Your summary of benefits

Matthew Thornton Health Plan, Inc./Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Access Blue NE HMO SOS 5000/0%/7150 Rx Tiered 5/25/40/30% 60min 300max/40% 400max 500/ded

Your Network: Access Blue NE HMO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	$20 copay per visit medical deductible does not apply
Mental Health & Substance Use Disorder Services	$20 copay per visit medical deductible does not apply
Specialist care	$60 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.*	$5,000 person / $12,000 family	Not covered
Overall Out-of-Pocket Limit	$7,150 person / $14,300 family	Not covered
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. Benefits are based on the setting in which covered services are received and how the provider bills.		
Doctor Visits (virtual and office) *Your plan requires the selection of a Primary Care Physician (PCP).*		
Preferred PCP *virtual and office*	No charge medical deductible does not apply	Not covered
Primary Care (PCP) *virtual and office*	$30 copay per visit medical deductible does not apply	Not covered
Mental Health and Substance Use Disorder Services *virtual and office*	$20 copay per visit medical deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care *virtual and office*	$60 copay per visit medical deductible does not apply	Not covered
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-network preventive prenatal and postnatal services are covered at 100%.*	No charge after medical deductible is met	Not covered
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$30 copay per visit medical deductible does not apply	Not covered
Manipulation Therapy	$30 copay per visit medical deductible does not apply	Not covered
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$30 copay per visit medical deductible does not apply	Not covered
Other Services in an Office		
Allergy Testing	No charge	Not covered
Prescription Drugs *Dispensed in the office*	No charge after medical deductible is met	Not covered
Surgery	**PCP** $30 copay per visit medical deductible does not apply **Specialist** $60 copay per visit medical deductible does not apply	Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Diagnostic Services **Lab**		
Office	No charge	Not covered
Site of Service Provider	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	No charge after medical deductible is met	Not covered
X-Ray		
Office	No charge after medical deductible is met	Not covered
Site of Service Provider	$125 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	No charge after medical deductible is met	Not covered
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	No charge after medical deductible is met	Not covered
Site of Service Provider	$250 copay per service medical deductible does not apply	Not covered
Outpatient Hospital	No charge after medical deductible is met	Not covered
Urgent Care		
Walk-in Center/Walk-in Doctor's Office Visit	$30 copay per visit medical deductible does not apply	Covered as In-Network
Urgent Care Center Visit	$100 copay per visit medical deductible does not apply	Covered as In-Network
Other Urgent Care services	No charge after medical deductible is met	Covered as In-Network
Emergency Care		
Emergency Room Facility Services *Your copay will be waived if admitted.*	$300 copay per visit after medical deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency Room Doctor and Other Services	No charge after medical deductible is met	Covered as In-Network
Emergency Room Doctor Services for Mental Health and Substance Use Disorders	$30 copay per visit after medical deductible is met	Covered as In-Network
Ambulance	No charge after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge	Not covered
Doctor Services	No charge	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	No charge after medical deductible is met	Not covered
Site of Service Provider	$250 copay per visit medical deductible does not apply	Not covered
Physician and other services *including surgeon fees*		
Hospital	No charge after medical deductible is met	Not covered
Site of Service Provider	No charge	Not covered
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	No charge after medical deductible is met	Not covered
Physician and other services *including surgeon fees*	No charge after medical deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Home Health Care	No charge after medical deductible is met	Not covered
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational and speech therapies is limited to 60 visits combined per benefit period.*		
Office	$30 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	No charge after medical deductible is met	Not covered
Pulmonary rehabilitation		
Office	$60 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	No charge after medical deductible is met	Not covered
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$60 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	No charge after medical deductible is met	Not covered
Dialysis/Hemodialysis *office and outpatient hospital*	No charge after medical deductible is met	Not covered
Chemo/Radiation Therapy		
Office	**PCP** $30 copay per visit medical deductible does not apply **Specialist**	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	$60 copay per visit medical deductible does not apply No charge after medical deductible is met	Not covered
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days per benefit period.*	No charge after medical deductible is met	Not covered
Inpatient Hospice	No charge after medical deductible is met	Not covered
Durable Medical Equipment *Durable Medical Equipment and Prosthetics are subject to a combined in network annual benefit deductible of no more than $100 per member per benefit period.*	20% coinsurance after deductible is met	Not covered
Prosthetic Devices *Durable Medical Equipment and Prosthetics are subject to a combined in network annual benefit deductible of no more than $100 per member per benefit period. Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after deductible is met	Not covered
Hearing Aids *Durable Medical Equipment and Prosthetics are subject to a combined in network annual benefit deductible of no more than $100 per member per benefit period.*	20% coinsurance after deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use a Tier 1 In-Network Pharmacy	Cost if you use a Tier 2 In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	$500 person / $1,000 family (does not apply to Tier 1a, Tier 1b drugs)	$500 person / $1,000 family (does not apply to Tier 1a, Tier 1b drugs)	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network: *Rx Choice Tiered Network*** **Drug List: *Essential*** *Drugs not included on the Essential drug list will not be covered.*			

