of any payments for Dental Care under the Plan, HealthTrust and the Plan will be subrogated to all of the Eligible Person's rights of recovery thereof against any third party and the Subscriber or Eligible Dependent will execute and deliver such instruments and papers and do whatever else is necessary to secure such rights. The Claims Administrator will, on behalf of HealthTrust and the Plan, diligently pursue the subrogation rights under the provisions of this paragraph.

(H) Northeast Delta Dental has established a procedure for resolving all questions raised by a Dentist in regard to claims for Dental Care and Benefits allowed or rejected pursuant to the terms of the Plan. Such procedure will be utilized both for the initial determination of such questions and also for the resolution of appeals made on the basis of such initial determinations. Resolution of claims disputes of Eligible Persons will be in accordance with the procedures as established by Northeast Delta Dental. However, HealthTrust will have the right of final determination of any disputed claim.

(I) HealthTrust and Northeast Delta Dental respect and carefully preserve the privacy and confidentiality of Subscribers and their Dependents. As part of that protection, compliance with all state and federal laws regarding privacy of personal and health information is maintained.

For a copy of either HealthTrust's or Northeast Delta Dental's Notice of Privacy Practices, which describes in detail their respective privacy practices, please visit HealthTrust's website (***www.healthtrustnh.org)*** or Northeast Delta Dental's website (***www.nedelta.com)***. Alternatively, for a copy of the Notice of Privacy Practices, or for any questions about their privacy practices, please contact:

Privacy Officer
HealthTrust
25 Triangle Park Drive
PO Box 617
Concord, NH 03302-0617
800.527.5001

Privacy Officer
Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
800-537-1715

(J) Non-ERISA Governmental Plan. The Plan is a governmental plan established and maintained by the Participating Group and HealthTrust, and as such is exempt from the provisions of the Employee Retirement and Income Security Act of 1974, as amended (ERISA).

(K) The Plan and this Plan Document shall be construed and enforced according to the applicable laws of the State of New Hampshire, except as the same may be superseded by applicable federal law.

(L) On occasion, HealthTrust may, at its option, choose not to enforce all the terms and conditions of the Plan; however, HealthTrust does not thereby waive or give up any rights to enforce any term or condition in the future. No agent of HealthTrust or Northeast Delta Dental has the right to change or waive any of the provisions of the Plan without the approval of an authorized representative of HealthTrust. Any condition, limitation, exclusion or other provision of this Plan Document which is found to be illegal or unenforceable for any reason will not affect the remaining provisions of this Plan Document.

SECTION VII. AMENDMENT AND TERMINATION OF PLAN

HealthTrust may, at its sole discretion at any time, amend or modify the Plan or this Plan Document through a written amendment approved by a duly authorized representative of HealthTrust. Upon the approval of any such amendment, it will become effective in accordance with its terms as to the Participating Group and all Eligible Persons. No individual or entity has any authority to make any oral changes or oral amendments to the Plan or this Plan Document. HealthTrust reserves the right to terminate the Plan at any time by giving advance notice of at least thirty (30) days to the Participating Group.

HealthTrust, Inc.

By: David Frydman
Interim Executive Director

APPENDIX A - DENTAL BENEFIT OPTIONS

HealthTrust
Available Dental Benefit Options (as of 7/1/15)

	1	1A	1B	1C*	1E	1F*	1G	1I*	1J	1L*	1O*	1P*	1Q	1R
A	100	100	100	100	100	100	100	100	100	100	100	100	100	100
B	80	80	80	80	80	80	80	80	80	80	80	80	80	80
C	50	50	50	50	50	50	50	60	50	60	50	60	80	50
D	50	50	50	50	50	50	50	60	50	60	50	50	50	50
DED	25/75	0	25/75	0	50/150	50/150	0	50/150	0	50/150	25/75	0	25/75	25/75
MAX	1,000	1,000	1,250	1,000	1,000	1,000	750	1,000**	1,500	1,500**	1,500**	1,500**	1,000	1,000**
	1S	**2**	**2A**	**3**	**3A**	**3B**	**3C**	**3D**	**3E**	**4**	**4A**	**4B**	**4C**	**4D**
A	100	100	100	100	100	100	100	100	100	100	100	100	100	100
B	80	80	80	80	80	80	80	80	80	80	80	80	80	80
C	50	50	50	50	50	50	50	50	50	0	0	0	0	0
D	50	0	0	0	0	0	0	0	0	0	0	0	0	0
DED	0	25/75	0	25/75	0	0	50/150	0	25/75	25/75	0	50/150	0	25/75
MAX	2,000	750	750	1,000	1,000	1,250	1,500	2,000	1,500	750	750	750	1,000	1,000
	5	**6**	**6A**	**6B**	**6C**	**6E**	**6F***	**8**	**8A**	**8B**	**10**	**10A**	**10B**	**12**
A	50	100	100	100	100	100	100	100	100	100	100	100	100	100
B	50	100	100	100	100	100	100	80	80	80	75	75	75	70
C	0	50	50	50	50	50	50	70	70	70	50	50	50	60
D	0	0	0	50	50	50	50	0	50	50	0	0	0	0
DED	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MAX	500	1,000	750	1,500	1,000	1,500**	1,000**	1,500	1,500**	2,000**	1,000	750	1,250	750
	13	**13A**	**15**	**15A**	**15C**	**15D**	**16**	**17**	**17A**	**18**	**18A**			
A	100	100	100	100	100	100	100	100	100	100	100			
B	70	70	60	60	60	60	60	50	50	50	50			
C	50	50	50	50	50	50	0	50	50	50	50			
D	0	0	0	0	0	0	0	50	50	0	0			
DED	0	0	0	0	0	25/75	0	25/75	0	25/75	0			
MAX	2,000	750	1,500	1,250	750	1,000	750	750	1,500**	750	1,500			

* Coverages with Adult Ortho
** $1,500 Maximum on Ortho (rather than traditional $1,000)
*** $750 Maximum on Ortho (rather than traditional $1,000)

APPENDIX B - DENTAL PLAN DESCRIPTION

Appendix B

Dental

Plan Description

for Benefits Provided by HealthTrust

HealthTrust

DELTA DENTAL®

Northeast Delta Dental

TABLE OF CONTENTS

INTRODUCTION AND GENERAL INFORMATION 1

I. DEFINITIONS 3

II. ELIGIBILITY/ENROLLMENT/TERMINATION OF COVERAGE/CONTINUATION OF COVERAGE 5

(A) Eligibility 5

(B) Enrollment 7

(C) Termination of Coverage 9

(D) Continuation of Coverage 9

III. HOW TO FILE A CLAIM 13

IV. BENEFITS 14

Coverage A - Diagnostic and Preventive Benefits 14

Coverage B - Basic Benefits 17

Coverage C - Major Benefits 21

Coverage D - Orthodontic Benefits 23

V. GENERAL EXCLUSIONS AND LIMITATIONS 24

VI. COORDINATION OF BENEFITS (DUAL COVERAGE) 26

VII. GENERAL CLAIMS INQUIRY 28

VIII. DISPUTED CLAIMS PROCEDURE 28

IX. DISPUTED CLAIMS REVIEW PROCEDURE 28

X. GENERAL PROVISIONS 29

Please see your Outline of Benefits provided to you upon initial enrollment and upon Plan updates for a description of the specific Benefits under the HealthTrust Dental Plan offered by your employer. You can also obtain a copy of the Outline of Benefits by contacting HealthTrust's Enrollee Services or Northeast Delta Dental's Customer Service.

INTRODUCTION AND GENERAL INFORMATION

HealthTrust would like to welcome you to the growing number of people receiving dental Benefits through our Dental Care programs. As an additional employee benefit, your employer is providing you with a Dental Care program. Coverage under the program is provided by HealthTrust, Inc. ("HealthTrust"), while Delta Dental Plan of New Hampshire ("Northeast Delta Dental") administers the program and pays the claims. You are encouraged to participate in Northeast Delta Dental's innovative Health through Oral Wellness® (HOW®) program to be eligible for additional preventive dental benefits based upon a risk assessment by your Dentist.

This booklet describes the terms and conditions of coverage and Benefits under the HealthTrust Dental Plan offered by your employer ("the Plan"). Please read the booklet carefully so that you will understand how to obtain Benefits under the Plan. But, before you turn the page, we would like you to know some of the reasons we selected Northeast Delta Dental as our Claims Administrator.

- Northeast Delta Dental is a not-for-profit organization established and supported by Dentists to make more Dental Care available to the general public.
- Northeast Delta Dental is affiliated with a national association known as Delta Dental Plans Association and other Delta Dental companies which provide Dental Care programs in all states and U.S. territories.

Delta Dental PPO and Delta Dental Premier Dentist National Networks

A substantial majority of Dentists nationwide participate with Delta Dental through Participating Dentist agreements. The coverage selected for your Plan uses Delta Dental's PPO and Premier networks of Participating Dentists. This Plan allows you to go to any Dentist of your choice and receive a level of Benefits for covered services, but you will generally receive the best value from your Plan if you visit a Participating Dentist.

Delta Dental PPO Dentists are part of a more limited network of Participating Dentists who offer lower fees to their Delta Dental PPO patients. Delta Dental PPO Dentists are reimbursed by Northeast Delta Dental based on the lesser of the actual submitted charge or Northeast Delta Dental's allowance for PPO Dentists in the geographic area in which the services were provided. PPO Dentists agree not to charge any difference between their fees and Northeast Delta Dental's allowance for PPO Dentists. Like all Dentists, PPO Dentists are allowed to charge for any applicable Co-payment, Deductibles, or non-covered services.

You will also receive Benefits under your Plan if you choose to visit a Delta Dental Premier Dentist. Delta Dental Premier Dentists are reimbursed by Northeast Delta Dental based on the lesser of the actual submitted charge or Northeast Delta Dental's allowance for Premier Dentists in the geographic area in which the services were provided. Delta Dental Premier Dentists agree not to charge any difference between their fees and Northeast Delta Dental's allowance for Premier Dentists. Like all Dentists, Premier Dentists are allowed to charge for any applicable Co-payment, Deductible, or non-covered services.

Remember - All Delta Dental PPO and Delta Dental Premier Dentists agree to:

- File your claim forms for you;
- Charge you no more than the amount allowed for payment by Northeast Delta Dental; and
- Accept payment directly from Northeast Delta Dental.

Non-Participating Dentists or Other Dental Providers (ODPs)

You may also choose to visit Dentists who are not Delta Dental Participating Dentists (Non-Participating Dentists) or Other Dental Providers (ODPs). For Non-Participating Dentists and ODPs, payment will be made based on the lesser of the actual submitted charge or Northeast Delta Dental's allowance for Non-Participating Dentists or ODPs in the geographic area in which the services were provided. When there is not sufficient fee information available for a specific dental procedure, Northeast Delta Dental will determine an appropriate payment amount. The Non-Participating Dentist or ODP may balance bill up to their submitted charge. Payment will be made to you unless the state in which the services are rendered requires that assignment of benefits be honored and Northeast Delta Dental receives written notice of an assignment on the claim form before payment for Benefits is made. Unless assignment of benefits applies, you will be responsible for paying the Dentist both the amount you receive from Northeast Delta Dental and any remaining balance due. You may be requested to bring a claim form for your visit. Claim forms can be downloaded from ***www.nedelta.com*** or you may call Northeast Delta Dental at 800.832.5700.

The Outline of Benefits provided to you upon initial enrollment and upon Plan updates sets forth details about the Plan offered by your employer, including the specific categories of dental Benefit coverage for which you are eligible. You can also obtain a copy of the Outline of Benefits by contacting HealthTrust or Northeast Delta Dental at the numbers listed below.

HealthTrust has sole and exclusive discretion in interpreting the Benefits provided under the Plan and the other terms, conditions, limitations, and exclusions set out in the Plan Document and this Dental Plan Description, and in making factual determinations related to the Plan and its Benefits. HealthTrust may, from time to time, delegate discretionary authority to Northeast Delta Dental or other entities or individuals providing services in regard to the Plan. HealthTrust reserves the right to change, interpret, modify, withdraw, or add Benefits to this Plan without prior notice to or approval by you or your employer. HealthTrust further reserves the right, at its discretion at any time, to terminate this Plan by giving advance notice of at least 30 days to your employer.

The legal documents governing the Plan consist of the Plan Document and this Dental Plan Description (including the Outline of Benefits). Any change or amendment to the Plan shall be made in a written amendment approved by an authorized representative of HealthTrust. No individual or entity has any authority to make any oral changes or amendments to the Plan.

This Dental Plan Description is intended to be a summary of the Benefits of the Plan. It is subject to, and superseded by the Plan Document. For a complete description of Benefits and the terms and conditions of coverage under the Plan, you may obtain a copy of the Plan Document from your employer or HealthTrust's Enrollee Services.

If you have any questions about your Plan, please check with your employer or call or write to HealthTrust or Northeast Delta Dental at the locations listed below. All correspondence with HealthTrust or Northeast Delta Dental should include your employer's name and number, your identification number and your telephone number.

HealthTrust:

HealthTrust
25 Triangle Park Drive
PO Box 617
Concord, NH 03302-0617
603.226.2861
800.527.5001

Northeast Delta Dental:

Delta Dental Plan of New Hampshire
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
603.223.1234
800.832.5700

I. DEFINITIONS

1. **Anniversary Date** means the first day of your Participating Group's Plan Year (either January 1 or July 1).

2. **Benefits** means the categories of covered Dental Care available to Eligible Persons enrolled in the Plan as described in this Dental Plan Description (including the Outline of Benefits).

3. **Claims Administrator** means Delta Dental Plan of New Hampshire, also known as Northeast Delta Dental, to whom claims administration of the Plan has been assigned.

4. **Co-payment** means the amount of the Dental Care cost that you (the Subscriber) or an Eligible Dependent is required to pay as specified in the Outline of Benefits.

5. **Deductible** means the portion of the charge for covered Dental Care that you (the Subscriber) or an Eligible Dependent must pay before the Plan's payment responsibility begins as specified in the Outline of Benefits.

6. **Denied** means that the fee for a procedure or service is not a Benefit under the Plan and is chargeable to the patient. The approved amount is not payable by the Plan, but is collectable from the patient.

7. **Delta Dental** means the dental service corporations and not-for-profit dental care companies, including Northeast Delta Dental, that comprise the members of Delta Dental Plans Association and which provide Dental Care programs in all states and U.S. territories.

8. **Dental Care** means dental services ordinarily provided by Dentists or ODPs for diagnosis or treatment of dental disease, injury, or abnormality based on valid dental need in accordance with generally accepted standards of dental practice at the time the service is rendered.

9. **Dental Enrollment Application (or Application)** means the form that must be completed, signed, and submitted by you and your employer to HealthTrust. An applicant is enrolled for Benefits under the Plan only upon acceptance of the Dental Enrollment Application by HealthTrust. This form is also used to notify HealthTrust of changes in enrollment information.

10. **Dental Plan Description (or DPD)** means this document, including the Outline of Benefits and all applicable riders, which documents are incorporated herein by this reference. The Dental Plan Description together with the Plan Document form the terms and conditions under which Northeast Delta Dental will administer your dental Plan.

11. **Dentist** means an individual duly licensed to practice dentistry in the state in which the Dental Care is provided.

12. **Denturist** means an individual licensed to practice denturism by the state in which the services are rendered. The practice of denturism includes:

    (a) The taking of denture impressions and bite registration for the purpose of or with a view to the making, producing, reproducing, construction, finishing, supplying, altering or repairing of a complete maxillary (upper) or complete mandibular (lower) prosthetic denture, or both, to be fitted to an edentulous arch or arches;

    (b) The fitting of a complete maxillary (upper) or mandibular (lower) prosthetic denture, or both, to an edentulous arch or arches, including the making, producing, reproducing, constructing, finishing, supplying, altering and repairing of dentures; and

    (c) The procedures incidental to the procedures specified in paragraphs (a) and (b), as defined by the applicable state licensing board.

    For the purpose of paying claims, Denturists will be treated as Other Dental Providers (ODPs). Claims submitted by a Denturist must be accompanied by a copy of a certificate of good oral health that has been issued for the patient by a Dentist. A copy of the Denturist's license must be filed with Northeast Delta Dental before claims can be processed.

13. **Dependent** means an individual who may be enrolled for Benefits under the Plan as described in Section II of this Dental Plan Description.

14. **Disallowed** means that the fee for a procedure or service is not payable by the Plan, nor collectable from the patient by a Participating Dentist. The Exclusions and Limitations provisions in Section IV and Section V identify services which are Disallowed. In each instance, a Participating Dentist agrees not to charge a separate fee.

15. **Eligible Dependents** means those Dependents who meet the eligibility criteria and are properly enrolled for coverage under the Plan as described in Section II of this Dental Plan Description.

16. **Eligible Persons** means you, the Subscriber, and your Eligible Dependent(s) who are enrolled for coverage under the Plan as described in Section II of this Dental Plan Description.

17. **Explanation of Benefits** means the notice which explains to an Eligible Person the Benefits that were paid by the Plan, whether any fees for services are Denied or Disallowed, and gives the reason(s) for the denial or disallowance. Northeast Delta Dental will produce an Explanation of Benefits (available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***) detailing what has been processed under your Plan's coverage.

18. **HealthTrust** means HealthTrust, Inc., a New Hampshire voluntary corporation.

19. **Maximum** means the maximum dollar amount the Plan will pay in any Plan Year (or lifetime for orthodontic Benefits) for covered Benefits as specified in the Outline of Benefits.

20. **Non-Participating Dentist** means a Dentist who has not signed a participating agreement with Northeast Delta Dental or another Delta Dental company.

21. **Northeast Delta Dental** means Delta Dental Plan of New Hampshire, also known as the Claims Administrator.

22. **Other Dental Provider (ODP)** means an individual, other than a Dentist, who provides dental services and is authorized and licensed to provide such services by the state in which the services are rendered.

23. **Outline of Benefits** means the document which describes the specific categories of dental Benefit coverage, and certain terms and conditions of coverage, available under the Plan selected by your employer.

24. **Participating Dentist** means a Dentist who has signed a participating agreement with Northeast Delta Dental or another Delta Dental company. A Participating Dentist agrees to abide by such uniform rules and regulations as are from time to time prescribed by Northeast Delta Dental or another Delta Dental company.

25. **Participating Group (or your employer)** means your employer that is a participating member of HealthTrust and has elected to provide dental coverage under the Plan.

26. **Plan** means the HealthTrust Dental Plan offered by your employer as described in the Plan Document and this Dental Plan Description.

27. **Plan Document** means the comprehensive description of the dental Benefit coverage available under the Plan.

28. **Plan Year** means the twelve (12) month period selected by your employer during which Eligible Persons may receive Benefits under the Plan as specified in the Outline of Benefits.

29. **Predetermination** means an administrative procedure where the Dentist or ODP submits the treatment plan to Northeast Delta Dental in advance of performing Dental Care. Northeast Delta Dental recommends that you ask your Dentist or ODP to request a Predetermination of proposed services that are considered to be other than brief or routine. A Predetermination provides an estimate of what your Plan will pay for the services which helps avoid confusion and misunderstanding between you and your Dentist or ODP.

30. **Probationary Period** means the period of time as determined by your employer before you become eligible for Benefits under the Plan.

31. **Processing Policies** means the policies approved by Northeast Delta Dental, as may be amended from time to time, to be used in processing claims for payment and treatment plans for Predetermination of Benefits. Most frequently used Processing Policies are contained in the terms, conditions, limitations and exclusions described in this DPD.

32. **Selected Benefits** means the specific coverage options selected by your employer as specified in the Outline of Benefits.

33. **Selected Percentage** means the percentage amount of charges for Selected Benefits which the Plan will pay as specified in the Outline of Benefits.

34. **Subscriber (or you)** means you, an employee or retiree who satisfies the eligibility criteria established by your employer and HealthTrust, and who is properly enrolled for coverage under the Plan as described in Section II of this Dental Plan Description.

II. ELIGIBILITY/ENROLLMENT/TERMINATION OF COVERAGE/CONTINUATION OF COVERAGE

(A) ELIGIBILITY

Your employer may choose to have either Employee Only (no Dependent coverage), or Employee and Dependents coverage. If Dependent coverage is offered and you elect to cover your eligible Dependents, you must enroll all of your eligible Dependents (other than Dependent children age 19 and over) who do not otherwise have dental coverage and keep them enrolled for the term of each Plan Year unless there is a qualified family status change (as described later in this Section II).

You and your Dependents are eligible to enroll in the Plan only if you meet all applicable eligibility requirements, including any Probationary Period established by your employer. For details regarding your employer's eligibility requirements, see the Outline of Benefits or ask your employer.

NOTE: By accepting coverage under the Plan, you represent that all statements made in your Dental Enrollment Application, or any other documentation that you provide with respect to your and your Dependent's eligibility and enrollment, are true to the best of your knowledge and belief. You must give your employer or HealthTrust information upon request that HealthTrust deems necessary to verify coverage eligibility. Examples of documentation that HealthTrust may need to decide coverage eligibility are information regarding: Dependent child status, incapacitated child status, marital status, divorce, legal separation, adoption or court orders regarding health care coverage for Eligible Dependent children.

HealthTrust reserves the right to retroactively cancel an Eligible Person's coverage under the Plan if you fail to provide verification upon request or misrepresent the eligibility status of you or any of your Dependents.

1. Eligible Employee

You are eligible to enroll as a Subscriber on the first day of the calendar month following the date determined by your employer and HealthTrust provided that you:

(a) are certified as being an eligible employee or retiree by your employer; and

(b) have satisfied any applicable Probationary Period.

2. Eligible Dependents (if Dependent Coverage is Offered by Your Employer)

You may enroll the following individuals as Dependents provided that Dependent coverage is offered by your employer:

(a) Your Spouse. Your spouse is eligible to enroll unless you are legally separated. Throughout this DPD, any reference to your "spouse" means:

i. the individual to whom you are lawfully married, as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same sex marriages; or

ii. the individual with whom you have entered into a lawful civil union as recognized under laws that provide same gender couples in lawful civil unions with the same rights, responsibilities and obligations as afforded to lawfully married couples.

Throughout this DPD any reference to "marriage" means a lawful marriage or lawful civil union. References to legal separation apply to marriage and civil union legal separations. References to divorce apply to the termination of a marriage or civil union.

Coverage is available for same-sex or opposite-sex domestic partners (including "common law" type relationships and other unmarried couples) **only if** your employer has purchased a Domestic Partner Rider and **only if** all of the criteria for domestic partner status and eligibility are met, as stated in the Domestic Partner Rider.

(b) Your (or your spouse's) child who is:

i. at least two (2) and under twenty-six (26) years of age whether married or unmarried; or

ii. an unmarried incapacitated dependent who is 26 years of age or older and physically or mentally incapable of self-support (as certified by a physician), when coverage would otherwise end because the child no longer meets any of the eligibility criteria outlined above.

The physical or mental incapacity must have occurred before the child reached age 26 and must have occurred while the Dependent was a covered Dependent child. Incapacitated Dependents may remain covered as long as their disability continues and as long as they are financially dependent on you and are incapable of self-support. HealthTrust must receive an Application for the incapacitated Dependent child status and medical certification of the incapacity by a physician within 31 days of the date coverage would otherwise end for the child. HealthTrust must approve a Dependent child's incapacitated status and may periodically request that the incapacitated status of the child be recertified.

In addition, a newborn child will be covered for the initial 31-day period following birth at no additional premium. Coverage may resume on the first day of the month following the child's second birthday if the child is properly enrolled at that time.

Definition of a Child

As used above, the term "child" means:

i. a natural child or a stepchild;

ii. a legally adopted child, or a child who has been placed for adoption with you or your spouse. (For this purpose, "placed for adoption" means that the child has been placed in the custody of you or your spouse pursuant to an adoption proceeding under the provisions of NH Revised Statutes Annotated 170-B before the adoption becomes final);

iii. a child for whom you or your spouse has been appointed the permanent legal guardian by court order; or

iv. a child otherwise required to be enrolled under the Plan by federal or state law or by court order.

A foster child or grandchild is not eligible for coverage as a Dependent unless the child meets the definition of "child" above.

(B) ENROLLMENT

If you have satisfied the eligibility requirements described in the preceding section, you may enroll yourself and all eligible Dependents by submitting a Dental Enrollment Application to your employer within 31 days from the date you first satisfy your Probationary Period. An applicant is considered enrolled only upon acceptance of the Dental Enrollment Application by HealthTrust. Provided that HealthTrust receives your Dental Enrollment Application within 31 days of the date you first satisfy any applicable Probationary Period, coverage will be effective as of the first day of the calendar month following your eligibility date. If the Dental Enrollment Application is received by HealthTrust after 31 days but within 60 days from the date you first satisfy any applicable Probationary Period, your coverage will become effective the first of the month following receipt of the application.

If you do not enroll yourself or your Dependents within 60 days after you first become eligible under the Plan, you may not enroll at a later date, except during an open enrollment period, a special enrollment period or in the event of a "qualified family status change" (as described later in this section).

NOTE: You and all your enrolled Dependents must remain enrolled throughout the Plan Year and may be removed only during an open enrollment period, except in the event of a qualified family status change.

1. **Open Enrollment Period.** There will be an annual open enrollment period during the 60 days prior to, and during the month which includes, your employer's Anniversary Date each year. If the Dental Enrollment Application is received by HealthTrust on or before the last day of the annual open enrollment period, coverage will become effective on the Anniversary Date. If, however, the Dental Enrollment Application is not received by HealthTrust by the end of the annual open enrollment period, the requested enrollment may not be made until the next open enrollment period. Special open enrollment periods may be allowed at the sole discretion of HealthTrust.

2. **Special Enrollment Period.** A special enrollment period will be offered to you and/or your eligible Dependents in the following circumstances:

   (a) Involuntary Loss of Other Insurance Coverage

   If you decline enrollment for yourself and/or your eligible Dependents when initially eligible or during an annual open enrollment because of coverage under another group dental plan or dental insurance, you will be permitted to enroll yourself and/or your Dependents in the Plan within 31 days after an involuntary loss of such other insurance coverage. For this purpose, an "involuntary loss" of other insurance coverage means (i) if the other coverage is COBRA continuation coverage, such COBRA coverage has been exhausted, or (ii) if the other coverage is not COBRA continuation coverage, the coverage has been terminated as a result of loss of eligibility (other than loss due to failure to pay premiums on a timely basis or termination of coverage for cause), or employer contributions towards the other coverage have been terminated.

   (b) New Dependents

   If you previously declined enrollment upon initial eligibility or during an annual open enrollment period and you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you will be permitted to enroll yourself and your Dependents in the Plan within 31 days after the marriage, birth, adoption, or placement for adoption. These special enrollment rights are in addition to your right to add Dependents to existing coverage as described in 3 (b) below.

   You and any Dependents who become eligible for enrollment pursuant to these Special Enrollment provisions may enroll in the Plan by submitting a completed Dental Enrollment Application in accordance with the above timeframes and the terms and conditions for enrollment set forth in the following section. Coverage of such individual(s) will become effective in accordance with that section and the applicable event allowing for special enrollment.

(c) Loss of Coverage, or Becoming Eligible for Premium Assistance, under Medicaid or a State's Children's Health Insurance Program.

If you and/or your Dependent(s) are eligible but not enrolled under the Plan, you may enroll during the Plan Year in either of the following situations:

i. You or your Dependent loses coverage under a Medicaid plan (under title XIX of the Social Security Act) or under a State Children's Health Insurance Plan (under title XXI of the Social Security Act) due to loss of eligibility for such coverage; or

ii. You or your Dependent becomes eligible for state funded group health plan premium assistance with respect to this Plan through a state Medicaid or Children's Health Insurance Program.

You must request enrollment under the Plan by submitting a completed Dental Enrollment Application within 60 days of the date the other coverage is lost or the date you or your Dependent is determined to be eligible for premium assistance (whichever is applicable). Coverage for you and/or your Dependent(s) will become effective as of the first of the month following the date coverage is lost or the date of your Dependent's eligibility for premium assistance.

3. Changes in Enrollment upon Qualified Family Status Changes

You may enroll or remove Dependents and/or change coverage type during a Plan Year provided that such change is due to and consistent with a qualified family status change. A "qualified family status change" includes:

(a) your marriage, divorce, or legal separation;

(b) a change in a child's eligibility under Section II (A) 2 (b) due to age (turning age 2 or 26) or incapacity;

(c) adoption, placement for adoption or a change in legal custody of a child who is at least two (2) years of age;

(d) death of your spouse or a Dependent child;

(e) a change in employment status of you or your spouse that affects dental benefits coverage (e.g., termination or commencement of employment, a change from part-time to full-time status or vice versa, an unpaid leave of absence, a strike or lockout);

(f) a significant change in your dental plan cost or coverage, or that of your spouse's, relating to you or your spouse's employment status or coverage;

(g) your spouse's employer holds open enrollment at a time other than your employer and, as a result of its benefit offerings, you would like to make a change and your employer recognizes this as a qualified change in status; or

(h) your or your Dependent's involuntary loss of, or becoming newly eligible for, other dental insurance coverage.

HealthTrust is not responsible for automatically changing your coverage type or adding or removing Dependents upon a qualified family status change event. You must request any desired change in coverage type and must promptly notify your employer and HealthTrust of any Dependent(s) to be added to or removed from coverage under the Plan.

You may enroll or remove Dependents and/or change your coverage type by submitting a Dental Enrollment Application to your employer within 31 days of the qualified family status change. The Application must include any requested change in coverage type. If a Dental Enrollment Application requesting to enroll Dependent(s) and/or to change coverage type is received by HealthTrust within 31 days of a qualified family status change, the requested change(s) will take effect on the first of the month following the date of the event. If the Dental Enrollment Application is not received by HealthTrust within the 31 days but is

received within 60 days from the date of the qualified family status change event, the requested change will become effective the first of the month following receipt of the Dental Enrollment Application. If a request is not made within 60 days, coverage of Eligible Dependents and coverage type may not be changed until the next open enrollment or special enrollment period.

4. Retroactivity Limit on Addition or Removal of Enrolled Dependents

Except as otherwise provided for in this DPD and the Plan Document, addition or removal of enrolled Dependents or changes of coverage type may not be made more than 31 days retroactively.

(C) TERMINATION OF COVERAGE

This section describes circumstances under which your coverage under the Plan will terminate. Whether or not you or your employer contacts HealthTrust to effect any of the terminations in this section, HealthTrust will administer the termination if HealthTrust has knowledge of the termination event. In no event are Benefits available for Dental Care rendered or delivered after the date coverage under the Plan terminates:

Subject to any right to continue coverage as described below in Section II (D), your (or your Eligible Dependents') coverage will automatically terminate on the earliest of the following dates:

1. The date HealthTrust ceases to offer the Plan to Participating Groups;
2. The date as of which your employer (or your subunit of your employer) terminates its participation in the Plan;
3. The end of the month during which you or your Eligible Dependent(s) no longer meet the eligibility requirements for coverage under the Plan, or such other date as of which your employer notifies HealthTrust to terminate your coverage;
4. The date specified by HealthTrust that your coverage will end because your employer failed to pay any required contribution for coverage under the Plan;
5. The date of your or your Eligible Dependents' enrollment if HealthTrust or the Claims Administrator determines that you have omitted or made a misrepresentation of fact on the Dental Enrollment Application (or other required documentation) or used fraud in obtaining or maintaining coverage under the Plan;
6. The date specified by HealthTrust that your employer failed to meet the Plan's or HealthTrust's requirements for participation or continued participation in the Plan or in HealthTrust; or
7. The date established by HealthTrust for other causes as permitted by law. Cause may include failure to disclose other dental plan coverage, fraud committed by an Eligible Person in connection with any claim filed under the Plan, if an unauthorized individual is allowed to use any Eligible Person's identification card, or if an Eligible Person otherwise cooperates in the unauthorized use of such Eligible Person's identification card.

