



Health. Join In.

Individual and Family Health Care Plans
for **New Hampshire**

Our plans fit your plans



Anthem Premier
Anthem SmartSense[®]



Our plans help fit the way you live

In a world that's constantly changing, one thing's for certain: it's important to have health care coverage you can depend on – coverage designed to help fit your budget, and your way of life.

Since 1942, Anthem Blue Cross and Blue Shield has provided health care coverage and security to our New Hampshire neighbors. And now, we're pleased to offer our Individual health care plans with added benefits and features of the Affordable Care Act.

You're in charge of your health and budget, and our Individual health care plans help keep it that way. We still offer a wide range of coverage options as unique as you are. And if you have any questions, we're here to help.

Experience you can rely on

Anthem is committed to helping simplify your life and improving your health. That's why we offer:

- **One of the largest provider networks in New Hampshire.**
With over 4,400 PPO doctors and more than 25 hospitals* throughout the state, chances are your doctor is one of ours.
- **Coverage that travels with you.**
No matter where life takes you, your health coverage goes with you. And the Blue Cross and Blue Shield Association's BlueCard® program makes it easy to access providers throughout the country.
- **A choice of plans to help fit your budget and lifestyle.**
No matter where you are in life, we've got a plan designed to help fit your health coverage needs, as well as your budget.

Why do you need health care coverage?

These days, an average stay in the hospital can cost more than \$20,000.** The financial risk you take without health coverage just isn't worth it. Not only does health care coverage help you stay healthy, it also gives you added security, because you know you have help to protect against the high cost of unexpected medical bills.

*BCBSA Provider Data Counts, 2011.

**Based on 2008 weighted national estimates from HCUP Nationwide Sample (NIS), Agency for Healthcare research and Quality (AHRQ), based on data collected by individual States and provided to AHRQ by the states. (Average stay of 3.8 days; average cost to uninsured of \$22,512.)

Some definitions so we're all on the same page

Network Discounts: With Anthem, you have access to one of the largest provider networks in the state. These network (or participating) providers have agreed to accept lower costs for their covered services to Anthem members — similar to volume discounts. These negotiated costs help reduce the overall cost of covered medical services, including your share of those costs.

This is true whether you are paying the entire cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With over 4,400 PPO doctors and more than 25 hospitals*, chances are your provider already participates. Just visit a network provider to take advantage of the savings.

With our PPO plans, you can always choose to receive services outside the network, but your share of the cost will be greater.

Cost-Sharing: The costs of medical care today can be staggering. Health care coverage from Anthem can help protect you against these high costs. With most health care coverage, you pay a monthly premium, then you share some of the cost of covered medical care with the company that provides your health care coverage. The level of cost-sharing you choose directly impacts your premium amount. The more you are willing to share in the cost, the lower your premium. With Anthem, you can choose your level of protection and the level of cost-sharing that works best for your health care needs and budget.

Deductible is the amount you have to pay each calendar year for covered services before your health care plan starts paying. Amounts met toward the deductible do not carryover from year to year. For some services, the plan will even begin to pay before the deductible is met. Usually, the higher a plan's deductible, the lower the premium. Network and non-network deductibles are separate and do not accumulate toward each other.

Coinsurance is the percentage of the cost of covered services that you will be responsible for, after your annual deductible is met. With some plans, you have a choice of

coinsurance levels. Much like your deductible, selecting a higher coinsurance typically lowers your monthly premium because it increases your share of the cost.

Copay is a specific dollar amount you have to pay for certain covered services.

Out-Of-Pocket Maximum is the most that you would pay in a calendar year for deductible and coinsurance for in-network covered services. Once you reach this maximum, the plan pays at 100% for most network services for the rest of the calendar year. There is a separate out-of-pocket maximum for non-network services. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.

Prescription Drugs are medications that must be authorized for use by your doctor. Anthem offers varying levels of prescription drug coverage. Depending on the plan, you may have coverage for generic drugs or generic and brand-name drugs.

Generic Drugs are prescription drugs that typically have been in use for some time and can be manufactured and distributed by numerous companies, so their cost is usually much lower. Generic drugs must, by law, contain the same active ingredients as their brand-name equivalent and have the same clinical benefit.

Brand-Name Drugs are prescription drugs that are manufactured and marketed under a registered name. They are usually patented and may be exclusively offered by certain manufacturers.

Tiers represent a cost level within the generic and brand-name prescription drug categories. The prescription drug coverage under your health care plan will differ for each of these tiers. Not all products have this tiering.

- **Tier 1:** Generally includes generic drugs and a few lower cost brand-name drugs.
- **Tier 2:** Generally includes generic and higher cost brand-name drugs.
- **Tier 3 and 4:** Includes the highest cost brand-name drugs.

Formulary is a list of prescription drugs our health care plans cover. They may include generic, preferred brand-name and specialty drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes medication from our formularies. There can be different formularies for different health care plans.

*BCBSA Provider Data Counts, 2011.

Anthem Premier

Is this the right plan for you?

Anthem Premier health care plans offer our highest level of benefits for a variety of services. Great for families or for individuals looking for richer benefits, Anthem Premier provides a number of benefits before the deductible, and strong coverage for prescription drugs.

Anthem Premier Plan Highlights

Anthem Premier offers robust benefits for both routine and unexpected medical care. Compared to our other plans, Anthem Premier has lower coinsurance levels across all deductibles offered. This added value helps lower your share of the cost once you satisfy your deductible.

