

SECTION A. Summary of Benefits - Silver Plan

This Summary is part of your Benefit Handbook. It states the Cost Sharing amounts that you must pay for Covered Benefits and some important limitations on your coverage. It also identifies any supplemental medical benefits included in your Plan.

For complete information on Covered Benefits, including limitations on your coverage, you must refer to Section C of the Benefit Handbook. For information on how the Tiered-Copayment HMO works, please see Section B of the Benefit Handbook.

Covered Benefits:	Your Cost Sharing:
Outpatient Professional Services	
• Ambulance Transport, Non-Emergency	Nothing
• Cardiac Rehabilitation	Nothing
• Diagnostic Laboratory and X-rays	Nothing
• Dialysis	Nothing
• Early Intervention Services - \$3,200 per calendar year, up to \$9,600 per lifetime	Tier 1: \$10 Copayment
• Formulas and Low Protein Foods	Nothing
• Home Care and Hospice	Nothing
• Physical therapy - limited to 24 visits per calendar year • Occupational therapy - limited to 24 visits per calendar year	\$10 Copayment
• Physician Services, except the three services listed below:	Tier 1: \$10 Copayment Tier 2: \$20 Copayment
Prenatal and Postpartum Care	Nothing
Allergy Injections	\$10 Copayment
Preventive Care, including: <ul style="list-style-type: none"> - Well child visits and immunizations - Routine physical exams (including vision and hearing screenings) - Annual gynecological exam (including family planning) - Nutritional counseling and health education - Mammograms, pap smears, lead screening, prostatic specific antigen (PSA) screening 	Nothing
• House Calls	Tier 1: \$10 Copayment Tier 2: \$20 Copayment
• Speech therapy - limited to 24 visits per calendar year	\$10 Copayment

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Covered Benefits:	Your Cost Sharing:
<ul style="list-style-type: none"> • Urgent Care Services 	50% of your Emergency Room Care Copayment
<ul style="list-style-type: none"> • Surgical Day Care 	Nothing
<ul style="list-style-type: none"> • Vision Hardware for Special Conditions 	Nothing
Emergency Services	
<ul style="list-style-type: none"> • Ambulance Transport, Emergency 	Nothing
<ul style="list-style-type: none"> • Emergency Dental Care - in a professional office within 72 hours of injury 	\$10 Copayment
<ul style="list-style-type: none"> • Emergency Room Care 	\$100 Copayment This Copayment is waived if admitted directly to the hospital from the emergency room
Inpatient Services	
<ul style="list-style-type: none"> • Acute Hospital Care • Maternity Care • Rehabilitation Hospital Care - limited to 60 days per calendar year • Skilled Nursing Facility Care - limited to 100 days per calendar year 	Nothing
Mental Health Services	
Important Note: Benefit limits do not apply to care for Serious Mental Illnesses. See Section C.5.a for details.	
<ul style="list-style-type: none"> • Inpatient Care - limited to 15 days per calendar year 	Nothing
<ul style="list-style-type: none"> • Partial Hospitalization - limited to 30 days per calendar year <p>Please note: Each partial hospitalization day counts as one-half of an inpatient day and is deducted from the limit available for inpatient care.</p>	Nothing
<ul style="list-style-type: none"> • Outpatient Care - limited to 20 visits per calendar year 	
Group Therapy	\$10 Copayment
Individual Therapy	\$10 Copayment
<ul style="list-style-type: none"> • Medication Management 	\$10 Copayment
<ul style="list-style-type: none"> • Psychological Testing 	\$10 Copayment

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Covered Benefits:	Your Cost Sharing:
Drug and Alcohol Rehabilitation Services	
<ul style="list-style-type: none"> • Inpatient Care - limited to 30 days per calendar year 	Nothing
<ul style="list-style-type: none"> • Partial Hospitalization - limited to 60 days per calendar year <p>Please note: Each partial hospitalization day counts as one-half of an inpatient day and is deducted from the limit available for inpatient care.</p>	Nothing
<ul style="list-style-type: none"> • Outpatient Care - limited to 20 visits per calendar year 	
Group Therapy	\$10 Copayment
Individual Therapy	\$10 Copayment
<ul style="list-style-type: none"> • Inpatient Detoxification 	Nothing
<ul style="list-style-type: none"> • Outpatient Detoxification 	\$10 Copayment
Durable Medical Equipment and Prosthetic Devices	
<ul style="list-style-type: none"> • Limited to \$2,500 per calendar year for all covered equipment. This limit does not apply to the five items listed below. 	Nothing
Blood Glucose Monitors, Insulin Pumps and Infusion Devices	Nothing
Breast Prostheses, including Replacements and Mastectomy Bras	Nothing
Medical Equipment and Supplies for Diabetes Treatment	Nothing
Oxygen and Respiratory Equipment	Nothing
Prosthetic Arms and Legs	Nothing
Other Health Services	
<ul style="list-style-type: none"> • Annual Eye Exam 	\$10 Copayment
<ul style="list-style-type: none"> • Chiropractic Care 	\$10 Copayment
<ul style="list-style-type: none"> • Hearing Aids limited to 2 per calendar year 	Nothing
<ul style="list-style-type: none"> • Telemedicine 	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Summary of Benefits. For example, for services provided by physician, see "Physician Services." For inpatient hospital care, see "Inpatient Services."