(D) CONTINUATION OF COVERAGE

1. Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) – COBRA is a federal law which requires the Participating Group to offer Eligible Persons ("qualified beneficiaries") the opportunity to continue group coverage under the Plan for a temporary period, at the Eligible Person's expense, when coverage would otherwise end because of certain "qualifying events." COBRA continuation rights under the Plan are available only through the Participating Group. HealthTrust assists the Participating Group with certain COBRA notice and other administrative requirements. Subscribers and covered spouses will receive a separate document, which describes the continuation rights in further detail, upon initial enrollment in the Plan.

2. **Qualifying Events** – Eligible Persons will become qualified beneficiaries if their coverage under the Plan would otherwise end due to one of the following qualifying events:

- Subscriber's hours of employment are reduced; or
- The Subscriber's employment ends for any reason other than gross misconduct.

Additionally, Eligible Dependents will become qualified beneficiaries if their coverage would otherwise end due to one of the following qualifying events:

- The Subscriber dies;
- The Subscriber divorces or legally separates;
- The Subscriber becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- In the case of an Eligible Dependent, he or she no longer meets the eligibility requirements for coverage under the Plan.

3. **Notices and Election Rights** – COBRA coverage is available under the Plan to qualified beneficiaries only after the Participating Group and HealthTrust have been notified that a qualifying event has occurred. **The Subscriber or an Eligible Dependent who is a qualified beneficiary must notify the Participating Group within 60 days of the date coverage under the Plan would otherwise end due to divorce, legal separation or a child losing Dependent status.** If the Participating Group and HealthTrust are not notified of these qualifying events within the 60-day notice period, any Eligible Person who loses coverage will not be offered the right to elect continuation coverage.

Once the Participating Group is notified of a qualifying event, the Participating Group must then notify HealthTrust. The Participating Group also must notify HealthTrust of other qualifying events including the Subscriber's death, termination of employment, reduction in hours of employment, or Medicare entitlement.

After HealthTrust receives notice that a qualifying event has occurred, HealthTrust will provide notice to eligible qualified beneficiaries of their right to elect COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA coverage and will have until the later of the following dates to make their election:

- 60 days after the date their coverage would otherwise end due to the qualifying event; or
- 60 days after the date the qualified beneficiary receives notice of the right to elect COBRA coverage.

If COBRA coverage is not elected by the election deadline, all COBRA rights will be forfeited and no continuation coverage will be available to the qualified beneficiary.

4. **Nature and Duration of COBRA Coverage** – If a qualified beneficiary elects COBRA, the qualified beneficiary generally will receive the same coverage and enrollment rights as are provided to similarly situated active employees of the Participating Group and their family members.

COBRA coverage is a temporary continuation of coverage under the Plan. The maximum period of COBRA coverage will depend on the nature of the qualifying event as follows:

- ***18 months*** if the qualifying event is the Subscriber's termination of employment or reduction in hours of employment (the 18-month period may be extended to 29 months if a qualified beneficiary is determined to be disabled by the Social Security Administration at any time during the first 60 days of COBRA coverage); or
- ***36 months*** if the qualifying event is the Subscriber's death, divorce or legal separation, Medicare entitlement, or a child losing Dependent status.

Additional non-COBRA continuation period for former or surviving spouses – In addition to the maximum COBRA coverage period, the following continuation periods are available under the Plan:

- If the qualifying event is divorce or legal separation and the former spouse is a qualified beneficiary age 55 or older at the time of the relevant court decree, the maximum continuation period will extend until the former spouse becomes eligible for coverage under another group dental plan or Medicare; or
- If the qualifying event is the Subscriber's death and the Subscriber's surviving spouse is a qualified beneficiary age 55 or older at the time of the death, the maximum continuation period will extend until the surviving spouse becomes eligible for coverage under another group dental plan or Medicare.

NOTE: The Plan does not provide additional continuation coverage rights to former spouses under NHRSA 415:18, VII-b.

COBRA coverage will terminate prior to the maximum coverage period upon certain termination events which apply under the COBRA law. Eligibility for COBRA coverage under the Plan will end if your employer terminates participation in the Plan for its active employees.

5. **Cost of Continuation Coverage** – You and other qualified beneficiaries will be obligated to pay the full cost for COBRA or other continuation coverage unless your employer has other premium payment arrangements. An administrative fee as allowed by law may also apply. Specific information regarding the premium cost and payment terms for continuation coverage will be included in the COBRA election notice provided upon a qualifying event.

6. **Continuation of Coverage Due to Military Service (USERRA)** – In the event you are no longer actively at work because you are called to military service in the Armed Forces of the United States, you may elect to continue coverage for you and any Eligible Dependents under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). "Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

   You may elect to continue to cover yourself and any Eligible Dependents under the Plan. You may be obligated to pay the full premium cost (and any applicable administrative fee) for continuation coverage under the Plan. This may include the amount your employer normally pays on your behalf. If your military service is for a period of less than 31 days, you may not be required to pay more than the active employee contribution, if any, for the continuation coverage. If continuation is elected under this provision, the maximum period of continuation coverage under the Plan shall be the lesser of:

   - 24 months; or
   - Your period of military service (measured from the date the military service begins and ending on the day after the date on which you fail to apply for re-employment or return to employment with your employer).

   Whether or not you elect continuation coverage, if you return to employment with your employer, you and your Eligible Dependents' coverage under the Plan will be reinstated. No Probationary Period or exclusions may be imposed on you or your Eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, the performance of military service.

For more information regarding COBRA and other continuation coverage rights and obligations, please contact your Group Benefits Administrator or HealthTrust, or refer to the COBRA information document provided to you upon initial enrollment. If you would like a current version of the COBRA initial notice, please contact HealthTrust.

7. **Availability of Individual Coverage** – When your group coverage under the Plan ends for any reason, including at the end of any continuation of coverage period, you may have access to an individual plan with Northeast Delta Dental. Individual policies will be subject to terms, conditions, and limitations set forth in the individual policy. Applications will be subject to Northeast Delta Dental's normal underwriting requirements. Application forms and information are available at ***www.deltadentalcoversme.com*** or at ***www.healthcare.gov***.

III. HOW TO FILE A CLAIM

To Use Your Plan Follow These Steps:

1. Please read this Dental Plan Description carefully to familiarize yourself with the Benefits and provisions of your dental Plan.
2. You will generally receive the best value from your Plan if you visit a Participating Dentist. Ask your Dentist if he or she participates with Delta Dental; visit Northeast Delta Dental's website at ***www.nedelta.com***; or call Northeast Delta Dental for information.
3. When you visit your dental office, inform them that you are covered under a Delta Dental program and provide your identification card or other means of verifying coverage. Your Dentist will perform an evaluation and plan the course of treatment. When the treatment has been completed, the claim form will be sent to Northeast Delta Dental for payment of covered services.
4. **Claims Process for Participating Dentists:** Participating Dentists have claim forms available in their offices, which they will submit directly to Northeast Delta Dental. A Participating Dentist will not charge you at the time of treatment for covered services, but may request payment for non-covered services, Deductibles or Co-payments. Northeast Delta Dental will pay the Participating Dentists directly, based on the lesser of the actual submitted charge or Northeast Delta Dental's allowance for Participating Dentists in the geographic area in which the services were provided. Participating Dentists agree not to charge any difference between their fees and Northeast Delta Dental's allowance. An Explanation of Benefits will be available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***. The Explanation of Benefits will indicate the amount the Eligible Person should pay, if any, to the Dentist.
5. **Claims Process for Non-Participating Dentists or Other Dental Providers (ODPs):** Your Plan provides coverage regardless of the Eligible Person's choice of Participating Dentist, Non-Participating Dentist or ODP. If you visit a Non-Participating Dentist, or ODP, you may be required to submit your own claim form and pay for services at the time they are provided. Claim forms are available by calling Northeast Delta Dental or visiting ***www.nedelta.com***. Payment will be made to you, the Subscriber, unless the state in which the services are rendered requires that assignment of benefits (directing that payment be sent to the Dentist or ODP) be honored and Northeast Delta Dental receives written notice of such assignment. Payment for treatment performed by a Non-Participating Dentist or ODP will be limited to the lesser of the provider's actual submitted charge or Northeast Delta Dental's allowance for Non-Participating Dentists in the geographic area in which services are provided. It is your responsibility to ensure that full payment is made to the Dentist or ODP. An Explanation of Benefits will be available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***. The Explanation of Benefits will indicate the amount the Eligible Person should pay, if any, to the Dentist.
6. You or someone in the dental office must fill in the patient information portion of the claim form. Please be sure information is complete and accurate to ensure the prompt and correct payment of your claim.

Predetermination of Benefits

HealthTrust and Northeast Delta Dental strongly encourage Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps to avoid any potential confusion regarding the Plan's payment and your financial obligation to the Dentist or ODP.

The Predetermination reflects your estimated Benefits based on the procedures and costs submitted by your dental office. Questions concerning Predetermination should be directed to Northeast Delta Dental's Customer Service at 800.832.5700 or 603.223.1234.

Please note that Predetermination does NOT guarantee payment. Rather, Predetermination is an estimate of Benefits payable based on your current Plan Benefits. A new Plan Year, additional paid Benefits and/or a change in Benefits under the Plan may alter the Plan's final payment, because payment is based on information at the time treatment is provided and Benefits are payable, which may be different than information available at the time the Predetermination estimate was given. Any changes in a Dentist's participating status or Northeast Delta Dental's allowance may also affect the Plan's final payment.

IV. BENEFITS

This Section IV describes the various coverage categories of dental benefits that may be selected under a HealthTrust Dental Plan. **You and your Eligible Dependents will only be entitled to those Benefit coverage categories selected by your employer. See your Outline of Benefits for the coverage categories selected.**

Benefits will be provided to you and your Eligible Dependents in accordance with the terms and conditions of the Plan, this DPD and the rules, regulations and Processing Policies (including applicable American Dental Association (ADA) dental terminology and CDT codes) of the Claims Administrator, as amended from time to time.

Coverage A - Diagnostic and Preventive Benefits

- Please refer to the Outline of Benefits for specific Benefit information.
- Only those coverage categories selected by your employer will apply.
- Time limitations will be measured from the date the services were most recently performed.

Diagnostic: Oral evaluations – twice in a calendar year. This can be a comprehensive, limited (problem focused) or periodic evaluation provided by a specialist or a general Dentist.

Radiographic images – a complete series or panoramic image once in any period of five (5) years; bitewing images once in a calendar year; and images of individual teeth as necessary.

Brush biopsy once in a calendar year, no age limit.

Preventive: Prophylaxis (cleaning) up to four (4) times in a calendar year (child prophylaxis through age thirteen (13), adult prophylaxis thereafter) This can be a routine prophylaxis under Diagnostic and Preventive Benefits (Coverage A) or periodontal maintenance under Basic Benefits (Coverage B).

A full mouth debridement is covered under Diagnostic and Preventive Benefits (Coverage A) once in a lifetime and, when performed, is counted towards your prophylaxis benefit.

Fluoride treatment twice in a calendar year through age eighteen (18).

Space Maintainers through age fifteen (15).

Sealants through age eighteen (18).

NOTE: ***Participants in Northeast Delta Dental's Health through Oral Wellness® (HOW®) program may be eligible for additional preventive benefits based on a clinical oral health risk assessment performed by your Dentist. Subject to the provisions of the Plan and this DPD, these additional preventive benefits may include: i) more frequent fluoride treatments, sealants, and full mouth debridement; and ii) availability of caries susceptibility tests, oral hygiene instruction, nutritional counseling, or tobacco cessation counseling.***

Coverage A Exclusions and Limitations. The following specific exclusions and limitations apply to Coverage A. Please see Section V for General Exclusions and Limitations.

- If the fee for a procedure or service is "**Disallowed**," it is not payable by the Plan, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "**Denied**," it is not payable by the Plan, but is chargeable to the patient as the procedure or service is not a Benefit under the Plan.

1. Oral evaluations of any kind are Disallowed if performed within ninety (90) days after periodontal surgery by the same Dentist/dental office.

2. Comprehensive oral evaluation and comprehensive periodontal evaluation are a covered Benefit once in a lifetime (unless there is history of no care for three (3) years) and is counted toward your oral evaluation Benefits. Subsequent comprehensive oral evaluations are covered as a periodic oral evaluation and are subject to frequency limitations.
3. The fee for oral evaluations for patients under age three (3), when performed on the same date of service by the same Dentist/dental office as a comprehensive evaluation, is Disallowed.
4. A panoramic radiographic image, with or without supplemental radiographic images (such as periapicals, bitewings, and/or occlusal) is considered a complete series for time limitations and any fee in excess of the fee for a complete series is Disallowed.
5. Payment for additional periapical radiographs within a thirty (30) day period of a complete series or panoramic film, unless there is evidence of trauma, is subject to a consulting Dentist's review. A Participating Dentist agrees not to charge a separate fee.
6. When Benefits are requested for a panoramic radiographic image in conjunction with a complete series by the same Dentist/dental office, fees for the panoramic radiographic image are Disallowed as a component of the complete series on the same date of service.
7. Routine working and final treatment radiographic images taken for endodontic therapy by the same Dentist/dental office are considered a component of the complete treatment procedure, and separate fees are Disallowed on the same date of service.
8. If the fee for bitewings, periapicals, intraoral occlusal and extraoral radiographic images is equal to or exceeds the fee for a full mouth series, it is considered a full mouth series for payment purposes and time limitations. Any fee in excess of the fee for the full mouth series is Disallowed on the same date of service.
9. Cone beam imaging and interpretation are not covered Benefits. Cone beam imaging, when performed by the same Dentist/dental office as an image interpretation, is combined as a cone beam capture and interpretation. Any fees in excess of the combined code are Disallowed.
10. Cephalometric images, oral/facial photographic images and diagnostic casts are not a covered Benefit.
11. Oral cancer screening, except brush biopsy, is not a covered Benefit.
12. Oral Pathology laboratory services are a covered Benefit when accompanied by a pathology report. If more than one of these procedures is billed for the same tooth site on the same day, by the same Dentist/ dental office, payment is allowed for the most inclusive procedure and the fee for the less inclusive procedure is Disallowed.
13. Laboratory tests for caries susceptibility are not a covered Benefit and the fees are Disallowed when billed with an oral evaluation for children under the age of three (3).
14. Caries risk assessment is a covered Benefit once in a period of three (3) years for children between the ages of three (3) and nineteen (19). Benefits for caries risk assessment are Disallowed if billed for children under the age of three (3), if billed within twelve (12) months by the same Dentist/dental office, or if performed with other risk assessments by the same Dentist/dental office.
15. A prophylaxis done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures, and the fee is Disallowed.
16. Space maintainers are a covered Benefit once in a lifetime per tooth for Eligible Dependents through age fifteen (15) when a space is being maintained for an erupting permanent tooth.
17. The replacement or repair of space maintainers is not a covered Benefit unless performed by a Dentist who did not perform the original placement.
18. Removal of a space maintainer is included as part of the total treatment. A fee for removal of a space maintainer is Disallowed if performed by the same Dentist/dental office as the initial placement or if performed with the recementation of a space maintainer.

19. Sealant Benefit limitation:

    (a) Sealants are a covered Benefit only to Eligible Persons through age eighteen (18).

    (b) Sealant Benefit includes the application of sealants to caries-free (no decay) and restoration-free permanent molars only.

    (c) Sealants are a covered Benefit no more than once per tooth in any period of three (3) years.

20. Pre-diagnostic services, such as screening and assessment of a patient, are not covered Benefits. Payment for a screening and assessment is Disallowed if billed with an oral evaluation.

21. Nutritional counseling, tobacco counseling, and oral hygiene instruction are not covered Benefits except for Eligible Persons participating in Northeast Delta Dental's Health through Oral Wellness® (HOW®) program.

22. Genetic test for susceptibility to diseases is not a covered Benefit.

Coverage B - Basic Benefits

- Please refer to the Outline of Benefits for specific Benefit information.
- Only those coverage categories selected by your employer will apply.
- Time limitations will be measured from the date the services were most recently performed.

Restorative: Amalgam (silver) and/or resin (white) restorations (fillings).

If Coverage C – Major Benefits is not offered, and unless otherwise specified in the Outline of Benefits, payment for restorative crowns and onlays will be at the Selected Percentage specified in the Outline of Benefits for a four (4) surface amalgam restoration.

Oral Surgery: Extractions and covered surgical procedures.

Periodontics: Prophylaxis (cleaning) up to four (4) times in a calendar year (child prophylaxis through age thirteen (13), adult prophylaxis thereafter). A prophylaxis can be routine under Diagnostic and Preventive Benefits (Coverage A) or periodontal maintenance under Basic Benefits (Coverage B).

A full mouth debridement under Diagnostic and Preventive Benefits (Coverage A) is covered once in a lifetime and, when performed, is counted towards your prophylaxis Benefit.

Endodontics: Pulpal therapy apicoectomies, retrograde fillings, and root canal therapy.

Denture Repair: Repair of a removable complete or partial denture to its original condition.

Clinical Crown Lengthening: Once in a lifetime per tooth.

Palliative Treatment: Minor emergency treatment for the relief of pain.

Anesthesia: General anesthesia or intravenous sedation, when administered in a dental office and in conjunction with: an extraction; tooth reimplantation; surgical exposure of a tooth; surgical placement of implant body (only when Coverage C - Major Benefits is specified in the Outline of Benefits); biopsy; transseptal fiberotomy; alveoloplasty; vestibuloplasty; incision and drainage of an abscess; frenulectomy and/or frenuloplasty.

General anesthesia will also be covered when administered in conjunction with procedures performed in the dental office for the following covered patients:

(a) A child under the age of six (6) who is determined by a Dentist in conjunction with a licensed primary care physician to have a dental condition of significant complexity which requires the child to receive general anesthesia for the treatment of such condition; or

(b) An individual who has exceptional medical circumstances or a developmental disability, as determined by a licensed physician, which place the individual at serious risk.

Coverage B Exclusions and Limitations. The following specific exclusions and limitations apply to Coverage B. Please see Section V for General Exclusions and Limitations.

- If the fee for a procedure or service is "**Disallowed**," it is not payable by the Plan, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "**Denied**," it is not payable by the Plan, but is chargeable to the patient as the procedure or service is not a Benefit under the Plan.

1. Restorations are a covered Benefit only once per surface in a period of twenty-four (24) months, irrespective of the number or combination of procedures performed. Fees for the replacement of amalgam

(silver) or resin (white) restorations within twenty-four (24) months by the same Dentist/dental office are Disallowed.

2. Fees for protective restorations are Disallowed if performed on the same date of service as a definitive restoration or palliative treatment by the same Dentist/dental office.

3. Payment is made for one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed. A Participating Dentist agrees not to charge a separate fee.

4. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A Participating Dentist agrees not to charge a separate fee.

5. Prefabricated stainless steel crowns are a covered Benefit once in a period of twenty-four (24) months. The fee for replacement of a stainless steel crown by the same Dentist/dental office within twenty-four (24) months is included in the initial crown placement and is Disallowed.

6. Tooth preparation, bases, copings, impressions, local anesthesia, or other services that are part of a complete dental procedure are considered components of, and included in the fee for, the complete procedure. A Participating Dentist agrees not to charge a separate fee.

7. Recementation of a crown, inlay, onlay or partial coverage restoration is a covered Benefit once per tooth per lifetime. Payment is Disallowed if performed within six (6) months of the initial placement by the same Dentist/dental office.

8. Recementation of a cast or prefabricated post and core is a covered Benefit once per tooth per lifetime. Payment is Disallowed if performed within six (6) months of the initial placement by the same Dentist/dental office, or if performed on the same date of service of a crown recementation by the same Dentist/dental office.

9. Pin retention is a covered Benefit once per tooth in a period of twenty-four (24) months in conjunction with all restorations. Fees for additional pins in the same tooth are Disallowed. The fee for pin retention is Disallowed when billed in conjunction with a core build-up.

10. Reattachment of a tooth fragment, including the incisal edge or cusp, is a covered Benefit. Payment is Disallowed if performed within twenty-four (24) months of a restoration on the same tooth by the same Dentist/dental office.

11. A frenulectomy or frenuloplasty is a covered Benefit once per site per lifetime, and the fee is Disallowed when billed on the same date as any other surgical procedure in the same surgical area by the same Dentist/ dental office.

12. Alveoloplasty is included in the fee for surgical extractions. Separate fees for these procedures are Disallowed if performed by the same Dentist/dental office in the same surgical area on the same date.

13. Routine post-operative visits are considered part of, and included in the fee for, the total procedure. A Participating Dentist agrees not to charge a separate fee.

14. Exploratory surgical services are not a covered Benefit. The patient is financially responsible.

15. Periodontal surgical procedures include all necessary postoperative care, finishing procedures, evaluations for three (3) months, as well as any surgical re-entry, except soft tissue grafts, for three (3) years. The fee for surgical re-entry by the same Dentist/dental office within three (3) years is Disallowed.

16. Fees for periodontal maintenance, when billed within three (3) months of periodontal therapy by the same Dentist/dental office, are Disallowed.

17. A prophylaxis done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures, and the fee is Disallowed.

18. Periodontal scaling and root planing is a covered Benefit per quadrant once in any period of twenty-four (24) months. Fees are Disallowed for twenty-four (24) months after the initial therapy if the retreatment is performed by the same Dentist/dental office. The fee for periodontal scaling and root planing is Disallowed if performed within four (4) weeks of periodontal surgery by the same Dentist/dental office.

19. Gingivectomy, gingival flap procedure, osseous surgery, bone replacement graft, distal wedge, or soft tissue graft procedure is a covered Benefit once in a period of three (3) years. The fee for surgical re-entry by the same Dentist/dental office within three (3) years is Disallowed.

20. Anterior deciduous root canal therapy is not a covered Benefit.

21. Root canal therapy is a covered Benefit once in a period of three (3) years. Retreatment of root canal therapy by the same Dentist/dental office within twenty-four (24) months is considered part of the original procedure. Fees for the retreatment by the same Dentist/dental office are Disallowed.

22. Root canal therapy is not a covered Benefit in conjunction with overdentures, and Benefits are Denied.

23. The fee for root amputation performed in conjunction with an apicoectomy by the same Dentist/dental office is Disallowed.

24. Direct or indirect pulp caps are a covered Benefit once in a period of three (3) years. A pulp cap performed on the same date of service as the final restoration by the same Dentist/dental office is considered part of a single complete restorative procedure and the fee for the pulp cap is Disallowed.

25. A partial pulpotomy is a covered Benefit, once per tooth per lifetime, on permanent teeth only. The fee for a partial pulpotomy is Disallowed if performed within thirty (30) days on the same tooth by the same Dentist/dental office as root canal therapy.

26. Pulpal therapy or therapeutic pulpotomy is a covered Benefit once in a three (3) year period per tooth on primary teeth only. If provided on permanent teeth, the Benefit is Denied.

27. Retrograde fillings are a covered Benefit once per root in a period of three (3) years. Retreatment within twenty-four (24) months of the original procedure by the same Dentist/dental office is Disallowed.

28. An apexification or an apicoectomy is a covered Benefit once per tooth in a period of three (3) years. The fee for retreatment by the same Dentist/dental office within twenty-four (24) months is Disallowed.

29. An internal root repair is a covered Benefit once in a lifetime on permanent teeth only. If performed on a primary tooth the Benefit is denied. The fee for an internal root repair is Disallowed if performed on the same date of service by the same Dentist/dental office as an apicoectomy or retrograde filling.

30. The fee for periradicular surgery without an apicoectomy performed on the same tooth, on the same date, by the same Dentist/dental office as an apicoectomy, retrograde filling and/or root amputation is Disallowed.

31. Pulpal debridement is a covered Benefit once in a three (3) year period. The fee for pulpal debridement is Disallowed if performed within thirty (30) days of a root canal treatment by the same Dentist/dental office. The fee for surgical removal of residual tooth roots is Disallowed when performed on the same date of service as an extraction by the same Dentist/dental office.

32. The fee for repair of a complete denture cannot exceed half the fee for a new appliance, and any excess fee billed by the same Dentist/dental office is Disallowed on the same date of service.

33. Fees for repairs of complete or partial dentures, if performed within six (6) months of initial placement by the same Dentist/dental office, are Disallowed.

34. Adjustment or repair of a denture is a covered Benefit twice in a twelve (12) month period for Eligible Persons age sixteen (16) and older. Fees for an adjustment or repair of a denture is Disallowed if performed within six (6) months of initial placement. The fee for an adjustment or repair of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same Dentist/dental office is Disallowed on the same date of service.

35. Clinical crown lengthening is a covered Benefit once per tooth per lifetime and only when performed in a healthy periodontal environment in which bone must be removed for placement of the restoration or crown or prosthetic device. The fee for clinical crown lengthening is Disallowed if performed on the same date of service by the same Dentist/dental office as the crown placement.

36. Clinical crown lengthening when done in conjunction with osseous surgery, crown preparations, or restorations is considered a component of, and included in the fee for the complete procedure. A Participating Dentist agrees not to charge a separate fee.

37. Clinical crown lengthening, when performed in conjunction with other periodontal procedures, will be subject to a dental consultant's review. Payment will be based on the most comprehensive procedure.

38. The fee for palliative treatment is Disallowed when submitted with all procedures except radiographic images and diagnostic codes, and is performed by the same Dentist/dental office on the same date.

39. Palliative treatment is part of the initiation of endodontic therapy and therefore is included in the fee when performed on the same date by the same Dentist/dental office, and a separate fee is Disallowed.

40. General anesthesia is a covered Benefit only when administered by a properly licensed Dentist in a dental office in conjunction with covered oral surgical procedures or when necessary due to concurrent medical conditions. Otherwise, the fee for general anesthesia is Denied.

41. Local anesthesia in conjunction with any procedure by the same Dentist/dental office is considered part of the overall procedure and fees are Disallowed.

42. A consultation is a covered Benefit only if performed by a Dentist that is not performing further treatment. The fee for a consultation is Disallowed if performed in conjunction with an oral evaluation by the same Dentist/dental office on the same date of service.

43. Interim caries arresting medicament application is not a covered Benefit.

44. Cleaning and inspection of a removable complete or partial denture is not a covered Benefit. The fee for cleaning and inspection of a removable complete or partial denture is Disallowed when done by the same Dentist/dental office on the same date of service as a reline or rebase of the denture. Otherwise, the fee for cleaning and inspection of a removable complete or partial denture is Denied.

NOTE: **HealthTrust and Northeast Delta Dental strongly encourage Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps to avoid any potential confusion regarding the Plan's payment and your financial obligation to the Dentist or ODP.**

Coverage C - Major Benefits

- Please refer to the Outline of Benefits for specific Benefit information.
- Only those coverage categories selected by your employer will apply.
- Time limitations will be measured from the date the services were most recently performed.

Restorative Crowns and Onlays:	Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations.
Prosthodontics:	Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures, including rebase and reline of such prosthetic appliances; core buildups; cast and prefabricated post and cores; and fixed partial denture and crown repairs.
Implant Services:	Surgical placement of an endosteal implant body, including healing cap.
Implant Supported Prosthetics:	Crowns, fixed or removable partial dentures, and full dentures anchored in place by an implanted device.

Coverage C Exclusions and Limitations. The following specific exclusions and limitations apply to Coverage C. Please see Section V for General Exclusions and Limitations.

- If the fee for a procedure or service is "**Disallowed**," it is not payable by the Plan, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "**Denied**," it is not payable by the Plan, but is chargeable to the patient as the procedure or service is not a Benefit under the Plan.

1. Coverage C - Major Benefits time limitations:
   - (a) Crowns, onlays, core buildups, and post and cores are a Benefit once per tooth in a period of seven (7) years.
   - (b) One (1) complete or immediate maxillary (upper) and one (1) complete or immediate mandibular (lower) denture in a period of seven (7) years.
   - (c) A removable or fixed partial denture in a period of seven (7) years unless the loss of additional teeth requires the construction of a new appliance.
   - (d) One (1) complete maxillary (upper) denture rebase and one (1) complete mandibular (lower) denture rebase in a period of seven (7) years.
   - (e) The period of seven (7) years referred to in (a), (b), (c) and (d) above is to be measured from the date the services were most recently performed.
   - (f) Implant body and implant abutment are covered Benefits once in a lifetime per site.
2. Onlays or crowns made of resin-based composite, porcelain, porcelain fused to metal, full cast metal, or resin fused to metal (where the metal is high noble metal, titanium, noble metal or predominantly base metal) are not covered Benefits for Eligible Dependents under the age of twelve (12).
3. Inlays are not a covered Benefit. An alternate benefit will be paid equal to an amalgam (silver) restoration. If an inlay is performed, the patient is responsible for any additional fee.
4. A core build-up is a covered Benefit once in a seven (7) year period per tooth for Eligible Persons age twelve (12) and older. The fees for core build-ups are Disallowed when build-ups are performed in conjunction with inlays, three-quarter (¾) crowns or onlays.
5. Removable or fixed partial dentures are not covered Benefits for patients under the age of twelve (12).
6. If abutment teeth have moved to partially close an edentulous area, only the number of pontics necessary to fill that area are covered Benefits. The Eligible Person will be responsible for any additional fee.

7. Recementation of a fixed partial denture is a covered Benefit once in a period of twelve (12) months.

8. The relining of a denture is a covered Benefit once in a period of three (3) years.

9. Sectioning of a fixed partial denture in order to remove the denture prior to placing a new denture is not a covered Benefit. Sectioning of a fixed partial denture to preserve a portion of the denture for continued use may be a covered Benefit but is subject to review by a dental consultant.

10. Implant services are not a covered Benefit for patients under the age of sixteen (16).

11. Eposteal and transosteal implants are optional. An allowance will be paid equal to an endosteal implant. The Eligible Person will be responsible for any additional fee.

12. Tissue conditioning is a covered Benefit two (2) times in a period of three (3) years. The fee for tissue conditioning is Disallowed if performed on the same date of service as a denture rebase or reline by the same Dentist/dental office.

NOTE: HealthTrust and Northeast Delta Dental strongly encourage Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps to avoid any potential confusion regarding the Plan's payment and your financial obligation to the Dentist or ODP.

Coverage D - Orthodontic Benefits

- Please refer to the Outline of Benefits for specific Benefit information.
- Only those coverage categories selected by your employer will apply.
- Time limitations will be measured from the date the services were most recently performed.

Orthodontics: Necessary treatment and procedures required for the correction of malposed (crooked) teeth for Eligible Dependent children until the end of the month of their nineteenth (19) birthday or as specified in the Outline of Benefits.