Features:

- Benefit options including doctors' office visits, with predictable copay, before the deductible.
- Pays the first \$50 toward network annual routine vision screening, per member.
- Preventive care benefits that help you focus on staying healthy.

You should know:

- Maternity benefits are available at an additional cost.
- Anthem Premier has our highest level of benefits available, so the premiums are typically more than our other plans.
- Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.

Prescription Drug Coverage

Anthem Premier offers broad prescription drug coverage before the deductible, including benefits for generic, brand-name and specialty drugs.

You will receive the highest level of benefits by asking your physician to prescribe a generic drug whenever possible. If you choose to purchase a brand-name drug when a generic drug is available, you will be responsible for the difference in the cost between brand-name and generic, plus your copay or coinsurance.

See your Benefit Guide for more details.

How to Customize your Anthem Premier Plan

With Anthem Premier, you have choice and flexibility to change the plan to better meet your needs. Anthem Premier offers a choice of:

Deductible: Anthem Premier deductibles range from \$500 to \$10,000. You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Coinsurance: Anthem Premier offers a choice of coinsurance options, including one with no coinsurance at all for most care, depending on the deductible you choose. The zero coinsurance options typically have higher deductibles, which can lower your premium in most cases.

Maternity Insurance: Add this option to complete your protection. See your Benefit Guide in the back of this brochure for more details.

Benefits Anthem Premier

Calendar Year Deductible		Your Choices							
Individual Policy	NETWORK:	\$500	\$1,500	\$2,500	\$2,500	\$3,500	\$5,000	\$7,500	\$10,000
	NON-NETWORK:	\$500	\$1,500	\$2,500	\$2,500	\$3,500	\$5,000	\$7,500	\$10,000
Family Policy	NETWORK:	\$1,000	\$3,000	\$5,000	\$5,000	\$7,000	\$10,000	\$15,000	\$20,000
	NON-NETWORK:	\$1,000	\$3,000	\$5,000	\$5,000	\$7,000	\$10,000	\$15,000	\$20,000
Network Coinsurance Options		20% ¹	20% ¹	20% ¹	0% ¹	0% ¹	0% ¹	0% ¹	0% ¹

Calendar Year Out-of-Pocket Maximum		Add Your Chosen Deductible to the Amount Below							
Individual Policy	NETWORK:	\$2,000	\$2,000	\$2,000	\$0	\$0	\$0	\$0	\$0
	NON-NETWORK:	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500
Family Policy	NETWORK:	\$4,000	\$4,000	\$4,000	\$0	\$0	\$0	\$0	\$0
	NON-NETWORK:	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000

How family deductibles and family out-of-pocket maximums work For family plans (with two or more members) any combination of family members can meet or contribute toward the family deductible or family out-of-pocket maximum. However, no individual member can contribute more than their individual deductible or out-of-pocket maximum.

Lifetime Maximum None

Covered Services Your Share of Costs (after deductible, unless waived or not subject to deductible)

Doctors' Office Visits	<p>NETWORK: Office Visits (deductible waived): \$30 Copay for primary care physician; \$40 Copay for specialist.</p> <p>NON-NETWORK: 30% Coinsurance</p>
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	<p>NETWORK: 20% or 0% Coinsurance²</p> <p>NON-NETWORK: 30% Coinsurance</p>
Inpatient Services (overnight hospital/facility stays)	<p>NETWORK: 20% or 0% Coinsurance²</p> <p>NON-NETWORK: 30% Coinsurance</p>
Outpatient Services (without overnight hospital/facility stays)	<p>NETWORK: 20% or 0% Coinsurance²</p> <p>NON-NETWORK: 30% Coinsurance</p>
Emergency Room Services	<p>NETWORK: 20% or 0% Coinsurance²</p> <p>NON-NETWORK: 20% or 0% Coinsurance²</p>
Preventive Care Services	<p>Covers nationally recommended preventive care for adults and children including immunizations, PSA screenings, Pap tests, mammograms and more.</p> <p>NETWORK: 0% Coinsurance, not subject to deductible</p> <p>NON-NETWORK: 30% Coinsurance</p>
Maternity	Not Covered (see Optional Coverage below)
Optional Coverage (at additional cost)	Maternity

Prescription Drug Coverage Anthem Premier

Retail Drugs (and Mail Order Drugs when available)	<p>NETWORK:</p> <ul style="list-style-type: none"> Generic and Brand-Name Drugs: \$15 Copay or 40% Coinsurance, whichever is greater. Specialty Drugs: 40% Coinsurance, up to a separate \$10,000 annual Prescription Drug out-of-pocket maximum per member. <p>NON-NETWORK: Same benefit as network, however, the member is responsible for filing the claim and for the difference between the pharmacy charge and our allowable charge, plus applicable copay or coinsurance.</p>
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Optional Drug Coverage (when available) Not applicable; Anthem Premier already includes Enhanced Drug Coverage.

Other Covered Benefits include but are not limited to: Ambulance, Chiropractic Care, Durable Medical Equipment, Home Health and Hospice Care, Physical/Occupational Therapy, Speech Therapy, Urgent Care, Routine Vision Exam

IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Contract/Policy. In the event of a conflict between the Contract/Policy and this Benefit Guide, the terms of the Contract/Policy will prevail.

