

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 and each covered member of your family. This information is listed in the NHP Provider Directory.

For the most up-to-date Provider information, go to NHP's website 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 and 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, earache and acute pain.

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

For questions or concerns about your NHP coverage, contact NHP's Customer Care Center at 800-462-5449 or TTY 800-655-1761, available Monday through Friday, 8:00 a.m.–6:00 p.m. (Thursday 8:00 a.m.–8:00 p.m.)

Utilization Management Program

The Utilization Management standards NHP uses were created to assure our members consistently receive high quality, appropriate medical care. To determine coverage, specific criteria is used to make Utilization

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Management decisions. This criteria is developed by physicians and meets the standards of national accreditation organizations. As new treatments and technologies become available, NHP updates its Utilization Management standards annually.

To make utilization decisions, NHP conducts, concurrent, and retrospective reviews of the health care services our members use.

Prospective Review

Determines if a procedure or treatment either you or your doctor is requesting is both medically appropriate and medically necessary.

Concurrent Review

During the course of treatment, such as hospitalization, concurrent review monitors the progress of treatment and determines for how long it will be deemed medically necessary.

Retrospective Review

After care has been provided, NHP reviews treatment outcomes to ensure that the health care services provided to you met certain quality standards.

Care Management

When members have a severe or chronic illness or condition, they may qualify for Care Management. NHP's care managers work one-on-one with members and their providers to find the most appropriate and cost-effective ways to manage a condition. Together, a treatment plan that best meets the member's needs is developed with the goal of promoting patient education, self-care, and providing access to the right kinds of health care services and options.

By completing the Health Needs Assessment that every new NHP member receives as part of their member kit, our care managers can identify any potential unmet needs that may benefit by care management assistance. Care managers then reach out to the member to see if they would be interested in joining one of our care management programs.

To learn more about Utilization Management or Care Management at NHP, please refer to your NHP Member Handbook or contact our Customer Care Center at 800-462-5449.

Exclusions

NHP does not cover the following services or supplies:

Acupuncture; Benefits From Other Sources; Biofeedback; Blood and Related Fees* Chiropractic Care; Cosmetic Services and Procedures; Custodial Care; Dentures; Diet Foods; Educational Testing and Evaluations; Exams Required by a Third Party; Experimental Services and Procedures; Eyewear/Laser Eyesight Correction;* Foot Care;* Gender Re-Assignment Surgery; Health Club Membership;† Hearing Aids; Massage Therapy; Non-Covered Providers; Personal Comfort Items; Reversal of Voluntary Sterilization; Self-Monitoring Devices*

*Except as specified in the NHP Member Handbook.

†Unless a specific discount or reimbursement for such memberships is identified as part of your plan.

NHP CareThree Select

Benefit summary

A Business Choice plan



This health plan meets **Minimum Creditable Coverage standards** and will satisfy the individual mandate that you have health insurance.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan meets **Minimum Creditable Coverage standards** that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

This disclosure is for minimum creditable coverage standards that are effective January 1, 2009. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards.

If you have questions about this notice, you may contact the Division of Insurance by calling 617-521-7794 or visiting its website at www.mass.gov/doi.



nhp.org



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 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. The NHP Member Handbook may include additional coverages and/or exclusions not listed on the Benefit Summary.

Select plans include a subset of NHP's full primary care network. Select providers include NHP's network of Community Health Centers, Harvard Vanguard Medical Associates, Lahey Clinic, Beth Israel Deaconess Medical Associates, and select other contracted providers.

| | |
|--|--|
| 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% |

| <i>OUTPATIENT MEDICAL CARE</i> | <i>COPAYMENT</i> |
|--|---------------------------------------|
| 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 |
| Colonoscopies* | Subject to deductible and coinsurance |
| Routine Laboratory Tests | Included in office visit |
| X-Rays and Diagnostic Tests* | Subject to deductible and coinsurance |

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

| <i>MENTAL HEALTH AND SUBSTANCE ABUSE CARE—OUTPATIENT</i> | <i>COPAYMENT</i> |
|--|-----------------------|
| Mental Health | \$25 per office visit |
| Substance Abuse Care | \$25 per office visit |

| <i>MENTAL HEALTH AND SUBSTANCE ABUSE CARE – INPATIENT</i> | <i>COPAYMENT</i> |
|---|------------------|
| Mental Health Care | No copayment |
| Substance Abuse Detoxification | No copayment |
| Substance Abuse Rehabilitation | No copayment |

