NEW HAMPSHIRE INTERLOCAL TRUST

	HMO $15 $500 Harvard Pilgrim (MD17282) In-Network HPHC HMO Participating Providers	**HMO LP $25 $1000** Harvard Pilgrim (MD13914) In-Network HPHC HMO Participating Providers	**Elevate Health Option HMO $1000** Harvard Pilgrim MD (18209) **Tier 1 Network** ElevateHealth Participating Providers	 HPHC HMO Participating Providers
Preventive Care Routine physical, gynecological, and well child exams; immunizations; age appropriate screenings.	Covered in Full	Covered in Full	Covered in Full	
Chemotherapy and Radiation			Covered in Full	Tier 2 Deductible; then 20% Coinsurance
X-Rays		Deductible; then Covered in Full		
Laboratory Tests		Covered in Full at **Select LP Providers** Deductible, then Covered in Full at **Other Plan Providers**		
Routine Maternity Care - Prenatal and Postpartum Counseling about alcohol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for complications.		Covered in Full	Covered in Full	
Inpatient Mental Health & Substance Abuse				
Home Health Care				
Oxygen & Respiratory Equipment				
Tier 1 Copayment Professional visits:				Tier 2 Deductible; then 20% Coinsurance
***Preferred* PCP Office Visit**	$15 Copay	$25 Copay	Covered in Full	
PCP Office Visit			$20 Copay	
Routine Annual Eye Exam (1 per year)				
Chiropractic Care; 12 visit limit				
Acupuncture; 20 visit limit			$20 Copay	
Outpatient Mental Health & Substance Abuse				
Tier 2 Copayment Professional visits:	$15 Copay	$25 Copay	$40 Copay	Tier 2 Deductible; then 20% Coinsurance
Specialist Office Visit				
Physical/Occupational/Speech Therapy	$15 Copay; PT/OT: combined 25 visit limit; ST 25 visit limit	$25 Copay; combined 60 visit limit	$40 Copay; combined 60 visit limit	
Allergy Injections	$5 Copay	$5 Copay	$5 Copay	
Outpatient Surgery; Freestanding Facility or Ambulatory Surgery Center	Deductible; then Covered in Full	Covered in Full at **Select LP Providers** Deductible. then Covered in Full at **Other Plan Providers**	$150 Copay	
Emergency Room (co-pay waived if admitted)	$100 Copay	$150 Copay	$200 Copay	
Prescription Drugs: Retail (30 day Supply)	$0/$10/$20/$30	$5/$20/$30	$0/$10/$20/$30	
Mail Order (90 day Supply)	$0/$10/$40/$60	$5/$20/$30	$0/$10/$40/$60	
Deductible: Limit one per year	$500 Deductible ($1,500 Family Maximum)	$1,000 Deductible ($3,000 Family Maximum)	Tier 1: $1,000 ($3,000 Family)	Tier 2: $3,000 ($6,000 Family)*
Hospital Inpatient	Deductible; then Covered in Full	Deductible; then Covered in Full	Tier 1 Deductible; then Covered in Full	Tier 2 Deductible; then 20% Coinsurance
Maternity Care - Delivery				
Advanced Radiology; CT Scans, PET Scans, MRI, MRA and Nuclear medicine services				
Outpatient Surgery; Hospital Facility		Covered in Full at **Select LP Providers** Deductible, then Covered in Full at **Other Plan Providers**		
Skilled Nursing Facility & Inpatient Rehabilitation combined 100 day limit		Deductible; then Covered in Full		
Ambulance - Emergency Transport			Tier 1 Deductible, then Covered in Full	
Durable Medical Equipment	Separate $100 Deductible; then 20% Coinsurance	Separate $100 Deductible; then 20% Coinsurance	Separate $100 deductible, then 20% Coinsurance	
Out of Pocket Maximum: Medical	$2,000 ($4,000 Family)	$2,500 ($5,000 Family)	$6,000 ($12,000 Family)	
Prescription Drugs	$4,000 ($8,000 Family)	$4,000 ($8,000 Family)		
Deductible Year	July-June	July-June	July-June	
Deductible Carry-Over Provision	Yes	No	Yes	
Lifetime Benefit	Unlimited	Unlimited	Unlimited	

*Any eligible medical expense incurred toward the Tier 1 Deductible in a Plan Year applies to both the Tier 1 and Tier 2 Deductibles and vice versa. The maximum Deductible amount will never exceed the Tier 2 Deductible.

Extraction of teeth impacted in bone is not a covered benefit.

This is only a summary of benefits, please consult the corresponding schedule of benefits. Exceptions & exclusions apply.

Benefit limits, deductibles and out of pocket maximums are based on a plan year.