¹ Your coinsurance will be higher with a non-network provider.
² Coinsurance is designated by the plan you choose.
NOTE: Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.

Anthem SmartSense[®]

Is this the right plan for you?

Anthem SmartSense was designed to offer affordable, solid protection without a lot of bells and whistles that may not be important to you.

Anthem SmartSense Plan Highlights

Anthem SmartSense offers affordable price options, solid protection that covers many essentials, and even some immediate benefits before the deductible.

Features:

- Coverage for the first three doctors' office visits with predictable copay.
- Preventive care benefits that help you focus on staying healthy.
- Choice of prescription drug coverage options.

You should know:

- Maternity benefits are available at an additional cost.
- After the first three visits, doctor visits are covered after the deductible.
- Generic drugs are available before the deductible, with a copay or coinsurance.
- Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.

Prescription Drug Coverage

Anthem SmartSense includes coverage for generic, select brand-name and specialty drugs.

For an additional cost, you can upgrade the Anthem SmartSense prescription benefit and extend coverage for brand-name and specialty drugs.

You will receive the highest level of benefits by asking your physician to prescribe a generic drug whenever possible. If you choose to purchase a brand-name drug on the formulary, when a generic drug is available, you will be responsible for the difference in the cost between brand-name and generic, plus your copay or coinsurance.

See your Benefit Guide for more details.

How to Customize your Anthem SmartSense Plan

With Anthem SmartSense, you have some choice and flexibility to change the plan to better meet your needs. Anthem SmartSense offers a choice of:

Deductible: Anthem SmartSense deductibles range from \$750 to \$12,000. You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Coinsurance: Anthem SmartSense offers a choice of coinsurance levels depending on the deductible you choose. Choosing a higher deductible can take your coinsurance for covered services to zero if you'd like to pay more toward your calendar year deductible first.

Prescription Drug Benefit: You can customize your plan by selecting the optional Enhanced Prescription Drug coverage, as described in your Benefit Guide.

Maternity Insurance: Add this option to complete your protection. See your Benefit Guide in the back of this brochure for more details.

Benefits

Calendar Year Deductible

Individual Policy	NETWORK:	
	NON-NETWORK:	
Family Policy	NETWORK:	
	NON-NETWORK:	

Network Coinsurance Options

Calendar Year Out-of-Pocket Maximum

Individual Policy	NETWORK:	
	NON-NETWORK:	
Family Policy	NETWORK:	
	NON-NETWORK:	

How family deductibles and family out-of-pocket maximums work

Lifetime Maximum

Covered Services

Doctors' Office Visits

Professional and Diagnostic Services
(X-ray, lab, anesthesia, surgeon, etc.)

Inpatient Services
(overnight hospital/facility stays)

Outpatient Services
(without overnight hospital/facility stays)

Emergency Room Services

Preventive Care Services

Maternity

Optional Coverage
(at additional cost)

Prescription Drug Coverage

Retail Drugs (and Mail Order Drugs when available)

Optional Drug Coverage
(when available)

Other Covered Benefits include but are not limited to:

IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Contract/Policy. In the event of a conflict between the Contract/Policy and this Benefit Guide, the terms of the Contract/Policy will prevail.

Anthem SmartSense®

Your Choices

	\$750	\$1,500	\$2,500	\$3,500	\$5,000	\$7,500	\$10,000	\$12,000
Individual Policy	\$750	\$1,500	\$2,500	\$3,500	\$5,000	\$7,500	\$10,000	\$12,000
Family Policy	\$1,500	\$3,000	\$5,000	\$7,000	\$10,000	\$15,000	\$20,000	\$24,000
	\$1,500	\$3,000	\$5,000	\$7,000	\$10,000	\$15,000	\$20,000	\$24,000
Network Coinsurance Options	30% ¹	30% ¹	30% ¹	30% ¹	30% ¹	30% ¹	0% ¹	0% ¹

Add Your Chosen Deductible to the Amount Below

Individual Policy	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$0	\$0
	\$6,500	\$6,500	\$6,500	\$6,500	\$6,500	\$6,500	\$6,500	\$6,500
Family Policy	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$0	\$0
	\$13,000	\$13,000	\$13,000	\$13,000	\$13,000	\$13,000	\$13,000	\$13,000

For family plans (with two or more members) any combination of family members can meet or contribute toward the family deductible or family out-of-pocket maximum. However, no individual member can contribute more than their individual deductible or out-of-pocket maximum.

None

Your Share of Costs (after deductible, unless waived or not subject to deductible)

NETWORK:
 · Office Visit Copay for first 3 yearly visits (deductible waived): **\$35 Copay** for primary care physician or specialist.
 · Office Visit Coinsurance for remaining visits: **30% Coinsurance** or **0% Coinsurance**²
NON-NETWORK: **50% Coinsurance** or **30% Coinsurance**²

NETWORK: **30% Coinsurance** or **0% Coinsurance**²
NON-NETWORK: **50% Coinsurance** or **30% Coinsurance**²

NETWORK: **30% Coinsurance** or **0% Coinsurance**²
NON-NETWORK: **50% Coinsurance** or **30% Coinsurance**²

NETWORK: **30% Coinsurance** or **0% Coinsurance**²
NON-NETWORK: **50% Coinsurance** or **30% Coinsurance**²

NETWORK: **30% Coinsurance** or **0% Coinsurance**²
NON-NETWORK: **30% Coinsurance** or **0% Coinsurance**²

