Your summary of benefits

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

Your Plan: Franklin Pierce University: Anthem BlueChoice Open Access Advantage 8000/0%/8000 (Prev Rx)

Your Network: Blue Choice POS

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	No charge after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$8,000 person / $16,000 family	$15,000 person / $30,000 family
Overall Out-of-Pocket Limit	$8,000 person / $16,000 family	$15,000 person / $30,000 family
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. In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other. Benefits are based on the setting in which covered services are received and how the provider bills.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) *virtual and office*	No charge after deductible is met	20% coinsurance after deductible is met
Mental Health and Substance Use Disorder Services *virtual and office*	No charge per visit after deductible is met	20% coinsurance after deductible is met
Specialist Care *virtual and office*	No charge after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-network preventive prenatal and postnatal services are covered at 100%.*	No charge after deductible is met	20% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	No charge after deductible is met	20% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	No charge after deductible is met	20% coinsurance after deductible is met
Acupuncture *Coverage is limited to 20 visits per benefit period.*	No charge after deductible is met	20% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	No charge after deductible is met	20% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	No charge after deductible is met	20% coinsurance after deductible is met
Surgery	**PCP** No charge after deductible is met **Specialist** No charge after deductible is met	20% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	20% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	20% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	No charge after deductible is met	20% coinsurance after deductible is met
Site of Service Provider	No charge after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	20% coinsurance after deductible is met
X-Ray		
Office	No charge after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Radiology Center	No charge after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	20% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	No charge after deductible is met	20% coinsurance after deductible is met
Freestanding Radiology Center	No charge after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	20% coinsurance after deductible is met
Urgent Care		
Walk-in Center/Walk-in Doctor's Office Visit	No charge after deductible is met	Covered as In-Network
Urgent Care Center Visit	No charge after deductible is met	Covered as In-Network
Other Urgent Care services	No charge after deductible is met	Covered as In-Network
Emergency Care		
Emergency Room Facility Services	No charge after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge after deductible is met	Covered as In-Network
Emergency Room Doctor Services for Mental Health and Substance Use Disorders	No charge after deductible is met	Covered as In-Network
Ambulance	No charge after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge after deductible is met	20% coinsurance after deductible is met
Doctor Services	No charge after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees		
Hospital	No charge after deductible is met	20% coinsurance after deductible is met
Ambulatory Surgical Center	No charge after deductible is met	20% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	No charge after deductible is met	20% coinsurance after deductible is met
Ambulatory Surgical Center	No charge after deductible is met	20% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	No charge after deductible is met	20% coinsurance after deductible is met
Physician and other services *including surgeon fees*	No charge after deductible is met	20% coinsurance after deductible is met
Home Health Care	No charge after deductible is met	20% coinsurance after deductible is met
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	No charge after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	20% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	No charge after deductible is met	20% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	No charge after deductible is met	20% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	No charge after deductible is met	20% coinsurance after deductible is met
Chemo/Radiation Therapy		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	**PCP** No charge after deductible is met **Specialist** No charge after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	20% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days per benefit period.*	No charge after deductible is met	20% coinsurance after deductible is met
Inpatient Hospice	No charge after deductible is met	20% coinsurance after deductible is met
Durable Medical Equipment	No charge after deductible is met	20% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	No charge after deductible is met	20% coinsurance after deductible is met
Hearing Aids	No charge after deductible is met	20% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base 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 In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
CarelonRx Mail. 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.*		
Preventive Drugs *See cost shares below for Prescription Drugs on the PreventiveRX Plus drug list.*		
Tier 1 Preventive - Typically Generic	No charge (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 Preventive - Typically Preferred Brand	No charge (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 1 - Typically Generic	0% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	0% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. 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

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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

Your summary of benefits

Anthem

Your Plan: Franklin Pierce University: Anthem BlueChoice Open Access Advantage 8000/0%/8000 (Prev Rx)

Your Network: Blue Choice POS

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:

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French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 772-4122.

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.

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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih ninízingo kojį' hodíilnih (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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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.