Ambetter from New Hampshire Healthy Families

Elite Bronze + Vision + Adult Dental: Expanded Bronze On Exchange Plan

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://ambetter.nhhealthyfamilies.com/2023-brochures.html, or call 1-844-265-1278 (TTY/TDD 1-855-742-0123). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-844-265-1278 (TTY/TDD 1-855-742-0123) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 individual / $0 family.	See the Common Medical Events chart below for your cost for services this plan covers.
Are there services covered before you meet your deductible?	Yes, except for Non-Preferred Brand (Tier 3) and Specialty drugs (Tier 4).	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, $3,800 individual / $7,600 family for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers: $8,700 individual / $17,400 family. Not applicable for out-of-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://ambetter.nhhealthyfamilies.com/findadoc or call 1-844-265-1278 (TTY/TDD 1-855-742-0123) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 Copay / visit	Not covered	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full.
	Specialist visit	$115 Copay / visit	Not covered	Covered No Limit.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$60 Copay / test for laboratory & professional services 50% Coinsurance for x-ray & diagnostic imaging 50% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	Not covered	Prior authorization may be required. Covered No Limit. Other places of service may include Hospital, Emergency Room, or Outpatient Facility. Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details.
	Imaging (CT/PET scans, MRIs)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Preferred Generic Retail: $5 Copay / prescription Generic Retail: $35 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail cost-sharing amount. FDA approved and over-the-counter contraceptives are not subject to cost-share.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at **https://ambetter.nhhealthyfamilies.com/2023formulary**.	Preferred brand drugs (Tier 2)	Retail: $195 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail cost-sharing amount. FDA approved and over-the-counter contraceptives are not subject to cost-share.
	Non-preferred brand drugs (Tier 3)	Retail: $250 Copay / prescription; subject to Rx drug deductible	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail cost-sharing amount. FDA approved and over-the-counter contraceptives are not subject to cost-share. $3,800 individual / $7,600 family Rx drug deductible for non-preferred brand and specialty drugs.
	Specialty drugs (Tier 4)	Retail: 50% Coinsurance; subject to Rx drug deductible	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order. FDA approved and over-the-counter contraceptives are not subject to cost-share. $3,800 individual / $7,600 family Rx drug deductible for non-preferred brand and specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	$2,500 Copay / visit ($1250 Copay / visit for facility; $1250 Copay / visit for physician fee)	$2,500 Copay / visit; deductible does not apply ($1250 Copay / visit; deductible does not apply	Covered No Limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			for facility; $1250 Copay / visit; deductible does not apply for physician fee)	
	Emergency medical transportation	50% Coinsurance	50% Coinsurance; deductible does not apply	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. If you receive service from an out of network ground/water ambulance provider, you may be subject to balance billing.
	Urgent care	$60 Copay / visit	$60 Copay / visit; deductible does not apply	Covered No Limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$3000 Copay / day	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	No charge	Not covered	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$45 Copay / office visit; 50% Coinsurance for other outpatient services	Not covered	Prior authorization may be required. Covered No Limit. (Primary care provider (PCP) and other practitioner visits do not require prior authorization).
	Inpatient services	$3000 Copay / day	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	$45 Copay / visit	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services, such as routine pre-natal and post-natal screenings. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	No charge	Not covered	Prior authorization not required for delivery professional services or delivery facility services. Cost-sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	$3000 Copay / day	Not covered	
If you need help recovering or have other special health needs	Home health care	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Rehabilitation services	Outpatient: 50% Coinsurance; Inpatient: $3000 Copay / day	Not covered	Outpatient: Prior authorization may be required. Outpatient rehabilitation services are limited to 20 visits per year per therapy (Occupational Therapy, Physical Therapy and Speech Therapy). Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Inpatient Rehabilitation is covered and has no limit.
	Habilitation services	50% Coinsurance	Not covered	Prior authorization may be required. Habilitation Services are limited to 20 visits per year per therapy (Occupational Therapy, Physical Therapy and Speech Therapy). Note: Habilitation therapy limits do not apply when provided for a mental health/substance use disorder diagnosis.
	Skilled nursing care	$3000 Copay / day	Not covered	Prior authorization may be required. Limited to 100 days per year in a facility.
	Durable medical equipment	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Respite Care covered as part of hospice services only.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge	Not covered	Limited to 1 item per year.
	Children's dental check-up	Not covered	Not covered	-----None-----