Covers nationally recommended preventive care for adults and children including immunizations, PSA screenings, Pap tests, mammograms and more.
NETWORK: **0% Coinsurance**, not subject to deductible
NON-NETWORK: Not Covered

Not Covered (see Optional Coverage below)

Maternity, Enhanced Drug Coverage

Anthem SmartSense

Standard Drug Coverage:
NETWORK:
 · Generic and Preferred Brand Drugs: **\$15 Copay** or **40% Coinsurance**, whichever is greater.
 · Non-Preferred Brand and Specialty Drugs: Member is responsible for entire cost after Anthem negotiated discount.
NON-NETWORK:
 Same benefits as network, however, member is responsible for filing and for the difference between the Anthem allowable charge and the actual cost of the drug, plus applicable copay and coinsurance.

Enhanced Drug Coverage:
NETWORK:
 · Generic and Brand-Name Drugs: **\$15 Copay** or **40% Coinsurance**, whichever is greater.
 · Specialty Drugs: **40% Coinsurance** up to a separate \$10,000 annual Prescription Drug out-of-pocket maximum per member.
NON-NETWORK:
 Same benefits as network, however, the member is responsible for filing the claim and for the difference between the Anthem allowable charge and the actual cost of the drug, plus applicable copay and coinsurance.

Ambulance, Chiropractic Care, Durable Medical Equipment, Home Health and Hospice Care, Physical/Occupational Therapy, Speech Therapy, Urgent Care

¹ Your coinsurance will be higher with a non-network provider.
² Coinsurance is designated by the plan you choose.
 NOTE: Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.



Your health resources

Remember to use our website as part of your overall health and wellness plan. You can even take an online health assessment and set up a private, secure page to help you keep track of your health goals.

On **anthem.com**, it's also easy to:

- Find a doctor or pharmacy
- Refill a prescription
- Check the status of a claim
- Get answers about your health benefits

And be sure to visit the Preventive Health Guidelines section. You can find out which screenings and immunizations are recommended, and you can easily search by age group and by category.

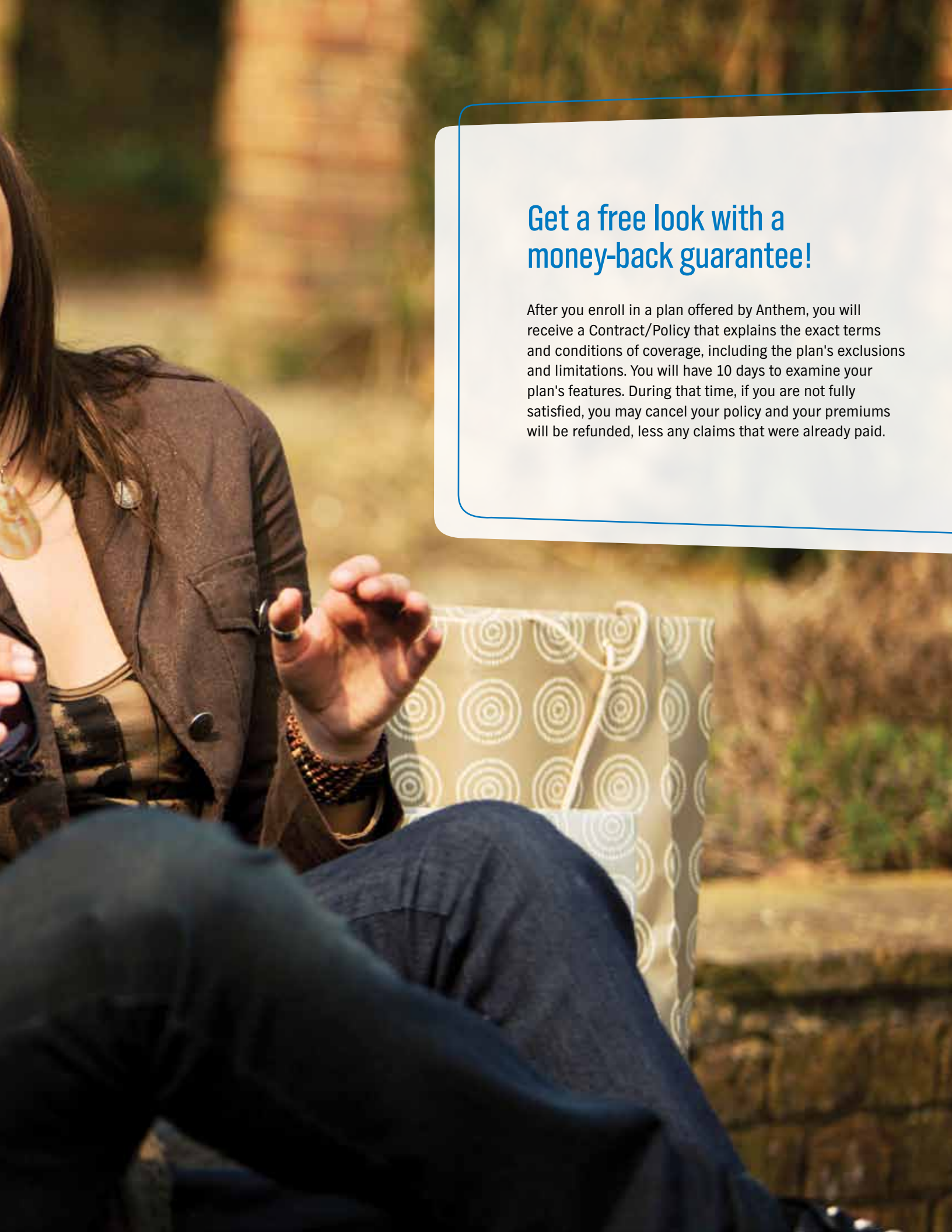
Here are just some of the many fun and interesting ways our website can help you focus on staying healthy:

- Calculate your Health Footprint and see how your healthy choices influence those around you
- Discover your spectrum of support through 360° Health®
- Check out the latest health news from online articles, videos and podcasts

So what's the word?