Placement of device to facilitate eruption of an impacted tooth.

Coverage D Exclusions and Limitations. The following specific exclusions and limitations apply to Coverage D. Please see Section V for General Exclusions and Limitations.

- If the fee for a procedure or service is "**Disallowed**," it is not payable by the Plan, nor collectable from the patient by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "**Denied**," it is not payable by the Plan, but is chargeable to the patient as the procedure or service is not a Benefit under the Plan.

1. Orthodontic Benefit limitations:

   (a) Orthodontic Benefits are provided until the end of the month of the Eligible Dependent's nineteenth (19) birthday. You, your spouse, and your Eligible Dependents age nineteen (19) and over will not be eligible for orthodontic Benefits unless adult coverage is specified in the Outline of Benefits.

   (b) For treatment commenced while a patient is eligible for orthodontic Benefits, the Claims Administrator will initiate payment of its liability up to the orthodontic Maximum specified in the Outline of Benefits once bands or orthodontic devices are placed.

   (c) For patients who become eligible after orthodontic treatment has commenced, the Claims Administrator will pro-rate the Plan's liability based on the number of remaining months of active treatment compared to the total number of months of active treatment.

   (d) Active treatment includes procedures undertaken and appliances used with those procedures for the purpose of bringing teeth into proper position and alignment. Active treatment does not include space maintainers, palate expanders or other devices used to prepare the patient for services to position and align teeth.

2. Clear orthodontic appliances are included in orthodontic Benefits, provided that upon the consulting Dentist's review of pretreatment radiographs, it is indicated that the patient has full adult dentition.

   Clear appliances are subject to all orthodontic limitations and conditions and are subject to review by a consulting Dentist. The patient is responsible for any difference between the cost of the clear orthodontic treatment and the cost of conventional orthodontic procedures.

3. The Plan's payment for orthodontic Benefits shall be limited to the lifetime Maximum per patient specified in the Outline of Benefits. The Claims Administrator will make one (1) payment at the start of treatment for the Plan's total liability.

4. For Participating Groups with orthodontic Benefits, placement of an appliance must take place for the Claims Administrator to make payment on diagnostic records. Diagnostic casts, photographs and other diagnostic records are included in the total case fee. If banding does not take place, the Plan has no liability beyond its share of the allowable fee for a comprehensive oral evaluation.

5. The replacement or repair of an orthodontic appliance is not a covered Benefit if done by the same orthodontist who placed the appliance. If performed by an orthodontist who did not originally place the appliance, payment will be made for one repair per lifetime.

6. Removable orthodontic retainer adjustment is not a covered Benefit. The fee for a removable orthodontic retainer adjustment is Disallowed if performed by the same Dentist/dental office who provided the orthodontic treatment. If provided by a different Dentist/dental office, the fee is Denied.

NOTE: HealthTrust and Northeast Delta Dental strongly encourage Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps to avoid any potential confusion regarding the Plan's payment and your financial obligation to the Dentist or ODP.

V. GENERAL EXCLUSIONS AND LIMITATIONS

1. Unless otherwise specified in this DPD (including the OOB), the dental Benefits provided by the Plan will not include the following:

   (a) Services for injuries or conditions compensable under workers' compensation or employer's liability laws.

   (b) Services that are determined by the Claims Administrator to be rendered for cosmetic reasons, such as bleaching or whitening of teeth, placement of veneers, correction of congenital malformations, or cosmetic surgery. (This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.)

   (c) Services, including but not limited to endodontics and prosthodontics (including restorative crowns and onlays), completed prior to the date you or your Eligible Dependent became enrolled in the Plan.

   (d) Unless otherwise required by law, services not provided by a Dentist, or under the supervision of a Dentist, or that are not within the scope of the license of the Dentist or of the license of the individual supervised by the Dentist.

   (e) Prescription drugs, premedications, the application of anti-microbial agents and/or relative analgesia.

   (f) Charges for: (i) hospitalization; (ii) general anesthesia or intravenous sedation for restorative dentistry (except as noted in Section IV, Coverage B - Basic Benefits); (iii) preventive control programs; (iv) periodontal splinting; (v) myofunctional therapy; (vi) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (vii) equilibration; and (vii) gnathological reporting.

   (g) Charges for failure to keep a scheduled visit with the Dentist.

   (h) Charges for completion of forms. Such charges will not be made to you or your Eligible Dependent by Participating Dentists.

   (i) Dental Care which is not necessary and customary, as determined by generally accepted standards of dental practice.

   (j) Dental Care or supplies which are not within the categories of Benefits defined in this DPD and selected by your employer as specified in the Outline of Benefits.

   (k) Appliances, procedures, or restorations for: (i) implant services (unless your employer offers Coverage C - Major Benefits); (ii) increasing vertical dimension; (iii) analyzing, altering, restoring, or maintaining occlusion; (iv) replacing tooth structure lost by attrition or abrasion; (v) correcting congenital or developmental malformations; or (vi) esthetic purposes.

   (l) Payments of Benefits incurred by you and/or your Eligible Dependent after the date you become ineligible for Benefits under the Plan.

   (m) Charges for Dental Care or supplies for which no charge would have been made in the absence of dental Benefits.

   (n) Charges for Dental Care or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.

(o) All services, including evaluations and radiographs, performed for orthodontic purposes where the employer does not offer Coverage D - Orthodontic Benefits. If services are rendered they should be done so with the agreement of the patient to assume additional cost.

(p) Temporary or incomplete services.

(q) A consultation unless performed by a provider who is not performing further services.

(r) Case presentation and treatment planning. The patient will be responsible for any additional fee.

(s) Athletic mouthguards and occlusal guards (nightguards).

(t) Pulp vitality tests.

2. Unless otherwise specified in the Outline of Benefits, the dental Benefits provided by the Plan will be limited as follows:

(a) Unless otherwise required by law, Dental Care rendered by anyone other than a Dentist or ODP shall not be a covered Benefit, except that scaling or cleaning of teeth and topical application of fluoride and such other treatment performed by a licensed dental hygienist shall be a Benefit, so long as the treatment is rendered under the supervision and guidance of a Dentist, in accordance with generally accepted standards of dental practice. All claims for payment for Dental Care received must be submitted under the name and license number of the Dentist rendering treatment or supervising treatment.

(b) Optional Dental Care: In all cases in which you or your Eligible Dependent agree, after consultation with your Dentist, to more expensive Dental Care than is customarily provided, the Plan will pay the Selected Percentage for the Dental Care which is customarily provided to restore the tooth to contour and function. You or your Eligible Dependent shall be responsible for the remainder of the Dentist's fee.

(c) Predetermination does not guarantee payment. Payment is based upon eligibility, Benefits selected by your employer, allowable charges at the time the Dental Care is rendered and the Dentist's participating status with Delta Dental. If Coordination of Benefits is involved, the amount of payment is subject to change dramatically depending on the payment made by the primary carrier.

(d) Services completed or in progress at your or your Eligible Dependent's date of death will be paid in full to the limit of the Plan's liability.

(e) When services for Dental Care in progress are interrupted and completed thereafter by another Dentist, the Claims Administrator will review the claim to determine the payment, if any, due each Dentist.

(f) Maximum Payment:

(i) The Maximum amount payable in any Plan Year, or portion thereof, will be limited to the amount specified in the Outline of Benefits.

(ii) The Plan's payment will be reduced by any Deductible as specified in the Outline of Benefits.

(g) Specialized techniques including, but not limited to, precision attachments, implant services (unless your employer offers Coverage C - Major Benefits), overdentures (and associated procedures), personalizations or characterization, are limited. The patient will be responsible for part of or the entire fee for these services.

(h) Diagnostic casts (study models) and/or photographs are not a covered Benefit under the Plan unless done for orthodontic purposes and your employer offers Coverage D - Orthodontic Benefits. The charge for such services should be included in the total case fee. The fees for subsequent diagnostic casts and/or photographs are Disallowed.

(i) Benefits are paid for amalgam (silver) or resin (white) restorations for the treatment of caries. If a tooth can be restored with amalgam or resin, use of gold, an inlay, an onlay, or a crown is at the option of the patient and the patient will be responsible for any additional fee.

(j) A claim (or satisfactory written proof acceptable to the Claims Administrator) must be furnished to the Claims Administrator at its principal office within twenty-four (24) months from the date the Dentist provided Dental Care. No payment will be made on a claim with dates of service in excess of the twenty-four (24) month limitation.

(k) The date of incurred liability refers to the date a service is subject to the applicable Deductible, Co-payment, Maximum Benefit, and limitations. The total cost of the service is applied to the Plan Year during which the service is completed, irrespective of the Plan Year in which the service is started.

The Plan's date of incurred liability for multiple visit procedures is as follows:

(i) Restorative Crowns and Onlays – Total cost for crowns and onlays will be incurred on the date that the crown or onlay is cemented.

(ii) Fixed Partial Dentures (abutment crowns and pontics) – The total cost for fixed partial dentures will be incurred on the date that the said appliance is cemented.

(iii) Removable Complete and Partial Dentures – Total cost for removable complete and partial dentures will be incurred on the date that the said appliance is delivered to the patient.

(iv) Endodontics – Total cost for endodontic treatment will be incurred when the canal is filled to completion.

(v) Implant Body – Total cost for the implant body, including healing cap, will be incurred on the date of surgical placement.

(vi) Implant Prosthetics – Total cost for the prosthetic portion of an implant will be incurred on the date the said appliance is cemented or delivered to the patient.

(vii) Orthodontics – Total cost for orthodontic treatment will be incurred on the date the initial bands, or a segment thereof, or a device, is placed in the patient's mouth.

VI. COORDINATION OF BENEFITS (DUAL COVERAGE)

In the event that any Eligible Person is entitled to benefits for Dental Care under any health care benefit program other than this Plan, the following Coordination of Benefits provisions will determine the sequence and the extent of payment of Benefits under this Plan. Such other benefit programs may include any other group or individual plan providing benefits for Dental Care in which the Eligible Person is enrolled.

When an Eligible Person is covered under another health care benefit program, the following rules will establish the order of determining liability:

1. When only one plan has a Coordination of Benefits provision, the plan without such provision will determine its benefits first.

2. The plan covering the Eligible Person solely as an employee will determine its benefits before the plan that covers the Eligible Person solely as a Dependent.

3. The plan covering the Eligible Person solely as a Dependent of the parent whose birthday occurs earlier in a calendar year will determine its benefits before the plan covering the Eligible Person solely as a Dependent of the parent whose birthday occurs later in a calendar year ("Birthday Rule"). A parent's year of birth is not relevant. If both parents have the same birthday (month and day), the benefits of the plan which covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time. If the other plan does not use the "Birthday Rule," then that plan's provisions will determine the order of liability.

4. Notwithstanding paragraph (3) above, the order of payment for the claims of a Dependent child whose parents are divorced or legally separated, or are not living together whether or not they have ever been married, will be as follows:

   (a) If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan;

   (b) If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of paragraph (3) above shall determine the order of benefits;

   (c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of paragraph (3) above shall determine the order of benefits; or

   (d) If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

      (i) the plan covering the custodial parent;

      (ii) the plan covering the custodial parent's spouse;

      (iii) the plan covering the non-custodial parent; and then

      (iv) the plan covering the non-custodial parent's spouse.

5. For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under paragraphs (3) and (4) as if those individuals were parents of the child.

6. If paragraphs (1) through (5) above do not establish an order of benefit determination, the benefits of the plan which has covered the Eligible Person for the longer period of time will be determined first.

7. When this Plan is the first to determine its Benefits under paragraphs (1) through (6) above, Benefits hereunder will be paid without regard to coverage under any other plan. When this Plan is not the first to determine its Benefits and there are remaining expenses of the type allowable hereunder, the Claims Administrator will pay up to the amount the Plan would have paid without regard to the payment by the other plan or the amount of such remaining expenses, whichever is less. In other words, the combined payment of both plans will not exceed the total cost of the Dental Care.

   The Claims Administrator may use such reasonable efforts as it deems suitable to determine the existence of other benefit programs but will be under no obligation to do so.

   The payment of Benefits under this Plan will be affected by the benefits that would be payable under any and all other plans only to the extent that the Claims Administrator is furnished with information relative to such other plans by the Eligible Person, the Participating Group, a representative of any other health care benefit program, or any other person.

8. For the purposes of determining the applicability and implementing the terms of this Section VI or any provisions of similar purpose of any other plan, the Claims Administrator may, without the consent of or notice to any person, release to or obtain from any health care benefit program or such other person with a legitimate interest in such information, any information with respect to any person which it deems to be necessary for such purposes. In so acting, the Claims Administrator will comply with all federal and state law requirements governing disclosures. Any person claiming Benefits under this Plan will furnish to the Claims Administrator such information as may be necessary to implement this provision.

9. Multiple Coverage. In coordinating benefits with any other health care benefit program, time limitations and frequency of service limitations will not change. Coverage for services, when a specified number are provided per a specified time period, will not be added together to provide more than the number of services specified per time period under this Plan. For example, if each plan covers two cleanings in a

calendar year, the combined plans will still only cover two cleanings in any calendar year. If a cleaning is covered under this Plan, but has been paid for, whether in full or part, by another plan, the cleaning will count toward the maximum number of cleanings allowed under this Plan.

VII. GENERAL CLAIMS INQUIRY

After a claim is submitted to and processed by the Claims Administrator (as described in Section III, HOW TO FILE A CLAIM), you will be sent or have access to an Explanation of Benefits. This notice explains to an Eligible Person the Benefits that were paid by the Plan, whether any fees for services were Denied or Disallowed, and gives the reason(s) for the denial or disallowance. An Explanation of Benefits will be available through Northeast Delta Dental's Benefit Lookup site at ***www.nedelta.com***.

If you have any questions regarding your Benefits, you may call Northeast Delta Dental's Customer Service for an explanation at 603.223.1234 or 800.832.5700.

The Customer Service Representative will need to know the claim number which is located at the top of your Explanation of Benefits or, if that information is not available, the Subscriber's identification number. This will enable a quick response to your inquiry.

VIII. DISPUTED CLAIMS PROCEDURE

If after you have followed the General Claims Inquiry procedure you disagree with the Benefit determination, you may use the Claims Administrator's Disputed Claims Procedure. You may request a review of your claim within six (6) months of the issuing of the Claims Administrator's original Explanation of Benefits. It is recommended that your written request for a review of your claim be personally delivered or mailed certified mail, return receipt requested, to the Vice President, Professional Relations, Northeast Delta Dental, One Delta Drive, PO Box 2002, Concord, New Hampshire, 03302-2002, but you may also submit your request by standard mail.

Your request for a review of your claim should reference the claim(s) in question, state your name and address, and the reasons you think the denial should be evaluated, and any additional materials you wish to present.

The Vice President, Professional Relations, or his or her designee, may request additional documents as necessary to make such a review and will promptly review your claim. If the claim is wholly or partially denied, you will be furnished with a notice of the decision within thirty (30) days after receipt of the disputed claim.

The written notice will include:

1. the specific reason(s) for denial, and
2. the specific reference to the Plan provision(s) upon which the denial is based.

If your request for review results in an additional payment, it will be made within fifteen (15) working days of the Vice President, Professional Relations' response. If you do not receive notice within the thirty (30) day period, the claim is considered denied in order that you may proceed to the Disputed Claims Review Procedure.

If you have any problem securing a review of your claim, contact your employer for assistance.

IX. DISPUTED CLAIMS REVIEW PROCEDURE

The Disputed Claims Review Procedure allows you to request a review from the Claims Administrator's Disputed Claims Review Committee after receipt of written notification of the Vice President, Professional Relations' denial of your claim. The Review Committee is composed of Participating Dentists, non-Dentist members of the Board of Directors, and representatives of group purchasers/groups.

You or your duly authorized representative may appeal to the Review Committee by filing a request for review within one hundred eighty (180) days from receipt of the Vice President, Professional Relations' notice denying the claim, or, if no date is given, within six (6) months of the notice. It is recommended that your written request be sent certified mail, return receipt requested, to the Review Committee at the Northeast Delta Dental address noted previously but you may also submit your request by standard mail. It must state specifically the reasons for requesting a review. It should contain issues, comments, and supporting materials stating why you believe the response of Northeast Delta Dental's Vice President, Professional Relations was incorrect. No later than thirty (30) days after receipt of your request, the Review Committee will render its written decision, including specific reasons for the decision.

In addition or as an alternative to the written request procedure, you may request a hearing before the Review Committee to consider matters raised in your appeal. At the hearing, you are entitled to representation by legal counsel or other duly authorized representatives, to request the presence of a stenographer to transcribe the hearing, to present evidence, to request the testimony of witnesses and to cross-examine witnesses. You or your representative may review the Plan Document and related pertinent documents. The hearing will be scheduled with prompt written notice to you not later than thirty (30) days after your request. A decision will be rendered not later than thirty (30) days after the hearing. The decision of the Review Committee will be in writing and will include specific reasons for the decision.

X. GENERAL PROVISIONS

Notice of Change of Status

You must notify HealthTrust, through your employer, of any event causing a change in the status of an Eligible Person. Events that can affect status include, but are not limited to, marriage, birth, death, divorce, a change in a child's age or dependent status, involuntary loss of other dental coverage, etc. For further details refer to ENROLLMENT in Section II of this Dental Plan Description.

Assignment

Benefits of Eligible Persons are personal and cannot be transferred or assigned.

Right of Recovery

In the event Benefits are paid under the Plan, the Plan and the Claims Administrator will be subrogated to all of the Eligible Person's rights of recovery against any third party that may be liable. The Eligible Person will execute and deliver such documents and do whatever else is necessary to secure such rights.

Doctor-Patient Relationship

The Eligible Person has the freedom to choose any Dentist. Dentists rendering service under the Plan are independent contractors and will maintain the traditional doctor-patient relationship. The Dentist will be solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility During Treatment

If an Eligible Dependent loses eligibility while receiving dental treatment, only covered services received while eligible will be considered for payment. Someone enrolled under this Plan may lose eligibility if such individual ceases to be an Eligible Person in accordance with the provisions of Section II of this DPD.

Maintaining Your Privacy

HealthTrust and Northeast Delta Dental respect and carefully preserve the privacy and confidentiality of Subscribers and their Dependents. As part of that protection, compliance with all state and federal laws regarding privacy of personal and health information is maintained.

For a copy of either HealthTrust's or Northeast Delta Dental's Notice of Privacy Practices, that describe in detail their respective privacy practices, please visit HealthTrust's website (***www.healthtrustnh.org)*** or Northeast Delta Dental's website (***www.nedelta.com)***. Alternatively, for a copy of the Notice of Privacy Practices, or if you have any questions about the privacy of your health information, please contact:

Privacy Officer
HealthTrust
25 Triangle Park Drive
PO Box 617
Concord, NH 03302-0617
800.527.5001

Privacy Officer
Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
800.537.1715

Non-ERISA Governmental Plan

The Plan is a governmental plan established and maintained by your employer and HealthTrust, and as such is exempt from the provisions of the Employee Retirement and Income Security Act of 1974, as amended (ERISA).

Waiver of Rights; Severability

On occasion, HealthTrust may, at its option, choose not to enforce all the terms and conditions of the Plan; however, HealthTrust does not thereby waive or give up any rights to enforce any term or condition in the future. No agent of HealthTrust or Northeast Delta Dental has the right to change or waive any of the provisions of the Plan without the approval of an authorized representative of HealthTrust. Any condition, limitation, exclusion or other provision of this document which is found to be illegal or unenforceable for any reason will not affect the remaining provisions of this DPD.

Applicable Law

The Plan, the Plan Document and this Dental Plan Description shall be construed and enforced according to the applicable laws of the State of New Hampshire, except as the same may be superseded by applicable federal law.

Amendment and Termination of Plan

HealthTrust may, at its sole discretion at any time, amend or modify the Plan through a written amendment approved by a duly authorized representative of HealthTrust. Upon the approval of any such amendment, it will become effective in accordance with its terms as to you and all other Eligible Persons. No individual or entity has any authority to make any oral changes or oral amendments to the Plan. HealthTrust reserves the right to terminate the Plan at any time by giving advance notice of at least thirty (30) days to your employer.

HealthTrust
PO Box 617 • 25 Triangle Park Drive • Concord, NH 03302-0617
Toll-Free: 800.527.5001 • Phone: 603.226.2861 • Fax: 603.226.2988
www.healthtrustnh.org

Northeast Delta Dental

Northeast Delta Dental
One Delta Dental • P.O. Box 2002 • Concord, NH 03302-2002
Customer Service: 800.832.5700 • 603.223.1234
TTY/Hearing Impaired Access Number: 800.332.5905
www.nedelta.com

Section 7d

Application and Membership Agreements

HealthTrust

HEALTHTRUST, INC.
APPLICATION AND MEMBERSHIP AGREEMENT

BCEP Solid Waste

This Application and Membership Agreement ("Membership Agreement") is made by and between BCEP Solid Waste ("Applicant") and HealthTrust, Inc., a New Hampshire voluntary corporation ("HealthTrust"), effective as of January 1, 2016 ("Effective Date"). This Membership Agreement sets forth the terms and conditions of Applicant's membership and/or continuing membership in HealthTrust.

Preamble

HealthTrust is a pooled risk management program operating pursuant to RSA 5-B and offering its member political subdivisions the opportunity to participate in its Coverage Programs and related services including, but not limited to, group medical, dental, short-term disability, long-term disability, and life coverages.

Applicant is eligible and wishes to become or remain a Member of HealthTrust and participate in certain Coverage Programs offered by HealthTrust and therefore is entering this Membership Agreement.

Agreement

Applicant and HealthTrust hereby mutually agree as follows:

1. **Application**. Applicant applies for membership (including continuing membership if applicable) in HealthTrust for the provision of group medical and/or other benefit plans as may be selected by Applicant from time to time.

2. **Eligibility**. Applicant hereby represents and warrants to HealthTrust that Applicant is an entity eligible for membership in HealthTrust in accordance with the HealthTrust Bylaws.

3. **Contingent on Acceptance**. Applicant understands and agrees that its membership in HealthTrust is contingent on HealthTrust's acceptance and execution of this Agreement.

4. **Governing Provisions**. Applicant shall be bound by the provisions of this Membership Agreement, the HealthTrust Articles of Incorporation, Bylaws, Rules, any applicable Coverage Documents, and any other agreements pursuant or incident thereto, all as amended and in effect from time to time (known collectively in the Bylaws as the "Operative Documents"). Applicant acknowledges receipt of the HealthTrust Bylaws.

5. **Member Rights**. As a Member, Applicant will have the rights provided in the Operative Documents including, without limitation, the right to participate in HealthTrust's Coverage Programs and the right to vote for the HealthTrust Board of Directors at annual meetings of the Members. Applicant acknowledges that pursuant to the current HealthTrust Bylaws, the person serving as the top administrative official of Applicant, or his or her designee, shall be entitled to cast a vote on behalf of Applicant at any meetings of the Members of HealthTrust unless and until

Applicant's Governing Board appoints, by resolution, a different representative to cast such a vote prior to the meeting(s) to which the designation relates.

6. **Selection of Coverage Programs and Services.** Subject to the terms and conditions of the Operative Documents, Applicant may select and periodically change the Coverage Programs and related services in which Applicant participates without amending this Membership Agreement. Applicant's participation (or continuing participation) in any of the Coverage Programs and/or related services is subject to:

(a) The proper and timely completion and execution by an authorized representative of Applicant of the documents, agreements, and forms for such participation as required by HealthTrust, and

(b) The policies, procedures, guidelines and Operative Documents that apply to any selected coverages including, without limitation, any applicable minimum participation requirements for such Coverage Program.

7. **Contributions.** Applicant agrees to pay in a timely manner all Contributions required to participate in HealthTrust and/or the applicable Coverage Programs pursuant to the terms of the Operative Documents.

8. **Surplus.** Applicant hereby acknowledges and agrees that any distribution of surplus, or a Member's rights thereto, shall be governed by the applicable terms of the HealthTrust Bylaws and/or other Operative Documents, as they may be amended from time to time. Applicant further agrees that HealthTrust may first apply any surplus due to Applicant to pay any unpaid and overdue Contributions or other amounts owed by Applicant to HealthTrust prior to returning the balance remaining of such surplus to Applicant.

9. **Health Plan Coverage Program Responsibilities.**

(a) Applicant acknowledges that, with respect to the group health (medical and/or dental) plan(s) offered to its Employees through HealthTrust, Applicant is responsible for complying with all applicable provisions of federal and state law governing such health plan(s) including, without limitation: (i) the continuation of coverage provisions set forth in Sections 2201 through 2208 of the Public Health Service Act ("COBRA"), (ii) the retiree medical coverage provisions set forth in New Hampshire RSA 100-A:50, and (iii) the Patient Protection and Affordable Care Act of 2010, as amended and implemented ("ACA").

(b) To assist Applicant in satisfying certain of its COBRA coverage obligations, HealthTrust provides base COBRA services on behalf of Applicant pursuant to a separate COBRA administrative services agreement which Applicant must sign as a condition of participating in HealthTrust's medical and/or dental Coverage Programs. In addition, Applicant may elect to receive additional COBRA billing services offered by HealthTrust pursuant to the separate COBRA administrative services agreement.

(c) To assist Applicant in satisfying certain of its retiree coverage obligations, HealthTrust may offer to provide and Applicant may elect and contract with HealthTrust to receive retiree billing services on behalf of Applicant pursuant to a separate retiree billing administrative services agreement.

10. **Provision of Information.** Applicant agrees to provide HealthTrust in a timely and accurate manner any and all information HealthTrust deems necessary or desirable with regard to HealthTrust's provision of the Coverage Programs and related services selected by Applicant, including but not limited to, all required eligibility and enrollment data.

11. **Safeguarding Personal Information**. HealthTrust may provide Applicant certain non-claims related information, including enrollment, billing, and payment information relevant to the administration of the medical and dental Coverage Programs in which Applicant participates. Some of this information may constitute protected health information, as defined by the Health Insurance Portability and Accountability Act of 1996, as amended and implemented. Examples of information HealthTrust may disclose to Members include: monthly invoices detailing coverage types and cost, payment and enrollment confirmation, and information necessary to assist Applicant in completing its IRS reporting required by the ACA. HealthTrust, at its discretion, also may provide Applicant with non-individually identifiable summary claims information in a manner consistent with state and federal law and applicable HealthTrust policies and procedures.

Applicant hereby certifies that with respect to any protected health information received from HealthTrust, Applicant will:

(a) Safeguard the privacy and security of the information,

(b) Not use or disclose the information beyond that which is necessary to administer the selected coverage(s),

(c) Not use the information for employment-related actions or decisions, and

(d) Restrict access to the information to only those individuals who require the information to administer the coverage(s).

Applicant also acknowledges and agrees that:

(e) HealthTrust will only provide such information to those individuals specifically identified in HealthTrust's database as authorized to receive such information on behalf of Applicant,

(f) HealthTrust does not share individually identifiable claims information unless authorized in writing by the covered person or otherwise permitted by applicable laws, and

(g) HealthTrust reserves the right to decide what, if any, information is provided to Applicant.

12. **Term and Termination**. The term of Applicant's membership (or continuing membership) in HealthTrust under this Membership Agreement begins on the Effective Date. Applicant's participation in specific Coverage Program(s) shall begin on the effective dates for such coverage as indicated in the Coverage Documents executed by Applicant in order to participate in such coverage. Membership in HealthTrust and participation in any Coverage Program shall continue until such coverage is terminated or cancelled in accordance with the terms of the HealthTrust Bylaws, Coverage Documents and/or other Operative Documents.

13. **Miscellaneous Provisions.**

(a) This Membership Agreement is governed by New Hampshire law and may only be modified by a written amendment signed by all applicable parties.

(b) All capitalized terms utilized but not defined herein shall have the same meaning as set forth in the HealthTrust Bylaws.

(c) Section headings contained in this Membership Agreement are solely for the purpose of reference, are not part of the agreement of the parties and shall not in any way affect the meaning or interpretation of this Membership Agreement.

14. **Certificate of Authorizing Resolution.** This Membership Agreement shall be accompanied by a certificate of authorizing resolution (or a copy of the resolution) of the Governing Body of Applicant in substantially the same form and content as contained in the attached Exhibit A that indicates Applicant has duly authorized its membership in HealthTrust in accordance with RSA 5-B and the execution and delivery of this Membership Agreement by the individual signing, which authorization is legally binding and remains in full force and effect as of the date hereof.

IN WITNESS WHEREOF, Applicant and HealthTrust have caused this Membership Agreement to be executed by their duly authorized officials:

For APPLICANT:

BCEP SOLID WASTE

Earl H Weir

Authorized Official Signature

EARL H. WEIR

Print Name

ADMINISTRATOR

Title

10/30/15

Date

For HEALTHTRUST, INC.:

David Frydman

David Frydman
Interim Executive Director

11-18-15

Date

EXHIBIT A

CERTIFICATE OF AUTHORIZING RESOLUTION

I hereby certify to *HealthTrust, Inc.* ("HealthTrust"), that the following is a true copy of a resolution adopted by the Governing Body of BCEP Solid Waste at a meeting duly held on 10/29/15 [Date]:

RESOLVED: That BCEP Solid Waste shall participate as a Member in the HealthTrust pooled risk management program for the provision of group medical and/or other benefit plans in accordance with the "Application and Membership Agreement" and NH RSA 5-B.

RESOLVED: That EARL WEIR ADMIN [**Name/Title**] is hereby authorized and directed to execute and deliver to HealthTrust, on behalf of BCEP Solid Waste, the "Application and Membership Agreement" in substantially the form presented to this meeting.

I further certify that the foregoing resolution remains in full force and effect without modification.

APPLICANT: BCEP SOLID WASTE

Date: 10/30/15

By: Earl H Weir
Duly Authorized

Name: EARL H. WEIR

Title: ADMINISTRATOR

HealthTrust

HEALTHTRUST, INC.
APPLICATION AND MEMBERSHIP AGREEMENT

Town of Allenstown

This Application and Membership Agreement ("Membership Agreement") is made by and between Town of Allenstown ("Applicant") and HealthTrust, Inc., a New Hampshire voluntary corporation ("HealthTrust"), effective as of January 1, 2016 ("Effective Date"). This Membership Agreement sets forth the terms and conditions of Applicant's membership and/or continuing membership in HealthTrust.

Preamble

HealthTrust is a pooled risk management program operating pursuant to RSA 5-B and offering its member political subdivisions the opportunity to participate in its Coverage Programs and related services including, but not limited to, group medical, dental, short-term disability, long-term disability, and life coverages.

Applicant is eligible and wishes to become or remain a Member of HealthTrust and participate in certain Coverage Programs offered by HealthTrust and therefore is entering this Membership Agreement.

Agreement

Applicant and HealthTrust hereby mutually agree as follows:

1. **Application.** Applicant applies for membership (including continuing membership if applicable) in HealthTrust for the provision of group medical and/or other benefit plans as may be selected by Applicant from time to time.

2. **Eligibility**. Applicant hereby represents and warrants to HealthTrust that Applicant is an entity eligible for membership in HealthTrust in accordance with the HealthTrust Bylaws.