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

| <i>EMERGENCY CARE</i> | <i>COPAYMENT</i> |
|---|---|
| <i>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.</i> | |
| 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) |

| <i>DENTAL CARE</i> | <i>COPAYMENT</i> |
|--|---|
| 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 |

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

†Cost of 60-day supply of medication.

| <i>OVER-THE-COUNTER DRUGS</i> | <i>COPAYMENT</i> |
|---|---|
| Select generic over-the-counter cough, cold and allergy medicines with a valid prescription and purchased at a participating pharmacy for up to a 30-day supply | \$0 to 50% coinsurance (depending on drug prescribed) |

For a complete list of over-the-counter drugs, visit www.nhp.org or contact our Customer Care Center at 800-462-5449 or TTY 800-655-1761.

| <i>ADDITIONAL SERVICES</i> | <i>COPAYMENT</i> |
|------------------------------------|---|
| 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 |
| Early Intervention | No copayment (from birth up to age three, up to \$5,200 per calendar year with a lifetime maximum of \$15,600) |
| Fitness Club Reimbursement† | \$150 Individual, \$300 Family, per calendar year |
| Home Health Care | No copayment |
| Hospice..... | No copayment |

‡NHP members enrolled in this plan are eligible to receive up to \$150 reimbursement, per individual, up to a maximum of \$300 per family, per calendar year toward health club membership at qualifying facilities. Reimbursement amounts may not exceed the amount paid for the membership. To be eligible, members must be enrolled in NHP for at least four months and submit their reimbursement requests by March 31 of the following calendar year. For additional information, please visit www.nhp.org or call our Customer Care Center at 800-462-5449.



Neighborhood Health PlanTM

Your health. Our promise.

*Applies to \$5,000 Individual/\$10,000 Family Out-of-Pocket Maximum per Calendar Year.

This Benefit Summary and the NHP Member Handbook comprise the Evidence of Coverage for NHP members.



Neighborhood Health Plan™

Dear NHP Member:

As you know, your NHP plan has a deductible that applies to diagnostic testing, as well as other services. This document is intended to explain those diagnostic tests that are considered routine, and thus excluded from your deductible obligation, and those diagnostic tests that are considered non-routine, and thus subject to a deductible.

NHP has relied upon the recommendations of the Massachusetts Health Quality Partners’ (MHQP)* Guidelines for Adult Preventive Care, Pediatric Preventive Care and Perinatal Care in order to determine which tests are routine, and which tests are non-routine. Those guidelines provide recommendations for the types of tests that should be included in all preventive and perinatal care doctor visits. NHP has endorsed those guidelines and we encourage our providers to follow them.

| Tests Not Subject to Deductible | Tests Subject to Deductible |
|---|--|
| Hemoglobin and hematocrit tests | All other tests, including but not limited to: |
| Hemoglobin electrophoresis | Colonoscopy |
| Blood type and antibody screen | Sigmoidoscopy |
| Fasting lipoprotein profile (cholesterol tests) | X-rays |
| Fasting blood glucose | Electrocardiogram (EKG) |
| Glucose tolerance test | Magnetic Resonance Imaging (MRI) |
| Serology testing for all sexually transmitted diseases, including chlamydia, gonorrhea, and syphilis. | Computerized Axial Tomography (CAT scan) |
| HIV serology test | Ultrasound |
| Hepatitis B and C serology tests | Thyroid test |
| Serology screening for rubella | Hemoglobin A1c (diabetic) test |
| Prostate specific antigen (PSA) | |
| Alpha-fetoprotein screening test (AFP) | |
| Group B strep test (GBS) | |
| Lead screening | |
| Routine urinalysis | |
| Urine dipstick for protein and glucose | |
| Urine cultures | |
| Fecal occult blood test | |
| TB skin test | |
| Pap smear (cervical cancer screening test) | |
| Mammogram | |

*MHQP brings together a large number of Massachusetts health care organizations—including the MA Department of Public Health, MA Medical Society, MA Hospital Association, physician specialty societies and several major health plans—to endorse and disseminate a variety of evidence-based practice guidelines.

For further information contact NHP’s Customer Care Center at 1-800-462-5449 (TTY 1-800-655-1761), Monday, Tuesday, Wednesday and Friday 8:00 a.m. to 6:00 p.m., and Thursday 8:00 a.m. to 8:00 p.m.

