SERVING NH 25+ YEARS SCHOOLCARE HEALTH BENEFIT PLANS

EXHIBIT A

HMO Super $20/$40 $1000 OA

Harvard Pilgrim (MD25212)

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
Laboratory Tests	
X-Rays	
Chemotherapy & Radiation	
Routine Maternity Care - Prenatal and Postpartum Counseling about alcohol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for complications.	
Inpatient Mental Health & Substance Abuse	
Home Health Care	
Oxygen & Respiratory Equipment	

Benefits Covered after a Copayment	
Tier 1 Copayment Professional visits:	$20 Copay
PCP Office Visit	
Routine Annual Eye Exam (1 per year)	
Acupuncture; unlimited visits	
Chiropractic Care; unlimited visits	
Outpatient Mental Health & Substance Abuse	
Tier 2 Copayment Professional visits:	$40 Copay
Specialist Office Visit	
Physical/Occupational/Speech Therapy; unlimited visits	
Allergy Injections	$5 Copay
Emergency Room (waived if admitted)	$150 Copay
Prescription Drugs: Retail (30 day Supply)	$0/$10/$20/$30
Mail Order (90 day Supply)	$0/$10/$40/$60

Benefits Covered after a Deductible	
Best Buy Deductible: Limit one per year	$1,000 Deductible ($3,000 Family Maximum)
Hospital Inpatient	Deductible; then Covered in Full
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 per year	
Ambulance - Emergency Transport	
Durable Medical Equipment	Separate $100 deductible; then 20% Coinsurance
Out of Pocket Maximum: Medical	$5000 ($10,000 Family)
Prescription Drugs	

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

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 plan year.

*Deductible year will follow your medical plans renewal

EXHIBIT A

SERVING NH 25+ YEARS SCHOOLCARE HEALTH BENEFIT PLANS

POS OA $20/$40 $1500

Harvard Pilgrim (MD25254)

	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)	$0/$10/$20/$30	
Mail Order (90 day supply)	$0/$10/$40/$60	
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

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

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

July-24

SERVING NH 25+ YEARS SCHOOLCARE HEALTH BENEFIT PLANS

HMO OA HSA $3500

Harvard Pilgrim (MD25316)
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.	
Routine Annual Eye Exam (1 per year)	

Benefits covered after a Deductible	
Laboratory Tests	Deductible; then Covered in Full
X-Rays	
Chemotherapy & Radiation Therapy	
Inpatient Mental Health & Substance Abuse	
Home Health Care	
Oxygen & 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	
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)	Deductible; then Covered In Full
Mail Order (90 day Supply)	Deductible; then Covered In Full
Durable Medical Equipment	Deductible; then Covered in Full

Other Benefit Features	
HSA Deductible: Individual	$3,500
Family	$7,000
Out of Pocket Maximum: Medical	Combined $3,500 ($7,000 Family)
Prescription Drugs	

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

Extraction of teeth impacted in bone is not a covered benefit.
This is only a summary of benefits, please consult corresponding schedule of benefits. Exceptions & exclusions apply.
Benefit limits, deductibles and out of pocket maximums are based on a plan year.

*Deductible year will follow your medical plans renewal

Apr-24

SERVING NH 25+ YEARS SCHOOLCARE HEALTH BENEFIT PLANS

HMO OA LP $25/$50 $3000

Harvard Pilgrim (MD25236)
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
Radiation Therapy	
Routine Maternity Care - Prenatal and Postpartum Counseling about alcohol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for complications.	
Inpatient Mental Health & Substance Abuse	
Home Health Care	
Oxygen & Respiratory Equipment	

Benefits Covered after a Copayment	
Tier 1 Copayment Professional Visits:	$25 Copay
PCP Office Visit	
Routine Annual Eye Exam (1 per year)	
Acupuncture; unlimited visits	
Chiropractic Care; unlimited visits	
Outpatient Mental Health & Substance Abuse	
Tier 2 Copayment Professional Visits:	$50 Copay
Specialist Office Visit	
Physical/Occupational/Speech Therapy; unlimited visits	
Chemotherapy	
Allergy Injections	$5 Copay
Prescription Drugs: Retail (30 day Supply)	$0/$10/$20/$30
Mail Order (90 day Supply)	$0/$10/$40/$60

Benefits Covered after a Deductible	
Best Buy Deductible: Limit one per year	$3,000 Deductible ($9,000 Family Maximum)
Hospital Inpatient	Deductible; then Covered in Full
Maternity Care - Delivery	
Advanced Radiology CT Scans, PET Scans, MRI, MRA and Nuclear medicine services	
X-rays	
Skilled Nursing Facility & Inpatient Rehabilitation; combined 100 day limit per year	
Ambulance - Emergency Transport	
Emergency Room (copayment waived if admitted)	Deductible; then $150 Copay
Diagnostic Lab Services	Covered in Full at **Select LP Providers** Deductible, then Covered in Full at **Other Plan Providers**
Outpatient Surgery	$75 Copay at **Select LP Providers** Deductible, then Covered in Full at **Other Plan Providers**
Scopic Procedures	
Durable Medical Equipment	Separate $100 Deductible; then 20% Coinsurance
Out of Pocket Maximum: Medical	$5,000 ($10,000 Family)
Prescription Drugs	

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

Select LP Providers are pre-determined by Harvard Pilgrim and are subject to change.
Extraction of teeth impacted in bone is not a covered benefit.
This is only a summary of benefits, please consult corresponding schedule of benefits. Exceptions & exclusions apply.
Benefit limits, deductibles and out of pocket maximums are based on a plan year.