3. **Contingent on Acceptance**. Applicant understands and agrees that its membership in HealthTrust is contingent on HealthTrust's acceptance and execution of this Agreement.

4. **Governing Provisions.** Applicant shall be bound by the provisions of this Membership Agreement, the HealthTrust Articles of Incorporation, Bylaws, Rules, any applicable Coverage Documents, and any other agreements pursuant or incident thereto, all as amended and in effect from time to time (known collectively in the Bylaws as the "Operative Documents"). Applicant acknowledges receipt of the HealthTrust Bylaws.

5. **Member Rights**. As a Member, Applicant will have the rights provided in the Operative Documents including, without limitation, the right to participate in HealthTrust's Coverage Programs and the right to vote for the HealthTrust Board of Directors at annual meetings of the Members. Applicant acknowledges that pursuant to the current HealthTrust Bylaws, the person serving as the top administrative official of Applicant, or his or her designee, shall be entitled to cast a vote on behalf of Applicant at any meetings of the Members of HealthTrust unless and until

Applicant's Governing Board appoints, by resolution, a different representative to cast such a vote prior to the meeting(s) to which the designation relates.

6. **Selection of Coverage Programs and Services**. Subject to the terms and conditions of the Operative Documents, Applicant may select and periodically change the Coverage Programs and related services in which Applicant participates without amending this Membership Agreement. Applicant's participation (or continuing participation) in any of the Coverage Programs and/or related services is subject to:

(a) The proper and timely completion and execution by an authorized representative of Applicant of the documents, agreements, and forms for such participation as required by HealthTrust, and

(b) The policies, procedures, guidelines and Operative Documents that apply to any selected coverages including, without limitation, any applicable minimum participation requirements for such Coverage Program.

7. **Contributions**. Applicant agrees to pay in a timely manner all Contributions required to participate in HealthTrust and/or the applicable Coverage Programs pursuant to the terms of the Operative Documents.

8. **Surplus**. Applicant hereby acknowledges and agrees that any distribution of surplus, or a Member's rights thereto, shall be governed by the applicable terms of the HealthTrust Bylaws and/or other Operative Documents, as they may be amended from time to time. Applicant further agrees that HealthTrust may first apply any surplus due to Applicant to pay any unpaid and overdue Contributions or other amounts owed by Applicant to HealthTrust prior to returning the balance remaining of such surplus to Applicant.

9. **Health Plan Coverage Program Responsibilities**.

(a) Applicant acknowledges that, with respect to the group health (medical and/or dental) plan(s) offered to its Employees through HealthTrust, Applicant is responsible for complying with all applicable provisions of federal and state law governing such health plan(s) including, without limitation: (i) the continuation of coverage provisions set forth in Sections 2201 through 2208 of the Public Health Service Act ("COBRA"), (ii) the retiree medical coverage provisions set forth in New Hampshire RSA 100-A:50, and (iii) the Patient Protection and Affordable Care Act of 2010, as amended and implemented ("ACA").

(b) To assist Applicant in satisfying certain of its COBRA coverage obligations, HealthTrust provides base COBRA services on behalf of Applicant pursuant to a separate COBRA administrative services agreement which Applicant must sign as a condition of participating in HealthTrust's medical and/or dental Coverage Programs. In addition, Applicant may elect to receive additional COBRA billing services offered by HealthTrust pursuant to the separate COBRA administrative services agreement.

(c) To assist Applicant in satisfying certain of its retiree coverage obligations, HealthTrust may offer to provide and Applicant may elect and contract with HealthTrust to receive retiree billing services on behalf of Applicant pursuant to a separate retiree billing administrative services agreement.

10. **Provision of Information**. Applicant agrees to provide HealthTrust in a timely and accurate manner any and all information HealthTrust deems necessary or desirable with regard to HealthTrust's provision of the Coverage Programs and related services selected by Applicant, including but not limited to, all required eligibility and enrollment data.

11. **Safeguarding Personal Information**. HealthTrust may provide Applicant certain non-claims related information, including enrollment, billing, and payment information relevant to the administration of the medical and dental Coverage Programs in which Applicant participates. Some of this information may constitute protected health information, as defined by the Health Insurance Portability and Accountability Act of 1996, as amended and implemented. Examples of information HealthTrust may disclose to Members include: monthly invoices detailing coverage types and cost, payment and enrollment confirmation, and information necessary to assist Applicant in completing its IRS reporting required by the ACA. HealthTrust, at its discretion, also may provide Applicant with non-individually identifiable summary claims information in a manner consistent with state and federal law and applicable HealthTrust policies and procedures.

Applicant hereby certifies that with respect to any protected health information received from HealthTrust, Applicant will:

(a) Safeguard the privacy and security of the information,

(b) Not use or disclose the information beyond that which is necessary to administer the selected coverage(s),

(c) Not use the information for employment-related actions or decisions, and

(d) Restrict access to the information to only those individuals who require the information to administer the coverage(s).

Applicant also acknowledges and agrees that:

(e) HealthTrust will only provide such information to those individuals specifically identified in HealthTrust's database as authorized to receive such information on behalf of Applicant,

(f) HealthTrust does not share individually identifiable claims information unless authorized in writing by the covered person or otherwise permitted by applicable laws, and

(g) HealthTrust reserves the right to decide what, if any, information is provided to Applicant.

12. **Term and Termination**. The term of Applicant's membership (or continuing membership) in HealthTrust under this Membership Agreement begins on the Effective Date. Applicant's participation in specific Coverage Program(s) shall begin on the effective dates for such coverage as indicated in the Coverage Documents executed by Applicant in order to participate in such coverage. Membership in HealthTrust and participation in any Coverage Program shall continue until such coverage is terminated or cancelled in accordance with the terms of the HealthTrust Bylaws, Coverage Documents and/or other Operative Documents.

13. **Miscellaneous Provisions.**

(a) This Membership Agreement is governed by New Hampshire law and may only be modified by a written amendment signed by all applicable parties.

(b) All capitalized terms utilized but not defined herein shall have the same meaning as set forth in the HealthTrust Bylaws.

(c) Section headings contained in this Membership Agreement are solely for the purpose of reference, are not part of the agreement of the parties and shall not in any way affect the meaning or interpretation of this Membership Agreement.

14. **Certificate of Authorizing Resolution.** This Membership Agreement shall be accompanied by a certificate of authorizing resolution (or a copy of the resolution) of the Governing Body of Applicant in substantially the same form and content as contained in the attached Exhibit A that indicates Applicant has duly authorized its membership in HealthTrust in accordance with RSA 5-B and the execution and delivery of this Membership Agreement by the individual signing, which authorization is legally binding and remains in full force and effect as of the date hereof.

IN WITNESS WHEREOF, Applicant and HealthTrust have caused this Membership Agreement to be executed by their duly authorized officials:

For APPLICANT:

TOWN OF ALLENSTOWN

Shaun Mulholland

Authorized Official Signature

Shaun Mulholland

Print Name

Town Administrator

Title

10/01/2015

Date

For HEALTHTRUST, INC.:

David Frydman

David Frydman
Interim Executive Director

10-5-15

Date

EXHIBIT A

CERTIFICATE OF AUTHORIZING RESOLUTION

I hereby certify to *HealthTrust, Inc.* ("HealthTrust"), that the following is a true copy of a resolution adopted by the Governing Body of Town of Allenstown at a meeting duly held on 09/28/2015 [Date]:

RESOLVED: That Town of Allenstown shall participate as a Member in the HealthTrust pooled risk management program for the provision of group medical and/or other benefit plans in accordance with the "Application and Membership Agreement" and NH RSA 5-B.

RESOLVED: That Shaun Mulholland/TA [**Name/Title**] is hereby authorized and directed to execute and deliver to HealthTrust, on behalf of Town of Allenstown, the "Application and Membership Agreement" in substantially the form presented to this meeting.

I further certify that the foregoing resolution remains in full force and effect without modification.

APPLICANT: TOWN OF ALLENSTOWN

Date: 10/01/2015

By: _____
Duly Authorized

Name: Shaun Mulholland

Title: Town Administrator

HealthTrust

HEALTHTRUST, INC.
APPLICATION AND MEMBERSHIP AGREEMENT

Town of Barnstead

This Application and Membership Agreement ("Membership Agreement") is made by and between Town of Barnstead ("Applicant") and HealthTrust, Inc., a New Hampshire voluntary corporation ("HealthTrust"), effective as of January 1, 2016 ("Effective Date"). This Membership Agreement sets forth the terms and conditions of Applicant's membership and/or continuing membership in HealthTrust.

Preamble

HealthTrust is a pooled risk management program operating pursuant to RSA 5-B and offering its member political subdivisions the opportunity to participate in its Coverage Programs and related services including, but not limited to, group medical, dental, short-term disability, long-term disability, and life coverages.

Applicant is eligible and wishes to become or remain a Member of HealthTrust and participate in certain Coverage Programs offered by HealthTrust and therefore is entering this Membership Agreement.

Agreement

Applicant and HealthTrust hereby mutually agree as follows:

1. **Application**. Applicant applies for membership (including continuing membership if applicable) in HealthTrust for the provision of group medical and/or other benefit plans as may be selected by Applicant from time to time.

2. **Eligibility**. Applicant hereby represents and warrants to HealthTrust that Applicant is an entity eligible for membership in HealthTrust in accordance with the HealthTrust Bylaws.

3. **Contingent on Acceptance**. Applicant understands and agrees that its membership in HealthTrust is contingent on HealthTrust's acceptance and execution of this Agreement.

4. **Governing Provisions**. Applicant shall be bound by the provisions of this Membership Agreement, the HealthTrust Articles of Incorporation, Bylaws, Rules, any applicable Coverage Documents, and any other agreements pursuant or incident thereto, all as amended and in effect from time to time (known collectively in the Bylaws as the "Operative Documents"). Applicant acknowledges receipt of the HealthTrust Bylaws.

5. **Member Rights**. As a Member, Applicant will have the rights provided in the Operative Documents including, without limitation, the right to participate in HealthTrust's Coverage Programs and the right to vote for the HealthTrust Board of Directors at annual meetings of the Members. Applicant acknowledges that pursuant to the current HealthTrust Bylaws, the person serving as the top administrative official of Applicant, or his or her designee, shall be entitled to cast a vote on behalf of Applicant at any meetings of the Members of HealthTrust unless and until

Applicant's Governing Board appoints, by resolution, a different representative to cast such a vote prior to the meeting(s) to which the designation relates.

6. **Selection of Coverage Programs and Services**. Subject to the terms and conditions of the Operative Documents, Applicant may select and periodically change the Coverage Programs and related services in which Applicant participates without amending this Membership Agreement. Applicant's participation (or continuing participation) in any of the Coverage Programs and/or related services is subject to:

(a) The proper and timely completion and execution by an authorized representative of Applicant of the documents, agreements, and forms for such participation as required by HealthTrust, and

(b) The policies, procedures, guidelines and Operative Documents that apply to any selected coverages including, without limitation, any applicable minimum participation requirements for such Coverage Program.

7. **Contributions**. Applicant agrees to pay in a timely manner all Contributions required to participate in HealthTrust and/or the applicable Coverage Programs pursuant to the terms of the Operative Documents.

8. **Surplus**. Applicant hereby acknowledges and agrees that any distribution of surplus, or a Member's rights thereto, shall be governed by the applicable terms of the HealthTrust Bylaws and/or other Operative Documents, as they may be amended from time to time. Applicant further agrees that HealthTrust may first apply any surplus due to Applicant to pay any unpaid and overdue Contributions or other amounts owed by Applicant to HealthTrust prior to returning the balance remaining of such surplus to Applicant.

9. **Health Plan Coverage Program Responsibilities**.

(a) Applicant acknowledges that, with respect to the group health (medical and/or dental) plan(s) offered to its Employees through HealthTrust, Applicant is responsible for complying with all applicable provisions of federal and state law governing such health plan(s) including, without limitation: (i) the continuation of coverage provisions set forth in Sections 2201 through 2208 of the Public Health Service Act ("COBRA"), (ii) the retiree medical coverage provisions set forth in New Hampshire RSA 100-A:50, and (iii) the Patient Protection and Affordable Care Act of 2010, as amended and implemented ("ACA").

(b) To assist Applicant in satisfying certain of its COBRA coverage obligations, HealthTrust provides base COBRA services on behalf of Applicant pursuant to a separate COBRA administrative services agreement which Applicant must sign as a condition of participating in HealthTrust's medical and/or dental Coverage Programs. In addition, Applicant may elect to receive additional COBRA billing services offered by HealthTrust pursuant to the separate COBRA administrative services agreement.

(c) To assist Applicant in satisfying certain of its retiree coverage obligations, HealthTrust may offer to provide and Applicant may elect and contract with HealthTrust to receive retiree billing services on behalf of Applicant pursuant to a separate retiree billing administrative services agreement.

10. **Provision of Information**. Applicant agrees to provide HealthTrust in a timely and accurate manner any and all information HealthTrust deems necessary or desirable with regard to HealthTrust's provision of the Coverage Programs and related services selected by Applicant, including but not limited to, all required eligibility and enrollment data.

11. **Safeguarding Personal Information**. HealthTrust may provide Applicant certain non-claims related information, including enrollment, billing, and payment information relevant to the administration of the medical and dental Coverage Programs in which Applicant participates. Some of this information may constitute protected health information, as defined by the Health Insurance Portability and Accountability Act of 1996, as amended and implemented. Examples of information HealthTrust may disclose to Members include: monthly invoices detailing coverage types and cost, payment and enrollment confirmation, and information necessary to assist Applicant in completing its IRS reporting required by the ACA. HealthTrust, at its discretion, also may provide Applicant with non-individually identifiable summary claims information in a manner consistent with state and federal law and applicable HealthTrust policies and procedures.

Applicant hereby certifies that with respect to any protected health information received from HealthTrust, Applicant will:

(a) Safeguard the privacy and security of the information,

(b) Not use or disclose the information beyond that which is necessary to administer the selected coverage(s),

(c) Not use the information for employment-related actions or decisions, and

(d) Restrict access to the information to only those individuals who require the information to administer the coverage(s).

Applicant also acknowledges and agrees that:

(e) HealthTrust will only provide such information to those individuals specifically identified in HealthTrust's database as authorized to receive such information on behalf of Applicant,

(f) HealthTrust does not share individually identifiable claims information unless authorized in writing by the covered person or otherwise permitted by applicable laws, and

(g) HealthTrust reserves the right to decide what, if any, information is provided to Applicant.

12. **Term and Termination**. The term of Applicant's membership (or continuing membership) in HealthTrust under this Membership Agreement begins on the Effective Date. Applicant's participation in specific Coverage Program(s) shall begin on the effective dates for such coverage as indicated in the Coverage Documents executed by Applicant in order to participate in such coverage. Membership in HealthTrust and participation in any Coverage Program shall continue until such coverage is terminated or cancelled in accordance with the terms of the HealthTrust Bylaws, Coverage Documents and/or other Operative Documents.

13. **Miscellaneous Provisions.**

(a) This Membership Agreement is governed by New Hampshire law and may only be modified by a written amendment signed by all applicable parties.

(b) All capitalized terms utilized but not defined herein shall have the same meaning as set forth in the HealthTrust Bylaws.

(c) Section headings contained in this Membership Agreement are solely for the purpose of reference, are not part of the agreement of the parties and shall not in any way affect the meaning or interpretation of this Membership Agreement.

14. **Certificate of Authorizing Resolution**. This Membership Agreement shall be accompanied by a certificate of authorizing resolution (or a copy of the resolution) of the Governing Body of Applicant in substantially the same form and content as contained in the attached Exhibit A that indicates Applicant has duly authorized its membership in HealthTrust in accordance with RSA 5-B and the execution and delivery of this Membership Agreement by the individual signing, which authorization is legally binding and remains in full force and effect as of the date hereof.

IN WITNESS WHEREOF, Applicant and HealthTrust have caused this Membership Agreement to be executed by their duly authorized officials:

For APPLICANT:

TOWN OF BARNSTEAD

Authorized Official Signature

Gordon Preston

Print Name

Chairman, Board of Selectmen

Title

Sept. 22, 2015

Date

For HEALTHTRUST, INC.:

David Frydman
Interim Executive Director

10-19-15

Date

EXHIBIT A

CERTIFICATE OF AUTHORIZING RESOLUTION

I hereby certify to *HealthTrust, Inc.* ("HealthTrust"), that the following is a true copy of a resolution adopted by the Governing Body of Town of Barnstead at a meeting duly held on 9-22-15 [Date]:

RESOLVED: That Town of Barnstead shall participate as a Member in the HealthTrust pooled risk management program for the provision of group medical and/or other benefit plans in accordance with the "Application and Membership Agreement" and NH RSA 5-B.

RESOLVED: That Gordon Preston [**Name/Title**] is hereby authorized and directed to execute and deliver to HealthTrust, on behalf of Town of Barnstead, the "Application and Membership Agreement" in substantially the form presented to this meeting.

I further certify that the foregoing resolution remains in full force and effect without modification.

APPLICANT: TOWN OF BARNSTEAD

Date: Sept. 22, 2015

By: _____
Duly Authorized

Name: Gordon Preston

Title: Chairman, Board of Selectmen

HealthTrust

HEALTHTRUST, INC.
APPLICATION AND MEMBERSHIP AGREEMENT

Town of Chichester

This Application and Membership Agreement ("Membership Agreement") is made by and between Town of Chichester ("Applicant") and HealthTrust, Inc., a New Hampshire voluntary corporation ("HealthTrust"), effective as of January 1, 2016 ("Effective Date"). This Membership Agreement sets forth the terms and conditions of Applicant's membership and/or continuing membership in HealthTrust.

Preamble

HealthTrust is a pooled risk management program operating pursuant to RSA 5-B and offering its member political subdivisions the opportunity to participate in its Coverage Programs and related services including, but not limited to, group medical, dental, short-term disability, long-term disability, and life coverages.

Applicant is eligible and wishes to become or remain a Member of HealthTrust and participate in certain Coverage Programs offered by HealthTrust and therefore is entering this Membership Agreement.

Agreement

Applicant and HealthTrust hereby mutually agree as follows:

1. **Application**. Applicant applies for membership (including continuing membership if applicable) in HealthTrust for the provision of group medical and/or other benefit plans as may be selected by Applicant from time to time.

2. **Eligibility**. Applicant hereby represents and warrants to HealthTrust that Applicant is an entity eligible for membership in HealthTrust in accordance with the HealthTrust Bylaws.

3. **Contingent on Acceptance**. Applicant understands and agrees that its membership in HealthTrust is contingent on HealthTrust's acceptance and execution of this Agreement.

4. **Governing Provisions**. Applicant shall be bound by the provisions of this Membership Agreement, the HealthTrust Articles of Incorporation, Bylaws, Rules, any applicable Coverage Documents, and any other agreements pursuant or incident thereto, all as amended and in effect from time to time (known collectively in the Bylaws as the "Operative Documents"). Applicant acknowledges receipt of the HealthTrust Bylaws.

5. **Member Rights**. As a Member, Applicant will have the rights provided in the Operative Documents including, without limitation, the right to participate in HealthTrust's Coverage Programs and the right to vote for the HealthTrust Board of Directors at annual meetings of the Members. Applicant acknowledges that pursuant to the current HealthTrust Bylaws, the person serving as the top administrative official of Applicant, or his or her designee, shall be entitled to cast a vote on behalf of Applicant at any meetings of the Members of HealthTrust unless and until

Applicant's Governing Board appoints, by resolution, a different representative to cast such a vote prior to the meeting(s) to which the designation relates.

6. **Selection of Coverage Programs and Services**. Subject to the terms and conditions of the Operative Documents, Applicant may select and periodically change the Coverage Programs and related services in which Applicant participates without amending this Membership Agreement. Applicant's participation (or continuing participation) in any of the Coverage Programs and/or related services is subject to:

(a) The proper and timely completion and execution by an authorized representative of Applicant of the documents, agreements, and forms for such participation as required by HealthTrust, and

(b) The policies, procedures, guidelines and Operative Documents that apply to any selected coverages including, without limitation, any applicable minimum participation requirements for such Coverage Program.

7. **Contributions**. Applicant agrees to pay in a timely manner all Contributions required to participate in HealthTrust and/or the applicable Coverage Programs pursuant to the terms of the Operative Documents.

8. **Surplus**. Applicant hereby acknowledges and agrees that any distribution of surplus, or a Member's rights thereto, shall be governed by the applicable terms of the HealthTrust Bylaws and/or other Operative Documents, as they may be amended from time to time. Applicant further agrees that HealthTrust may first apply any surplus due to Applicant to pay any unpaid and overdue Contributions or other amounts owed by Applicant to HealthTrust prior to returning the balance remaining of such surplus to Applicant.

9. **Health Plan Coverage Program Responsibilities**.

(a) Applicant acknowledges that, with respect to the group health (medical and/or dental) plan(s) offered to its Employees through HealthTrust, Applicant is responsible for complying with all applicable provisions of federal and state law governing such health plan(s) including, without limitation: (i) the continuation of coverage provisions set forth in Sections 2201 through 2208 of the Public Health Service Act ("COBRA"), (ii) the retiree medical coverage provisions set forth in New Hampshire RSA 100-A:50, and (iii) the Patient Protection and Affordable Care Act of 2010, as amended and implemented ("ACA").

(b) To assist Applicant in satisfying certain of its COBRA coverage obligations, HealthTrust provides base COBRA services on behalf of Applicant pursuant to a separate COBRA administrative services agreement which Applicant must sign as a condition of participating in HealthTrust's medical and/or dental Coverage Programs. In addition, Applicant may elect to receive additional COBRA billing services offered by HealthTrust pursuant to the separate COBRA administrative services agreement.

(c) To assist Applicant in satisfying certain of its retiree coverage obligations, HealthTrust may offer to provide and Applicant may elect and contract with HealthTrust to receive retiree billing services on behalf of Applicant pursuant to a separate retiree billing administrative services agreement.

10. **Provision of Information**. Applicant agrees to provide HealthTrust in a timely and accurate manner any and all information HealthTrust deems necessary or desirable with regard to HealthTrust's provision of the Coverage Programs and related services selected by Applicant, including but not limited to, all required eligibility and enrollment data.

11. **Safeguarding Personal Information**. HealthTrust may provide Applicant certain non-claims related information, including enrollment, billing, and payment information relevant to the administration of the medical and dental Coverage Programs in which Applicant participates. Some of this information may constitute protected health information, as defined by the Health Insurance Portability and Accountability Act of 1996, as amended and implemented. Examples of information HealthTrust may disclose to Members include: monthly invoices detailing coverage types and cost, payment and enrollment confirmation, and information necessary to assist Applicant in completing its IRS reporting required by the ACA. HealthTrust, at its discretion, also may provide Applicant with non-individually identifiable summary claims information in a manner consistent with state and federal law and applicable HealthTrust policies and procedures.

Applicant hereby certifies that with respect to any protected health information received from HealthTrust, Applicant will:

(a) Safeguard the privacy and security of the information,

(b) Not use or disclose the information beyond that which is necessary to administer the selected coverage(s),

(c) Not use the information for employment-related actions or decisions, and

(d) Restrict access to the information to only those individuals who require the information to administer the coverage(s).

Applicant also acknowledges and agrees that:

(e) HealthTrust will only provide such information to those individuals specifically identified in HealthTrust's database as authorized to receive such information on behalf of Applicant,

(f) HealthTrust does not share individually identifiable claims information unless authorized in writing by the covered person or otherwise permitted by applicable laws, and

(g) HealthTrust reserves the right to decide what, if any, information is provided to Applicant.

12. **Term and Termination**. The term of Applicant's membership (or continuing membership) in HealthTrust under this Membership Agreement begins on the Effective Date. Applicant's participation in specific Coverage Program(s) shall begin on the effective dates for such coverage as indicated in the Coverage Documents executed by Applicant in order to participate in such coverage. Membership in HealthTrust and participation in any Coverage Program shall continue until such coverage is terminated or cancelled in accordance with the terms of the HealthTrust Bylaws, Coverage Documents and/or other Operative Documents.

13. **Miscellaneous Provisions.**

(a) This Membership Agreement is governed by New Hampshire law and may only be modified by a written amendment signed by all applicable parties.

(b) All capitalized terms utilized but not defined herein shall have the same meaning as set forth in the HealthTrust Bylaws.

(c) Section headings contained in this Membership Agreement are solely for the purpose of reference, are not part of the agreement of the parties and shall not in any way affect the meaning or interpretation of this Membership Agreement.

14. **Certificate of Authorizing Resolution**. This Membership Agreement shall be accompanied by a certificate of authorizing resolution (or a copy of the resolution) of the Governing Body of Applicant in substantially the same form and content as contained in the attached Exhibit A that indicates Applicant has duly authorized its membership in HealthTrust in accordance with RSA 5-B and the execution and delivery of this Membership Agreement by the individual signing, which authorization is legally binding and remains in full force and effect as of the date hereof.

IN WITNESS WHEREOF, Applicant and HealthTrust have caused this Membership Agreement to be executed by their duly authorized officials:

For APPLICANT:

TOWN OF CHICHESTER

Jodi Pinard

Authorized Official Signature

Jodi Pinard

Print Name

Town Administrator

Title

10/20/15

Date

For HEALTHTRUST, INC.:

David Frydman

David Frydman
Interim Executive Director

12-8-15

Date

EXHIBIT A

CERTIFICATE OF AUTHORIZING RESOLUTION

I hereby certify to *HealthTrust, Inc.* ("HealthTrust"), that the following is a true copy of a resolution adopted by the Governing Body of Town of Chichester at a meeting duly held on 10/20/15 [Date]:

RESOLVED: That Town of Chichester shall participate as a Member in the HealthTrust pooled risk management program for the provision of group medical and/or other benefit plans in accordance with the "Application and Membership Agreement" and NH RSA 5-B.

RESOLVED: That Jodi Pinard, Town Administrator [**Name/Title**] is hereby authorized and directed to execute and deliver to HealthTrust, on behalf of Town of Chichester, the "Application and Membership Agreement" in substantially the form presented to this meeting.

I further certify that the foregoing resolution remains in full force and effect without modification.

APPLICANT: TOWN OF CHICHESTER

Date: 10/20/15

By: _____
Duly Authorized

Name: D. Michael Paveglio

Title: Chairman, BOS

HealthTrust

HEALTHTRUST, INC.
APPLICATION AND MEMBERSHIP AGREEMENT

Town of Epsom

This Application and Membership Agreement ("Membership Agreement") is made by and between Town of Epsom ("Applicant") and HealthTrust, Inc., a New Hampshire voluntary corporation ("HealthTrust"), effective as of September 1, 2015 ("Effective Date"). This Membership Agreement sets forth the terms and conditions of Applicant's membership and/or continuing membership in HealthTrust.

Preamble

HealthTrust is a pooled risk management program operating pursuant to RSA 5-B and offering its member political subdivisions the opportunity to participate in its Coverage Programs and related services including, but not limited to, group medical, dental, short-term disability, long-term disability, and life coverages.

Applicant is eligible and wishes to become or remain a Member of HealthTrust and participate in certain Coverage Programs offered by HealthTrust and therefore is entering this Membership Agreement.

Agreement

Applicant and HealthTrust hereby mutually agree as follows:

1. **Application**. Applicant applies for membership (including continuing membership if applicable) in HealthTrust for the provision of group medical and/or other benefit plans as may be selected by Applicant from time to time.

2. **Eligibility**. Applicant hereby represents and warrants to HealthTrust that Applicant is an entity eligible for membership in HealthTrust in accordance with the HealthTrust Bylaws.

3. **Contingent on Acceptance**. Applicant understands and agrees that its membership in HealthTrust is contingent on HealthTrust's acceptance and execution of this Agreement.

4. **Governing Provisions**. Applicant shall be bound by the provisions of this Membership Agreement, the HealthTrust Articles of Incorporation, Bylaws, Rules, any applicable Coverage Documents, and any other agreements pursuant or incident thereto, all as amended and in effect from time to time (known collectively in the Bylaws as the "Operative Documents"). Applicant acknowledges receipt of the HealthTrust Bylaws.

5. **Member Rights**. As a Member, Applicant will have the rights provided in the Operative Documents including, without limitation, the right to participate in HealthTrust's Coverage Programs and the right to vote for the HealthTrust Board of Directors at annual meetings of the Members. Applicant acknowledges that pursuant to the current HealthTrust Bylaws, the person serving as the top administrative official of Applicant, or his or her designee, shall be entitled to cast a vote on behalf of Applicant at any meetings of the Members of HealthTrust unless and until

Applicant's Governing Board appoints, by resolution, a different representative to cast such a vote prior to the meeting(s) to which the designation relates.

6. **Selection of Coverage Programs and Services**. Subject to the terms and conditions of the Operative Documents, Applicant may select and periodically change the Coverage Programs and related services in which Applicant participates without amending this Membership Agreement. Applicant's participation (or continuing participation) in any of the Coverage Programs and/or related services is subject to:

(a) The proper and timely completion and execution by an authorized representative of Applicant of the documents, agreements, and forms for such participation as required by HealthTrust, and

(b) The policies, procedures, guidelines and Operative Documents that apply to any selected coverages including, without limitation, any applicable minimum participation requirements for such Coverage Program.

7. **Contributions**. Applicant agrees to pay in a timely manner all Contributions required to participate in HealthTrust and/or the applicable Coverage Programs pursuant to the terms of the Operative Documents.

8. **Surplus**. Applicant hereby acknowledges and agrees that any distribution of surplus, or a Member's rights thereto, shall be governed by the applicable terms of the HealthTrust Bylaws and/or other Operative Documents, as they may be amended from time to time. Applicant further agrees that HealthTrust may first apply any surplus due to Applicant to pay any unpaid and overdue Contributions or other amounts owed by Applicant to HealthTrust prior to returning the balance remaining of such surplus to Applicant.

9. **Health Plan Coverage Program Responsibilities**.

(a) Applicant acknowledges that, with respect to the group health (medical and/or dental) plan(s) offered to its Employees through HealthTrust, Applicant is responsible for complying with all applicable provisions of federal and state law governing such health plan(s) including, without limitation: (i) the continuation of coverage provisions set forth in Sections 2201 through 2208 of the Public Health Service Act ("COBRA"), (ii) the retiree medical coverage provisions set forth in New Hampshire RSA 100-A:50, and (iii) the Patient Protection and Affordable Care Act of 2010, as amended and implemented ("ACA").

(b) To assist Applicant in satisfying certain of its COBRA coverage obligations, HealthTrust provides base COBRA services on behalf of Applicant pursuant to a separate COBRA administrative services agreement which Applicant must sign as a condition of participating in HealthTrust's medical and/or dental Coverage Programs. In addition, Applicant may elect to receive additional COBRA billing services offered by HealthTrust pursuant to the separate COBRA administrative services agreement.

(c) To assist Applicant in satisfying certain of its retiree coverage obligations, HealthTrust may offer to provide and Applicant may elect and contract with HealthTrust to receive retiree billing services on behalf of Applicant pursuant to a separate retiree billing administrative services agreement.

10. **Provision of Information**. Applicant agrees to provide HealthTrust in a timely and accurate manner any and all information HealthTrust deems necessary or desirable with regard to HealthTrust's provision of the Coverage Programs and related services selected by Applicant, including but not limited to, all required eligibility and enrollment data.

