Schedule of Benefits

NHP Prime™ HMO plan for GIC members

Exclusively for members of the Group Insurance Commission

This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance. Please see the last page for additional information.

Schedule of Benefits

This Schedule of Benefits is a general description of your coverage as a member of Neighborhood Health Plan (NHP). For more information about your benefits, log into **mynhp.org** to see your plan documents and get personalized information about your plan or call NHP Customer Service at **866-567-9175** (TTY 711).

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.

Specialty Care Provider Tiers: NHP tiers the following specialties: Allergy/Immunology, Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology & Oncology, Nephrology, Neurology, OB/GYN, Ophthalmology, Orthopedic Surgery, Podiatry, Pulmonology, Rheumatology, and Urology services. NHP based this Specialty Provider Tiering on quality and cost-efficiency standards authorized by the GIC for its Clinical Performance Improvement initiative (CPI). Each contracted specialist has been given a quality and cost-efficiency score based on the CPI data that places it into one of three levels:

*** Tier 1 (excellent) ** Tier 2 (good) * Tier 3 (standard)

- *** **Tier 1** Copayment is **$30** per office visit and includes specialists with the highest combined quality and cost-efficiency scores.
- ** **Tier 2** Copayment is **$60** per office visit and includes specialists with scores that fall within the middle range.
- * **Tier 3** Copayment is **$90** per office visit and includes specialists with standard scores.

Please note that the office visit Copayment for Specialty Providers who are not being tiered is **$60**. Your Copayment for outpatient Mental Health or Substance Use providers is **$20**.

Please refer to the NHP GIC Provider Directory to verify your Specialty Provider's tier. To obtain the most up-to-date information on NHP providers, please refer to the online provider directory at nhp.org/find-a-doctor.

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

Deductible per benefit period	**Medical/Behavioral Health (Combined): $500 Individual/$1,000 Family** **Prescription: $100/$200**
Out-of-Pocket Maximum per benefit period	**Medical/Behavioral Health/Prescription (Combined):** **$5,000 Individual/$10,000 Family**

The Deductible, Coinsurance and Copayments for Medical, Behavioral Health Services, and Prescription Drug expenses apply to the annual Out-of-Pocket Maximum. This Schedule of Benefits and the NHP Member Handbook comprise the Evidence of Coverage for NHP members covered on this health plan.

OUTPATIENT MEDICAL CARE

Preventive Services

Annual Physical Exams*	No Member Cost-Sharing
Annual Gynecological Exams*	No Member Cost-Sharing
Family Planning Services	No Member Cost-Sharing
Immunizations & Vaccinations	No Member Cost-Sharing
Preventive Laboratory Tests	No Member Cost-Sharing
Screening Colonoscopy	No Member Cost-Sharing
Screening Mammography	No Member Cost-Sharing
Well Child Visits	No Member Cost-Sharing

*Services for specific conditions during an annual exam may be subject to cost sharing.

Other Primary & Specialty Care Office Visits

(Some specialty copayments are tiered: Tier 1/Tier 2/Tier 3)	Tier 1	Tier 2	Tier 3
Office Visits for Other Primary Care	$20 copayment		
Allergy/Immunology	$30 copayment	$60 copayment	$90 copayment
Cardiology	$30 copayment	$60 copayment	$90 copayment
Dermatology	$30 copayment	$60 copayment	$90 copayment
Endocrinology	$30 copayment	$60 copayment	$90 copayment
ENT/Otolaryngology	$30 copayment	$60 copayment	$90 copayment
Gastroenterology	$30 copayment	$60 copayment	$90 copayment
General Surgery	$30 copayment	$60 copayment	$90 copayment
Hematology & Oncology	$30 copayment	$60 copayment	$90 copayment
Nephrology	$30 copayment	$60 copayment	$90 copayment
Neurology	$30 copayment	$60 copayment	$90 copayment
OB/GYN	$30 copayment	$60 copayment	$90 copayment
Ophthalmology	$30 copayment	$60 copayment	$90 copayment
Orthopedic Surgery	$30 copayment	$60 copayment	$90 copayment
Podiatry	$30 copayment	$60 copayment	$90 copayment
Pulmonology	$30 copayment	$60 copayment	$90 copayment
Rheumatology	$30 copayment	$60 copayment	$90 copayment
Urology	$30 copayment	$60 copayment	$90 copayment
Office Visits for Other Specialty Care	$60 copayment		
Allergy Shots	No Member Cost-Sharing		
Cardiac Rehabilitation Service	No Member Cost-Sharing		
Routine Eye Exams (one visit per member every 24 months)	$60 copayment		
Hearing Exams	$60 copayment		
Infertility Services	$60 copayment		
Physical Therapy/Occupational Therapy (up to 90 consecutive days per condition per benefit period)	$35 copayment		
Second Opinion (PCP)	$20 copayment		
Second Opinion (Tiered specialist)	$30 copayment	$60 copayment	$90 copayment
Second Opinion (Non-Tiered specialist)	$60 copayment		
Speech Therapy	$35 copayment		
Routine Prenatal and Postnatal Care	No Member Cost-Sharing		