Healthy.

If you have questions or want more details about your options, call your Anthem Sales Representative or Broker today!

A woman with long dark hair, wearing a brown blazer and a patterned top, is sitting outdoors. She is holding a silver gift bag with a white circular pattern. The background is a blurred natural setting with trees and a stone wall. A white text box with a blue border is overlaid on the right side of the image.

Get a free look with a money-back guarantee!

After you enroll in a plan offered by Anthem, you will receive a Contract/Policy that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You will have 10 days to examine your plan's features. During that time, if you are not fully satisfied, you may cancel your policy and your premiums will be refunded, less any claims that were already paid.

Additional information

Because we're dedicated to making the application process simple, you can apply through the mail, online or over the phone.

Who can apply?

All Individual plans are available to:

- New Hampshire residents.
- Applicants under age 18 are eligible to apply, but a parent or guardian must sign the application.
- Married couples and domestic partners that meet eligibility requirements may apply.
- Families with dependent children under age 26 are eligible.

Those applying must submit:

- An Enrollment Application
- Health Statement
- Your first month's premium

These health plans are medically underwritten. This means your premium and acceptance is based on a review of your medical history. The Subscriber Contract/Policy will be mailed to you once you are a member.

Sign up for our easy, no hassle payment option.

No matter which plan option you choose, we'll make it easy for you to make your monthly premium payments.

Through our Electronic Fund Transfer (EFT) program, we automatically withdraw funds from your bank account each month for the required premium amount. No check writing. No postage costs. No coverage lapse because you forgot to mail the payment. See ... we said we make it easy.

Sound good? Then complete the billing section of the Enrollment Application. If applying online, sign up for EFT while completing the online application.

**If you have questions
or want more details about
your options, call your
Anthem Sales Representative
or Broker today!**



Individual health coverage. Your plans. Your choices.

Make sure you have all the facts.

This brochure is only one piece of your plan information. Please make sure you have all the facts about the benefits offered by the plans described — including what's covered, and what isn't. This policy has exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance broker, Anthem, or visit us on the web. You may also see the enclosed Coverage Details. This document should be included with your information kit, or if you have printed this from your computer, it should be at the end of this document. If you don't have this document, be sure to contact your Anthem Sales Representative or Broker.

This brochure is intended as a brief summary of benefits and services; it is not your Contract/Policy. If there is any difference between this brochure and your Contract/Policy, the provisions of the Contract/Policy will prevail. Benefits and premiums are subject to change.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Ready to enroll?

Call your Anthem Sales Representative or Broker today!



Health. Join In.

Individual and Family Health Care Plans for **New Hampshire**

New Hampshire Coverage Details

Things you need to know before you buy...



Anthem Premier, Anthem SmartSense® and Lumenos® HSA Plus

Before choosing a health care plan, please review the following information, along with the other materials enclosed.

The plans outlined in this document are Major Medical Expense Coverage. Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the contract/policy.

Who can apply?

To be eligible for membership as a policyholder, the applicant must:

1. Be a resident of New Hampshire;
2. Agree to pay for the cost of premium that Anthem Blue Cross and Blue Shield (Anthem) requires; and
3. Satisfy the following requirements to guarantee renewability:
 - a) Eligibility criteria continues to be met;
 - b) There are no fraudulent or material misrepresentations on the application;
 - c) Membership has not been terminated by Anthem under the terms of this policy.

If an individual is under 26 years of age and is covered either by his or her biological parents or guardians as defined by the State of New Hampshire, he or she is eligible for coverage provided he or she meets eligibility criteria specified in the Eligibility policy stated above. Anthem requires the parent/guardian to sign the applications as the applicant for the insured. Applicants under age 18 are eligible to apply. Married couples and domestic partners that meet eligibility requirements may apply. Families with unmarried, dependent children up to age 26 are eligible as well. Those applying must complete a Health Statement. Acceptance into either plan is based on our review of your completed Application and Health Statement.

Pre-Existing Conditions

For members age 19 and older, there is an exclusion period for pre-existing conditions. A pre-existing condition means a condition, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or received during the three months immediately preceding the effective date of coverage under your policy. Examples of care or treatment include, but are not limited to, health services such as: medication, office visits, tests, injections, therapies, hospitalization and use of medical equipment, supplies or devices.