11. **Safeguarding Personal Information**. HealthTrust may provide Applicant certain non-claims related information, including enrollment, billing, and payment information relevant to the administration of the medical and dental Coverage Programs in which Applicant participates. Some of this information may constitute protected health information, as defined by the Health Insurance Portability and Accountability Act of 1996, as amended and implemented. Examples of information HealthTrust may disclose to Members include: monthly invoices detailing coverage types and cost, payment and enrollment confirmation, and information necessary to assist Applicant in completing its IRS reporting required by the ACA. HealthTrust, at its discretion, also may provide Applicant with non-individually identifiable summary claims information in a manner consistent with state and federal law and applicable HealthTrust policies and procedures.

Applicant hereby certifies that with respect to any protected health information received from HealthTrust, Applicant will:

(a) Safeguard the privacy and security of the information,

(b) Not use or disclose the information beyond that which is necessary to administer the selected coverage(s),

(c) Not use the information for employment-related actions or decisions, and

(d) Restrict access to the information to only those individuals who require the information to administer the coverage(s).

Applicant also acknowledges and agrees that:

(e) HealthTrust will only provide such information to those individuals specifically identified in HealthTrust's database as authorized to receive such information on behalf of Applicant,

(f) HealthTrust does not share individually identifiable claims information unless authorized in writing by the covered person or otherwise permitted by applicable laws, and

(g) HealthTrust reserves the right to decide what, if any, information is provided to Applicant.

12. **Term and Termination**. The term of Applicant's membership (or continuing membership) in HealthTrust under this Membership Agreement begins on the Effective Date. Applicant's participation in specific Coverage Program(s) shall begin on the effective dates for such coverage as indicated in the Coverage Documents executed by Applicant in order to participate in such coverage. Membership in HealthTrust and participation in any Coverage Program shall continue until such coverage is terminated or cancelled in accordance with the terms of the HealthTrust Bylaws, Coverage Documents and/or other Operative Documents.

13. **Miscellaneous Provisions.**

(a) This Membership Agreement is governed by New Hampshire law and may only be modified by a written amendment signed by all applicable parties.

(b) All capitalized terms utilized but not defined herein shall have the same meaning as set forth in the HealthTrust Bylaws.

(c) Section headings contained in this Membership Agreement are solely for the purpose of reference, are not part of the agreement of the parties and shall not in any way affect the meaning or interpretation of this Membership Agreement.

14. **Certificate of Authorizing Resolution**. This Membership Agreement shall be accompanied by a certificate of authorizing resolution (or a copy of the resolution) of the Governing Body of Applicant in substantially the same form and content as contained in the attached Exhibit A that indicates Applicant has duly authorized its membership in HealthTrust in accordance with RSA 5-B and the execution and delivery of this Membership Agreement by the individual signing, which authorization is legally binding and remains in full force and effect as of the date hereof.

IN WITNESS WHEREOF, Applicant and HealthTrust have caused this Membership Agreement to be executed by their duly authorized officials:

For APPLICANT:

TOWN OF EPSOM

Authorized Official Signature

Donald J. Harty
Print Name

Chairman, Board of Selectmen
Title

9-21-15
Date

For HEALTHTRUST, INC.:

David Frydman
Interim Executive Director

9-28-15
Date

EXHIBIT A

CERTIFICATE OF AUTHORIZING RESOLUTION

I hereby certify to *HealthTrust, Inc.* ("HealthTrust"), that the following is a true copy of a resolution adopted by the Governing Body of Town of Epsom at a meeting duly held on 9-21-15 **[Date]**.

RESOLVED: That Town of Epsom shall participate as a Member in the HealthTrust pooled risk management program for the provision of group medical and/or other benefit plans in accordance with the "Application and Membership Agreement" and NH RSA 5-B.

RESOLVED: That Donald J. Harty, Chair **[Name/Title]** is hereby authorized and directed to execute and deliver to HealthTrust, on behalf of Town of Epsom, the "Application and Membership Agreement" in substantially the form presented to this meeting.

I further certify that the foregoing resolution remains in full force and effect without modification.

APPLICANT: TOWN OF EPSOM

Date: 9-21-15

By: _____
Duly Authorized

Name: Donald J. Harty

Title: Chairman, Board of Selectmen

HealthTrust

Health Trust

OCT 05 2015

Initials _____
Processed _____

HEALTHTRUST, INC.
APPLICATION AND MEMBERSHIP AGREEMENT

Town of Pembroke

This Application and Membership Agreement ("Membership Agreement") is made by and between Town of Pembroke ("Applicant") and HealthTrust, Inc., a New Hampshire voluntary corporation ("HealthTrust"), effective as of January 1, 2016 ("Effective Date"). This Membership Agreement sets forth the terms and conditions of Applicant's membership and/or continuing membership in HealthTrust.

Preamble

HealthTrust is a pooled risk management program operating pursuant to RSA 5-B and offering its member political subdivisions the opportunity to participate in its Coverage Programs and related services including, but not limited to, group medical, dental, short-term disability, long-term disability, and life coverages.

Applicant is eligible and wishes to become or remain a Member of HealthTrust and participate in certain Coverage Programs offered by HealthTrust and therefore is entering this Membership Agreement.

Agreement

Applicant and HealthTrust hereby mutually agree as follows:

1. **Application**. Applicant applies for membership (including continuing membership if applicable) in HealthTrust for the provision of group medical and/or other benefit plans as may be selected by Applicant from time to time.

2. **Eligibility**. Applicant hereby represents and warrants to HealthTrust that Applicant is an entity eligible for membership in HealthTrust in accordance with the HealthTrust Bylaws.

3. **Contingent on Acceptance**. Applicant understands and agrees that its membership in HealthTrust is contingent on HealthTrust's acceptance and execution of this Agreement.

4. **Governing Provisions**. Applicant shall be bound by the provisions of this Membership Agreement, the HealthTrust Articles of Incorporation, Bylaws, Rules, any applicable Coverage Documents, and any other agreements pursuant or incident thereto, all as amended and in effect from time to time (known collectively in the Bylaws as the "Operative Documents"). Applicant acknowledges receipt of the HealthTrust Bylaws.

5. **Member Rights**. As a Member, Applicant will have the rights provided in the Operative Documents including, without limitation, the right to participate in HealthTrust's Coverage Programs and the right to vote for the HealthTrust Board of Directors at annual meetings of the Members. Applicant acknowledges that pursuant to the current HealthTrust Bylaws, the person serving as the top administrative official of Applicant, or his or her designee, shall be entitled to cast a vote on behalf of Applicant at any meetings of the Members of HealthTrust unless and until

Applicant's Governing Board appoints, by resolution, a different representative to cast such a vote prior to the meeting(s) to which the designation relates.

6. **Selection of Coverage Programs and Services**. Subject to the terms and conditions of the Operative Documents, Applicant may select and periodically change the Coverage Programs and related services in which Applicant participates without amending this Membership Agreement. Applicant's participation (or continuing participation) in any of the Coverage Programs and/or related services is subject to:

(a) The proper and timely completion and execution by an authorized representative of Applicant of the documents, agreements, and forms for such participation as required by HealthTrust, and

(b) The policies, procedures, guidelines and Operative Documents that apply to any selected coverages including, without limitation, any applicable minimum participation requirements for such Coverage Program.

7. **Contributions**. Applicant agrees to pay in a timely manner all Contributions required to participate in HealthTrust and/or the applicable Coverage Programs pursuant to the terms of the Operative Documents.

8. **Surplus**. Applicant hereby acknowledges and agrees that any distribution of surplus, or a Member's rights thereto, shall be governed by the applicable terms of the HealthTrust Bylaws and/or other Operative Documents, as they may be amended from time to time. Applicant further agrees that HealthTrust may first apply any surplus due to Applicant to pay any unpaid and overdue Contributions or other amounts owed by Applicant to HealthTrust prior to returning the balance remaining of such surplus to Applicant.

9. **Health Plan Coverage Program Responsibilities**.

(a) Applicant acknowledges that, with respect to the group health (medical and/or dental) plan(s) offered to its Employees through HealthTrust, Applicant is responsible for complying with all applicable provisions of federal and state law governing such health plan(s) including, without limitation: (i) the continuation of coverage provisions set forth in Sections 2201 through 2208 of the Public Health Service Act ("COBRA"), (ii) the retiree medical coverage provisions set forth in New Hampshire RSA 100-A:50, and (iii) the Patient Protection and Affordable Care Act of 2010, as amended and implemented ("ACA").

(b) To assist Applicant in satisfying certain of its COBRA coverage obligations, HealthTrust provides base COBRA services on behalf of Applicant pursuant to a separate COBRA administrative services agreement which Applicant must sign as a condition of participating in HealthTrust's medical and/or dental Coverage Programs. In addition, Applicant may elect to receive additional COBRA billing services offered by HealthTrust pursuant to the separate COBRA administrative services agreement.

(c) To assist Applicant in satisfying certain of its retiree coverage obligations, HealthTrust may offer to provide and Applicant may elect and contract with HealthTrust to receive retiree billing services on behalf of Applicant pursuant to a separate retiree billing administrative services agreement.

10. **Provision of Information**. Applicant agrees to provide HealthTrust in a timely and accurate manner any and all information HealthTrust deems necessary or desirable with regard to HealthTrust's provision of the Coverage Programs and related services selected by Applicant, including but not limited to, all required eligibility and enrollment data.

11. **Safeguarding Personal Information**. HealthTrust may provide Applicant certain non-claims related information, including enrollment, billing, and payment information relevant to the administration of the medical and dental Coverage Programs in which Applicant participates. Some of this information may constitute protected health information, as defined by the Health Insurance Portability and Accountability Act of 1996, as amended and implemented. Examples of information HealthTrust may disclose to Members include: monthly invoices detailing coverage types and cost, payment and enrollment confirmation, and information necessary to assist Applicant in completing its IRS reporting required by the ACA. HealthTrust, at its discretion, also may provide Applicant with non-individually identifiable summary claims information in a manner consistent with state and federal law and applicable HealthTrust policies and procedures.

Applicant hereby certifies that with respect to any protected health information received from HealthTrust, Applicant will:

(a) Safeguard the privacy and security of the information,

(b) Not use or disclose the information beyond that which is necessary to administer the selected coverage(s),

(c) Not use the information for employment-related actions or decisions, and

(d) Restrict access to the information to only those individuals who require the information to administer the coverage(s).

Applicant also acknowledges and agrees that:

(e) HealthTrust will only provide such information to those individuals specifically identified in HealthTrust's database as authorized to receive such information on behalf of Applicant,

(f) HealthTrust does not share individually identifiable claims information unless authorized in writing by the covered person or otherwise permitted by applicable laws, and

(g) HealthTrust reserves the right to decide what, if any, information is provided to Applicant.

12. **Term and Termination**. The term of Applicant's membership (or continuing membership) in HealthTrust under this Membership Agreement begins on the Effective Date. Applicant's participation in specific Coverage Program(s) shall begin on the effective dates for such coverage as indicated in the Coverage Documents executed by Applicant in order to participate in such coverage. Membership in HealthTrust and participation in any Coverage Program shall continue until such coverage is terminated or cancelled in accordance with the terms of the HealthTrust Bylaws, Coverage Documents and/or other Operative Documents.

13. **Miscellaneous Provisions.**

(a) This Membership Agreement is governed by New Hampshire law and may only be modified by a written amendment signed by all applicable parties.

(b) All capitalized terms utilized but not defined herein shall have the same meaning as set forth in the HealthTrust Bylaws.

(c) Section headings contained in this Membership Agreement are solely for the purpose of reference, are not part of the agreement of the parties and shall not in any way affect the meaning or interpretation of this Membership Agreement.

14. **Certificate of Authorizing Resolution**. This Membership Agreement shall be accompanied by a certificate of authorizing resolution (or a copy of the resolution) of the Governing Body of Applicant in substantially the same form and content as contained in the attached Exhibit A that indicates Applicant has duly authorized its membership in HealthTrust in accordance with RSA 5-B and the execution and delivery of this Membership Agreement by the individual signing, which authorization is legally binding and remains in full force and effect as of the date hereof.

IN WITNESS WHEREOF, Applicant and HealthTrust have caused this Membership Agreement to be executed by their duly authorized officials:

For APPLICANT: TOWN OF PEMBROKE

Authorized Official Signature

DAVID M Jodoin

Print Name

TOWN Administrator

Title

9/24/15

Date

For HEALTHTRUST, INC.:

David Frydman

David Frydman
Interim Executive Director

10-7-15

Date

EXHIBIT A

CERTIFICATE OF AUTHORIZING RESOLUTION

I hereby certify to *HealthTrust, Inc.* ("HealthTrust"), that the following is a true copy of a resolution adopted by the Governing Body of Town of Pembroke at a meeting duly held on 9/21/15 [Date]:

RESOLVED: That Town of Pembroke shall participate as a Member in the HealthTrust pooled risk management program for the provision of group medical and/or other benefit plans in accordance with the "Application and Membership Agreement" and NH RSA 5-B.

RESOLVED: That David M Jodoin Town Administrator [**Name/Title**] is hereby authorized and directed to execute and deliver to HealthTrust, on behalf of Town of Pembroke, the "Application and Membership Agreement" in substantially the form presented to this meeting.

I further certify that the foregoing resolution remains in full force and effect without modification.

APPLICANT: TOWN OF PEMBROKE

Date: Sept. 24, 2015

By: Justine M. Courtemanche
Duly Authorized

Name: Justine M. Courtemanche

Title: Chair-Board of Selectman

HealthTrust

HEALTHTRUST, INC.
APPLICATION AND MEMBERSHIP AGREEMENT

Town of Pittsfield

This Application and Membership Agreement ("Membership Agreement") is made by and between Town of Pittsfield ("Applicant") and HealthTrust, Inc., a New Hampshire voluntary corporation ("HealthTrust"), effective as of January 1, 2016 ("Effective Date"). This Membership Agreement sets forth the terms and conditions of Applicant's membership and/or continuing membership in HealthTrust.

Preamble

HealthTrust is a pooled risk management program operating pursuant to RSA 5-B and offering its member political subdivisions the opportunity to participate in its Coverage Programs and related services including, but not limited to, group medical, dental, short-term disability, long-term disability, and life coverages.

Applicant is eligible and wishes to become or remain a Member of HealthTrust and participate in certain Coverage Programs offered by HealthTrust and therefore is entering this Membership Agreement.

Agreement

Applicant and HealthTrust hereby mutually agree as follows:

1. **Application**. Applicant applies for membership (including continuing membership if applicable) in HealthTrust for the provision of group medical and/or other benefit plans as may be selected by Applicant from time to time.

2. **Eligibility**. Applicant hereby represents and warrants to HealthTrust that Applicant is an entity eligible for membership in HealthTrust in accordance with the HealthTrust Bylaws.

3. **Contingent on Acceptance**. Applicant understands and agrees that its membership in HealthTrust is contingent on HealthTrust's acceptance and execution of this Agreement.

4. **Governing Provisions**. Applicant shall be bound by the provisions of this Membership Agreement, the HealthTrust Articles of Incorporation, Bylaws, Rules, any applicable Coverage Documents, and any other agreements pursuant or incident thereto, all as amended and in effect from time to time (known collectively in the Bylaws as the "Operative Documents"). Applicant acknowledges receipt of the HealthTrust Bylaws.

5. **Member Rights**. As a Member, Applicant will have the rights provided in the Operative Documents including, without limitation, the right to participate in HealthTrust's Coverage Programs and the right to vote for the HealthTrust Board of Directors at annual meetings of the Members. Applicant acknowledges that pursuant to the current HealthTrust Bylaws, the person serving as the top administrative official of Applicant, or his or her designee, shall be entitled to cast a vote on behalf of Applicant at any meetings of the Members of HealthTrust unless and until

Applicant's Governing Board appoints, by resolution, a different representative to cast such a vote prior to the meeting(s) to which the designation relates.

6. **Selection of Coverage Programs and Services**. Subject to the terms and conditions of the Operative Documents, Applicant may select and periodically change the Coverage Programs and related services in which Applicant participates without amending this Membership Agreement. Applicant's participation (or continuing participation) in any of the Coverage Programs and/or related services is subject to:

(a) The proper and timely completion and execution by an authorized representative of Applicant of the documents, agreements, and forms for such participation as required by HealthTrust, and

(b) The policies, procedures, guidelines and Operative Documents that apply to any selected coverages including, without limitation, any applicable minimum participation requirements for such Coverage Program.

7. **Contributions**. Applicant agrees to pay in a timely manner all Contributions required to participate in HealthTrust and/or the applicable Coverage Programs pursuant to the terms of the Operative Documents.

8. **Surplus**. Applicant hereby acknowledges and agrees that any distribution of surplus, or a Member's rights thereto, shall be governed by the applicable terms of the HealthTrust Bylaws and/or other Operative Documents, as they may be amended from time to time. Applicant further agrees that HealthTrust may first apply any surplus due to Applicant to pay any unpaid and overdue Contributions or other amounts owed by Applicant to HealthTrust prior to returning the balance remaining of such surplus to Applicant.

9. **Health Plan Coverage Program Responsibilities**.

(a) Applicant acknowledges that, with respect to the group health (medical and/or dental) plan(s) offered to its Employees through HealthTrust, Applicant is responsible for complying with all applicable provisions of federal and state law governing such health plan(s) including, without limitation: (i) the continuation of coverage provisions set forth in Sections 2201 through 2208 of the Public Health Service Act ("COBRA"), (ii) the retiree medical coverage provisions set forth in New Hampshire RSA 100-A:50, and (iii) the Patient Protection and Affordable Care Act of 2010, as amended and implemented ("ACA").

(b) To assist Applicant in satisfying certain of its COBRA coverage obligations, HealthTrust provides base COBRA services on behalf of Applicant pursuant to a separate COBRA administrative services agreement which Applicant must sign as a condition of participating in HealthTrust's medical and/or dental Coverage Programs. In addition, Applicant may elect to receive additional COBRA billing services offered by HealthTrust pursuant to the separate COBRA administrative services agreement.

(c) To assist Applicant in satisfying certain of its retiree coverage obligations, HealthTrust may offer to provide and Applicant may elect and contract with HealthTrust to receive retiree billing services on behalf of Applicant pursuant to a separate retiree billing administrative services agreement.

10. **Provision of Information**. Applicant agrees to provide HealthTrust in a timely and accurate manner any and all information HealthTrust deems necessary or desirable with regard to HealthTrust's provision of the Coverage Programs and related services selected by Applicant, including but not limited to, all required eligibility and enrollment data.

11. **Safeguarding Personal Information**. HealthTrust may provide Applicant certain non-claims related information, including enrollment, billing, and payment information relevant to the administration of the medical and dental Coverage Programs in which Applicant participates. Some of this information may constitute protected health information, as defined by the Health Insurance Portability and Accountability Act of 1996, as amended and implemented. Examples of information HealthTrust may disclose to Members include: monthly invoices detailing coverage types and cost, payment and enrollment confirmation, and information necessary to assist Applicant in completing its IRS reporting required by the ACA. HealthTrust, at its discretion, also may provide Applicant with non-individually identifiable summary claims information in a manner consistent with state and federal law and applicable HealthTrust policies and procedures.

Applicant hereby certifies that with respect to any protected health information received from HealthTrust, Applicant will:

(a) Safeguard the privacy and security of the information,

(b) Not use or disclose the information beyond that which is necessary to administer the selected coverage(s),

(c) Not use the information for employment-related actions or decisions, and

(d) Restrict access to the information to only those individuals who require the information to administer the coverage(s).

Applicant also acknowledges and agrees that:

(e) HealthTrust will only provide such information to those individuals specifically identified in HealthTrust's database as authorized to receive such information on behalf of Applicant,

(f) HealthTrust does not share individually identifiable claims information unless authorized in writing by the covered person or otherwise permitted by applicable laws, and

(g) HealthTrust reserves the right to decide what, if any, information is provided to Applicant.

12. **Term and Termination**. The term of Applicant's membership (or continuing membership) in HealthTrust under this Membership Agreement begins on the Effective Date. Applicant's participation in specific Coverage Program(s) shall begin on the effective dates for such coverage as indicated in the Coverage Documents executed by Applicant in order to participate in such coverage. Membership in HealthTrust and participation in any Coverage Program shall continue until such coverage is terminated or cancelled in accordance with the terms of the HealthTrust Bylaws, Coverage Documents and/or other Operative Documents.

13. **Miscellaneous Provisions.**

(a) This Membership Agreement is governed by New Hampshire law and may only be modified by a written amendment signed by all applicable parties.

(b) All capitalized terms utilized but not defined herein shall have the same meaning as set forth in the HealthTrust Bylaws.

(c) Section headings contained in this Membership Agreement are solely for the purpose of reference, are not part of the agreement of the parties and shall not in any way affect the meaning or interpretation of this Membership Agreement.

14. **Certificate of Authorizing Resolution**. This Membership Agreement shall be accompanied by a certificate of authorizing resolution (or a copy of the resolution) of the Governing Body of Applicant in substantially the same form and content as contained in the attached Exhibit A that indicates Applicant has duly authorized its membership in HealthTrust in accordance with RSA 5-B and the execution and delivery of this Membership Agreement by the individual signing, which authorization is legally binding and remains in full force and effect as of the date hereof.

IN WITNESS WHEREOF, Applicant and HealthTrust have caused this Membership Agreement to be executed by their duly authorized officials:

For APPLICANT: TOWN OF PITTSFIELD

Cara M. Marston
Authorized Official Signature

Cara M. Marston
Print Name

Town Administrator
Title

12/15/2015
Date

For HEALTHTRUST, INC.:

David Frydman
Interim Executive Director

12/18/15
Date

EXHIBIT A

CERTIFICATE OF AUTHORIZING RESOLUTION

I hereby certify to *HealthTrust, Inc.* ("HealthTrust"), that the following is a true copy of a resolution adopted by the Governing Body of Town of Pittsfield at a meeting duly held on 12/15/2015 [Date]:

RESOLVED: That Town of Pittsfield shall participate as a Member in the HealthTrust pooled risk management program for the provision of group medical and/or other benefit plans in accordance with the "Application and Membership Agreement" and NH RSA 5-B.

RESOLVED: That Cara M. Marston / Town Administrator [**Name/Title**] is hereby authorized and directed to execute and deliver to HealthTrust, on behalf of Town of Pittsfield, the "Application and Membership Agreement" in substantially the form presented to this meeting.

I further certify that the foregoing resolution remains in full force and effect without modification.

APPLICANT: TOWN OF PITTSFIELD

Date: 12/15/2015

By: _____
Duly Authorized

Name: Eric R. Nilsson

Title: Chair, Board of Selectmen

HealthTrust

HEALTHTRUST, INC.
APPLICATION AND MEMBERSHIP AGREEMENT

Town of Strafford

This Application and Membership Agreement ("Membership Agreement") is made by and between Town of Strafford ("Applicant") and HealthTrust, Inc., a New Hampshire voluntary corporation ("HealthTrust"), effective as of January 1, 2016 ("Effective Date"). This Membership Agreement sets forth the terms and conditions of Applicant's membership and/or continuing membership in HealthTrust.

Preamble

HealthTrust is a pooled risk management program operating pursuant to RSA 5-B and offering its member political subdivisions the opportunity to participate in its Coverage Programs and related services including, but not limited to, group medical, dental, short-term disability, long-term disability, and life coverages.

Applicant is eligible and wishes to become or remain a Member of HealthTrust and participate in certain Coverage Programs offered by HealthTrust and therefore is entering this Membership Agreement.

Agreement

Applicant and HealthTrust hereby mutually agree as follows:

1. **Application**. Applicant applies for membership (including continuing membership if applicable) in HealthTrust for the provision of group medical and/or other benefit plans as may be selected by Applicant from time to time.

2. **Eligibility**. Applicant hereby represents and warrants to HealthTrust that Applicant is an entity eligible for membership in HealthTrust in accordance with the HealthTrust Bylaws.

3. **Contingent on Acceptance**. Applicant understands and agrees that its membership in HealthTrust is contingent on HealthTrust's acceptance and execution of this Agreement.

4. **Governing Provisions**. Applicant shall be bound by the provisions of this Membership Agreement, the HealthTrust Articles of Incorporation, Bylaws, Rules, any applicable Coverage Documents, and any other agreements pursuant or incident thereto, all as amended and in effect from time to time (known collectively in the Bylaws as the "Operative Documents"). Applicant acknowledges receipt of the HealthTrust Bylaws.

5. **Member Rights**. As a Member, Applicant will have the rights provided in the Operative Documents including, without limitation, the right to participate in HealthTrust's Coverage Programs and the right to vote for the HealthTrust Board of Directors at annual meetings of the Members. Applicant acknowledges that pursuant to the current HealthTrust Bylaws, the person serving as the top administrative official of Applicant, or his or her designee, shall be entitled to cast a vote on behalf of Applicant at any meetings of the Members of HealthTrust unless and until

Applicant's Governing Board appoints, by resolution, a different representative to cast such a vote prior to the meeting(s) to which the designation relates.

6. **Selection of Coverage Programs and Services**. Subject to the terms and conditions of the Operative Documents, Applicant may select and periodically change the Coverage Programs and related services in which Applicant participates without amending this Membership Agreement. Applicant's participation (or continuing participation) in any of the Coverage Programs and/or related services is subject to:

(a) The proper and timely completion and execution by an authorized representative of Applicant of the documents, agreements, and forms for such participation as required by HealthTrust, and

(b) The policies, procedures, guidelines and Operative Documents that apply to any selected coverages including, without limitation, any applicable minimum participation requirements for such Coverage Program.

7. **Contributions.** Applicant agrees to pay in a timely manner all Contributions required to participate in HealthTrust and/or the applicable Coverage Programs pursuant to the terms of the Operative Documents.

8. **Surplus**. Applicant hereby acknowledges and agrees that any distribution of surplus, or a Member's rights thereto, shall be governed by the applicable terms of the HealthTrust Bylaws and/or other Operative Documents, as they may be amended from time to time. Applicant further agrees that HealthTrust may first apply any surplus due to Applicant to pay any unpaid and overdue Contributions or other amounts owed by Applicant to HealthTrust prior to returning the balance remaining of such surplus to Applicant.

9. **Health Plan Coverage Program Responsibilities.**

(a) Applicant acknowledges that, with respect to the group health (medical and/or dental) plan(s) offered to its Employees through HealthTrust, Applicant is responsible for complying with all applicable provisions of federal and state law governing such health plan(s) including, without limitation: (i) the continuation of coverage provisions set forth in Sections 2201 through 2208 of the Public Health Service Act ("COBRA"), (ii) the retiree medical coverage provisions set forth in New Hampshire RSA 100-A:50, and (iii) the Patient Protection and Affordable Care Act of 2010, as amended and implemented ("ACA").

(b) To assist Applicant in satisfying certain of its COBRA coverage obligations, HealthTrust provides base COBRA services on behalf of Applicant pursuant to a separate COBRA administrative services agreement which Applicant must sign as a condition of participating in HealthTrust's medical and/or dental Coverage Programs. In addition, Applicant may elect to receive additional COBRA billing services offered by HealthTrust pursuant to the separate COBRA administrative services agreement.

(c) To assist Applicant in satisfying certain of its retiree coverage obligations, HealthTrust may offer to provide and Applicant may elect and contract with HealthTrust to receive retiree billing services on behalf of Applicant pursuant to a separate retiree billing administrative services agreement.

10. **Provision of Information**. Applicant agrees to provide HealthTrust in a timely and accurate manner any and all information HealthTrust deems necessary or desirable with regard to HealthTrust's provision of the Coverage Programs and related services selected by Applicant, including but not limited to, all required eligibility and enrollment data.

11. **Safeguarding Personal Information.** HealthTrust may provide Applicant certain non-claims related information, including enrollment, billing, and payment information relevant to the administration of the medical and dental Coverage Programs in which Applicant participates. Some of this information may constitute protected health information, as defined by the Health Insurance Portability and Accountability Act of 1996, as amended and implemented. Examples of information HealthTrust may disclose to Members include: monthly invoices detailing coverage types and cost, payment and enrollment confirmation, and information necessary to assist Applicant in completing its IRS reporting required by the ACA. HealthTrust, at its discretion, also may provide Applicant with non-individually identifiable summary claims information in a manner consistent with state and federal law and applicable HealthTrust policies and procedures.

Applicant hereby certifies that with respect to any protected health information received from HealthTrust, Applicant will:

(a) Safeguard the privacy and security of the information,

(b) Not use or disclose the information beyond that which is necessary to administer the selected coverage(s),

(c) Not use the information for employment-related actions or decisions, and

(d) Restrict access to the information to only those individuals who require the information to administer the coverage(s).

Applicant also acknowledges and agrees that:

(e) HealthTrust will only provide such information to those individuals specifically identified in HealthTrust's database as authorized to receive such information on behalf of Applicant,

(f) HealthTrust does not share individually identifiable claims information unless authorized in writing by the covered person or otherwise permitted by applicable laws, and

(g) HealthTrust reserves the right to decide what, if any, information is provided to Applicant.

12. **Term and Termination**. The term of Applicant's membership (or continuing membership) in HealthTrust under this Membership Agreement begins on the Effective Date. Applicant's participation in specific Coverage Program(s) shall begin on the effective dates for such coverage as indicated in the Coverage Documents executed by Applicant in order to participate in such coverage. Membership in HealthTrust and participation in any Coverage Program shall continue until such coverage is terminated or cancelled in accordance with the terms of the HealthTrust Bylaws, Coverage Documents and/or other Operative Documents.

13. **Miscellaneous Provisions.**

(a) This Membership Agreement is governed by New Hampshire law and may only be modified by a written amendment signed by all applicable parties.

(b) All capitalized terms utilized but not defined herein shall have the same meaning as set forth in the HealthTrust Bylaws.

(c) Section headings contained in this Membership Agreement are solely for the purpose of reference, are not part of the agreement of the parties and shall not in any way affect the meaning or interpretation of this Membership Agreement.

14. **Certificate of Authorizing Resolution.** This Membership Agreement shall be accompanied by a certificate of authorizing resolution (or a copy of the resolution) of the Governing Body of Applicant in substantially the same form and content as contained in the attached Exhibit A that indicates Applicant has duly authorized its membership in HealthTrust in accordance with RSA 5-B and the execution and delivery of this Membership Agreement by the individual signing, which authorization is legally binding and remains in full force and effect as of the date hereof.

IN WITNESS WHEREOF, Applicant and HealthTrust have caused this Membership Agreement to be executed by their duly authorized officials:

For APPLICANT: TOWN OF STRAFFORD

Authorized Official Signature

James W Andersen
Print Name

Selectman Chairman
Title

11-24-15
Date

For HEALTHTRUST, INC.:

David Frydman
Interim Executive Director

12-8-15
Date

EXHIBIT A

CERTIFICATE OF AUTHORIZING RESOLUTION

I hereby certify to *HealthTrust, Inc.* ("HealthTrust"), that the following is a true copy of a resolution adopted by the Governing Body of Town of Strafford at a meeting duly held on 11/24/2015 [Date]:

RESOLVED: That Town of Strafford shall participate as a Member in the HealthTrust pooled risk management program for the provision of group medical and/or other benefit plans in accordance with the "Application and Membership Agreement" and NH RSA 5-B.

