

# About Your NHP Membership

## **BEFORE COVERAGE BEGINS FOR CERTAIN SERVICES, YOU PAY A DEDUCTIBLE EACH CALENDAR YEAR.**

Your Plan Deductible is an amount you pay for certain services each calendar year. Refer to those covered services marked "subject to deductible".

**Individual members** are responsible for the *individual deductible* per calendar year.

**Family member's** deductible payments contribute toward the *family deductible* per calendar year. The family deductible can be satisfied by combining deductibles paid for by covered family members. Each family member's contribution will not exceed the amount set for an individual deductible.

Once you have satisfied your deductible, you are subject to 20% coinsurance until the out-of-pocket maximum is met. The family out-of-pocket maximum is satisfied by combining deductibles and coinsurance amounts paid by covered family members.

## **BEFORE PRESCRIPTION COPAYMENTS BEGIN, YOU PAY A DEDUCTIBLE EACH CALENDAR YEAR**

The Prescription Deductible is an amount you pay each calendar year before prescription drug coverage begins.

Individual and/or family members contribute towards the prescription deductible.

Once the deductible is met, copayments apply.

## **FOR SERVICES THAT ARE NOT SUBJECT TO THE DEDUCTIBLE, THERE IS EITHER A COPAYMENT OR NO CHARGE.**

There are services that require a copayment, those with no charge, and those that are subject to a deductible. Your copayment is a fixed amount you pay for certain services. Copayments do not count toward your plan or prescription deductible.

## **CHOOSING A PRIMARY CARE PROVIDER OR SITE**

When you become a member of Neighborhood Health Plan you must choose a Primary Care Provider (PCP) for yourself and each covered member of your family. You will find a complete listing of PCP's in the NHP Provider Directory.

For the most up-to-date Provider information, go to NHP's web site at [www.nhp.org](http://www.nhp.org) or call our Customer Care Center at 800-462-5449 or TTY 800-655-1761.



## **YOUR PRIMARY CARE PROVIDER**

Your PCP arranges your health care including referrals that may be required. Your PCP is the first person you call when you need medical care.

## **URGENT CARE**

If you need Urgent Care, call your PCP to arrange where you will receive treatment. Examples of conditions requiring Urgent Care include, but are not limited to, fever, sore throat and earache.

## **EMERGENCY CARE**

In an emergency, go to the nearest emergency facility, or call 911, or your local emergency number. Please refer to your Benefit Summary for copayment amount. Your copayment is waived if you are admitted to the hospital.

All follow-up care must be arranged by your PCP. You, or someone on your behalf, should notify your PCP within 48 hours.

## **CUSTOMER CARE CENTER**

NHP's Customer Care Center is available Monday through Friday, 8:30 am - 6:00 pm. For questions or concerns regarding your NHP coverage, contact NHP's Customer Care Center at 800-462-5449 or TTY 800-655-1761.

# NHP CareThree Select

A Business Choice Plan

Benefit Summary  
Effective July 1, 2007

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Neighborhood Health Plan  
*Getting better together.*

Neighborhood Health Plan  
*Getting better together.*

# NHP CareThree Select

This Benefit Summary is a general description of your coverage as a member of Neighborhood Health Plan (NHP). For more information about your benefits, visit [www.nhp.org](http://www.nhp.org) or call NHP's Customer Care Center at 800-462-5449 or TTY 800-655-1761. All services must be medically necessary and some may require prior authorization or referral. The NHP Member Handbook may include additional coverages and/or exclusions not listed on the Benefit Summary.

|  |                                    |
|--|------------------------------------|
| Individual Plan Deductible per Calendar Year .....                                       | \$ 2,000 Individual maximum        |
| Family Plan Deductible per Calendar Year.....  | \$ 4,000 Family maximum            |
| Individual Prescription Drug Deductible per Calendar Year .....                          | \$ 100 Deductible, then copayments |
| Family Plan Prescription Drug Deductible per Calendar Year.....                          | \$ 200 Deductible, then copayments |
| Individual Plan Out-of-Pocket Maximum per Calendar Year (for indicated services ■) ..... | \$ 5,000                           |
| Family Plan Out-of-Pocket Maximum per Calendar Year (for indicated services ■) .....     | \$ 10,000                          |
| Coinsurance .....  | 20 %                               |

| <b>OUTPATIENT MEDICAL CARE</b>  | <b>COPAYMENT</b>                      |
|---|---------------------------------------|
| Office Visits for Primary and Specialty Care.....                                     | \$ 25 per office visit                |
| Allergy Tests and Shots .....   | Included in office visit              |
| Cardiac Rehabilitation Services .....   | \$ 25 per office visit                |
| Eye Exams (once every 12 months) .....  | \$ 25 per office visit                |
| Family Planning Services.....   | \$ 25 per office visit                |
| Gynecological Exams .....   | \$ 25 per office visit                |
| Hearing Exams .....   | \$ 25 per office visit                |
| Immunizations/Vaccinations .....  | Included in office visit              |
| Infertility Services ■.....   | Subject to deductible and coinsurance |
| Physical and Occupational Therapies (up to 90 consecutive days per condition) ■ ..... | Subject to deductible and coinsurance |
| Prenatal and Postnatal Care .....   | \$ 25 per office visit                |
| Routine Check-Up/Physical Exams.....  | \$ 25 per office visit                |
| Speech Therapy .....  | \$ 25 per office visit                |
| Well Baby and Pediatric Care .....  | \$ 25 per office visit                |
| Mammograms .....  | Included in office visit              |
| Outpatient Surgery ■.....   | Subject to deductible and coinsurance |
| Laboratory Tests .....  | Included in office visit              |
| X-Rays and Diagnostic Tests ■.....  | Subject to deductible and coinsurance |