No benefits are available for services that you receive in treatment of a pre-existing condition during the first nine months of coverage under your policy. The nine-month exclusion period begins on your effective date and ends nine months after your effective date. Services that you receive after the nine-month exclusion period ends will be covered, subject to all of the terms and conditions of your policy. Exception: If you were covered by a health plan before you enrolled in this plan, you may be entitled to receive proof of prior coverage from your prior plan. You should submit the proof to Anthem with your enrollment form or with a request for prior coverage credit. Anthem will credit any period of creditable coverage toward meeting the nine-month exclusion period described above. Coverage under most group health plans is creditable. Medicare, Medicaid and CHAMPUS are also examples of creditable coverage. Short-term, nonrenewable individual policies for medical, hospital or major medical coverage issued pursuant to RSA 415:5, III, or other law are also considered creditable coverage. Certain coverage is not creditable, as defined in NH RSA 420-G and other applicable laws. Examples of noncreditable coverages are: Medicare supplemental policies, separate policies covering only accident, disability, liability, auto liability or Workers' Compensation plans, nonmedical dental or vision benefits, long-term care policies or policies covering only specified diseases or illnesses. Please note that if you experienced a "break in coverage" equal to 63 or more consecutive days, the coverage you had before the break will not be credited. A "break in coverage" means a period of time when you were not covered under a public or private health insurance or health benefit plan (insured or self-insured) that is defined as "creditable coverage" under applicable laws, such as NH RSA 420-G.

Renewal/Termination of Coverage

Membership will not be terminated solely due to medical risk factors, such as health status or current or past medical conditions. We may not renew your coverage for the following reasons:

1. Nonpayment of required premiums
2. Any act or practice that constitutes fraud or intentional misrepresentation of material fact found on the application
3. If Anthem has notified the New Hampshire Insurance Department in accordance with all of the terms and conditions of NH RSA 420-G:6, VII, that it will cease to offer this coverage in New Hampshire's Individual market

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the precertification, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific time frames to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Precertification Review / Pre-Admission Review

Precertification review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that:

1) the procedure is medically necessary; and 2) the procedure meets your health care plan's specific guidelines prior to being performed.

Requests for precertification review may include, but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Precertification review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care, and assigns an expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians and member-assigned health care professionals (or member authorized representative), and takes place by telephone, electronically and/or on-site.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g., without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed health care professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

What Our Individual Health Plans Do Not Cover

The following limitations and exclusions will help you understand what your health care plan does not include. These are just some of the plans' limitations and exclusions. Please review your Subscriber Contract/Policy (including any riders, endorsements or amendments) for a complete description of coverage, limitations and exclusions. The Subscriber Contract/Policy will be mailed to you once you are a member. Anthem's internal appeal process is also described in the Subscriber Contract/Policy.

Exclusions

Benefits are not available for:

- Any services that is not medically necessary
- Alternative Medicines or Complementary Medicine
- Amounts That Exceed the Maximum Allowable Benefit
- Artificial Insemination, assisted reproductive technologies and infertility drugs
- Biofeedback Services
- Care Furnished by a Family Member
- Care Received When You Are Not Covered Under This Policy
- Chelating Agents
- Care or Complications Related To Non-covered Services
- Chiropractic Services (Except as stated in Covered Services)
- Claims submitted 12 or months after the date of service
- Contraceptive Services (except where stated in Covered Services)
- Convenience Services
- Cosmetic Services
- Custodial or Convalescent Care
- Dental Services
- Disease or Injury Sustained as a Result of War or Participation in Riot or Civil Disobedience
- Domiciliary Care
- Educational, Instructional, Vocational Services and Developmental Disability Services
- Experimental/Investigational Services
- Food and Food Supplements (Except as required by applicable law)
- Foot Care, Foot Orthotics and Corrective Shoes
- Free Care
- Government Programs
- Health club memberships
- Hospitalization and Other Services Related to Noncovered Care
- Human organ transplants other than those listed in the Subscriber Contract as covered benefits
- Mental Health and Substance Abuse
- Medications related to travel
- Missed Appointments
- Maternity Services (Except as stated in Covered Services)
- Nonmember Biological Parents
- Nutritional and/or dietary supplements (Except as required by applicable law)
- Pre-existing Conditions Exclusion Period for Members age 19 and older
- Premarital Laboratory Work
- Preventive Care (Except as required by applicable law)
- Private Duty Nurses
- Processing Fees
- Radial keratotomy or other surgery to correct vision
- Rehabilitation Services (Except as stated in Covered Services)
- Reversal of Voluntary Sterilization

- Sclerotherapy for Varicose Veins and Treatment of Spider Veins (Except as stated in Covered Services)
- Services Not Specified as Covered
- Sex Change Treatment
- Smoking Cessation Drugs, Programs or Services
- Surrogate Parenting
- Transportation (Except as stated in Covered Services)
- Temporomandibular Joint Syndrome (TMJ)
- Vision Care
- Wigs (Except as required by law)
- Workers' Compensation
- Weight loss programs

Limitations

- Hearing Aid — 1 hearing aid per ear within a 60 month period
- Home Health Care/Respiratory Services — 100 visits per calendar year
- Chiropractic Therapy — 15 visits per calendar year
- Physical Therapy 20 visits per calendar year
- Occupational Therapy 20 visits per calendar year
- Speech Therapy 20 visits per calendar year
- Skilled Nursing Benefits 100 days per calendar year
- Rehabilitation Facility 100 days per calendar year
- Early Intervention Services — \$3,200 per member per calendar year and \$9,600 per Lifetime.
- Routine Pap Test — 1 per member per calendar year
- Routine PSA Test — 1 per member per calendar year
- Wigs — \$350 limit (as stated in contract)

In addition our Premier plan limits

- Routine vision exams — 1 per member per 12 months up to \$50

Your Rights and Responsibilities

We are committed to:

- Recognizing and respecting you as a member
- Encouraging your open discussions with your health care professionals and providers
- Providing information to help you become an informed health care consumer
- Providing access to health benefits and our network providers
- Sharing our expectations of you as a member

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Have privacy for your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.

- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.
- For assistance at any time, contact your local insurance department:
Phone: 800-852-3416
Write: Life, Accident and Health Consumer Affairs Coordinator
New Hampshire Insurance Department
21 Fruit Street, Suite 14
Concord, NH 03301

You have the responsibility to:

- Choose a participating primary care physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits, or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers, in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.

Access to the MIB

Information regarding your insurability will be treated as confidential. Anthem or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at **866-692-6901** (TTY: **886-346-3642**). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is

**50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734**

Information for consumers about MIB may be obtained on its website, at www.mib.com.

Anthem, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Notices of Privacy Practices

We've combined a couple of required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices
- Breast reconstruction surgery benefits

State Notice of Privacy Practices

As mentioned in our HIPAA notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request.

HIPAA Notice of Privacy Practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or, to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law. If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is the genetic information of an individual for such purposes.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How We Protect Information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who should not have access out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice.

A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Breast Reconstruction Surgery Benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy
- Surgery and reconstruction of the other breast to restore a symmetrical appearance
- Protheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema

All applicable benefit provisions will apply, including existing deductibles, copays and/or coinsurance.

The content of this document is not a legal policy or contract. It is intended as a quick reference to inform you about the health plans, programs and services available to individuals from Anthem in New Hampshire. Please refer to your contract/policy documents to determine your rights to benefits and coverage, as well as your obligations under the health plan you purchase.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Coverage Details, Enrollment Application and Health Statement. If you did not receive one or more of these materials, please contact your Anthem sales representative or Broker to request them.

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Outline of Coverage Anthem Premier Cost Sharing Schedule

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Individual major medical expense coverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

Covered Services	Benefits *
	<i>Please see page 1 of your Cost Sharing Schedule for your Copayment, Deductible and Coinsurance and Out-of-Network amounts.</i>
Standard Deductible	In-Network \$500-\$10,000 per Member, per year* \$1,000-\$20,000 per family, per year* Out of Network \$500-\$10,000 per Member, per year* \$1,000-\$20,000 per family, per year*
Standard Coinsurance	In-Network 0-20%* Out-of-Network 30%*

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Out-of-Network Benefits, you may be responsible for paying the difference between the MAB and the provider’s charge.

<p>Daily Hospital Room and Board (semiprivate room rate)</p> <p>Miscellaneous hospital services</p>	<p>You pay the Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowable Benefit after the Out-of Pocket Maximum has been met.</p>
<p>Emergency room charge</p>	<p>You pay the Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowable Benefit after the Out-of Pocket Maximum has been met.</p>
<p>Surgical services</p> <p>Anesthesia services</p> <p>In-hospital medical services</p>	<p>You pay the Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowable Benefit after the Out-of Pocket Maximum has been met.</p>
<p>Out-of-hospital care</p> <p>Office visits</p>	<p>After you pay the Visit Copayment and any Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowable Benefit after the Out-of Pocket Maximum has been met.</p>
<p>Other Benefits</p> <p>durable medical equipment ambulance</p>	<p>You pay the Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowable Benefit after the Out-of Pocket Maximum has been met.</p>

Renewal Provided that all other terms and conditions of membership are met, you renew your coverage each time you pay your premium. We may not renew your coverage for any of the following reasons:

- We do not receive your premium payment on time (due date plus the grace period). The “grace period” means a period of 31 days following the date which premium payment is due. Cancellation for nonpayment is considered cancellation by you, not Anthem, and is effective on the date the premium was due.
- For fraud or intentional misrepresentation on the part of an individual, an individual’s representative or on the part of a dependent. The Subscriber represents that all statements made in his or her application forms and those of dependents are true to the best of his or her knowledge and belief. Any significant misrepresentations or omissions may cause Anthem to deny renewal, provided that the non-renewal occurs within two years from the Subscriber’s date of enrollment. If a Subscriber furnishes any fraudulent statements which are material to the acceptance of his or her application or continued membership, Anthem may deny renewal.
- Anthem ceases to offer Anthem Premier coverage in New Hampshire’s individual market, has provided 90 days notification to the New Hampshire Insurance Department and is otherwise in accordance with all of the terms and conditions of New Hampshire law regarding such action.

Premium This is a medically underwritten benefit health plan. Your premium rate is based on Anthem’s review of your enrollment form, health statement and any other required information. Your initial premium is guaranteed for 12 months from your Effective Date, except that premium will automatically change when you add or remove a Member or when you change your coverage.

After your initial 12-month premium guarantee expires, your premium rate will automatically change when your age changes, you add or remove a Member or when you change your coverage. Your premium rate will also change if Anthem increases the rates for all Members who have coverage like yours. You will receive 60 days advance notice of premium rate changes not related to age, coverage change or membership changes. Anthem’s rating methods comply with all New Hampshire law.