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care (Children)
- Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility. Services to treat the underlying medical conditions that cause infertility are covered - e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency.)
- Long-term care (Long Term Acute Care is a covered benefit. Long Term Nursing Care/ Custodial Care is not a covered benefit.)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (Medically necessary for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity.)
- Chiropractic care (Limited to 12 visits per year)
- Dental care (Adult-visit & item limits apply per year. $1,000 annual dollar limit per year per person.)
- Hearing aids (Benefits are available for one hearing aid per ear each time a hearing aid prescription changes.)
- Routine eye care (Adult-one visit & one item per year. Dollar allowance applies to hardware.)
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Ambetter from New Hampshire Healthy Families at 1-844-265-1278 (TTY/TDD 1-855-742-0123); New Hampshire Insurance Department, 21 South Fruit Street, Suite 14, Concord, NH 03301, Phone No. 800-852-3416.; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); or

Office of Personnel Management Multi-State Plan Program at https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: New Hampshire Insurance Department, 21 South Fruit Street, Suite 14, Concord, NH 03301, Phone No. 800-852-3416.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-265-1278 (TTY/TDD 1-855-742-0123).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-265-1278 (TTY/TDD 1-855-742-0123).

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$115
Hospital (facility) copayment	$3000
Other coinsurance	50%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles *	$10
Copayments	$3,600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,870**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$115
Hospital (facility) copayment	$3000
Other coinsurance	50%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles *	$3,500
Copayments	$700
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,620**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$115
Hospital (facility) copayment	$3000
Other coinsurance	50%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles *	$10
Copayments	$1,100
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,910**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de NH Healthy Families, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-265-1278 (TTY 1-855-742-0123).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from NH Healthy Families, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-844-265-1278 (TTY 1-855-742-0123).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from NH Healthy Families 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-844-265-1278 (TTY 1-855-742-0123)。
Nepali:	यदि तपाईं वा तपाईले मद्दत गरिरहनुभएको कोही व्यक्तिसँग Ambetter from NH Healthy Families सम्बन्धी कुनै प्रश्नहरू भएको खण्डमा तपाईंहरूसँग आफ्नै भाषामा निःशुल्क मद्दत र जानकारी प्राप्त गर्ने अधिकार छ। दोभाषेसँग कुरा गर्नका लागि 1-844-265-1278 (TTY 1-855-742-0123) नम्बरमा कल गर्नुहोस्।
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from NH Healthy Families, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-265-1278 (TTY 1-855-742-0123).
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from NH Healthy Families, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-265-1278 (TTY 1-855-742-0123).
Greek:	Εάν εσείς ή κάποιος που βοηθάτε, έχετε ερωτήσεις σχετικά με την Ambetter from NH Healthy Families, έχετε το δικαίωμα να ζητήσετε βοήθεια και πληροφορίες στη γλώσσα σας, χωρίς χρέωση. Για να μιλήσετε με διερμηνέα, καλέστε το 1-844-265-1278 (TTY 1-855-742-0123).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from NH Healthy Families، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-265-1278 (TTY 1-855-742-0123).
Serbo-Croatian:	Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from NH Healthy Families, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-844-265-1278 (TTY 1-855-742-0123).
Indonesian:	Jika Anda, atau orang yang Anda bantu, memiliki pertanyaan tentang Ambetter from NH Healthy Families, Anda berhak mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk berbicara dengan juru bicara, hubungi 1-844-265-1278 (TTY 1-855-742-0123).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from NH Healthy Families 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-265-1278 (TTY 1-855-742-0123) 로 전화하십시오.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from NH Healthy Families вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-844-265-1278 (TTY 1-855-742-0123).
French Creole:	Si oumenm, oubyen yon moun w ap ede, gen kesyon nou ta renmen poze sou Ambetter from NH Healthy Families, ou gen tout dwa pou w jwenn èd ak enfòmasyon nan lang manman w san sa pa koute w anyen. Pou w pale avèk yon entèprèt, sonnen nimewo 1-844-265-1278 (TTY 1-855-742-0123).
Bantu:	Niba wowe cyangwa undi muntu wese uri gufasha yaba afite ikibazo kijyanye na Ambetter from NH Healthy Families, ufite uburenganzira bwo guhabwa amakuru mu rurimi wunva utishyuye. Kugira ngo uvugane n'umusobanuzi, Hamagara 1-844-265-1278 (TTY 1-855-742-0123).
Polish:	Jeżeli ty lub osoba, której pomagasz, macie pytania na temat planów oferowanych za pośrednictwem Ambetter from NH Healthy Families, macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-844-265-1278 (TTY 1-855-742-0123).

Statement of Non-Discrimination

Ambetter from NH Healthy Families complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from NH Healthy Families does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from NH Healthy Families:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Ambetter from NH Healthy Families at 1-844-265-1278 (TTY 1-855-742-0123).

If you believe that Ambetter from NH Healthy Families has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter from NH Healthy Families Appeals Department, 2 Executive Park Drive, Bedford, NH 03110, 1-844-265-1278 (TTY 1-855-742-0123), Fax 1-877-851-3992. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from NH Healthy Families is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.