RESOLVED: That JAMES W ANDERSEN, CHAIRMAN BOARD OF SELECTMEN [**Name/Title**] is hereby authorized and directed to execute and deliver to HealthTrust, on behalf of Town of Strafford, the "Application and Membership Agreement" in substantially the form presented to this meeting.

I further certify that the foregoing resolution remains in full force and effect without modification.

APPLICANT: TOWN OF STRAFFORD

Date: 11-24-15

By: _____
Duly Authorized

Name: JAMES W ANDERSEN

Title: Selectman Chairman

Section 7e

Staff Biographies

HealthTrust

MEET YOUR SERVICE TEAM

YOUR GROUP'S ASSIGNED ADVISORS

Candace Schaefer,
Benefits Advisor
Phone: 603.230.3392
Email: cschaefer@healthtrustnh.org

Ashley Brigham,
Wellness Advisor
Phone: 603.226.1306
Email: abrigham@healthtrustnh.org

Scott Weden, Benefits and Wellness Manager

- Phone: 603.230.3388
- Email: sweden@healthtrustnh.org

Kevin Flanagan, Member Relations Advisor

- Phone: 603.226.1326
- Email: kflanagan@healthtrustnh.org

William Byron, Wellness Assistant Manager

- Phone: 603.230.3311
- Email: wbyron@healthtrustnh.org

Melisa Briggs, Benefits Assistant Manager

- Phone: 603.230.3370
- Email: mbriggs@healthtrustnh.org

Please feel free to contact us with your questions, concerns and feedback. It is our privilege to serve you.

CANDACE SCHAEFER
Benefits Advisor

Candace Schaefer joined HealthTrust in January 2014 as a Benefits Advisor. An experienced problem-solver, Candace developed a keen understanding of the unique needs and challenges of municipalities, quasi-governmental and nonprofit organizations through her previous work as Director of Constituent Services for United States Senator Jeanne Shaheen and as a community representative for Congressman Paul Hodes. She now brings that deep understanding to her work with HealthTrust's public sector Members. Candace earned her Bachelor of Arts in Politics with minors in Public Policy Studies and French Language Studies from Saint Anselm College in Manchester.

ASHLEY BRIGHAM
Wellness Advisor

Ashley Brigham joined HealthTrust in January 2014 as a Wellness Advisor. A registered and licensed dietitian, Ashley's previous experience included working with patients at Health South Rehabilitation Hospital in Concord. Ashley received her Bachelor of Science in Dietetics from the University of Delaware and in 2013 became a Registered Dietitian and earned her license to practice in the State of New Hampshire. In 2014, Ashley was certified as a Worksite Wellness Specialist through the National Wellness Institute. Ashley sits on the nominating committee for the New Hampshire Dietetic Association. She is a member of the Academy of Nutrition and Dietetics, the Wellness Council of America (WELCOA), and the Wellness Institute of America.

Scott Weden
Manager, Benefits and Wellness

Scott has a diverse professional background related to several facets of local government as an employee, administrator, and elected official. At HealthTrust he is the Manager of the Benefits and Wellness Department. Prior to joining HealthTrust, Scott held the position of Police Chief in the Town of Holderness. A native of New Hampshire, Scott currently resides in Plymouth, and prior to that in Ashland for 43 years, where he served on the Ashland Fire Department rising through the ranks from firefighter to Chief.

Scott manages a staff of eleven that provides benefit administration and wellness management to over 300 municipalities and schools in the State of New Hampshire. He oversees the design, implementation, administration, evaluation and maintenance for all HealthTrust *Slice of Life* programs including health assessments, biometric screenings, SmartShopper, LifeResources EAP, and the Health Awareness program. He also manages and coordinates services and programs provided by outside vendors and consultants relative to the services supported by HealthTrust. Scott was instrumental in the development of HealthTrust's first *Healthcare Summit*, which provided an insightful, comprehensive look at what's ahead for healthcare coverage for Member Groups, and he works closely with internal and external sources to develop and implement alternative plans and programs to benefit our Members.

Scott attended Saint Anselm College and the University of New Hampshire with studies in Public Administration and Criminal Justice in addition to completing an array of certificate programs applicable to all areas of his expertise. He is a member of several related professional organizations.

KEVIN FLANAGAN
Member Relations Advisor

Kevin's background includes over 20 years' experience in healthcare, occupational health, risk and health management. He holds a degree in Business Administration from Northeastern University and a Master of Public Health from the University of New Hampshire. Kevin is an active member of the New Hampshire Occupational Health Surveillance Program Advisory Committee and is certified in Health Cost Management.

William D. Byron
Assistant Wellness Manager

Bill is an experienced risk and health educator, data analyzer, and health management consultant for cities, towns, schools and municipalities.

He consults and assists chief administrative/executive officers, senior management and risk and health management coordinators in identifying healthcare cost containment strategies and alternative safety and health management programming, beneficial to their employee groups. He is a member of the National Wellness Institute, and is currently a Council Member for the Governor's Council on Physical Activity and Health. Bill attended Roger Williams University and received a Bachelors of Science Degree, majoring in Health and Human Services. He also has certifications as a Certified Worksite Wellness Program Manager, Certified Ergonomic Assessment Specialist II. His many achievements include a twenty-two year career in the United States Navy, working as the Director of Health Services for 22 commands throughout New York, New Jersey, and New England. He assisted in authoring and implementing the Uniformed Services Physical Readiness Training Program.

Melisa A. Briggs
Assistant Manager, Benefits

Melisa Briggs has been with HealthTrust for almost 20 years. She leads the Benefits Advisor Team that provides account management services and benefit plan consultation to our Members. Melisa and her team provide extensive support to Member groups and their employees through plan administration and benefit education sessions.

Melisa works closely with vendors and attends national employee benefit conferences to stay abreast of trends and initiatives in healthcare and benefit plan design. She has obtained a Certificate of Achievement in Public Plan Policy through the International Foundation of Employee Benefits with a concentration in Employee Benefits.

Section 7f

Brochures

Slice of Life

Your Way to Better Health

Slice of Life 2016

Welcome to **Slice of Life**, HealthTrust's comprehensive wellness program – and your way to better health. We invite you, your covered spouse and dependent children age 18 and older to complete the Health Assessment (HA) by logging in to your secure account at *www.healthtrustnh.org* and clicking the orange box that says "Take my Health Assessment." If you don't yet have a secure account, simply visit *www.healthtrustnh.org*, click on the "New User" prompt in the orange "Health Coverage Login" box and follow the prompts to create an account. (Your secure HealthTrust account also gives you access to your accounts at Onlife Health, CVS/caremark and SmartShopper. Only one user name and one password to remember!)

Once you complete your Health Assessment, you can earn rewards in **Slice of Life**. Here are some program highlights.

Health Assessment (Onlife Health 866.564.5237)

- Access through your secure account at *www.healthtrutsnh.org*. (Have your Anthem ID card handy to sign up.)
- Earn $75 upon completion
- Earn 200 bonus points in the Points Program by completing your HA by 3/31/16
- Completely confidential and voluntary
- Receive a wellness report, customized to you
- Gain access to personal health coaches
- Gateway to all **Slice of Life** components where you can receive up to an additional $350/year in rewards and reimbursements

Biometric Health Screening

- Earn $50 and 50 points (after you complete your HA)
- Have your screening with your own Primary Care Provider (PCP) or at a HealthTrust screening event.
- Register for a screening event for 2016 at *https://healthtrust.bioiq.com* (have your Anthem ID card handy).
- Download or print the 2016 Biometric Health Screening form to complete with your own PCP by visiting *www.healthtrustnh.org*, clicking the "Forms and Documents" button and scrolling down to **Slice of Life**.
- Learn your essential health numbers
- Results uploaded automatically into your HA

Points Program

- Receive $100 every 6 months (up to $200/year) by earning 500 points (after completing HA)
- Points awarded for online tracking, contacting a health coach, doctor-ordered screenings, and more
- AlwaysOn app lets you track your points on your phone.

Continued on reverse.

- Earn 25 points for bi-yearly dental cleaning (up to 50 points per year), if you have dental coverage through HealthTrust
- Connect your mobile fitness device or app to your online physical activity tracker and earn 100 points. Once you connect your device or app, your activity is tracked automatically. Earn 25 points for every 150 minutes of activity or 50,000 steps tracked, up to 250 points/quarter, 1000 points/year.
- Each 200 points earned per quarter equals one entry into a quarterly drawing for one of ten $1,000 gift cards (after completing HA)

Health Awareness Program

- Earn up to $100 reimbursement for taking eligible health and safety classes (after completing HA)
- Earn up to $200 class reimbursement for each dependent under age 18 (after enrollee completes HA)
- For eligibility information and form submission instructions visit *www.healthtrustnh.org*, click on the "Forms and Documents" button, scroll down and click on Health Awareness Program Reimbursement Request Form (2016).

SmartShopper* (800.824.9127)

- Earn $25 to $500 for each doctor-ordered, cost-effective service
- Shop by phone or online in less than five minutes
- Shop any time before – even the same day as – your appointment
- Learn the facts about medical costs in your area
- Confidential, voluntary

Condition Management & Prevention

- Flu vaccine reimbursement
- Future Moms: $50 reward and complimentary phone consultation with a registered nurse
- Condition Care and Complex Care support
- 24/7 NurseLine (800.544.1901)

LifeResources – Employee Assistance Program (800.759.8122)

- Help with personal problems that may affect your job, health and well-being
- Complimentary behavioral health therapy (up to 6 sessions per issue)
- Complimentary 30-minute consultation per legal issue with attorney
- Complimentary 60-minute phone consultation per issue with financial planner
- 5,000+ online resources
- Savings Center – Up to 25% discounts on some purchases
- New "LifeResources-EAP" mobile app available

HealthTrust-U

- Points for online courses, challenges, health tracking and coaching
- Points for HealthTrust wellness classes
- Points for Health & Safety Coordinator events
- Take Control! enrollee portal resources
- Podcasts and webinars

**Retirees with Medicomp Three coverage are not eligible for the SmartShopper program.*

HealthTrust

Learn more at *www.healthtrustnh.org*. Questions? Contact HealthTrust Enrollee Services at 800.527.5001.

Your Concerns Are Your Business

All aspects of the program are absolutely confidential and voluntary, so no one will know you're involved – including your employer – unless you choose to tell them. Nothing is entered into your medical or employment records.

And It's Free

There is no cost to employees, retirees or their household members or dependents for use of our online services, telephone counseling or consultation for each legal or financial matter.

We're Here When You Need Us – Get Started Today

Call our toll-free number **800.759.8122** (TTY users, please use Relay) to speak confidentially with a counselor who cares and is professionally trained to help you. We're available 24 hours a day, seven days a week.

HealthTrust

P.O. Box 617 • Concord, NH 03302
Tel: 800.527.5001 • Fax: 603.226.2988
www.healthtrustnh.org

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EMPLOYEE ASSISTANCE PROGRAM

Support and Solutions for Everyday Life

LifeResources

Life can get pretty stressful sometimes – even overwhelming.

Wouldn't it be great if you had a personal consultant you could call on? Someone who can provide guidance, resources and support just when you need it most?

HealthTrust's **Slice of Life** program has always focused on smart lifestyle choices and preventing health problems, but your well-being includes more than good physical health. That's why **Slice of Life** offers the *LifeResources – Employee Assistance Program* with tools to help you manage life's biggest stressors. Learn more about participating in **Slice of Life** at *www.healthtrustnh.org* and start living your healthiest, happiest life possible.

Slice of Life
Your Way to Better Health

Please note: *Some **Slice of Life** programs may not be available to all enrollees. For program and eligibility details, log in to your secure online account or call HealthTrust Enrollee Services at **800.527.5001***

LifeResources

Whether your daily challenges are routine, like wanting a pet sitter or more urgent, such as needing someone to talk with about anxiety you have been feeling, LifeResources is a one-stop, multi-service, invaluable asset you can turn to. Like a personal concierge, we guide you to the solutions that make things less stressful and more manageable for you – the solutions you need to stay in charge of your life.

The Helpful Solutions You Need

From child and elder care to drug and alcohol counseling, from financial and legal consultations to finding a plumber, LifeResources has services that can help you with many of life's challenges. This benefit helps you, your household members and your dependents address both everyday needs and growing personal concerns, keeping your life on course.

No Issue Too Big – or Too Small

LifeResources helps with the kinds of issues, large or small, that can affect your health and happiness as well as your work and family life. LifeResources provides up to six free telephone counseling sessions per issue or, if you prefer, we'll locate a qualified private provider to see you in person. Whether you'd benefit from a one-time consultant or ongoing support, we're just a call or click away.

Professional Care and Support

Sometimes a particular concern becomes too much to handle alone and begins affecting work, family and personal well-being. That's when professional guidance can help. Our licensed and highly skilled counselors are ready to help with a wide range of personal concerns, including stress about work or life issues, couple or parent /child conflicts, depression or other emotional concerns, or substance abuse.

Top Legal and Financial Services

You may, on occasion, need the services of a lawyer or financial service professional. For each legal issue, LifeResources affords you one free 30-minute office or telephone consultation with an experienced attorney (excluding job or criminal related concerns). If you want to continue to work with that attorney, you receive 25% off the attorney's hourly fee. For each financial issue, you receive a free 30- to 60-minute telephone consultation with a financial planner or certified public accountant.

Examples of legal and financial matters include:

- Family law proceedings (divorce and custody)
- Insurance and auto accident claims
- Real estate and landlord/tenant issues
- Estate planning (wills and trusts)
- Retirement and college planning
- Tax advice and preparation
- Buying and selling your home
- Debt counseling

Work/Life Online

For such common concerns as finding the right summer camp or financial advisor, or tips on choosing an electrician or plumber, our state-of-the-art online resource, **Work/Life Online**, provides useful tips and tools as well as a searchable provider database in a wide range of service areas.

Some of the ways you can use the website:

- Locate a child care provider
- Research colleges for your teenager
- Find a pet sitter for your Labrador Retriever
- Find an assisted living unit for your mother
- Calculate your mortgage payments
- Research a disease
- Assess your relationship commitment level

Plus, valuable features to guide you to healthy learning and decision making include:

- Over 5,000 regularly updated articles
- Over 90 online training programs
- A broad range of self-assessment tools
- Money-saving discount offers

Access Work/Life Online

AllOneHealthEAP.com

username: *healthtrust*

password: *member*

800.759.8122

P.O. Box 617
25 Triangle Park Drive
Concord, New Hampshire 03302-0617
Local: 603-226-2861
Toll free: 800-527-5001
Fax: 603-226-2988
Website: healthtrustnh.org

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of New Hampshire, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Anthem health and wellness programs

For your health, for your life

- 24/7 NurseLine
- Preventive care resources
- Wellness information
- Discounts
- Care management

Available to enrollees of:

34843NHMENABS Rev. 08/13

SpecialOffers@Anthem

The Anthem logo on your medical ID card allows you to save on healthy living products and services. Log on to anthem.com and get discounts on:

- Fitness equipment
- Weight-loss programs
- Hearing aids
- Baby and maternity items
- Books
- Child safety products
- Alternative therapy services
- And more!

Help just for you

We'll help you and your family get the care you need at the right time. We look at the care you've been getting to see what steps you can take to avoid problems in the future.

Important notes

Certain programs listed at anthem.com are not available to HealthTrust enrollees and their covered family members. That's because similar programs are offered through HealthTrust's *Slice of Life* health management program or through CVS Caremark, HealthTrust's prescription benefit manager.

For the *Slice of Life* program or prescription drug information, visit healthtrustnh.org. Or, call HealthTrust at 800-527-5001. You can also get prescription drug information at caremark.com or by calling CVS Caremark at 888-726-1631.

Our health and wellness programs aren't your typical health care management program. They're designed to help you lead the healthiest life possible — whether you're already healthy and just want to stay that way, or you're managing a long-term condition that needs regular attention.

The programs offer preventive care resources, wellness information, discounts and care management. You and your family automatically have some of these offerings. Check out our other programs by logging into anthem.com and clicking on **Health & Wellness**. You will need to register first if you haven't already done so. You can also call one of the toll-free numbers listed below:

Health and wellness offering	*Toll-free number*
24/7 NurseLine	**800-544-1901** (press "1" to talk to a registered nurse)
AudioHealth Library	**800-544-1901** (press "9" to access and select AudioHealth Library topics)
ConditionCare	**866-596-9812** (to self-enroll and speak with a ConditionCare nurse)
Future Moms	**866-347-8360** (24/7 access to a registered nurse for help with pregnancy issues and for postpartum support)

24/7 NurseLine and AudioHealth Library

Call 800-544-1901 to speak to an experienced registered nurse — day or night — to discuss symptoms you're experiencing, how to get the right care in the right setting and more. You can also use the toll-free number to access a library of more than 400 audio recordings on the latest health topics. Press "1" to talk to a registered nurse, or press "9" to access the audio library.

Health management and coordination

The following health and wellness programs are automatically made available to you and your family members, when needed, to help you manage and coordinate care:

ConditionCare — A nurse coach and support team of experts works with you to help you better understand how to improve your health. Conditions include asthma, diabetes, heart disease, and chronic obstructive pulmonary disease (COPD).

ComplexCare — You get 24-hour, toll-free access to ComplexCare nurse coaches for support, education and tips on how to manage one or more health conditions. The nurse coach will also coordinate care between your doctors and other health services and helps you reach your personal health goals.

Future Moms — Educational materials and support from a nurse specializing in obstetrics. Plus 24/7 telephone access for expecting mothers to talk to a registered nurse about pregnancy questions or issues.

Case Management — Our dedicated nurse case managers contacts you if you have serious health issues and helps resolve your concerns. The nurse can contact doctors, explain how your health plan works or coordinate care with home health care firms. We take on these tasks and more so you can focus on getting better.

Staying Healthy Reminders — Sometimes a gentle reminder can be the boost you need to help you be your healthy best. Our Staying Healthy Reminders are helpful mailers sent to your home to remind you about important preventive health screenings or exams based on your age or gender. Staying Healthy Reminders cover just about everything from shots, mammograms, and pelvic exams to testing for osteoporosis, colorectal cancer and cholesterol.

Staying Healthy Reminders are already part of your health plan, so there's nothing to join and no extra to pay. All you need to do is keep an eye on your mailbox!

Web-based resources

Get the following Web-based resources by logging in at anthem.com and clicking on **Health & Wellness**:

- *Preventive Health Guidelines* — Listed by age groups and other categories
- *Health Topics* — Search alphabetically or by conditions, procedures/surgeries and age or sex
- *Patient Safety* — Tips, research, quality-related links and more
- *Your Health and Wellness in New Hampshire* — Access Anthem's Healthy Solutions newsletter and Journey Forward: Tools and Resources for Cancer Survivors

Anthem.com wellness resources

Log in at anthem.com and click on **Health & Wellness** > **Wellness Tool Kit** to access a personalized, online resource center full of information to help manage and improve your health. It features articles, interactive tools, calculators and quizzes on topics such as women's, men's and children's health, mental health and specific health conditions. You can:

- Use Health Trackers to chart your health measurements over time.
- Calculate your Body Mass Index.
- Get the latest information on medical alerts and recalls.
- Learn to achieve and maintain a positive mood through the Emotional Health Lifestyle Improvement Program.
- Use *Web*MD's Symptom Checker.
- Set up a secure and personal Health Record.
- Access a childhood immunization schedule for children 6 years and under.
- Learn to keep your kids active for each stage of their growth.
- Access the latest, in-depth information on a specific condition.

HealthTrust

Choosing the Best Medical Plan for You and Your Family

Selecting a medical coverage plan can feel daunting. You're making a decision that could impact your family's healthcare; what could be more important? Here's the good news: You are choosing a plan provided by HealthTrust. That means no matter which plan you select you will have high quality coverage. This quick reference guide can be a first step to choosing the best plan for you and your family.

Why a HealthTrust Plan is Right for You

- For more than 30 years, HealthTrust has provided coverage exclusively for employees who work in New Hampshire's public sector (including teachers and school staff, police officers, firefighters, public works employees, and other municipal, school and county employees) and their covered family members.
- We cover more public sector employees than any other organization in New Hampshire.
- We offer exceptional service. When you call HealthTrust at 800.527.5001 you speak with an Enrollee Services Representative who is knowledgeable about our coverage plans, programs and services, and who works right in our office in Concord. Most issues are resolved within four minutes.
- We partner only with the best:
  - Medical coverage is provided in partnership with Anthem Blue Cross and Blue Shield in New Hampshire,
  - Dental plans are provided in partnership with Northeast Delta Dental, and
  - Prescription medication coverage is provided in partnership with CVS/caremark.
- Our **Slice of Life** wellness program offers the resources and support you need to live your healthiest life.

Vision Care

Routine eye care is an important part of your overall health. That's why HealthTrust partners with Anthem and Delta Dental to offer a vision discount program to all enrollees, retirees and their eligible family members who are enrolled in medical and/or dental plan coverage.

Discounts are available at:

- Private practicing ophthalmologists, optometrists and opticians
- Leading optical retailers such as Target Optical, LensCrafters and Pearle Vision

Anthem

- Discounts of up to 30 percent off retail price for vision care services
- For more information, go to: *www.healthtrustnh.org*, and click "Coverage."

Northeast Delta Dental

- Discounts of up to 35 percent for vision care services through EyeMed Vision Care
- For more information: *www.delta.com* (Type Vision Discounts in the search box.)

Dental Care

HealthTrust offers dental care coverage plans in collaboration with Northeast Delta Dental. Coverage under the program is provided by HealthTrust, while Northeast Delta Dental administers the program and pays the claims.

All of HealthTrust's dental plans offer:

- Comprehensive coverage, including up to 100 percent coverage for preventive care
- An extensive network of dentists
- Direct billing convenience through most New Hampshire dental offices; enrollees are not required to pay up front when visiting a participating dentist
- Exceptional claims service

"Peace of Mind" Coverage

The death of a family member is an overwhelming, stressful time, and survivors may be forced to make critical and difficult decisions regarding finances, housing, caregiving and other issues. That's why HealthTrust offers Transition Care and Survivor Care plans that allow us to continue providing medical and/or dental benefits to your covered family members as long as they are eligible.

- **Transition Care:** If you die while you are actively employed and have a HealthTrust-sponsored medical and/or dental plan, Transition Care allows your covered family members to continue coverage through your employer at no cost for up to 12 months.
- **Survivor Care:** If you die while performing your job duties, Survivor Care allows your covered family members to continue their HealthTrust-sponsored medical and/or dental plan coverage through your employer at no cost until they experience an event that changes their eligibility (such as a spouse becoming eligible for Medicare or remarrying, or a dependent child no longer meeting the definition of dependent). Survivor Care works in conjunction with COBRA or your employer's retiree coverage policy.

Ensuring Continued Coverage

HealthTrust complies fully with HIPAA, the Health Insurance Portability and Accountability Act of 1996. If you experience a loss of coverage or certain life events, HIPAA provides additional opportunities to enroll in a group health plan, while also ensuring the confidentiality and security of your health information.

- If you decline coverage for either yourself or your eligible dependents, you may be able to enroll yourself and/or your eligible dependents in coverage at a later date if there is a loss of other coverage. You must enroll and provide the required supporting documentation within 31 days of the date your other coverage ends.
- If you have a qualifying life event (e.g. change in your marital status, birth or adoption of a child, death of dependent or change in employment status) you may be able to enroll yourself and your eligible dependents in coverage. You must enroll and provide the applicable required supporting documentation within 31 days of the qualifying life event.

HealthTrust

For more information about HealthTrust coverage plans, please visit our website or contact us at the address or numbers below.

PO Box 617 • Concord, NH 03302-0617 • Tel. 603.226.2861 • Toll Free 800.527.5001
Fax: 603.226.2988 • Email: enrolleeservices@healthtrustnh.org • Website: *www.healthtrustnh.org*

6 Essential Medical Services All HealthTrust Plans Cover

1. Preventive services (screenings, routine check-ups, eye exams, and vaccines are covered in full)
2. Physician office visits and consultations
3. Medical and surgical care
4. Inpatient hospital care
5. Emergency care
6. Prescription medications

All plans include an extensive provider network to connect you with the best healthcare providers.

Prescription Medication Coverage

All medical plans include prescription medication benefits that support your overall health, treat illness or chronic disease and manage pain.

CVS/caremark

- Short-Term Medications: Enrollees in an Access Blue New England HMO or BlueChoice POS plan receive a prescription plan ID card through CVS/caremark for obtaining short-term prescription medications at a network retail pharmacy.
- Up to a 34-day supply of short-term medications may be obtained at a network retail pharmacy.
- Long-Term Medications: All enrollees have access to the *CVS/caremark Mail Service Program*. Convenient and easy to use, the mail service program offers up to a 90-day supply of long-term or maintenance medication and will lower your prescription costs.

Anthem/Express Scripts

- Short-Term Medications: Enrollees in a Lumenos plan use their Anthem medical ID card for obtaining short-term prescription medications at a network retail pharmacy.
- Up to a 34-day supply of short-term medications may be obtained at a network retail pharmacy.
- Long-Term Medications: Enrollees in Lumenos have access to the Express Scripts home delivery program. Convenient and easy to use, the mail service program offers up to a 90-day supply of long-term or maintenance medication.

(*See reverse side for vision, dental and other coverage.*)

Your Quick Guide To HealthTrust Medical Coverage Plans

HealthTrust Medical plans	Access Blue New England HMO	OR	Access Blue New England Site of Service	OR	BlueChoice Point of Service (POS)	OR	Lumenos HDHP
How the plan works	You choose a Primary Care Provider (PCP) from a network of medical providers throughout the six New England states (CT, MA, ME, NH, RI and VT). You can choose one PCP for your family or different PCPs for each covered family member. You have access to in-network primary care, specialist care, urgent care, hospitals and other medical facilities anywhere in New England without a referral. PCP referral is required to see an out-of-network specialist.		This plan works similarly to the Access Blue New England HMO plan: You choose a Primary Care Provider (PCP) from a network of medical providers throughout the six New England states. The difference: This plan offers a preferred cost-effective network for medical labs and outpatient facilities. If you select a provider from the preferred cost-effective network, you can reduce your own costs. If you choose another provider within the network, you may pay more, and your cost will be applied toward your deductible. PCP referral is required to see an out-of-network specialist.		Each time you or your covered family member need care, you can choose to see your PCP or another provider inside or outside of the BlueChoice network. If your PCP coordinates your care, you pay the least in out-of-pocket expenses. If you self-refer to an in-network or out-of-network provider, your costs will be higher.		You can access care from any provider; costs are lower if you see an in-network provider. This is a high deductible health plan that qualifies to be used in conjunction with a Health Savings Account (HSA). All covered medical and prescription expenses, with the exception of in-network preventive care services, are applied toward the deductible. Once you meet your deductible, covered medical and prescription expenses are paid in full if you use a network provider. If you seek care out of network, your out-of-pocket costs are higher.
Do I need to select a PCP?	Yes. A PCP must be selected for coverage.		Yes. A PCP must be selected for coverage.		No. However, it is recommended that a PCP be selected to receive the highest level of benefits.		No. However, it is recommended that a PCP be selected.
Are PCP referrals required?	No. Referrals are not required for in-network providers. Please note that referrals are required for out-of-network providers.		No. Referrals are not required for in-network providers. Please note that referrals are required for out-of-network providers.		No. However, if you receive services from another provider without a PCP referral, you will pay more out of pocket.		No. However, costs are significantly lower if you seek medical care within the Lumenos network.
Copayment?	Yes. Copayments apply for PCP and specialist office visits. Copayments do not apply for in-network preventive care services.		Yes. Copayments apply for PCP and specialist office visits. Copayments do not apply for in-network preventive care services.		Yes. Copayments apply for PCP and specialist office visits. Your out-of-pocket costs will be higher for self-referred care. Copayments do not apply to in-network preventive care services.		No. Copayments do not apply.
Deductible?	No, for most services. Some plans include a deductible for certain services such as DME and inpatient hospitalization.		Yes. Deductibles apply for certain services.		Yes. Deductibles may apply for self-referred services and DME.		Yes. Deductible applies to all services (including prescription expenses) except for in-network preventive care services.
Coinsurance?	No, for most services. Some plans include coinsurance for certain services such as DME.		No, for most services. Some plans include coinsurance for certain services such as DME.		Yes. Coinsurance may apply for self-referred services and DME.		Yes. Typically 30% for out-of-network services.

Benefits Glossary

Coinsurance: Your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, in some plans, after you have paid your annual deductible, your medical plan will cover 80 percent of costs and you will pay the remaining 20 percent.

Copayment: A flat fee that you pay each time you seek covered medical services, usually when you receive the service. For example, the copayment for a PCP-referred visit to your dermatologist or a physical therapist might be $20; for emergency room services, it might be $100.

Deductible: The amount you have to pay for medical services before your medical plan benefits begin. For example, if your plan carries a $500 deductible, each year you will need to pay the first $500 of your medical expenses before your plan begins to pay at least part of your medical costs.

DME: Durable Medical Equipment (including but not limited to crutches, apnea monitors, oxygen and oxygen equipment, wheelchairs, hospital beds for home use, and home dialysis equipment)

Maximum Allowed Amount (MAA): The amount a plan allows for a particular service in your geographical area. (If you choose an out-of-network provider who charges more than the MAA, you are responsible for the difference; this difference does not apply to your annual out-of-pocket limit.)

Out-of-Pocket Limit: The maximum amount you are required to pay for covered medical expenses in one year. Once your limit is met, the plan pays 100 percent of eligible medical and prescription drug expenses, up to the MAA, for the remainder of the year. Note: Premiums and non-covered medical services do not count toward the out-of-pocket limit.

Slice of Life

Your Way to Better Health

Health Assessment (HA)

- Earn $75 upon completion
- Confidential, voluntary
- Receive a wellness report, customized to you
- Gateway to the full **Slice of Life** program where you can earn up to $425/year
- Gain access to personal health coaches

Health through Oral Wellness (HOW) – New in 2016!

- Earn up to 50 points for twice-yearly dental check-ups
- Receive enhanced preventive benefits tailored to your risk factors
- View oral health resources online

Biometric Health Screening

- Earn $50 and 50 points (after you complete your HA)
- Have your screening with your own PCP or at a HealthTrust screening event
- Learn your essential health numbers
- Results uploaded into your HA

LifeResources – Employee Assistance Program

- Help with personal problems that may affect your job, health and well-being
- Complimentary behavioral health therapy (up to 6 sessions per issue)
- Complimentary 30-minute consultation with attorney
- Complimentary 60-minute phone consultation with financial planner
- 5,000+ online resources
- Savings Center – Up to 25% discounts on some purchases

Points Program

- Receive $100 every 6 months (up to $200/year) by earning 500 points (after completing HA)
- Points awarded for doctor-referred screenings, online health tracking, contacting a health coach, more
- Each 200 points earned per quarter equals one entry into quarterly drawing for one of ten $1000 gift cards
- 100 points for connecting your fitness device or app with your **Slice of Life** account

Condition Management & Prevention

- Flu vaccine reimbursement
- Future Moms: $50 reward and complimentary phone consultation
- Condition Care and Complex Care support
- 24/7 NurseLine

HealthTrust-U

- Points for online courses, challenges, and coaching
- Points for HealthTrust worksite workshops and interactive demonstrations
- Prizes and points for Wellness Coordinator events
- Take Control! enrollee portal resources
- Webinars and podcasts

SmartShopper*

- Earn $25 to $500 for each eligible doctor-ordered, cost-effective service
- Shop by phone or online in less than 5 minutes
- Learn the facts about medical costs in your area
- Confidential, voluntary
- Shop same day as service or before

**Retirees with Medicomp Three coverage are not eligible to participate in SmartShopper.*

Health Awareness Program

- Earn up to $100 reimbursement for taking health and safety classes (after completing HA)
- Up to $200 class reimbursement for each dependent under age 18 (after enrollee completes HA)

For more information or to create a secure account, visit *www.healthtrustnh.org*.