Covered Prescription Drug Benefits	Cost if you use a Tier 1 In-Network Pharmacy	Cost if you use a Tier 2 In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Tier 1 In-Network and Tier 2 In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*			
Tier 1a - Typically Lower Cost Generic	$5 copay per prescription, Pharmacy deductible does not apply (retail) and $13 copay per prescription, Pharmacy deductible does not apply (home delivery)	$20 copay per prescription, Pharmacy deductible does not apply (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 1b - Typically Generic	$25 copay per prescription, Pharmacy deductible does not apply (retail) and $63 copay per prescription, Pharmacy deductible does not apply (home delivery)	$40 copay per prescription, Pharmacy deductible does not apply (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	$40 copay per prescription after Pharmacy deductible is met (retail) and $120 copay per prescription after Pharmacy deductible is met (home delivery)	$55 copay per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	Greater of $60 or 30% coinsurance up to $300 per prescription after Pharmacy deductible is met (retail) and Greater of $180 or 30% coinsurance up to $900 per prescription after Pharmacy deductible is met (home delivery)	Greater of $75 or 45% coinsurance up to $400 per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use a Tier 1 In-Network Pharmacy	Cost if you use a Tier 2 In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Tier 4 - Typically Specialty (brand and generic)	40% coinsurance up to $400 per prescription after Pharmacy deductible is met (retail and home delivery)	50% coinsurance up to $500 per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Adult and children's vision services count towards your out-of-pocket limit.		
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	$20 copay	$0 copayment up to plan's Maximum Allowed Amount
Frames *Limited to 1 unit every 2 benefit periods.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Lenses *Limited to 1 unit every 2 benefit periods.*	$20 copay	$0 copayment up to plan's Maximum Allowed Amount
Elective Contact Lenses *Limited to 1 unit every 2 benefit periods.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Non-Elective Contact Lenses *Limited to 1 unit every 2 benefit periods.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	$20 copay	Reimbursed Up to $48
Frames *Limited to 1 unit every 2 benefit periods.*	$100 Allowance	Reimbursed Up to $52
Lenses *Limited to 1 unit every 2 benefit periods combined with OON Coverage. OON Reimbursement: Single* Reimbursed Up to $32*, Bifocal* Reimbursed Up to $47*, Trifocal* Reimbursed Up to $66*.*	$20 copay	Receives Reimbursement
Elective Contact Lenses *Limited to 1 unit every 2 benefit periods.*	$100 Allowance	Reimbursed Up to $84
Non-Elective Contact Lenses *Limited to 1 unit every 2 benefit periods.*	No charge	Reimbursed Up to $210

Notes:

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- The representations of benefits in this document are subject to NH insurance Department (NHID) approval and are subject to change.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Questions: (833) 772-4122 or visit us at www.anthem.com

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This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 772-4122

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 772-4122.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 772-4122:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 772-4122。

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 772-4122 تماس بگیرید.

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Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 772-4122.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 772-4122.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(833) 772-4122 にお電話ください。

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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (833) 772-4122.

Language Access Services:

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 772-4122.

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Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 772-4122.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 772-4122.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 772-4122.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 772-4122.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.