Other Outpatient Services

Diagnostic, Laboratory and X-ray	Subject to deductible
High-tech Radiology (MRI, CT, PET Scan, Nuclear Cardiac Imaging)	$100 copayment, then subject to deductible (maximum of one copayment per day)
Outpatient Surgery—Facility Fee	$250 copayment, then subject to deductible*
Outpatient Surgery—Professional Fee	No Member Cost-Sharing

INPATIENT MEDICAL CARE

Inpatient Medical Services—Facility Fee	$275 copayment, then subject to deductible*
Inpatient Medical Services—Professional Fee	No Member Cost-Sharing
Inpatient Care in a Skilled Nursing Facility (for up to 100 days per benefit period)	Subject to deductible
Inpatient Care in a Skilled Nursing Facility—Professional Fee	Subject to deductible
Inpatient Care in a Rehabilitation Facility (for up to 60 days per benefit period)	$275 copayment, then subject to deductible*
Inpatient Care in a Rehabilitation Facility—Professional Fee	Subject to deductible
Inpatient Maternity—Facility Fee	$275 copayment, then subject to deductible*
Routine Nursery and Newborn Care	No Member Cost-Sharing

*Per admission/occurrence with a cap of four copayments per benefit period, with a maximum of one inpatient copayment per quarter. Inpatient copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital: you must contact NHP to have the copayment waived.

BEHAVIORAL HEALTH SERVICES—OUTPATIENT

Mental Health Care or Substance Use Care	$20 copayment

BEHAVIORAL HEALTH SERVICES—INPATIENT

Mental Health Care—Facility Fee	No Member Cost-Sharing
Mental Health Care—Professional Fee	No Member Cost-Sharing
Substance Use Detoxification or Rehabilitation—Facility Fee	No Member Cost-Sharing
Substance Use Detoxification or Rehabilitation—Professional Fee	No Member Cost-Sharing

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	$20 copayment

EMERGENCY CARE

In an emergency, go to the nearest emergency room or call 911. 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	$100 copayment, then subject to deductible (copayment waived if admitted to hospital for inpatient care)
Ambulance Services (emergency transport only)	Subject to deductible
Emergency Dental Care (within 72 hours of accident or injury)	$100 copayment, then subject to deductible (copayment waived if admitted to hospital for inpatient care)

PRESCRIPTION DRUGS

With a valid prescription and purchased at a participating pharmacy for up to a 30-day supply	Generic: Subject to prescription deductible, then $10 copayment Preferred brand-name: Subject to prescription deductible, then $30 copayment Non-preferred brand-name: Subject to prescription deductible, then $65 copayment
Access90: 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 prescription deductible, then $25 copayment Preferred brand-name: Subject to prescription deductible, then $75 copayment Non-preferred brand-name: Subject to prescription deductible, then $165 copayment

OVER-THE-COUNTER DRUGS

For a complete list of over-the-counter drugs, visit www.nhp.org or call NHP Customer Service at 1-866-567-9175 (TTY 711).

Select generic over-the-counter medicines and products with a valid prescription and purchased at a participating pharmacy.	Subject to prescription deductible, then $0-$30 copayment (depending on drug prescribed)

ADDITIONAL SERVICES

Diabetic Supplies	No Member Cost-Sharing
Dialysis (inpatient or outpatient)	No Member Cost-Sharing
Disposable Medical Supplies	Subject to deductible
Durable Medical Equipment	Subject to deductible
Early Intervention (from birth up to age three)	No Member Cost-Sharing
Fitness Program Reimbursement	Up to $150/Individual, $300/Family per calendar year
Hearing Aids (age 21 and under)	Covered up to $2,000 per affected ear every 36 months
Hearing Aids (age 22 and older)	Covered up to $1,700 every 2 years
Home Health Care	No Member Cost-Sharing
Hospice Care	No Member Cost-Sharing
Orthotics	Subject to deductible
Oxygen Supplies and Therapy	No Member Cost-Sharing
Prosthetic Devices	Subject to deductible
Radiation and Chemotherapy	No Member Cost-Sharing
Routine Foot Care (covered for diabetes and some circulatory diseases)	$60 copayment
Smoking Cessation (up to 300 minutes of counseling per benefit period, including telephonic counseling)	No Member Cost-Sharing
Wigs (when medically necessary for hair loss due to cancer treatment or other conditions)	Subject to deductible

ABOUT YOUR NHP MEMBERSHIP

For questions or concerns about your NHP coverage, call NHP Customer Service at 1-866-567-9175 (TTY 711), available Monday through Friday, 8:00 a.m.–6:00 p.m. (Thursday 8:00 a.m.–8:00 p.m.)

Benefit Period
Your benefit period resets on your employer's anniversary date.

Copayments, Coinsurance, or Deductibles Required for Certain Services
Before coverage begins for certain services, you pay a deductible each benefit period. Your Plan deductible is an amount you pay for certain services each benefit period. For some services, before the deductible is satisfied, members may also be required to pay a copayment.

All members are responsible for the individual deductible per benefit period. Family member's deductible payments contribute toward the family deductible per benefit period. The family deductible can be satisfied by combining the deductibles paid for by covered family members. Each family member's contribution will not exceed the amount set for an individual deductible.

All medical, behavioral health, and prescription drug copayments, deductibles and coinsurance amounts paid apply toward the out-of-pocket maximum. Once the individual out-of-pocket maximum is satisfied, these services are covered for the member in full through the remainder of the benefit period. The family out-of-pocket maximum is satisfied by combining the deductible, coinsurance, and copayment amounts paid by covered family members. Once the family out-of-pocket maximum is satisfied, these services are covered for all family members in full through the remainder of the benefit period.

Your Primary Care Provider (PCP)
Your PCP arranges your health care and is the first person you call when you need medical care. Be sure to check with your PCP to find out office hours and whether urgent care is offered.

NHP requires the designation of a PCP. You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP.

For information on how to select a PCP, or a list of the most up-to date provider information, or a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.nhp.org or call NHP Customer Service.

Preventive Care Services
NHP covers eligible preventive services for adults, women (including pregnant women) and children, which includes coverage for annual physical exams, immunizations, well child visits and annual gynecological exams. For a complete list of eligible preventive care services, please visit www.nhp.org or call NHP Customer Service.

Primary Care Provider (PCP) and Obstetrical Rights
You do not need prior authorization from NHP or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. However, the health care professional may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

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 or an earache.

Emergency Care
In an emergency, go to the nearest emergency room or call 911. Please refer to this Schedule of Benefits for your cost sharing amount. If you pay a copayment, it is waived if you are admitted to the hospital for inpatient care. All follow-up care must be arranged by your PCP. You, or someone on your behalf, should notify your PCP within 48 hours.

Referrals
NHP requires referral for specialist services provided by in-network NHP Providers, except the following: Gynecologist or Obstetrician for routine, preventive or urgent care; Family Planning services; Outpatient and Diversionary Behavioral Health Services; Physical Therapy; Occupational Therapy; Speech Therapy; Routine Eye exam; and Emergency Services.

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 are used to make Utilization Management decisions. These criteria are developed by physicians and meet the standards of national accreditation organizations. As new treatments and technologies become available, we update our Utilization Management standards annually.

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

Initial Determination *(Prospective Review or Prior Authorization)*
Determines in advance 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.

To learn more about Utilization Management or Care Management at NHP, please refer to your NHP Member Handbook or call NHP Customer Service.

Benefit Exclusions
Services or supplies that NHP does not cover include: Acupuncture; Benefits from other sources; Diet foods; Educational testing and evaluations; Massage therapy; Out-of-network providers; Non-emergency care when traveling outside the U.S.

Additional benefit exclusions apply, for a complete list please refer to your GIC Member Handbook.

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, 2017 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, 2017. 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.