NHP Prime HMO HSA 2000/4000 PY 40/85

TThis Schedule of Benefits 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 Customer Service at 800-462-5449 (TTY 800-655-1761). To find a provider, please visit www.nhp.org.

All covered services must be medically necessary and some may require prior authorization. Please check with your PCP or treating provider to determine if a prior authorization is necessary. The NHP Member Handbook may include additional coverage and/or exclusions not listed on the Schedule of Benefits.

MEDICAL CARE DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

Deductible per Plan Year	**Medical/Behavioral Health/ Prescription (Combined): $2,000 Individual, $4,000 Family**
Out-of-Pocket Maximum per Plan Year	**Medical/Behavioral Health/Prescription (Combined): $6,350 Individual, $12,700 Family**

OUTPATIENT MEDICAL CARE

Preventive Services

Annual Physical Exams	No copayment
Annual Gynecological Exams	No copayment
Well Child Visits	No copayment
Immunizations and Vaccinations	No copayment
Preventive Laboratory Tests	No copayment
Screening Colonoscopy	No copayment
Screening Mammography	No copayment

Other Primary & Specialty Care Office Visits

Office Visits for Other Primary Care	Subject to deductible, then $40 copayment
Office Visits for Other Specialty Care	Subject to deductible, then $85 copayment
Cardiac Rehabilitation Service	Subject to deductible, then $85 copayment
Chiropractic Care (12 visits per member per plan year)	Subject to deductible, then $40 copayment
Routine Eye Exams (one visit per member every 12 months)	Subject to deductible, then $85 copayment
Family Planning Services	No copayment
Hearing Exams	Subject to deductible, then $85 copayment
Infertility Services	Subject to deductible, then $85 copayment
Physical Therapy/Occupational Therapy (up to 60 visits combined per plan year)	Subject to deductible, then $40 copayment
Speech Therapy	Subject to deductible, then $40 copayment
Routine Prenatal and Postnatal Care	Subject to deductible

Other Outpatient Services

Allergy Shots	Subject to deductible
Diagnostic, Laboratory, and X-ray	Subject to deductible
High-tech Radiology (MRI, CT, PET Scan, Nuclear Cardiac Imaging)	Subject to deductible, then $750 copayment
Outpatient Surgery–Facility Fee	Subject to deductible, then $750 copayment
Outpatient Surgery–Professional Fee	Subject to deductible

INPATIENT MEDICAL CARE

Inpatient Medical Services—Facility Fee	Subject to deductible, then $1,000 copayment
Inpatient Medical Services—Professional Fee	Subject to deductible
Inpatient Care in a Skilled Nursing Facility (for up to 100 days per plan year)	Subject to deductible, then $1,000 copayment
Inpatient Care in a Skilled Nursing Facility—Professional Fee	Subject to deductible
Inpatient Care in a Rehabilitation Facility (for up to 60 days per plan year)	Subject to deductible, then $1,000 copayment
Inpatient Care in a Rehabilitation Facility—Professional Fee	Subject to deductible
Inpatient Maternity—Facility Fee	Subject to deductible, then $1,000 copayment
Inpatient Maternity—Professional Fee	Subject to deductible
Routine Nursery and Newborn Care	No copayment

BEHAVIORAL HEALTH SERVICES—OUTPATIENT

Mental Health (eight initial visits, then authorization required for additional visits)	Subject to deductible, then $40 copayment
Substance Abuse Care (eight initial visits, then authorization required for additional visits)	Subject to deductible, then $40 copayment

BEHAVIORAL HEALTH SERVICES—INPATIENT

Inpatient Mental Health Care—Facility Fee	Subject to deductible, then $1,000 copayment
Inpatient Mental Health Care—Professional Fee	Subject to deductible
Inpatient Substance Abuse Detoxification or Rehabilitation—Facility fee	Subject to deductible, then $1,000 copayment
Inpatient Substance Abuse Detoxification or Rehabilitation—Professional Fee	Subject to deductible

All Medical/Behavioral Health/Prescription combined Deductibles, Coinsurance, and Copayments (including Prescriptions) apply to the Medical Out-of-Pocket Maximum.

This Schedule of Benefits and the NHP Member Handbook (or Subscriber Agreement) comprise the Evidence of Coverage for NHP members covered on this health plan.

URGENT CARE

Care for an illness, injury or condition serious enough that a person would seek immediate care, but not so severe as to require Emergency room care.

Urgent Care	Subject to deductible, then $40 copayment

EMERGENCY CARE

If 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 $750 copayment (copayment waived if admitted to hospital)
Ambulance Services (emergency transport only)	Subject to deductible, then $750 copayment

DENTAL CARE

Emergency Dental Care (within 72 hours of accident or injury)	Subject to deductible, then $750 copayment (copayment waived if admitted to hospital)

PRESCRIPTION DRUGS

With a valid prescription and purchased at a participating pharmacy for up to a 30-day supply	Generic: Subject to deductible, then $50 copayment Preferred brand name: Subject to deductible, then $80 copayment Non-preferred brand name: Subject to deductible, then $120 copayment
Access 90: With a valid prescription for a 90-day supply of a maintenance medication and purchased through the mail or at a participating pharmacy	Generic: Subject to deductible, then $100 copayment Preferred brand name: Subject to deductible, then $160 copayment Non-preferred brand name: Subject to deductible, then $360 copayment

OVER-THE-COUNTER DRUGS

For a complete list of over-the-counter drugs, visit www.nhp.org or call NHP Customer Service at 800-462-5449 (TTY 800-655-1761).

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	Subject to deductible, then $0–$80 copayment (depending on drug prescribed)

ADDITIONAL SERVICES

Disposable Medical Supplies	Subject to deductible, then 20% coinsurance
Diabetic Supplies	Subject to deductible
Oxygen Supplies	Subject to deductible
Durable Medical Equipment	Subject to deductible, then 20% coinsurance
Early Intervention (from birth up to age three)	Subject to deductible
Fitness Program Benefit	Coverage for one month of membership fees (minimum of $150) at a qualified health club for either a covered Subscriber or one covered Dependent (see Member Handbook or www.nhp.org for qualifications)
Hearing Aids (age 21 and under)	Covered up to $2,000 for each affected ear every 36 months
Home Health Care	Subject to deductible
Hospice	Subject to deductible
Routine Foot Care (covered for diabetes and some circulatory diseases)	Subject to deductible, then $85 copayment
Weight Loss Program Benefit	Coverage for six months of membership fees in a Jenny Craig or Weight Watchers program for either a covered Subscriber or one covered Dependent (see Member Handbook or www.nhp.org for qualifications)
Wigs (scalp hair prosthesis for cancer patients)	Subject to deductible, then 20% coinsurance

For questions or concerns about your NHP coverage, call NHP Customer Service at 800-462-5449 (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.)

Neighborhood Health Plan™

Your health. Our promise.