

# 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 deductible and coinsurance amounts paid for 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.

**Neighborhood Health Plan**  
*Getting better together.*

*Coverage within reach.  
Care beyond expectations.*



# NHP Three Select Neighborhood Health Plan

## *Benefit Summary*

Issued and Effective July 1, 2007

To contact the Health Connector call 1-877-MA-ENROLL or go to their Web site, [MAHealthConnector.org](http://MAHealthConnector.org).

# NHP Three 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 %

## 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 ■ (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

## MENTAL HEALTH AND SUBSTANCE ABUSE CARE – OUTPATIENT

### COPAYMENT

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

## MENTAL HEALTH AND SUBSTANCE ABUSE CARE – INPATIENT

### COPAYMENT

Mental Health Care (biologically based and other state mandated coverage - no limit, non biologically based covered in full up to 60 days per member per calendar year) .....	No copayment
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

The following copayments apply after deductible has been met:

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 preferred brand ◆ non-preferred brand ◆
◆ 2 times 30-day supply retail cost	

## OVER-THE-COUNTER DRUGS

### COPAYMENT

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 % copayment (depending on drug prescribed)
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For a complete list of over-the-counter drugs, visit [www.nhp.org](http://www.nhp.org) or contact our Customer Care Center at 800-462-5449 or TTY 800-655-1761.

## 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
Early Intervention (from birth up to age three, up to \$5,200 per calendar year with a lifetime maximum of \$15,600) .....	No copayment
Home Health Care .....	No copayment
Hospice .....	No copayment