The Plan does not cover:

1. Services your PCP or a Plan Provider has not provided, arranged or approved except: (1) in a Medical Emergency, (2) when you are outside of the Service Area; or (3) the special services that do not require a referral, listed in Section B.2.h.
2. Services for cosmetic purposes, except as described in this Handbook.
3. Commercial diet plans, weight loss programs and any services in connection with such plans or programs.
4. Gender reassignment surgery and all related drugs and procedures.
5. Dental Care, except the specific dental services covered under this Benefit Handbook.
6. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational..
7. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of myopia, hyperopia and astigmatism.
8. Transportation other than by ambulance.
9. Cost for any services for which you are entitled to treatment at government expense, including military service connected disabilities.
10. Costs for services for which payment is required to be made by a Workers' Compensation plan or an employer under state or federal law.
11. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy.
12. Educational services or testing. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; or (3) to treat learning disabilities.
13. Sensory integrative praxis tests.
14. Testing of central auditory processing.
15. Physical examinations and testing for insurance, licensing or employment.
16. Routine foot care, biofeedback, pain management programs, and sports medicine clinics.
17. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
18. Charges after the date on which your membership ends.
19. Charges for missed appointments.
20. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary.
21. Inpatient charges after your hospital discharge.
22. Follow-up care after an emergency room visit, unless provided or arranged by your PCP.

SECTION E. General Exclusions

23. Rest or Custodial Care.
24. Personal comfort or convenience items (including telephone and television charges).
25. Exercise equipment.
26. Wigs, except as required by state law.
27. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
28. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services.
29. Any devices or special equipment needed for sports or occupational purposes.
30. Any home adaptations, including, but not limited to home improvements and home adaptation equipment.
31. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal.)
32. Any form of surrogacy.
33. Infertility treatment for Members who are not medically infertile.
34. Routine maternity care when you are traveling outside the Service Area.
35. Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery.
36. Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray.
37. Services for which no charge would be made in the absence of insurance.
38. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook.
39. Services for non-Members.
40. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
41. Birth control drugs, implants, injections and devices, unless your Plan includes coverage for prescription drugs.
42. Home health care services that extend beyond care on a short-term intermittent basis.
43. Private duty nursing
44. A provider's charge to file a claim or to transcribe or copy your medical records.
45. Any service or supply furnished along with a non-Covered Benefit.
46. Taxes or governmental assessments on services or supplies.
47. Planned home births.

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48. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook.
49. Acupuncture, aromatherapy, treatment with crystals and alternative medicine.
50. Myotherapy.
51. Methadone maintenance.
52. Services for which no coverage is provided in this Benefit Handbook or Prescription Drug Brochure (if applicable).
53. Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant.
54. Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs.
55. Unless otherwise specified in this Benefit Handbook or the Summary of Benefits (and required by New Hampshire law), the Plan does not cover food or nutritional supplements, including FDA-approved medical foods obtained by prescription.
56. Preventive Dental Care for children.
57. Infertility consult or evaluation
58. Therapeutic donor insemination, including related sperm procurement and banking.
59. Advanced reproductive technologies, including, but not limited to, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intra-cytoplasmic sperm injection (ICSI), and donor egg procedures, including related egg and inseminated egg procurement, processing and banking.
60. Voluntary sterilization, including tubal ligation and vasectomy.
61. Voluntary termination of pregnancy.
62. Foot orthotics
63. Extraction of teeth impacted in bone
64. Telemonitoring, telemedicine services involving e-mail, fax, or audio-only telephone, telemedicine services involving stored images forwarded for future consultation, i.e. "store and forward" telecommunication
65. Services for any condition with only a "V Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder.