

About your NHP membership

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 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.

Commonwealth Care

Benefit summary

Plan Type II



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 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 Commonwealth Care—Plan Type II

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.

You are covered for most routine, specialty, and hospital care. To receive benefits, care must be provided or arranged by an NHP Commonwealth Care Provider. Services may be subject to pre-authorization.

All services are subject to possible pre-authorization and medical necessity determination.

<i>OUTPATIENT MEDICAL CARE</i>	<i>COPAYMENT</i>
Office Visits for Primary Care.....	\$10 copayment
Office Visits for Specialty Care.....	\$18 copayment
Immunizations/Vaccinations.....	No copayment
Outpatient Surgery (Outpatient Hospital/Ambulatory Surgery Centers).....	\$50 copayment
X-Rays and lab tests.....	No copayment
Mammograms.....	No copayment
Abortion Services.....	\$50 copayment
<i>INPATIENT MEDICAL CARE</i>	<i>COPAYMENT</i>
Room and board (includes deliveries/surgery/x-rays/labs).....	\$50 copayment
<i>PRESCRIPTION DRUGS</i>	<i>COPAYMENT</i>
<i>Please see section "Maximum Annual Out-of-Pocket Expenses."</i>	
With a valid prescription and purchased at a participating pharmacy for up to a 30-day supply.....	\$10 generic \$20 preferred \$40 non-preferred brand
With a valid prescription for a maintenance medication and purchased through the mail program for a 90-day supply.....	\$20 generic \$40 preferred \$120 non-preferred brand
<i>OVER-THE-COUNTER DRUGS</i>	<i>COPAYMENT</i>
<i>Please see section "Maximum Annual Out-of-Pocket Expenses."</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.....	\$10–\$40 copayment (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>URGENT CARE</i>	<i>COPAYMENT</i>
Urgent Care provided at your primary care site or arranged by your NHP Provider.....	\$10 copayment
<i>EMERGENCY CARE</i>	<i>COPAYMENT</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.	
Care you receive in an emergency room, in or out of the NHP Service Area.....	\$50 per visit [†]

<i>MENTAL HEALTH AND SUBSTANCE ABUSE CARE—OUTPATIENT</i>	<i>COPAYMENT</i>
Mental Health/Substance Abuse Care.....	\$10 copayment
Substance Abuse Detoxification.....	\$10 copayment
Methadone treatment and related services.....	No copayment

<i>MENTAL HEALTH AND SUBSTANCE ABUSE CARE—INPATIENT</i>	<i>COPAYMENT</i>
Mental Health Care at a psychiatric hospital.....	\$50 copayment
Substance Abuse Rehabilitation.....	\$50 copayment
Substance Abuse Detoxification.....	\$50 copayment

<i>MENTAL HEALTH AND SUBSTANCE ABUSE CARE—DIVERSIONARY</i>	<i>COPAYMENT</i>
Community-based services (family stabilization teams, community support programs, community-based acute treatment/partial hospitalization, psychiatric day treatment and certain substance abuse programs).....	No copayment

<i>REHABILITATION SERVICES</i>	<i>COPAYMENT</i>
Extended Inpatient Care (100 combined days per Benefit Year)	
In a skilled nursing facility.....	No copayment
In a rehabilitation hospital or chronic disease hospital.....	\$50 copayment [†]
Short-term outpatient rehabilitation following injury or illness, including physical/occupational/speech therapy.....	
.....	\$10 copayment [†]
Home Health Care.....	No copayment
Cardiac Rehabilitation.....	No copayment

<i>ADDITIONAL SERVICES</i>	<i>COPAYMENT</i>
Ambulance Services (emergency transport only).....	No copayment
Durable Medical Equipment/Supplies/Prosthetics/Oxygen & Respiratory Therapy Equipment.....	No copayment
Hospice care.....	No copayment
Wellness (family planning/nutrition/prenatal/nurse midwife).....	No copayment
Orthotics.....	No copayment
Podiatry.....	\$5 copayment
Vision (exams and glasses every 24 months).....	\$10 copayment

<i>MAXIMUM ANNUAL OUT-OF-POCKET EXPENSES</i>	<i>COPAYMENT</i>
Pharmacy.....	\$500 copayments per benefit year [§]
The All Services out-of-pocket maximum.....	\$750 per benefit year [§]
	This includes services rendered that have a copayment, excluding pharmacy.

*Copayment waived if transferred from another inpatient unit.
[†]Copayment waived if admitted to an inpatient unit.
[‡]\$20 combined sessions of PT/OT/ST unless waived with prior authorization per benefit year.
[§]Benefit year is July 1 to June 30.

Not all Massachusetts Mandated Benefits are required to be included in Commonwealth Care Plans.