Program subject to change without notice.

8 Easy Ways to Maximize Your Benefits

1. **Understand your coverage.** Review your benefits plan with your covered family members. If your plan requires a copayment, deductible or coinsurance, be prepared to pay these amounts when accessing care.

2. **Keep your ID cards handy.** Be ready to present your medical and/or prescription ID card to your PCP, retail pharmacy, or other healthcare provider when you need services.

3. **Use network providers** to limit your out-of-pocket expenses.

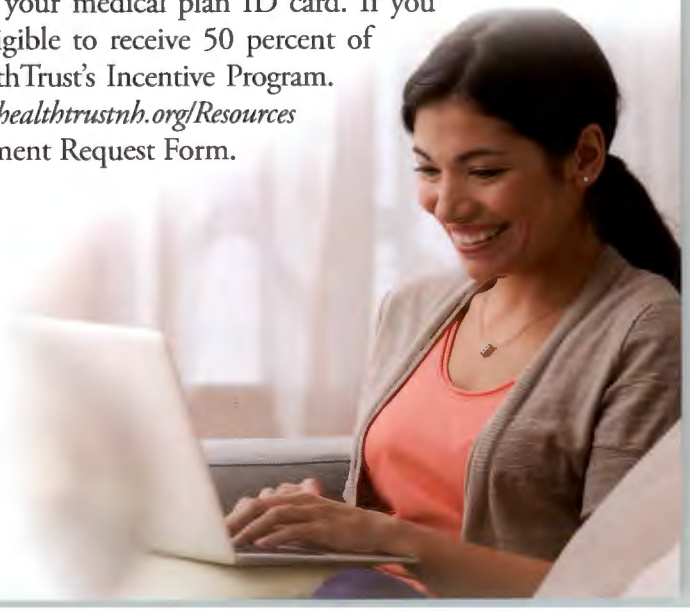
4. **Contact SmartShopper** if your doctor refers you for lab services, screening exams, or certain other procedures to explore the options in your area. If you choose to go to a cost-effective facility, you will receive a reward check ranging from $25 to $500. Log in to your secure account at *www.healthtrustnh.org* and click the SmartShopper button, or call SmartShopper at 800.824.9127.

5. **Go to the emergency room only in an emergency.** In life- or limb-threatening situations, the best action is to call 911 or go directly to your closest emergency room. For non-emergencies (high fevers, cuts, sprains) call your primary care provider and follow recommendations for seeking services or seek care from an urgent care or walk-in center. For health advice any time of day, call the 24/7 NurseLine, 800.544.1901, provided by HealthTrust through Anthem.

6. **Participate in Slice of Life.** HealthTrust's comprehensive wellness program helps to keep you and your covered family members healthy, informed and productive. Each covered adult in your family can earn up to $425 per year in rewards by participating fully in **Slice of Life**. Full program details are available on the back of this page or log in to your secure account at *www.healthtrustnh.org* and click on the **Slice of Life** icon.

7. **Notify your employer** of any changes to: your address, coverage status, dependent eligibility, or important life events such as marriage, divorce/legal separation or birth.

8. **Read your statements carefully.** To ensure billing accuracy, review your Explanation of Benefits from Anthem and make sure you were billed only for services you received. If you notice a claim error, call the Member Services toll-free phone number on the back of your medical plan ID card. If you find an error that is identified and corrected, you may be eligible to receive 50 percent of the savings for that claim error (up to $1,000) through HealthTrust's Incentive Program. You can learn more about the program by visiting *www.healthtrustnh.org/Resources* and clicking on the HealthTrust Incentive Program Reimbursement Request Form.



HealthTrust

800.527.5001
www.healthtrustnh.org

Sign up for

LiveHealth Online
before the first symptom

Because life won't wait for you to feel better

With LiveHealth Online, you can see a doctor 24/7 using the webcam on your computer or mobile device. You do not have to schedule an appointment. Doctors can answer questions, make a diagnosis and even prescribe basic medications when needed.* Best of all, online doctor visits are covered by all HealthTrust medical plans, other than Medicomp Three. You pay no more than the applicable office visit cost share amount under your plan.

With LiveHealth Online, you get:

- Immediate doctor visits through live video
- Your choice of board-certified doctors
- Private, secure and convenient online visits

Cost for HealthTrust enrollees and covered family members

Your copay or deductible up to $49 per medical visit or $95 per mental health visit.

apple.com

play.google.com/store

Anthem BlueCross BlueShield

HealthTrust

When to use LiveHealth Online

Some of the most common uses include:

- Cold and flu symptoms
- Allergies
- Sinus infections
- Migraines
- Upper respiratory infections
- Bronchitis
- Family health questions
- Stress, depression, anxiety and other related issues

Sign up for LiveHealth Online today!

Download our mobile app for free from the App Store® or Google Play™, or sign up online.

livehealthonline.com

* Outside of the State of New Hampshire, some state laws require a face-to-face visit before allowing prescriptions. To check availability in your state, go to livehealthonline.com. Prescription availability is defined by physician judgment and state regulations. LiveHealth Online is available in most states and is expected to expand to more in the near future. Visit the home page of livehealthonline.com to view the service map by state.

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Registering with LiveHealth Online is quick and easy

Visit livehealthonline.com to get started. Then follow these steps:

1. Enter your first and last name
2. Provide and confirm your email address
3. Create a secure password for your account
4. Read the "Terms of Use" and check the box to agree
5. Choose your location in the drop-down box of states
6. Enter your birth date
7. Choose your gender
8. For the question "Do you have insurance?" select **Yes.** Be sure to have your Anthem member ID card handy to complete your insurance information.
9. For **Health Plan**, in the drop-down box select **Anthem Blue Cross and Blue Shield**
10. For **Subscriber ID**, enter your identification number, which is found on your Anthem member ID card
11. Select **Yes** if you are the primary subscriber or **No** if you are not the primary subscriber
12. Select the green **Finish** button

Your account securely stores your personal and health information

You can be confident knowing you can easily connect with doctors when you need to consult about certain conditions, share your health history, and schedule online visits at times that fit your schedule.

How LiveHealth Online works

Questions about how to use LiveHealth Online?

Call toll free at 1-855-603-7985, or email customersupport@livehealthonline.com. If you send us an email, please include your name, email address and a phone number where we can reach you.

* Select a doctor licensed to practice in the state where you're physically located. If that doctor is seeing another patient, you can choose to go to an online waiting room or you can select another doctor who is available at that moment.

SEE HEALTHCARE DIFFERENTLY.

SmartShopper

Save Money and Earn
Cash Rewards on Healthcare Services!

www.healthtrustnh.org

SmartShopper: 800.824.9127 | M-TH: 8:30-8:00PM EST | F: 8:30-5:00PM EST

Answers To Questions You May Have About HealthTrust SmartShopper

1. What is SmartShopper? SmartShopper is a program that helps you be a savvy medical consumer by reminding you that you have choices when it comes to your healthcare. If your doctor recommends a particular medical service, SmartShopper can tell you how much that test or procedure costs at different in-network facilities in your area. If you choose a cost-effective option, you can qualify for a cash reward. SmartShopper does not offer medical advice and is not a substitute for medical care from your doctor, but it can help you optimize your healthcare by making you aware of your options.

2. How do I know if I am eligible to participate in SmartShopper? All HealthTrust enrollees (and their family members) who have medical coverage* through Anthem are eligible to participate in the SmartShopper program and are automatically enrolled in it. You can contact SmartShopper anytime to research care options by calling **800.824.9127** or signing in to your secure healthcare login at **www.healthtrustnh.org** and clicking on the SmartShopper button. (*Note: Medicomp Three-covered retirees are not eligible for the SmartShopper program.)

3. Will I have to change my Primary Care Provider (PCP) to use SmartShopper or will my medical benefits change? No. SmartShopper will not affect your relationship with your PCP or your medical benefits. As always, if you have questions about your benefits, you can contact HealthTrust's Enrollee Services department at **800.527.5001**, or Anthem at the phone number listed on the back of your Anthem ID card.

4. Do I need to spend any money to participate in SmartShopper? No. SmartShopper is provided at no cost.

5. How can I qualify for a reward? Qualifying for a reward is simple and fast. If your doctor recommends a particular medical procedure, service or test, contact SmartShopper either by telephone (**800.824.9127**) or by clicking the SmartShopper button on your secure healthcare login at **www.healthtrustnh.org** before receiving the medical service. If you call SmartShopper, a customer service expert will tell you if the service you are researching is eligible, and if it is, will give you cost-effective options in your area that qualify for an incentive. If you go online, you can view a list of eligible medical tests and procedures and the cost-effective options in your area. In either case, if you choose one of the options identified by SmartShopper, you can qualify for a reward.

6. What medical services qualify for a reward? Currently, as a HealthTrust enrollee, you can receive rewards through SmartShopper by choosing cost-effective options for common screening exams (colonoscopy, mammogram), diagnostic tests (CT Scans, MRIs, ultrasounds), certain surgical procedures (including carpal tunnel surgery, gall bladder surgery, hernia repair surgery, knee or shoulder surgery), some treatments and therapies (including Remicade infusion, physical therapy), lab services, and more. For a complete list of covered medical services, log in to **www.healthtrustnh.org** and click on the SmartShopper button. The program includes a core set of services, but may grow over time to cover more.

7. How much money can I receive as a reward? SmartShopper offers up to three levels of incentives, based on where you live, the choice of location and the costs within the area. You will always have the option to qualify for the highest reward. Where possible, a second incentive option will also be provided. Rewards currently range from $25 up to $500.

8. How will I receive my reward? If you qualify for a reward, a check will be mailed to you within 45 to 60 days of claim payment. If 60 days pass and you have not received your check, please call SmartShopper at **800.824.9127**.

9. Can my covered family members use SmartShopper themselves or do I have to shop for them? As the enrollee, you can shop for medical services for yourself and your covered dependents under age 18. Dependents age 18 and older need to shop for their own services in order to receive a reward.

10. Who can I contact if I have questions about the status of my reward check or about the SmartShopper website? For questions related to your rewards, you can call SmartShopper at **800.824.9127**, or email your questions to **SmartShopperSupport@vitals.com**.

11. Am I obligated to use the most cost-effective facility after shopping with SmartShopper? No. SmartShopper is completely voluntary. You can receive a reward by choosing any of the options suggested by SmartShopper. If you prefer to go to a facility that is not on the list of options suggested by SmartShopper, you can do that, too; you will not receive a reward, but you will have the benefit of knowing that there are lower cost options available to you if you want them.

12. What if my doctor already scheduled me to go to a facility not on the SmartShopper list of options? Call SmartShopper (**800.824.9127**) and a customer service expert will determine if the service qualifies for a reward. If not, you may need to reschedule your appointment to qualify for a reward, and possibly to obtain a new referral from your PCP.

13. What if the facility I usually go to is already the most cost-effective option? If you are already scheduled at a cost-effective facility on the SmartShopper list, you still qualify for a reward simply for making the phone call or going online and exploring your options. You must shop to receive the reward.

14. Do I have to pay taxes on the cash rewards I receive? If you receive cash rewards of $600 or greater in one year, SmartShopper will send you a 1099 tax form to file with the Internal Revenue Service.

15. How do I know the cost-effective options suggested by SmartShopper are also high quality options? All health centers on your SmartShopper list are part of the Anthem network and have met Anthem's strict quality standards. The facilities are well-known and fully licensed to provide services in New Hampshire. Consult your doctor, or log in to **www.anthem.com** for more information regarding quality.

16. Will my employer have access to my personal health information if I use SmartShopper? No. SmartShopper does not share personal information about you or your dependents with your employer or anyone else. It is completely confidential. SmartShopper may send your employer aggregate data (such as how many people from your company used the program in a given year), but your personal, identifiable information will not be shared.

17. Can I access SmartShopper from my smart phone? Yes. SmartShopper is a fully mobile platform. You can use it with any mobile device.

18. Can I shop for more than one service at a time? Yes. If your doctor has referred you for more than one type of service (for example, knee surgery, an MRI and post-surgery physical therapy), you can shop for all services at the same time, or opt to shop for each individually. The choice is yours.

19. Can I receive a reward for shopping for physical therapy? Yes. If your doctor refers you for physical therapy, you can receive one reward for the full course of treatment. (Multiple physical therapy sessions for the same health issue qualify for only one reward.)

20. Can I receive a reward regardless of when I shop? In order to receive a reward from SmartShopper, you need to shop before you receive your medical services or test. You can shop as late as the same day of the services or tests as long as you shop before them. If you choose a cost-effective option, you should be eligible for a reward.

Program is subject to change without notice. Medicomp Three-covered retirees are not eligible for the SmartShopper program.
11.15

HealthTrust

SEE HEALTHCARE DIFFERENTLY.

SmartShopper

Save Money and Earn
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Incentive Reward Services	Incentive Amount (most cost-effective)	Incentive Amount (2nd most cost-effective)	Incentive Amount (3rd most cost-effective)
Back Surgery (inpatient laminectomy)	$500	$250	N/A
Back Surgery (outpatient laminectomy, diskectomy, foraminotomy)	$250	$100	$50
Bariatric Surgery (inpatient laparoscopic gastric bypass)	$500	$250	N/A
Bladder Repair for incontinence (sling)	$250	$100	$50
Bone and Joint Imaging of Whole Body	$150	$75	$50
Bone Density Study of Spine or Pelvis	$50	$25	N/A
Bunionectomy	$150	$75	$50
Colonoscopy	$150	$75	$50
CT Scan	$150	$75	$50
Ear Surgery Insertion of Ventilating Tube	$150	$75	$50
Eye Surgery - Cataract Removal	$150	$75	$50
Gall Bladder Removal (laparoscopic)	$250	$100	$50
Groin - Hernia Repair	$250	$100	$50
Hand Surgery - Carpal Tunnel	$150	$75	$50
Knee Surgery (arthroscopic)	$250	$100	$50
Lab Services	$25	N/A	N/A
Laparoscopic Tubal Block or Tubal Ligation	$250	$100	$50
Lithotripsy - Fragmenting of Kidney Stones	$250	$100	$50
Mammogram	$50	$25	N/A
MRI	$150	$75	$50
Nasal/Sinus - Corrective Surgery - Septoplasty	$150	$75	$50
Nasal/Sinus - Endoscopy - Sinus Surgery	$150	$75	$50
PET Scan	$150	$75	$50
Physical Therapy	$150	N/A	N/A
Remicade Infusion Therapy	$500	N/A	N/A
Repair of Umbilical Hernia (5 years and older)	$250	$100	$50
Shoulder Surgery (arthroscopic)	$250	$100	$50
Spinal Fusion of Neck - Front	$500	$250	N/A
Stomach - Upper GI Examination (endoscopy)	$150	$75	$50
Tonsillectomy & Adenoidectomy	$150	$75	$50
Ultrasounds (non-maternity)	$50	$25	N/A

Program is subject to change without notice. Medicomp Three-covered retirees are not eligible for the SmartShopper program. Please note that members will be presented all incentive options EXCEPT when the second and/or third option is 50% higher than the most cost-effective option in the area. In this situation, only the top incentive will be offered. For certain inpatient procedures, only one incentive option is provided. All shopping needs to be done before services are rendered either by calling or logging in.

HealthTrust

Anthem BlueCross BlueShield

See how easy it is to save money on vision care

Go to anthem.com and see what great offers you can find

Enjoy up to a 30% savings at thousands of providers nationwide on things such as a complete pair of prescription eyeglasses, most sunglasses and lens options. Members can choose from private vision specialists or retail stores such as LensCrafters®, Target Optical®, JCPenney Optical® and most Pearle Vision® locations. Go to **anthem.com**, log in, and select Discounts to find the nearest participating provider.

Eyewear discounts

Wearing eyeglasses can be more stylish than ever now that you can enjoy savings of 30% off the retail price for:

- Eyeglasses (frames, lenses, and lense options)
- Prescription sunglasses

Non-prescription sunglasses and eyewear accessories

You can also enjoy savings of 20% off the retail price on:

- Non-prescription sunglasses
- Eyeglass accessories

When you get a service, just **show your Anthem ID card** to a participating provider to get your discounts.

Choose the right eyewear for you

Selecting eyewear is a personal choice. That's why you can pick any available frame at participating provider locations. Choose from hundreds of styles, including brand-name designer frames.

More savings at SpecialOffers@Anthem℠

Saving money is good. Saving money on things that are good for you — that's even better. With SpecialOffers, you can get over 50 discounts on products and services for better health and well-being, like dietary supplements and other wellness products, products to babyproof your home, even pet insurance and much more! It's just one of the perks of being a member. Go to **anthem.com**, log in, and select Discounts to see what kind of deals you can get.

To find the discounts and nearest participating provider available to you, log in to **anthem.com** and choose Discounts.

INDEPENDENT PROVIDERS · 1-800 CONTACTS · LensCrafters · Pearle Vision · sears optical · Target Optical · jcp optical

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50621NHMENABS Rev. 12/14

Anthem BlueCross BlueShield

If you don't ask, you may pay more

Need lab work or outpatient care? Remind your doctor that you have the Site of Service program.

Site of Service

More choices. More savings.

Use your Site of Service program to save money on lab tests and outpatient surgery

At Anthem Blue Cross and Blue Shield (Anthem), our Site of Service program helps you get quality care for less money.

Here's how it works:

- Your doctor wants you to get a lab test. If you use one of the **labs** listed on Anthem's *Find a Doctor* tool, you pay $0 for services. Whether you need a blood, urine or strep test, you have no out-of-pocket cost. That means no deductible or coinsurance.
- Your doctor asks you to get a routine outpatient service, like knee arthroscopy. If you use an **ambulatory surgery center (ASC)** listed on **anthem.com/siteofservicenh** for same-day surgery, you'll pay less for your care. You'll pay a one-time, low-cost copay for the covered service.[1] Your copay will range from $100-$125. See your plan details for the exact amount. From taking out your appendix to taking out your tonsils, Site of Service can save you thousands. Consider that arthroscopic knee surgery alone can cost over $9,100.[2]

Site of Service means you have the choice to save — because the little things can really add up.

Lab

To find a lab near you, log on to **anthem.com** and choose **Find a Doctor**. Then, follow the prompts.

All independent labs in New Hampshire, including Quest Diagnostics®, LabCorp, Converge™ Diagnostic Services LLC and NorDx, are part of Anthem's Site of Service program, as well as some hospital-based labs.

ASC

To locate a convenient ASC and find out which services it provides, visit **anthem.com/siteofservicenh**. Or call the Customer Service number on your member ID card.

We'll keep looking for ways to lower your health care costs — while giving you access to the best care possible.

To learn more about the Site of Service benefit program, bookmark **anthem.com/siteofservicenh** for the latest updates.

With the exception of Lumenos® Blue Choice HSA and HRA health plans.

1 Additional services may be required at the ASC as part of your surgery or procedure and be subject to deductible and/or coinsurance. An example of such a service is pathology (the study and diagnosis of a disease) or work that is not sent to one of the labs found on Anthem's *Find a Doctor* tool.

2 Cost is based on Anthem claims data for the average paid amount for knee arthroscopy at NH hospitals in 2014.

31301NHMENABS Rev. 11/14

Site of Service frequently asked questions

Here are answers to some common questions about the Site of Service program:

Q: How does Anthem's Site of Service program help lower costs?

A: It can reduce your out-of-pocket costs, as well as the overall cost of health care. By using labs found on Anthem's *Find a Doctor* tool, which include all independent labs in New Hampshire and some hospital labs, you will not have a copay for your lab services. It's one of the ways we are working to help ensure you have access to affordable care when you need it.

Q: How do I find a zero-cost lab through the Site of Service program?

A: Just log on to **anthem.com** and choose **Find a Doctor**. Then, follow the prompts.

Q: What if I don't use a zero-cost lab located on Anthem's *Find a Doctor* tool?

A: You may use any lab you'd like. However, if you choose a lab that's not listed on the *Find a Doctor* tool, your share of the costs may be higher.

Q: Does an independent lab provide the same type and quality of service as a hospital outpatient lab?

A: Yes, independent labs specialize in these types of services. They have the same level of quality and offer the same types of services as other outpatient labs.

Q: Can my doctor use an independent lab for my lab work?

A: Yes, when your doctor orders lab work, ask him or her to order your lab work at an independent lab. Even if your doctor usually uses another hospital lab not found on the *Find a Doctor* tool, he or she can order your lab work at an independent lab.

Q: My doctor doesn't have a contract with any independent labs. How can he or she get one?

A: Your doctor can easily set up an account with independent labs (for example, LabCorp, Quest Diagnostics®, Converge™ Diagnostic Services LLC or NorDx) through their websites.

While the account is being set up, your doctor can still order your lab work at an independent lab by giving you the laboratory order form. You'll need to take the form to the lab. Once your doctor has an account with the lab, the lab will automatically pick up your specimen(s) from the doctor's office.

Q: My doctor says he or she doesn't want to use one of the labs that I've requested under the Site of Service program. What can I do?

A: Remind your doctor that under New Hampshire law, you have the right to choose where you want to receive services, including lab services. Your doctor is required to give you a laboratory order form to take to the lab you want to use.

Q: What are ASCs?

A: ASCs are ambulatory surgery centers that provide a wide range of same-day surgical services, such as a tonsillectomy or knee arthroscopy.

Q: How can I find an ASC?

A: Go to **anthem.com/siteofservicenh** and choose **ambulatory surgery centers** or call the Customer Service number on your member ID card.

Q: I'm going to have surgery. How can I find out whether it can be done at an ASC?

A: Ask your doctor to recommend a surgeon who may be able to perform your surgery at an ASC.

Q: How much will I have to pay if I use an ASC?

A: If you use an ASC found on **anthem.com/siteofservicenh** for same-day surgery, you'll have one low copay. Your copay will range from $100-$125. See your plan details for the exact amount.*

* If you need additional care as part of the surgery or procedure, you may have to pay coinsurance and/or a deductible (the amount you pay before the plan pays). For example, you may pay more for pathology or lab work if it is not sent to one of the labs found on Anthem's *Find a Doctor* tool. Make sure your doctor at the ASC knows you have Anthem's Site of Service program.

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Anthem BlueCross BlueShield

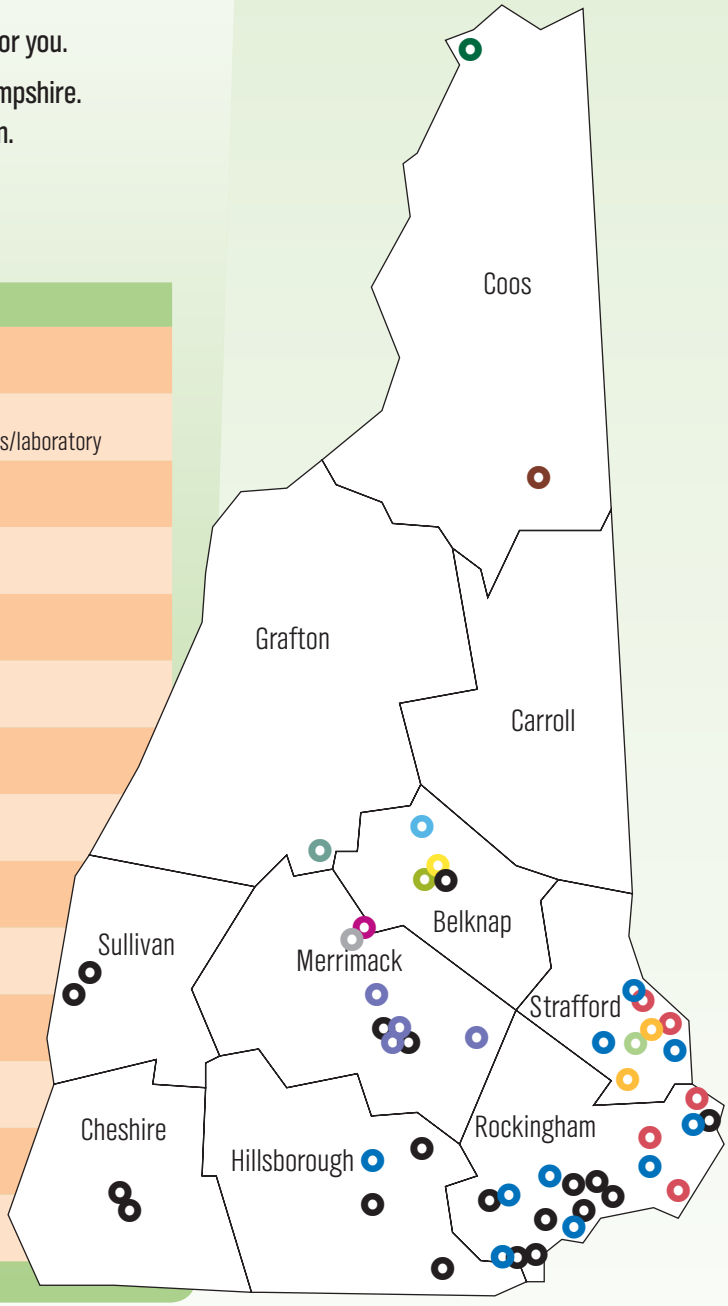
Find a high-quality, Site of Service lab facility today!

Great news! We've got high-quality, Site of Service lab choices for you.

Please take a look at our map and contact list of labs in New Hampshire. As a member, your visits will be covered 100% by your health plan.

For the most up-to-date information or for questions, please **Member Services at 1-800-870-3122**

Name	Phone number/Website
Androscoggin Valley Hospital	1-603-752-2200 avhnh.org
Concord Hospital Independent Outpatient Laboratory	1-603-225-2711 concordhospital.org/services/laboratory
Franklin Regional Hospital Lab	1-603-521-3211 ext. 3243 lrgh.org
Granite State Lab	1-603-330-7057 granitestatelab.com
Interlakes Clinical Laboratory	1-603-521-3211 ext. 3243 lrgh.org
Laboratory Corporation of America	1-855-277-8669 labcorp.com
Laconia Clinic Laboratory	1-603-521-3211 ext. 3243 lrgh.org
Lakes Region General Hospital Lab	1-603-521-3211 ext. 3243 lrgh.org
Newfound Clinical Lab	1-603-521-3211 ext. 3243 lrgh.org
Nordx	1-800-773-5814 nordx.org
Quest Diagnostics Incorporated	1-866-697-8378 questdiagnostics.com
Upper Connecticut Valley Hospital	1-603-237-4971 ucvh.org
Wentworth-Douglass Hospital	1-603-740-2559 wdhospital.com
Westside Clinical Laboratory	1-603-521-3211 ext. 3243 lrgh.org



- Androscoggin Valley Hospital
- Concord Hospital Independent Outpatient Laboratory
- Franklin Regional Hospital Lab
- Granite State Lab
- Interlakes
- LabCorp
- Laconia
- Lakes Region
- Newfound Clinical Lab
- Nordx
- Quest Diagnostics Incorporated
- Upper Connecticut Valley Hospital
- Wentworth-Douglass Hospital
- Westside

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You can save money on outpatient surgery and other procedures through Anthem's Site of Service benefit option.

When your employer chooses the Site of Service benefit option, use one of these ambulatory surgery centers (ASC) to help lower your out-of-pocket costs.

Facility	Dental	Ear, Nose & Throat	Gastroenterology	General	Gynecology	Neurology	Ophthalmology	Oral & Maxillofacial	Orthopedic	Pain Management	Plastic	Podiatry	Urology	Vascular
Androscoggin Valley Hospital Berlin, NH 603-752-2200 avhnh.org		X		X	X				X				X	
Atlantic Plastic Surgery Center Portsmouth, NH 603-431-8819 atlanticplasticsurg.com					X					X	X	X		
Barrington Surgical Care Barrington, NH 603-664-0100 nhpain.com										X				
Bedford Ambulatory Surgery Center Bedford, NH 603-622-3670 bedfordsurgical.com		X	X	X					X	X	X	X	X	X
Capital Orthopedic Surgery Center LLC Concord, NH 603-228-7211 concordortho.com									X					
Capital Orthopedic Surgery Center LLC Derry, NH 603-425-6966 concordortho.com									X					
Cataract and Laser Center Andover, MA 978-475-0959 CLCandover.comcastbiz.net							X				X			
Center for Pain Solutions Nashua, NH 603-577-3003 painsolutionsusa.com										X				

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You can save money on outpatient surgery and other procedures through Anthem's Site of Service benefit option.

Anthem BlueCross BlueShield

When your employer chooses the Site of Service benefit option, use one of these ambulatory surgery centers (ASC) to help lower your out-of-pocket costs.

Facility	Dental	Ear, Nose & Throat	Gastroenterology	General	Gynecology	Neurology	Ophthalmology	Oral & Maxillofacial	Orthopedic	Pain Management	Plastic	Podiatry	Urology	Vascular
Concord ASC at Horseshoe Pond Concord, NH 603-415-9460 concordasc.com		X		X				X	X	X	X			X
Concord Endoscopy Center LLC Concord, NH 603-415-9450 giaofnh.com			X											
Concord Eye Surgery LLC Concord, NH 603-224-6503							X							
Dartmouth Hitchcock Clinic Manchester, NH 603-629-1800 dartmouth-hitchcock.org			X											
Dartmouth Hitchcock Clinic Nashua, NH 603-577-4000 dartmouth-hitchcock.org			X											
Elliot One Day Surgery Center Manchester, NH 603-663-5900 elliot1-day.com	X	X		X	X	X	X	X	X	X	X	X	X	X
Franklin Regional Hospital ASC Franklin, NH 603-934-2060 lrgh.org	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hillside Surgery Center Gilford, NH 603-524-7514 hillsidesurgerycenter.com		X					X		X	X	X			
Laconia Clinic ASC Laconia, NH 603-527-2760 laconiaclinic.com			X	X	X	X			X			X	X	

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Facility	Dental	Ear, Nose & Throat	Gastroenterology	General	Gynecology	Neurology	Ophthalmology	Oral & Maxillofacial	Orthopedic	Pain Management	Plastic	Podiatry	Urology	Vascular
Lakes Region General Hospital ASC Laconia, NH 603-524-3211 lrgh.org	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Lakes Region Urology ASC Laconia, NH 603-524-8660 lrgh.org													X	
Merrimack Valley Endoscopy Center Haverhill, MA 978-521-3235 pmaonline.com			X											
Nashua Ambulatory Surgery Center Nashua, NH 603-882-0950 nashuasurgical.com		X							X	X				
Northeast Surgical Care Newington, NH 603-431-5563 northeastsurgicalcare.com		X					X		X	X				
Novamed Surgery Center of Bedford LLC Bedford, NH 603-627-9540 nheyesurgicenter.com							X							
Novamed Surgery Center of Nashua LLC Nashua, NH 603-882-9800 novamedsurgeryofnashua.com							X							
Orchard Surgical Center LLC Salem, NH 603-685-4346 orchardsurgical.com		X	X	X	X		X	X	X		X	X	X	
Paincare Centers Inc. Merrimack, NH 603-424-8866 painmd.com										X				

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You can save money on outpatient surgery and other procedures through Anthem's Site of Service benefit option.

