

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.

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.

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. 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 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 No Rx

A Business Choice Plan

Benefit Summary
Effective July 1, 2007

Neighborhood Health Plan
Getting better together.

Neighborhood Health Plan
Getting better together.

NHP CareThree Select No Rx

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 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 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 %

OUTPATIENT MEDICAL CARE

COPAYMENT

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

INPATIENT MEDICAL CARE

COPAYMENT

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

MENTAL HEALTH AND SUBSTANCE ABUSE CARE – OUTPATIENT

COPAYMENT

Mental Health	\$ 25 per office visit (biologically based and other state mandated coverage - no limit, non biologically based up to 25 visits per member per calendar year)
Substance Abuse Care.....	\$ 25 per office visit (biologically based and other state mandated coverage - no limit, non biologically based covered in full up to 60 days per member per calendar year)

MENTAL HEALTH AND SUBSTANCE ABUSE CARE – INPATIENT

COPAYMENT

Mental Health Care	No copayment (biologically based and other state mandated coverage - no limit, 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

URGENT CARE

COPAYMENT

Urgent Care provided at your primary care site or arranged by your NHP Provider	\$ 25 per office visit
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EMERGENCY CARE

COPAYMENT

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.

Care you receive in an emergency room, in or out of NHP Service Area ■	Subject to deductible then \$100 per visit (waived if admitted to hospital)
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DENTAL CARE

COPAYMENT

Emergency Dental Care immediately following accident or injury.....	\$ 25 for office visit \$ 100 in emergency room (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

PRESCRIPTION DRUGS

COPAYMENT

Prescription Drugs.....	No coverage
Over-the-Counter Drugs	No coverage

ADDITIONAL SERVICES

COPAYMENT

Ambulance Services ■	Subject to deductible and coinsurance
Disposable Medical Supplies ■.....	Subject to deductible and coinsurance
Durable Medical Equipment	No copayment up to \$2,500 per calendar year
Home Health Care	No copayment
Hospice.....	No copayment