

Your summary of benefits



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

Your Contract Code: 9CGN

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 (copay is waived for members up to age 19)
Mental Health & Substance Use Disorder Services	\$20 copay per visit medical deductible does not apply (copay is waived for members up to age 19)
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 an Out-of-Network Provider
Overall Deductible <i>Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.</i>	\$5,000 person / \$12,000 family	Not covered
Overall Out-of-Pocket Limit	\$7,150 person / \$14,300 family	Not covered
<p>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.</p> <p>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.</p> <p>Benefits are based on the setting in which covered services are received and how the provider bills.</p>		
Doctor Visits (virtual and office) <i>Your plan requires the selection of a Primary Care Physician (PCP). For members up to age 19, visits with In-Network Providers for primary care and mental health and substance use disorder services are covered at no charge.</i>		
Preferred PCP <i>virtual and office</i>	No charge medical deductible does not apply	Not covered
Primary Care (PCP) <i>virtual and office</i>	\$30 copay per visit medical deductible does not apply	Not covered
Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$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 an Out-of-Network Provider
Specialist Provider <i>virtual and office</i>	\$60 copay per visit medical deductible does not apply	Not covered
<p><u>Other Practitioner Visits</u></p> <p>Maternity Doctor services (prenatal/postpartum care and delivery) <i>In-Network preventive prenatal and postpartum services are covered at 100%.</i></p> <p>Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p> <p>Manipulation Therapy</p> <p>Acupuncture <i>Coverage is limited to 20 visits per benefit period.</i></p>	<p>No charge after medical deductible is met</p> <p>\$30 copay per visit medical deductible does not apply</p> <p>\$30 copay per visit medical deductible does not apply</p> <p>\$30 copay per visit medical deductible does not apply</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Other Services in an Office</u></p> <p>Allergy Testing</p> <p>Prescription Drugs <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>No charge</p> <p>No charge after medical deductible is met</p> <p><u>PCP</u> \$30 copay per visit medical deductible does not apply</p> <p><u>Specialist</u> \$60 copay per visit medical deductible does not apply</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Not covered
<p><u>Diagnostic Services Lab</u></p> <p>Office</p> <p>Site of Service Provider</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><u>Diagnostic Services X-Ray</u></p> <p>Office</p> <p>Site of Service Provider</p> <p>Outpatient Hospital</p>	<p>No charge after medical deductible is met</p> <p>No charge medical deductible does not apply</p> <p>No charge after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Diagnostic Services Advanced Diagnostic Imaging</u> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Site of Service Provider</p> <p>Outpatient Hospital</p>	<p>No charge after medical deductible is met</p> <p>No charge medical deductible does not apply</p> <p>No charge after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Urgent Care</u></p> <p>Walk-in Center/Walk-in Doctor's Office Visit</p> <p>Urgent Care Center Visit</p> <p>Other Urgent Care services</p> <p><u>Emergency Care</u></p> <p>Emergency Room Facility Services <i>Your copay will be waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Emergency Room Doctor Services for Mental Health and Substance Use Disorders</p> <p>Ambulance</p>	<p>\$30 copay per visit medical deductible does not apply</p> <p>\$100 copay per visit medical deductible does not apply</p> <p>No charge after medical deductible is met</p> <p>\$300 copay per visit after medical deductible is met</p> <p>No charge after medical deductible is met</p> <p>\$30 copay per visit after medical deductible is met</p> <p>No charge after medical deductible is met</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Site of Service Provider</p> <p>Physician and other services <i>including surgeon fees</i></p> <p>Hospital</p> <p>Site of Service Provider</p>	<p>No charge after medical deductible is met</p> <p>No charge medical deductible does not apply</p> <p>No charge after medical deductible is met</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></p> <p>Facility Fees</p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>No charge after medical deductible is met</p> <p>No charge after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p><u>Home Health Care</u></p>	<p>No charge after medical deductible is met</p>	<p>Not covered</p>
<p><u>Therapy Services</u></p> <p>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical, occupational and speech therapies is limited to 60 visits combined per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$30 copay per visit medical deductible does not apply</p> <p>No charge after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p>Pulmonary rehabilitation</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$60 copay per visit medical deductible does not apply</p> <p>No charge after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$60 copay per visit medical deductible does not apply</p> <p>No charge after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Dialysis/Hemodialysis <i>office and outpatient hospital</i></p>	<p>No charge after medical deductible is met</p>	<p>Not covered</p>
<p>Chemo/Radiation Therapy</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>PCP \$30 copay per visit medical deductible does not apply</p> <p>Specialist \$60 copay per visit medical deductible does not apply</p> <p>No charge after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 150 days combined per benefit period.</i></p>	<p>No charge after medical deductible is met</p>	<p>Not covered</p>
<p>Inpatient Hospice</p>	<p>No charge after medical deductible is met</p>	<p>Not covered</p>
<p><u>Additional Services, Equipment and Devices</u></p> <p>Durable Medical Equipment <i>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.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Prosthetic Devices <i>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.</i>	20% coinsurance after deductible is met	Not covered
Wigs <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after medical deductible is met	Not covered
Hearing Aids <i>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.</i>	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 <i>combined for Tier 1 In-Network and Tier 2 In-Network Pharmacies</i>	\$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.*

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 our home delivery 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 \$10 copay per prescription, Pharmacy deductible does not apply (home delivery)	\$20 copay per prescription, Pharmacy deductible does not apply (retail only)	Not covered (retail and home delivery)
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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 1b - Typically Generic	\$25 copay per prescription, Pharmacy deductible does not apply (retail) and \$50 copay per prescription, Pharmacy deductible does not apply (home delivery)	\$40 copay per prescription, Pharmacy deductible does not apply (retail only)	Not covered (retail and home delivery)
Tier 2 - Typically Preferred Brand	\$40 copay per prescription after Pharmacy deductible is met (retail) and \$80 copay per prescription after Pharmacy deductible is met (home delivery)	\$55 copay per prescription after Pharmacy deductible is met (retail only)	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 only)	Not covered (retail and home delivery)
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 only)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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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) <i>Limited to 1 exam per benefit period.</i>	\$20 copay	\$0 copayment up to plan's Maximum Allowed Amount
Frames <i>Limited to 1 unit every 2 benefit periods.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Lenses <i>Limited to 1 unit every 2 benefit periods.</i>	\$20 copay	\$0 copayment up to plan's Maximum Allowed Amount
Elective Contact Lenses <i>Limited to 1 unit every 2 benefit periods.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Non-Elective Contact Lenses <i>Limited to 1 unit every 2 benefit periods.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) <i>Limited to 1 exam per benefit period.</i>	\$20 copay	Reimbursed Up to \$48
Frames <i>Limited to 1 unit every 2 benefit periods.</i>	\$100 Allowance	Reimbursed Up to \$52
Lenses <i>Limited to 1 unit every 2 benefit periods. Out-of-Network Reimbursement: Single Reimbursed Up to \$32, Bifocal Reimbursed Up to \$47, Trifocal Reimbursed Up to \$66.</i>	\$20 copay	Receives Reimbursement
Elective Contact Lenses <i>Limited to 1 unit every 2 benefit periods.</i>	\$100 Allowance	Reimbursed Up to \$84
Non-Elective Contact Lenses <i>Limited to 1 unit every 2 benefit periods.</i>	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.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- 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.

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

Your summary of benefits



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

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

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document

Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Դարձապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող էք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください。視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to 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. You can also call 1-800-368-1019 (TDD: 1-800-537-7697) or visit

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>