NEW HAMPSHIRE INTERLOCAL TRUST

	HMO OA LP $25 $1000 Harvard Pilgrim (MD25223) In Network	ElevateHealth Options HMO OA $1000 Harvard Pilgrim (MD25240) **Tier 1 Network** ElevateHealth Providers	 **Tier 2 Network** Other HPHC HMO Providers	HMO OA Super $1500 Harvard Pilgrim (MD25264) In Network
Preventive Care Routine physical, gynecological, and well child exams; immunizations; age appropriate screenings.	Covered in Full	Covered in Full		Covered in Full
Routine Maternity Care - Prenatal and Postpartum Counseling about alcohol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for complications.				
Routine Annual Eye Exam (1 per year)	$25 Copay	$20 Copay	Tier 2 Deductible; then 20% Coinsurance	
Chemotherapy and Radiation	Covered in Full	Covered in Full		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			
Inpatient Mental Health & Substance Abuse	Covered in Full	Covered in Full		
Home Health Care				
Oxygen & Respiratory Equipment				
Tier 1 Copayment Professional visits:	$25 Copay	$20 Copay; First two visits Covered in Full	Tier 2 Deductible; then 20% Coinsurance	Deductible; then 20% Coinsurance
PCP Office Visit				
Chiropractic Care; unlimited visits		$20 Copay		
Acupuncture; unlimited visits			$20 Copay	
Outpatient Mental Health & Substance Abuse		$20 Copay		
Tier 2 Copayment Professional visits:		$40 Copay	Tier 2 Deductible; then 20% Coinsurance	
Specialist Office Visit				
Physical/Occupational/Speech Therapy; unlimited visits				
Allergy Injections	$5 Copay	$5 Copay		
Emergency Room (co-pay waived if admitted)	$150 Copay	$200 Copay		
Prescription Drugs: Retail (30 day Supply)	$5/$20/$30	$0/$10/$20/$30		Deductible; then 10% Coinsurance
Mail Order (90 day Supply)	$5/$20/$30	$0/$10/$40/$60		Deductible; then 10% Coinsurance
Deductible: Limit one per year	$1,000 Deductible ($3,000 Family Maximum)	Tier 1: $1,000 ($3,000 Family)	Tier 2: $3,000 ($6,000 Family)	$1,500 Deductible ($3,000 Family Maximum)
Hospital Inpatient	Deductible; then Covered in Full	Tier 1 Deductible; then Covered in Full	Tier 2 Deductible; then 20% Coinsurance	Deductible; then 20% Coinsurance
Maternity Care - Delivery				
Advanced Radiology; CT Scans, PET Scans, MRI, MRA and Nuclear medicine services				
Outpatient Surgery	**Covered in Full** at Select LP Providers **Deductible, then Covered in Full** at Other Plan Providers	**$150 Copay** at Freestanding Facility or Ambulatory Surgery Center; **Tier 1 Deductible, then Covered in Full** at Hospital Facility		
Skilled Nursing Facility & Inpatient Rehabilitation combined 100 day limit	Deductible; then Covered in Full	Tier 1 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		
Out of Pocket Maximum: Medical	$5,000 ($10,000 Family)	$5,000 ($10,000 Family)		$2,000 ($4,000 Family)
Prescription Drugs				
Deductible Year	Plan Year	Plan Year		Plan Year
Deductible Carry-Over Provision	No	Yes		No
Lifetime Benefit	Unlimited	Unlimited		Unlimited

Select LP Providers are pre-determined by Harvard Pilgrim and are subject to change.

EHO: Any eligible medical expense incurred toward the Tier 1 Deductible in a Calendar 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.