SERVING NH 25+ YEARS SCHOOLCARE HEALTH BENEFIT PLANS

Elevate Health Option HMO OA $2000

Harvard Pilgrim (MD25247)

Tier 1 Network	Tier 2 Network
ElevateHealth Participating Providers	HPHC HMO Participating Providers

Benefits covered in Full (no cost to the member)		
Preventive Care Routine physical, gynecological, and well child exams; immunizations; age appropriate screenings.	Covered in Full	
Chemotherapy and Radiation	Covered in Full	Tier 2 Deductible; then 20% Coinsurance
X-Rays		
Laboratory Tests		
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
Inpatient Mental Health & Substance Abuse		
Home Health Care		
Oxygen & Respiratory Equipment		

Benefits covered after a Copayment		
Tier 1 Copayment Professional visits:		Tier 2 Deductible; then 20% Coinsurance
PCP Office Visit	$25 Copay	
First two visits covered in full		
Routine Annual Eye Exam (1 per year)		
Chiropractic Care; unlimited visits		
Acupuncture; unlimited visits		$25 Copay
Outpatient Mental Health & Substance Abuse		
Tier 2 Copayment Professional visits:	$50 Copay	Tier 2 Deductible; then 20% Coinsurance
Specialist Office Visit		
Physical/Occupational/Speech Therapy; unlimited visits		
Allergy Injections	$5 Copay	
Outpatient Surgery; Freestanding Facility	$150 Copay	
Prescription Drugs: Retail (30 day Supply)	$5/$15/$30/$50	
Mail Order (90 day Supply)	$5/$15/$30/$50	

Benefits covered after a Deductible		
Deductible: Limit one per year	Tier 1: $2,000 ($4,000 Family)	Tier 2: $4,000 ($8,000 Family)
Hospital Inpatient	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		
Skilled Nursing Facility & Inpatient Rehabilitation; combined 100 day limit		
Outpatient Surgery; Hospital Facility	Tier 1 Deductible; then $150 Copay	
Ambulance - Emergency Transport	Tier 1 Deductible; then Covered in Full	
Emergency Room (co-pay waived if admitted)	Tier 1 Deductible; then $250 Copay	
Durable Medical Equipment	Tier 1 Deductible; then 20% Coinsurance	
Out of Pocket Maximum: Medical	$5,000 ($10,000 Family)	
Prescription Drugs		

Deductible Year: Plan** Deductible Carry-Over Provision: Yes Lifetime Benefit: Unlimited

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.

Mar-24

SERVING NH 25+ YEARS SCHOOLCARE HEALTH BENEFIT PLANS

HMO OA Super $1500

Harvard Pilgrim (MD25265)
In-Network

Benefits covered in Full (no cost to the member)	
Preventive Care Routine physical, gynecological, and well child exams; immunizations; age appropriate screenings.	Covered in Full
Routine Maternity Care - Prenatal and Postpartum Counseling about alcolhol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for complications.	
Doctor on Demand - Medical Urgent Care Telemedicine app used via smart device or web cam enabled computer	
Routine Annual Eye Exam (1 per year)	

Benefits covered after a Deductible	
Laboratory Tests	Deductible; then 20% Coinsurance
X-Rays	
Chemotherapy & Radiation Therapy	
Inpatient Mental Health & Substance Abuse	
Home Health Care	
Durable Medical Equipment Including Oxygen and Respiratory Equipment	
Professional visits:	
Physician Services/Office Visit	
Acupuncture; unlimited visits	
Chiropractic Care; unlimited visits	
Physical/Occupational/Speech Therapy; unlimited visits	
Outpatient Mental Health & Substance Abuse	
Allergy Injections	
Emergency Room	
Urgent Care Convenience care clinic, Urgent care center or Hospital urgent care center	
Hospital Inpatient	
Maternity Care - Delivery	
Advanced Radiology CT Scans, PET Scans, MRI, MRA and Nuclear medicine services	
Outpatient Surgery	
Skilled Nursing Facility & Inpatient Rehabilitation; combined 100 day limit	
Ambulance - Emergency Transport	
Prescription Drugs: Retail (30 day Supply)	10% Coinsurance**
Mail Order (90 day Supply)	10% Coinsurance**

Other Benefit Features	
Deductible: Individual	$1,500
Two Person & Family	$3,000
Out of Pocket Maximum: Medical	Combined $2,000 ($4,000 Family)
Prescription Drugs	

Deductible Year: Plan* **Deductible Carry-Over Provision:** No **Lifetime Benefit:** Unlimited

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

*Deductible year will follow your medical plans renewal

Apr-24

**Per Script Max: $75 Retail Supply (30 Day Supply); $150 Mail Order Supply (90 Day Supply)

SERVING NH 25+ YEARS SCHOOLCARE HEALTH BENEFIT PLANS

POS $20/$40 $1500

Harvard Pilgrim (MD24029)

	In-Network	Out-of-Network
Benefits Covered in Full (no cost to the member)		
Preventive Care Routine physical, gynecological, and well child exams; immunizations; age appropriate screenings.	Covered in Full	Deductible; then 20% Coinsurance
Laboratory Tests		
Chemotherapy & Radiation Therapy		
Routine Maternity Care - Prenatal and Postpartum Counseling about alcohol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for complications.		
Home Health Care		
Oxygen & Respiratory Equipment		
Inpatient Mental Health & Substance Abuse	Covered in Full	20% Coinsurance
Benefits Covered after a Copayment		
Tier 1 Copayment Professional Visits:	$20 Copay	Deductible; then 20% Coinsurance
PCP Office Visit		
Routine Annual Eye Exam (1 per year)		
Acupuncture; unlimited visits		
Chiropractic Care; unlimited visits		
Outpatient Mental Health & Substance Abuse	$20 Copay	20% Coinsurance
Tier 2 Copayment Professional visits:	$40 Copay	Deductible; then 20% Coinsurance
Specialist Office Visit		
Physical/Occupational/Speech Therapy; unlimited visits		
Allergy Injections	$5 Copay	Deductible; then 20% Coinsurance
Emergency Room (waived if admitted)	$100 Copay	$100 Copay
Prescription Drugs: Retail (30 day supply)	$10/$30/$50	
Mail Order (90 day supply)	$15/$45/$70	
Benefits Covered after a Deductible		
Best Buy Deductible: Limit one per year	$1,500 Deductible ($4,500 Family Maximum)	$1,500 Deductible ($4,500 Family Maximum)
Hospital Inpatient	Deductible; then Covered in Full	Deductible; then 20% Coinsurance
Maternity Care Delivery		
Advanced Radiology; CT Scans and MRIs		
X-rays		
Outpatient Surgery		
Skilled Nursing Facility & Inpatient Rehabilitation; combined 100 day limit per year		
Ambulance - Emergency Transport	Deductible; then Covered in Full	Deductible; then Covered in Full
Durable Medical Equipment	Separate $100 Deductible; then 20% Coinsurance	Deductible; then 20% Coinsurance
Out of Pocket Maximum: Medical	$5,000 ($10,000 Family)	$6,000 ($12,000 Family)
Prescription Drugs		

Deductible Year: Plan* **Deductible Carry-Over Provision:** Yes **Lifetime Benefit:** Unlimited

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