The following is a brief description of services that are not covered:

- alternative medicine or complementary medicine
- amounts that exceed the Maximum Allowable Benefit
- any service, care or supply that is experimental, investigational or not medically necessary
- artificial insemination, any kind of assistive reproduction technology, surrogacy services or services for non-Member biological parents
- biofeedback services
- care furnished by a family member
- chelating agents
- complications of noncovered or unauthorized services
- cosmetic services
- custodial care and convenience services
- education evaluation or other education services, services for developmental disabilities or career counseling
- food products and wigs, except as required by law
- foot care, foot orthotics and corrective shoes
- free care
- home test kits
- hospital or professional care related to noncovered services

- maternity services, unless you have purchased a Maternity Rider.
- marriage counseling, couple's therapy, sex therapy, hypnotherapy, assertiveness training, recreational, sleep, music and religions therapies, milieu therapy, psychoanalysis, confinement due to adverse socioeconomic conditions, placement services, or conservatorship proceedings
- missed appointments,
- preexisting conditions for Member age 19 and older,
- chiropractic services except as stated in your Policy
- Health Club memberships
- Benefits for Mental Health and Substance Abuse

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Outline of Coverage

Anthem SmartSense Cost Sharing Schedule

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Individual major medical expense coverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

Covered Services	Benefits *
Standard Deductible	<p><i>Please see page 1 of your Cost Sharing Schedule for your Copayment, Deductible and Coinsurance and Out-of-Network amounts.</i></p> <p>In-Network \$750-\$12,000 per Member, per year * \$1,500-\$24,000 per family, per year *</p> <p>Out of Network \$750-\$12,000 per Member, per year * \$1,500-\$24,000 per family, per year *</p>
Standard Coinsurance	<p>In-Network 0-30%*</p> <p>Out-of-Network 30-50%*</p>

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Out-of-Network Benefits, you may be responsible for paying the difference between the MAB and the provider's charge.

<p>Daily Hospital Room and Board (semiprivate room rate)</p> <p>Miscellaneous hospital services</p>	<p>You pay the Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowable Benefit after the Out-of Pocket Maximum has been met.</p>
<p>Emergency room charge</p>	<p>You pay the Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowable Benefit after the Out-of Pocket Maximum has been met.</p>
<p>Surgical services</p>	<p>You pay the Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowable Benefit after the Out-of Pocket Maximum has been met.</p>
<p>Anesthesia services</p>	
<p>In-hospital medical services</p>	
<p>Out-of-hospital care</p> <p>Office visits</p>	<p>After you pay the Visit Copayment and any Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowable Benefit after the Out-of Pocket Maximum has been met.</p>
<p>Other Benefits durable medical equipment ambulance</p>	<p>You pay the Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowable Benefit after the Out-of Pocket Maximum has been met.</p>

Renewal Provided that all other terms and conditions of membership are met, you renew your coverage each time you pay your premium. We may not renew your coverage for any of the following reasons:

- We do not receive your premium payment on time (due date plus the grace period). The “grace period” means a period of 31 days following the date which premium payment is due. Cancellation for nonpayment is considered cancellation by you, not Anthem, and is effective on the date the premium was due.
- For fraud or intentional misrepresentation on the part of an individual, an individual’s representative or on the part of a dependent. The Subscriber represents that all statements made in his or her application forms and those of dependents are true to the best of his or her knowledge and belief. Any significant misrepresentations or omissions may cause Anthem to deny renewal, provided that the non-renewal occurs within two years from the Subscriber’s date of enrollment. If a Subscriber furnishes any fraudulent statements which are material to the acceptance of his or her application or continued membership, Anthem may deny renewal.
- Anthem ceases to offer Anthem SmartSense coverage in New Hampshire’s individual market, has provided 90 days notification to the New Hampshire Insurance Department and is otherwise in accordance with all of the terms and conditions of New Hampshire law regarding such action.

Premium This is a medically underwritten benefit health plan. Your premium rate is based on Anthem’s review of your enrollment form, health statement and any other required information. Your initial premium is guaranteed for 12 months from your Effective Date, except that premium will automatically change when you add or remove a Member or when you change your coverage.

After your initial 12-month premium guarantee expires, your premium rate will automatically change when your age changes, you add or remove a Member or when you change your coverage. Your premium rate will also change if Anthem increases the rates for all Members who have coverage like yours. You will receive 60 days advance notice of premium rate changes not related to age, coverage change or membership changes. Anthem’s rating methods comply with all New Hampshire law.

The following is a brief description of services that are not covered:

- alternative medicine or complementary medicine
- amounts that exceed the Maximum Allowable Benefit
- any service, care or supply that is experimental, investigational or not medically necessary
- artificial insemination, any kind of assistive reproduction technology, surrogacy services or services for non-Member biological parents
- biofeedback services
- care furnished by a family member
- chelating agents
- complications of noncovered or unauthorized services
- cosmetic services
- custodial care and convenience services
- education evaluation or other education services, services for developmental disabilities or career counseling
- food products and wigs, except as required by law
- foot care, foot orthotics and corrective shoes
- free care
- home test kits
- hospital or professional care related to noncovered services

- maternity services, unless you have purchased a Maternity Rider.
- marriage counseling, couple's therapy, sex therapy, hypnotherapy, assertiveness training, recreational, sleep, music and religions therapies, milieu therapy, psychoanalysis, confinement due to adverse socioeconomic conditions, placement services, or conservatorship proceedings
- missed appointments,
- preexisting conditions for Member age 19 and older,
- chiropractic services except as stated in your Policy
- Health Club memberships
- Benefits for Mental Health and Substance Abuse

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