| <b>INPATIENT MEDICAL CARE</b>                       | <b>COPAYMENT</b>   |
|---|--|
| Inpatient Medical Services ■ .....                  | Subject to deductible and coinsurance<br>(semi-private room and board or private room, if medically necessary) |
| Inpatient Care in a Skilled Nursing Facility ■..... | Subject to deductible and coinsurance<br>(for up to 100 days per calendar year)                                |
| Inpatient Care in a Rehabilitation Facility ■ ..... | Subject to deductible and coinsurance<br>(for up to 60 days per calendar year)                                 |
| Inpatient Maternity ■ .....                         | Subject to deductible and coinsurance  |
| Routine Nursery and Newborn Care.....               | No copayment   |

| <b>MENTAL HEALTH AND SUBSTANCE ABUSE CARE – OUTPATIENT</b> | <b>COPAYMENT</b>  |
|--|---|
| Mental Health .....  | \$ 25 per office visit<br>(biologically based and other state mandated coverage - no limit,<br>non biologically based up to 25 visits per member per calendar year) |
| Substance Abuse Care .....                                 | \$ 25 per office visit  |

| <b>MENTAL HEALTH AND SUBSTANCE ABUSE CARE – INPATIENT</b> | <b>COPAYMENT</b>  |
|---|---|
| Mental Health Care .....                                  | No copayment<br>(biologically based and other state mandated coverage - no limit,<br>non biologically based covered in full up to 60 days per member per calendar year) |
| Substance Abuse Detoxification.....                       | No copayment  |
| Substance Abuse Rehabilitation.....                       | No copayment  |

| <b>URGENT CARE</b>  | <b>COPAYMENT</b>       |
|---|------------------------|
| Urgent Care provided at your primary care site or arranged by your NHP Provider ..... | \$ 25 per office visit |

| <b>EMERGENCY CARE</b>   | <b>COPAYMENT</b>   |
|---|--|
| <b>If, in your judgement, you require emergency medical care, go to the nearest emergency room or call 911 or your local emergency number. When admitted to a hospital for emergency care, you or a family member should notify your PCP within 48 hours.</b> |  |
| Care you receive in an emergency room, in or out of NHP Service Area ■ .....  | Subject to deductible then \$100 per visit<br>(waived if admitted to hospital) |

| <b>DENTAL CARE</b>  | <b>COPAYMENT</b>   |
|---|--|
| Emergency Dental Care immediately following accident or injury..... | \$ 25 for office visit<br>\$ 100 in emergency room<br>(waived if admitted to hospital) |
| Extraction of Impacted or Infected Wisdom Teeth.....                | \$ 25 per office visit   |
| Preventive Dental Care (one visit every 12 months) .....            | No copayment   |

| <b>PRESCRIPTION DRUGS ■</b>   | <b>COPAYMENT</b>  |
|---|---|
| The following copayments apply after deductible has been met:             |   |
| With a valid prescription and purchased at a participating pharmacy ..... | \$ 15 generic drugs<br>50 % preferred brand<br>50 % non-preferred brand     |
| for up to a 30-day supply   |   |
| With a valid prescription for a maintenance medication and purchased..... | \$ 30 generic drugs<br>50 % preferred brand ◆<br>50 % non-preferred brand ◆ |
| through the mail order program for a 90-day supply                        |   |
| ◆ Cost of 60 day supply of medication.                                    |   |

| <b>OVER-THE-COUNTER DRUGS</b>   | <b>COPAYMENT</b>   |
|---|--|
| Select generic over-the-counter cough, cold and allergy medicines with a valid .....  | \$ 0 to 50 % copayment<br>prescription and purchased at a participating pharmacy for up to a 30-day supply<br>(depending on drug prescribed) |
| <b>For a complete list of over-the-counter drugs, visit <a href="http://www.nhp.org">www.nhp.org</a> or contact our Customer Care Center at 800-462-5449 or TTY 800-655-1761.</b> |  |

| <b>ADDITIONAL SERVICES</b>         | <b>COPAYMENT</b>  |
|------------------------------------|---|
| Ambulance Services ■ .....         | Subject to deductible and coinsurance   |
| Disposable Medical Supplies ■..... | Subject to deductible and coinsurance   |
| Durable Medical Equipment .....    | No Copayment<br>up to \$2,500 per calendar year   |
| Early Intervention .....           | No copayment<br>(from birth up to age three, up to \$5,200 per calendar year with a lifetime maximum of \$15,600) |
| Home Health Care .....             | No copayment  |
| Hospice.....                       | No copayment  |