When your employer chooses the Site of Service benefit option, use one of these ambulatory surgery centers (ASC) to help lower your out-of-pocket costs.

Facility	Dental	Ear, Nose & Throat	Gastroenterology	General	Gynecology	Neurology	Ophthalmology	Oral & Maxillofacial	Orthopedic	Pain Management	Plastic	Podiatry	Urology	Vascular
Paincare Centers Inc. Somersworth, NH 603-692-2000 painmd.com										X				
Portsmouth Regional ASC Portsmouth, NH 603-433-0941 prasc.com		X	X	X	X		X		X	X	X	X	X	
Rye Surgical Center Rye, NH 603-319-1581 nhpain.com										X				
Stratham ASC Stratham, NH 603-772-2076 strathamasc.com		X	X	X	X				X		X	X		
The Surgery Center of Greater Nashua Nashua, NH 603-578-9909 surgerycenternashua.org		X	X	X	X				X			X		
Upper Connecticut Valley Hospital Colebrook, NH 603-237-4971 ucvh.org				X					X				X	
Wentworth Surgery Center Somersworth, NH 603-285-9288 wentworthsurgerycenter.com		X	X	X	X	X	X	X	X	X		X	X	

List of facilities and services provided is intended as a guide to the types of surgical procedures that may be provided at the Site of Service facilities. Coverage for procedures offered at facilities varies based on the actual procedure performed and the services covered under your health benefit plan. Contact Anthem customer service for additional information regarding plan coverage prior to services being rendered. This information is provided as a guide only and is subject to change. The list of facilities can also be found on Anthem's *Find a Doctor* tool on anthem.com.

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DELTA DENTAL

Go Green! with Northeast Delta Dental's Benefit Lookup Site

At Northeast Delta Dental, we strive daily to give you the best experience possible. That includes investments in technology to give you access to the information and tools you need, all while helping reduce paper waste and our carbon footprint.

Welcome to the Northeast Delta Dental Benefit Lookup site! Now you can enjoy 24/7 access to your benefit and claim information, print additional identification cards, read your benefit booklet and Explanation of Benefits (EOB), download our mobile app, register for the Health through Oral Wellness® (HOW®) program, and so much more—*all when it's convenient for you!*

Registration is simple:

1. Go to **NortheastDeltaDental.com** and click on **PATIENTS**
2. Click on **REGISTER HERE** under Benefit Lookup login
3. Complete the three-step registration process

Note: You will need your Subscriber ID number (found on your ID card or by calling Customer Service at 1-800-832-5700).

- OVER -

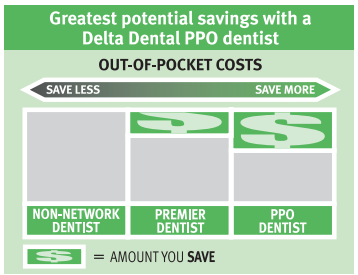
Visit Northeast Delta Dental's website at NortheastDeltaDental.com for helpful information.

Finding a dentist in your area is easy!

Click **Find a Dentist** in the **Patients** section of our website, enter some general information about your location and network type, click **Search**, and a list of dentists serving your area will be displayed. Note: If you are enrolled in a PPO plus Premier Program, please be sure to search both networks.

Stretch your annual maximum dollars!

If your Northeast Delta Dental plan includes our PPO network, and if you are looking for ways to save money on your dental care and lower your out-of-pocket dental expenses, consider looking for a Northeast Delta Dental PPO dentist for your care



Health through Oral Wellness® (HOW®)

Health through Oral Wellness is a program designed to promote better oral health and overall health for Northeast Delta Dental Members. HOW is all about YOU because it's based on your own specific oral health risks and needs. Best of all, it's secure, confidential, and absolutely FREE.

1. **REGISTER -** Go to **HealthThroughOralWellness.com** and click on "Register Now"
2. **KNOW YOUR SCORE** - After you register, please take the free oral health risk assessment by clicking on "Free Assessment" in the **Know Your Score** section of the website
3. **SHARE YOUR SCORE WITH YOUR DENTIST**
   The next step is to share your results with your dentist at your next dental visit
   - Your dentist can discuss your results with you and perform a clinical version of the assessment
   - Based on your risk, as shown on your clinical assessment, you may be eligible for additional preventive benefits at no cost if your employer participates in the HOW program.*

**Additional preventive benefits are subject to the provisions of your Northeast Delta Dental policy. Only the clinical risk assessment performed by your dentist can determine your eligibility for additional preventive benefits.*

EyeMed Vision Discount Program

Our vision discount program is available free to all Northeast Delta Dental subscribers and their dependents. Great Savings – Up to 35% off eyewear. Choose from any available frame, including quality name-brand products like Brooks Brothers®, Ann Klein®, Vogue®, and many more at provider locations.

Learn more at NortheastDeltaDental.com or from our Customer Service Representatives at 1-800-832-5700.

- OVER -

Why Offer Dental Benefits to Your Employees?

Regular professional cleanings to remove plaque and hard deposits such as calculus (tartar) and stains are important for maintaining good oral health and can help prevent the progression of periodontal (gum) disease, which can lead to active infections and tooth loss.

There is also evidence that periodontal disease may be linked to medical conditions, including diabetes, heart disease and low weight, preterm birth.

HealthTrust

PO Box 617 • 25 Triangle Park Drive • Concord, NH 03302-0617
Tel: 603.226.2861 • Fax: 603.226.2988 • NH Toll Free: 800.527.5001
www.healthtrustnh.org

Dental benefits are a valuable part of offering a complete employee benefits program.

Group Dental Rates

for January – December 2016

HealthTrust

Northeast Delta Dental – A Reliable Resource

Centrally based in Concord, New Hampshire, Northeast Delta Dental has been a partner of HealthTrust for more than 20 years.

DELTA DENTAL

Northeast Delta Dental

This partnership provides our members with an extensive local and national network of participating dentists, comprehensive benefits and exemplary customer service.

Expansive Network of Participating Dentists

Northeast Delta Dental enjoys a unique relationship with nearly three out of every four dentists throughout the United States. These are dentists who participate with Northeast Delta Dental throughout New Hampshire, Maine and Vermont, as well as Delta Dental Premier participating dentists nationally.

Patients are free to seek dental care from any dentist—participating or nonparticipating.

However, your covered employees will get the best value from their dental benefits when they receive dental care from a participating dentist for the following reasons:

No Balance Billing—Patients cannot be billed the difference between a participating dentist's submitted charge and Delta Dental's approved amount.

Less Paperwork—Participating dentists complete and submit dental claim forms directly to Northeast Delta Dental.

Direct Payment—Northeast Delta Dental pays the participating dentist directly so patients do not have to pay the covered amount up front and wait for reimbursement.

Minimum Enrollment Criteria

A minimum of 75 percent of all eligible employees must be enrolled in your selected dental coverage plan(s). Employees who are already covered under a group dental program through other employment—or their spouse's employment—do not count toward the 75 percent requirement.

In order to offer dependent coverage, at least 50 percent of enrolled employees with eligible dependents must agree to enroll all of their eligible dependents who are not already covered under another group dental program, such as those offered through a spouse's employer or NH Medicaid.

Northeast Delta Dental pays the participating dentist directly so patients do not have to pay the covered amount up front and wait for reimbursement.

Who's Eligible for Dental Coverage?

The following persons are eligible for all dental coverage options available through HealthTrust:

- **One Person** - Employee
- **Two Persons** - Employee and spouse; employee with only one dependent
- **Family** - Employee plus spouse and all eligible dependent children; employee with two or more eligible dependent children.

Dependent coverage commences at age two. Please contact HealthTrust for additional information regarding dependent eligibility.

Questions? Please Contact Us!

Need more information regarding eligibility or have questions regarding HealthTrust's dental coverage options? If so, please contact your group's HealthTrust Benefits Advisor directly by calling 800.527.5001.

Our Most Popular Dental Plan Designs ▼

IMPORTANT: Rates shown are guaranteed from January 1 through December 31, 2016.

BENEFITS	*Options 1A and 1S*		*Options 1 and 1B*		*Options 3A and 3D*	
***COVERAGE A (no deductible)** **Diagnostic:** Evaluations; X-rays **Preventive:** Cleanings **(4x per Calendar Year)**; fluoride; space maintainers; sealants for children	100%		100%		100%	
DEDUCTIBLE (person/family) per Calendar Year (for Coverages B & C)	$0		$25/$75		$0	
***COVERAGE B** Fillings - Amalgam (silver) and composite **(white)**; extractions; root canal therapy; periodontal treatment; repair of a removable denture; emergency treatment	80%		80%		80%	
***COVERAGE C** **Prosthodontics:** Removable and fixed partial dentures (bridges); crowns; dentures; onlays; implants	50%		50%		50%	
*+**COVERAGE D** **Orthodontics:** Correction of crooked teeth for dependent children to age 19	50%		50%		not a benefit	
Plan Option Number	***1A***	***1S***	***1***	***1B***	***3A***	***3D***
Benefit Maximum per person, per Calendar Year	$1,000	$2,000	$1,000	$1,250	$1,000	$2,000
**Rates shown apply when only one dental plan is offered. If employees are given a choice between two or three dental plans, a rate adjustment will be made to each plan offered. Your HealthTrust Benefits Advisor can provide you with more information on this rate adjustment.*	**Monthly Rates**		**Monthly Rates**		**Monthly Rates**	
One Person	$40.98	$44.35	$40.37	$41.61	$40.98	$44.35
Two Person	$79.27	$85.68	$78.14	$80.48	$78.76	$85.18
Family	$143.39	$153.26	$142.16	$145.60	$137.40	$147.27

*Benefit percentages shown are based upon the lesser of the actual submitted charge or Delta Dental's allowance under the plan.

+Coverage D has a separate lifetime maximum of $1,000 per eligible dependent up to age 19.

POCKET GUIDE

Northeast Delta Dental

Welcome to the Health through Oral Wellness® (HOW®) program!

A healthy mouth is part of a healthy life, and Northeast Delta Dental's innovative **Health through Oral Wellness [HOW]** program works with your existing dental benefits to help you achieve and maintain better oral wellness. **HOW** is all about YOU because it's based on your own specific oral health risk and needs. Best of all, it's secure, confidential, and absolutely **FREE**.

To make it easy for you to learn all about the Health through Oral Wellness Program, we encourage you to visit the website

HealthThroughOralWellness.com

and watch the short video there. This video tells you a lot about the program.

READY TO BE PART OF HOW?

HOW®
SMILE COACH

HERE'S HOW TO GET STARTED...

1. REGISTER

Go to **HealthThroughOralWellness.com** and click on "Register Now"

2. KNOW YOUR SCORE

After you register, please take the free oral health risk assessment by clicking on "Free Assessment" in the **Know Your Score** section of the website

3. SHARE YOUR SCORE WITH YOUR DENTIST

The next step is to share your results with your dentist at your next dental visit

- Your dentist can discuss your results with you and perform a clinical version of the assessment
- Based on your risk, as shown on your clinical assessment, you may be eligible for additional preventive benefits at no cost!*

**Additional preventive benefits are subject to the provisions of your Northeast Delta Dental policy. Only the clinical risk assessment performed by your dentist can determine your eligibility for additional preventive benefits.*

Do you know how important your oral health is to your overall health?

- Periodontal disease is an inflammation of the gums that can lead to infection and the eventual breakdown of the bones, gums, and connective tissue that support your teeth. Periodontal disease can also have a negative impact on diabetes and cardiovascular disease, and can lead to pre-term, low birth-weight babies.

- Oral cancer is particularly dangerous because in its early stages it may not be noticed by the patient, as it can frequently progress without producing pain or other symptoms. Left untreated, oral cancer can lead to serious medical complications and even death.

- Tooth decay is damage that occurs when bacteria in your mouth makes acids that eat away at your teeth, which can result in a hole in a tooth (called a cavity) that can lead to a painful toothache, infection, and tooth loss.

Good oral health is important at all stages of your life.

You've got access to valuable resources for oral health and much more. Learn all about the life stages of oral health and what type of preventive measures you can take to ensure optimal wellness.

To learn more, go to **HealthThroughOralWellness.com**.

LIFE STAGES OF ORAL HEALTH

AGES 0-3

BABY BASICS

Even though they have fewer teeth—or none at all, for a while—babies require the same attention to oral health as adults.

SMALL BITES

DO clean your baby's gums and teeth from birth.

DO take your child to the dentist by age one, or six months after the first tooth comes in.

DON'T wash a pacifier with your own mouth.

DON'T give milk, juice, or other sugary drinks at nap time or bedtime.

LIFE STAGES OF ORAL HEALTH

AGES 4-12

KIDDING AROUND

Even though it can be hard to get young kids to slow down, it's important to make time for oral hygiene. Starting good habits now will set the stage for a lifetime of healthy smiles.

SMALL BITES

DO supervise your child's brushing until age 8 and flossing until age 10.

7 **DO** take your child to the orthodontist by age 7.

DO discuss sealants with your child's dentist as the permanent molars come in.

DON'T forget that healthy meals and snacks are the key to good oral health.

LIFE STAGES OF ORAL HEALTH

AGES 13-19

TEEN TEETH

With extra care and some gentle reminders, a teen's oral health will be in great shape for the college years and beyond.

SMALL BITES

DO keep an eye out to make sure your teen is maintaining good oral health habits.

DO buy sugar-free gum if your teen chews gum.

DO keep healthy snacks on hand for hungry teens.

DON'T stock up on sodas and sports drinks for your teen.

LIFE STAGES OF ORAL HEALTH

AGES 20-35

YOUNG ADULT CARE

With newfound independence comes newfound responsibility in tip-top shape during the young adult years.

SMALL BITES

DO continue to see your dentist on a regular basis.

DO learn how to manage your stress levels.

DO be extra aware of oral health changes during pregnancy.

DON'T engage in behaviors such as smoking or excessively drinking alcohol.

LIFE STAGES OF ORAL HEALTH

AGES 36-64

MIDLIFE MATTERS

Taking a few preventive measures in your 40s and 50s can have a big impact on good oral health into your golden years.

SMALL BITES

DO remember to take care of yourself even when you're busy taking care of others.

DO be aware of your oral cancer risk and get regular screenings.

DO know that people with diabetes or heart disease are more likely to have gum disease.

DON'T forget that you need extra calcium to keep your teeth and bones strong.

LIFE STAGES OF ORAL HEALTH

AGES 65+

THE GOLDEN YEARS

An increase in age doesn't have to mean a decrease in good oral health.

SMALL BITES

- **DO** continue to brush twice a day and floss daily.
- **DO** increase calcium intake to maintain good bone health.
- **DO** discuss your options if you need to replace teeth.
- **DO** get screened for oral cancer and other dental diseases.

INSTRUCTIONS FOR THE PATIENT

HOW® HEALTH *through* ORAL WELLNESS®

Here's how to get started...

1. REGISTER

Go to **HealthThroughOralWellness.com** and click on "Register Now"

2. KNOW YOUR SCORE

After you register, please take the free oral health risk assessment by clicking on "Free Assessment" in the **Know Your Score** section of the website

3. SHARE YOUR SCORE WITH YOUR DENTIST

The next step is to share your results with your dentist at your next dental visit

- Your dentist can discuss your results with you and perform a clinical version of the assessment
- Based on your risk, as shown on your clinical assessment, you may be eligible for additional preventive benefits at no cost!*

**Additional preventive benefits are subject to the provisions of your Northeast Delta Dental policy. Only the clinical risk assessment performed by your dentist can determine your eligibility for additional preventive benefits.*

INSTRUCTIONS FOR THE DENTIST ON NEXT PAGE

(SHARE WITH YOUR DENTIST)

INSTRUCTIONS FOR THE DENTIST

HOW®

HEALTH *through* ORAL WELLNESS®

Getting started is quick and easy—you can perform this assessment on your patients immediately!

1. Go to **nedelta.com/Providers**, log into Benefit Lookup, click on the HOW registration link, and follow the on-screen instructions
2. Click "Find my Practice Information," select the dentist and location from the list, and click "Submit." Please note that a separate registration is required for each practice location
3. Complete the required fields and click "Register"
4. You will receive an email from PreViser advising you to complete and validate your registration by visiting **previser.com/free** and selecting "My Account"

To learn how to maximize the value of using this important tool, please view the training videos from PreViser University on their website at **previser.com/free**.

If you have questions or are unable to locate the dentist information you entered, please call Northeast Delta Dental's Professional Relations department at 1-800-537-1715.

**Additional preventive benefits are subject to the provisions of your patient's Northeast Delta Dental policy*

Over-the-Counter Products

Each employer can elect to allow employees participating in a Healthcare FSA to be reimbursed with their designated pre-tax dollars for certain over-the-counter (OTC) products. HealthTrust makes a list available that identifies allowable OTC supplies and equipment, drugs and medicines allowable with a prescription and items not considered eligible for reimbursement.

Extended Reimbursement Deadline

In the past, the Internal Revenue Service's "use-or-lose" rule required employees to use all of their designated FSA funds during a plan year or forfeit remaining balances. Now, however, employers may opt to offer an extended reimbursement deadline allowing participants in either the Dependent Care Reimbursement or Healthcare FSA to carry forward balances for up to two-and-a-half months and receive reimbursement for qualified expenses incurred during those extended months. This feature reduces the pressure of having to spend FSA monies before a plan year ends. Consider this add-on feature when offering HealthTrust's Dependent Care Reimbursement or Healthcare FSA at your workplace!

GETTING STARTED

To start offering HealthTrust's FSA Administration service, contact your Benefits Advisor directly or call **800.527.5001**. It's as simple as that! You can also email us at **fsa@healthtrustnh.org.**

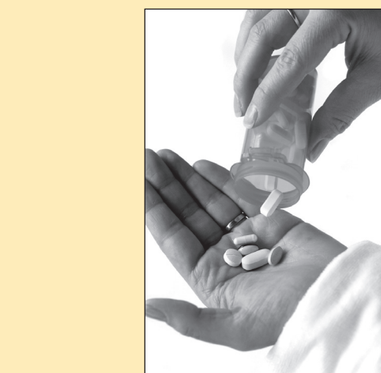
HealthTrust

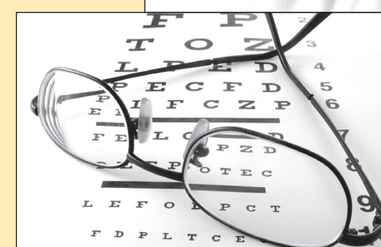
PO Box 617 • Concord, NH 03302-0617
Tel: 603.226.2861 • 800.527.5001 (NH Toll Free) • Fax: 603.415.3099
Website: *www.healthtrustnh.org*

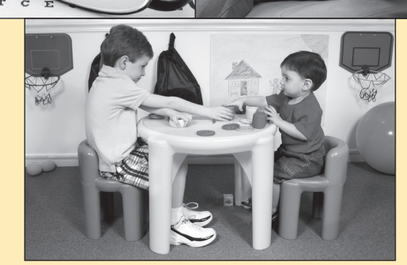
FSA-01
Rev: 9/13

HealthTrust

FLEXIBLE SPENDING ACCOUNT ADMINISTRATION







For HealthTrust Member Groups

At HealthTrust, we are committed to being a provider of high quality benefits and health management services. Through this commitment, we are able to partner with you in providing tax-saving plans to your covered employees through our convenient Flexible Spending Account (FSA) Administration service.

Funded through pre-tax dollars and authorized by Internal Revenue Code sections 125 and 129, the FSA plans outlined on the following pages can be used by your employees for reimbursement of eligible healthcare and dependent care expenses. They are available through HealthTrust to offer tax savings for you, the employer, and your employees while also helping to support employee recruitment, retention and job satisfaction.

PLAN DOCUMENT PREPARATION

Section 125 of the Internal Revenue Code (IRC) allows employees to have their medical and/or dental premiums payroll deducted using pre-tax* dollars (*prior to federal income or Social Security tax deductions). This offering is referred to as a premium conversion plan. Premium conversion plans can provide welcome savings for your employees in times of growing healthcare costs and personal budgeting constraints.

The IRC requires employers to have formal plan documents in place when implementing premium conversion, healthcare or dependent care reimbursement plans. **Through our Plan Document Preparation service, HealthTrust will develop and update all plan documents as required by federal law changes related to premium conversion plans or healthcare/dependent care reimbursement accounts.**

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Through this FSA offering, your employees may be reimbursed for their health, vision and dental care expenses that are medically necessary but not covered through their benefits programs or any other source. Employees can access their designated healthcare FSA funds by submitting a reimbursement request form (or by using a related debit card should your group choose to offer that feature – see the "Customizable Components" section below for more related information) after purchasing eligible medical products or incurring medical expenses up to the amount specified through their individual election.

Examples of medical expenses reimbursable through a Healthcare FSA include the following:

- Healthcare plan deductible
- Percentage of covered expenses that the healthcare plan doesn't pay
- Dental expenses not reimbursed through a dental plan
- Hearing expenses, including examinations and hearing aids
- Vision expenses, including examinations, lenses and frames
- Contact lenses, including solutions
- Chiropractic expenses
- Acupuncture

Certain over-the-counter products can also be reimbursed if your group chooses this option (see the "Customizable Components" section of this brochure for more related information).

DEPENDENT CARE REIMBURSEMENT

This FSA plan reimburses participants for eligible daycare (including eldercare) expenses related to IRS-defined dependents so that employees may work as productively and worry-free as possible. Tax savings result by allowing up to $5,000 in pre-tax dollars to be set aside for daycare expenses that are incurred for any child under the age of 13, or for other dependents who are physically or mentally unable to care for themselves.

Examples of expenses reimbursable through a dependent care FSA include the following:

- Dependent care provided in a private home (when the costs are reported as income)
- Dependent care provided in a child or adult daycare center
- Nursery school
- After-school program
- Summer daycare

HOW THE FSA PLANS WORK

Your employees simply complete an enrollment form in order to participate in any of our FSA offerings. If participating in either the Dependent Care Reimbursement or Healthcare FSA, HealthTrust will provide an informational brochure that explains how the program works and features a convenient worksheet for estimating their yearly out-of-pocket reimbursable expenses. Money allocated for either of these FSA offerings is automatically deducted from each paycheck and deposited into an FSA account with HealthTrust.

Employees may draw upon dependent care reimbursement funds as eligible expenses are incurred. Participating employees have access to the full amount of their Healthcare FSA on the first day of the plan year. Direct deposit is available, allowing employees to have reimbursements directly deposited into a specified account. As an alternative, employees can choose to have reimbursement checks sent to their homes.

CUSTOMIZABLE COMPONENTS

The following options are available for you to customize HealthTrust's FSA offerings and create tax-saving plans tailored for your employees.

Debit Card Feature

Participating employees can easily manage their FSAs with a designated debit card used for exclusively purchasing eligible medical products or services up to the amount specified in their FSA plan. This provides employees with convenient access to their FSA funds while eliminating the need to complete and submit reimbursement forms. Receipts to substantiate debit card transactions will be requested in accordance with applicable IRS regulations.

Guidelines for Billing Administration for Retirees

Here are important guidelines to keep in mind when considering HealthTrust's billing administration service for your retirees:

- Participating Member Groups must complete a *Retiree Contribution Allocation Table* upon electing this service and whenever rate changes occur.
- This service will apply to all retirees in a participating Member Group.
- Member Groups must pay their portion of retiree coverage costs exactly as billed by HealthTrust. All pending adjustments will be reflected on future invoices.
- Each participating Member Group will continue to maintain all related enrollment paperwork for their retirees.

PLEASE NOTE: Member Groups will be notified prior to cancellation of coverage due to nonpayment for any individual retiree and their covered dependents. Ultimate responsibility for payment of retiree coverage rests with Member Groups. Retirees who are cancelled for nonpayment may not be eligible for reinstatement.

GETTING STARTED

To enroll in HealthTrust's billing services, simply contact your Benefits Advisor directly or call **800.527.5001**. It's as simple as that!

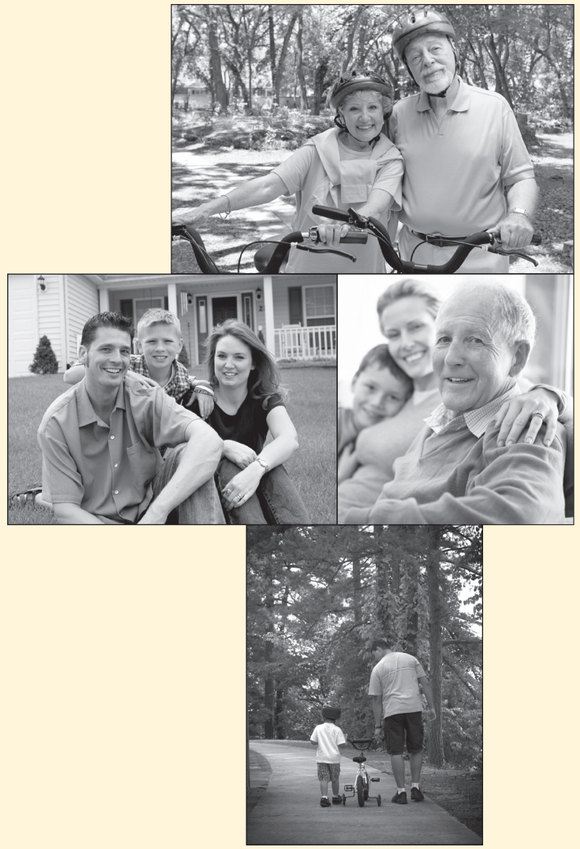
HealthTrust

P.O. Box 617 • Concord, NH 03302-0617
Tel: 603.226.2861 • 800.527.5001 (NH Toll Free) • Fax: 603.226.2988
Website: *www.healthtrustnh.org*

Form #HT-051
Revision Date 9/13

HealthTrust

BILLING SERVICES



For HealthTrust-covered COBRA Qualified Beneficiaries and Retirees

At HealthTrust, we are committed to being a provider of high quality benefits and health management services. We partner with you to make providing those services to your covered employees a seamless process.

We particularly understand the growing complexities of both COBRA and retiree billing administration. That's why we now offer the following value-added services to our Member Groups.

INDIVIDUAL BILLING FOR COBRA BENEFICIARIES

At HealthTrust, we already proactively assist you with meeting the initial and ongoing notification requirements of COBRA. COBRA is the federal law requiring employers to offer covered employees and their family members the opportunity for a temporary extension of medical and/or dental coverage at their own expense due to certain qualifying events.

As an added convenience, you may now opt to have HealthTrust provide individual billing administration for your COBRA qualified beneficiaries.

As part of our COBRA administration service, HealthTrust:

- Directly bills COBRA qualified beneficiaries who have chosen to take advantage of extended coverage.
- Collects contribution payments from COBRA participants, relieving Member Groups of the administrative burden of doing so.
- Generates informative monthly reports for Member Groups listing COBRA qualified beneficiaries who have been billed by HealthTrust, along with their medical and/or dental benefit plan, coverage type and contribution amounts.

Although COBRA qualified beneficiaries are still considered part of your Member Group, *HealthTrust handles all related COBRA paperwork* – from initial election through ongoing maintenance to cancellation and, if applicable, reinstatement. This eliminates the responsibilities of tracking COBRA grace periods and notifying HealthTrust whenever COBRA payments are late.

Guidelines for Individual Billing for COBRA Beneficiaries

Following are important guidelines you need to know when considering HealthTrust's individual billing administration for your COBRA qualified beneficiaries:

- This service applies to all HealthTrust-covered medical and/or dental COBRA beneficiaries.
- As allowed by COBRA, an administrative fee of two percent will be charged to each COBRA qualified beneficiary to cover the cost of this service. There is *no additional cost* to the Member Group.
- COBRA billing must apply to all HealthTrust covered members within a Member Group.
- In addition to billing and collection services, HealthTrust will manage all enrollment and membership changes directly with COBRA qualified beneficiaries, leaving you more time to focus on other priorities.
- A 60-day advance notice is required to initiate HealthTrust's individual billing service for COBRA qualified beneficiaries.
- HealthTrust COBRA administration will follow COBRA guidelines regarding contribution payment. COBRA coverage will suspend for any invoice not paid in full by the first day of the coverage period. If payment is not received within the 30-day grace period, COBRA coverage will be cancelled with no reinstatement rights, as allowed by COBRA.

BILLING ADMINISTRATION FOR RETIREES

Administering benefits for your retired employees is a challenging task. The added accounting burden of these responsibilities – collecting payments, dealing with insufficient funds and acting as a collection agency – can be overwhelming. Now, HealthTrust can handle all retiree billing and collection for you!

At *no additional cost* to you or the retiree, HealthTrust:

- Issues invoices directly to retirees and/or the Member Groups.
- Collects the required coverage contributions from the individual retiree, the Member Group and the New Hampshire Retirement System (NHRS), if applicable.
- Generates easy-to-read monthly reports that list each billed retiree, their benefit plan and coverage type. Additionally, a listing of the Member Group's, the retiree's and New Hampshire Retirement System's coverage contribution amounts are provided for each billing period.

For Member Groups Utilizing HealthTrust to Administer New Hampshire Retirement System Payments

If you currently utilize HealthTrust to administer NHRS payments and you would also like HealthTrust's retiree billing administration service, please know that:

- HealthTrust will bill all parties for their applicable portion of the contribution. (*Examples:* If a retiree is responsible for 80 percent and you pay 20 percent toward coverage costs, HealthTrust will bill each contributor their appropriate percentage. Or, if NHRS pays a $200 subsidy toward a retiree's coverage costs while you pay $100 and the retiree pays $100, HealthTrust will bill all three parties their required contribution.)

For Member Groups That Do Not Utilize HealthTrust to Administer New Hampshire Retirement System Payments

If you currently do not have HealthTrust administer NHRS payments and you would now like to use HealthTrust's billing administration service for retirees, please know that:

- HealthTrust will coordinate all subsidy payments directly with the NHRS.
- HealthTrust will bill all parties for their applicable portion of the contribution. (*Examples:* If a retiree is responsible for 80 percent and you pay 20 percent toward coverage costs, HealthTrust will bill each contributor their appropriate percentage. Or, if NHRS pays a $200 subsidy toward a retiree's coverage costs while you pay $100 and the retiree pays $100, HealthTrust will bill all three parties their required contribution.)
- A new *Retirement Annuity Deduction Authorization for Retiree Insurance Benefits* form (HT-003) must be completed by each of your existing retirees.

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