Benefit Comparison Chart for Dartmouth College Employees

Covered Services	BlueChoice®† (POS)		
	Option 1 What you pay when your PCP provides/arranges your care	**Option 2** What you pay when seeking care directly from a BlueChoice specialist	**Option 3** What you pay when seeking care from any out-of-network provider
Physician Services			$300 deductible No more than $900 per family each year 20% coinsurance No more than $1,200 per member each year Some self referred benefits are subject to precertification requirements. Refer to your Subscriber Certificate for details. Individual out-of-pocket $1,500 Family out-of-pocket, per year $4,500
Office visit, specialist visit, physical exam, well child office visit (2 years and older)	$10 copay per visit	$25 copay per visit	
Well baby office visit (under 2 years old)	You pay $0	You pay $0	
Routine Gyn Visit**		You pay $10	
Childhood immunizations	You pay $0	$150 deductible No more than $450 per family each year 20% coinsurance No more than $900 per member each year Individual out-of-pocket $1,050 Family out-of-pocket, per year $3,150	
Other physician services, surgical services, inpatient medical care, diagnostic testing, lab, x-ray, maternity care	You pay $0		
Outpatient Services	You pay $0		
Inpatient Hospital Services	You pay $0		
Skilled Nursing Facility and Rehabilitation (100 days per member per calendar year)	You pay $0		
Hospice Services	You pay $0		
Home Health Services Subject to medical necessity	You pay $0		
Physical and Occupational Therapy (Combined $5,000 per member per calendar year)	You pay $0		
Speech Therapy ($5,000 per member per calendar year)	You pay $0		
Emergency Room	You pay $50 ($0 if admitted)	$50 copay — ($0 if admitted)	$75 copay — ($0 if admitted) $50 copay — life threatening illness/injury
Ambulance (subject to medical necessity)	You pay $0	You pay $0	You pay $0
Chiropractic Services** (Maximum of 20 visits per year)		You pay $10	Subject to Option 3 deductible and coinsurance
Inpatient Mental Health & Substance Abuse Services*	You pay $0 when arranged through BHN	N/A	Subject to Option 3 deductible and coinsurance
Outpatient Mental Health & Substance Abuse Services*	You pay $10 when arranged through BHN		Subject to Option 3 deductible and coinsurance
Prescription Drug	$30 copayment for nonformulary brand $15 copayment for formulary brand $5 copayment for generic Mail order benefits available for 90 day supply at copayment listed above		
Vision Care**	Annual exam for adults and children. $40 reimbursement toward eyewear.		
Maximum Lifetime Benefit	Unlimited		
Fitness Reimbursement	Up to $200 per family, per year		

* Care is arranged through Behavioral Health Network (BHN) by calling 1-800-228-5975
** No Primary Care Physician referral needed.

This chart is intended for summary purposes only. Please refer to your Subscriber Certificate for details.

In New Hampshire, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of New Hampshire, Inc., an independent licensee of the Blue Cross and Blue Shield Association.
® Registered marks of the Blue Cross and Blue Shield Association.
† BlueChoice is administered by Anthem Blue Cross and Blue Shield and underwritten by Matthew Thornton Health Plan.

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<table>
<tr><th rowspan="2">Covered Services</th><th colspan="2">Preferred Blue® (PPO)</th><th>Indemnity</th></tr>
<tr><th>Network</th><th>Out-of-Network</th><th>$1,500 Deductible</th></tr>
<tr><td>Physician Services
Office visit, specialist visit, physical exam, routine GYN visit, well child office visit (2 years and older)
Well baby office visit (under 2 years old)</td><td>$15 copay per visit</td><td rowspan="10">$500 deductible
No more than $1,500 per family each year

20% coinsurance
No more than $1,000 per member each year, no more than $3,000 per family per calendar year

Some out-of-network benefits are subject to precertification requirements. Refer to your Subscriber Certificate for details

Annual out-of-pocket, maximum
$1,500 per individual
$4,500 per family</td><td rowspan="12">You Pay:

Deductible
$1,500 individual
$3,000 family

100% coverage after deductible

Annual out-of-pocket maximum
$1,500 Individual, $3,000 family</td></tr>
<tr><td>Childhood immunizations</td><td>You pay $0</td></tr>
<tr><td>Medical Services
Medical exam, injections (including allergy injections)</td><td>$15 per visit</td></tr>
<tr><td>Lab, X-ray and ultrasound</td><td>Covered in full</td></tr>
<tr><td>Outpatient Services
Physician and professional services, surgery, anesthesia, delivery of baby
Inpatient Hospital Services
Semi-private room and board
Physician in-hospital care, maternity care, surgery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy</td><td>Subject to:
$250 deductible per member, no more than $750 per family per calendar year

Covered at 100% after the deductible is met</td></tr>
<tr><td>Skilled Nursing Facility and Physical Rehabilitation Facility
(100 days per member per calendar year for each**)</td><td>You pay $0</td></tr>
<tr><td>Hospice Services</td><td>You pay $0</td></tr>
<tr><td>Home Health Services
Subject to medical necessity</td><td>You pay $50</td></tr>
<tr><td>Physical, Occupational and Speech Therapy
(Combined $5,000 per member per calendar year**)</td><td>$15 copay per visit</td></tr>
<tr><td>Emergency Room</td><td>You pay $75
(You pay $0 if admitted)</td></tr>
<tr><td>Ambulance (subject to medical necessity)</td><td>Deductible/Coinsurance</td><td>Same as network</td></tr>
<tr><td>Chiropractic Services
(Maximum of 20 visits per year**)</td><td>You pay $15</td><td>Subject to deductible and coinsurance</td></tr>
<tr><td>Inpatient Mental Health & Substance Abuse Services*</td><td>Subject to deductible and coinsurance</td><td>Subject to deductible and coinsurance</td><td rowspan="2">Subject to deductible and then 20% coinsurance after deductible is met</td></tr>
<tr><td>Outpatient Mental Health & Substance Abuse Services*</td><td>You pay $15 when arranged through BHN</td><td>Subject to deductible and coinsurance</td></tr>
<tr><td>Prescription Drug</td><td colspan="2">$30 copayment for nonformulary brand
$15 copayment for formulary brand
$5 copayment for generic
Mail order benefits available for 90 day supply at copayment listed above</td><td>Subject to deductible</td></tr>
<tr><td>Vision Care</td><td>$15 copay</td><td>$15 copay</td><td>N/A</td></tr>
<tr><td>Maximum Lifetime Benefit</td><td>unlimited</td><td>unlimited</td><td>unlimited</td></tr>
<tr><td>Fitness Reimbursement</td><td>up to $200 per family per year</td><td>up to $200 per family per year</td><td>up to $200 per family per year</td></tr>
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** PPO Only

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