

\$25 / \$45 / \$1500



Neighborhood Health Partnership

A UnitedHealthcare Company

HMO

SUMMARY OF BENEFITS

A quick glance at this Summary of Benefits will introduce you to the important advantages of the Neighborhood Health Partnership (NHP) HMO.

The Summary of Benefits, although a helpful tool, is only a summary. Always refer to your Member Handbook for a fuller explanation of your coverage or call Member Services at 305-715-2500 or 1-800-354-0222 when you have a question about your plan. In the event of a conflict between this Summary of Benefits and the Member Handbook, the Member Handbook will control.

Services must be provided by health care providers which have contracts with NHP, referred to as "Plan Providers", "Plan Physicians" or "Plan Hospitals", unless in an Emergency or upon prior authorization by Plan.

Features	Coverage When Care Is Managed By Your PCP												
Co-payments	<table><tbody><tr><td>Primary Care Physician (PCP) (Office Visit)</td><td>\$25</td></tr><tr><td>Specialist (Office Visit)</td><td>\$45</td></tr><tr><td>Urgent Care Center</td><td>\$50</td></tr><tr><td>Radiology</td><td>\$100 per service after deductible</td></tr><tr><td>Outpatient Therapy</td><td>\$50</td></tr><tr><td>Allergy Testing</td><td>\$25 per visit</td></tr></tbody></table>	Primary Care Physician (PCP) (Office Visit)	\$25	Specialist (Office Visit)	\$45	Urgent Care Center	\$50	Radiology	\$100 per service after deductible	Outpatient Therapy	\$50	Allergy Testing	\$25 per visit
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Deductible	All benefits not subject to a co-payment are subject to a calendar year deductible of \$1,500 per member, or \$3,000 per family, whichever comes first.												
Co-Insurance	100% once calendar year deductible is met. Co-payments may apply.												
Out of Pocket Maximum for Co-payments	The limit which you and your eligible family members have on the amount of co-payments you will be required to pay in a Calendar Year is: \$3,000 per Member per Calendar Year.												
Primary Care Physician	Your PCP is responsible for coordinating all your health care services, including referrals to Specialists. Your PCP or Specialist must obtain Pre-Authorization for designated services, including but not limited to: all inpatient care, outpatient surgical procedures, durable medical equipment (DME), home health services, home infusion, hospice care, rehabilitation, skilled nursing facility, transplants and other services.												
Referrals	Your PCP is responsible for coordinating all referrals to specialists, except for the following specialties which you may directly access, as indicated: <ul style="list-style-type: none">• Gynecology (a well woman exam and visits for necessary follow-up). Additional visits require referrals.• Podiatry.• Chiropractic. Coverage is limited to 12 visits per year.• Dermatology (5 visits per calendar year). Additional visits require referrals.• Alcohol/chemical dependency treatment. Services must be provided by NHP's behavioral health network.• Mental health. Services must be provided by NHP's behavioral health network.												
Prescription Drugs	<ul style="list-style-type: none">• If your Employer has elected to provide coverage for prescription drugs, you will receive a copy of a Prescription Drug Rider setting forth your prescription drug coverage.												

YOUR NHP PLAN COVERAGE

IMPORTANT NOTICE: Unless otherwise stated, care, services or treatment not managed by your Primary Care Physician, not Medically Necessary, or not prior authorized by NHP are not Covered Services. Services must be provided by Plan Providers, except when prior authorized or in the case of an Emergency Medical Condition. **You must check your Member Handbook for further details relating to your coverage.**

Services & Supplies	Coverage When Care Is Managed By Your PCP
Alcohol, drug, chemical dependency <i>(Services must be provided by NHP's behavioral health network)</i>	Maximum benefit of \$2,000 per calendar year. PCP referral not required. <i>Outpatient:</i> 100% after \$45 co-payment. <i>Inpatient:</i> limited to crisis intervention for medical detoxification only, covered at 100% for hospital admission, after \$500 co-payment per day (5 day maximum).
Ambulance	100% after deductible in emergency situations only, or when authorized by NHP to transfer you to an NHP facility.
Chiropractic services	100% after \$45 co-payment; limited to 12 treatments per calendar year; PCP referral not required.
Dermatology	100% after \$45 office visit co-payment; PCP referral not required for 5 visits per calendar year; further visits require PCP referral.
Diabetes	100% after \$45 office visit co-payment; services include outpatient self management training and educational services.
DME and disposable medical supplies	100% of DME and disposable medical supplies used in connection with DME; limited to a lifetime medical maximum benefit of \$2,500.
Emergency room services	100% after deductible for emergencies (deductible for emergency room waived if patient is admitted to hospital).
Family Planning	100% surgical sterilization, implantable contraceptives and intrauterine birth control devices.
Gynecology	100% after \$45 office visit co-payment; PCP referral not required for one well-women exam and necessary follow-up thereto; further visits require a PCP referral.
Hearing exams <i>(children through age 17)</i>	100% when performed by PCP, to determine need for hearing correction; one exam per Calendar Year.
Home health services	100% for up to 60 visits per calendar year or spell of illness; custodial care is not covered.
Home infusion services	100% for up to 60 visits per calendar year or spell of illness.
Hospice care	100% after deductible to lifetime maximum benefit of 180 days.
Hospital care	100% after deductible for inpatient; 100% after deductible for outpatient surgery.
Laboratory, X-rays and other diagnostic services	100%. \$100 copay for MRI, MRA, CAT, PET, and Nuclear Testing after deductible.
Mammograms	100% for one baseline for women age 35 through 39, one every year for women age 40 and over, or more frequently based on physician's recommendation.
Mastectomy	100% after deductible.
Maternity care, including pre- and post- natal care, delivery*	100% after \$45 co-payment for initial OB visit; Inpatient: 100% after deductible.

Services & Supplies	Coverage When Care Is Managed By Your PCP
Mental health <i>(Services must be provided by NHP's behavioral health network)</i>	<i>Outpatient:</i> 100% after \$45 co-payment; maximum of 20 visits per calendar year. PCP referral not required. <i>Inpatient:</i> 100% for hospital admission, after \$500 co-payment per day (5 day maximum) per admission; maximum benefit period of 30 days per calendar year.
Newborn Children*	100% after \$25 co-payment for well baby care and treatment of illness or injury, including congenital defects and prematurity.
Organ Transplant Services	100% after applicable co-payments, after prior approval by NHP Medical Director.
Osteoporosis	100% after \$45 co-payment for diagnosis and treatment of high-risk individuals.
Outpatient therapies	100% after \$50 co-payment for physical (including chest physiotherapy), respiratory, speech, cardiac and occupational therapy up to 20 visits per calendar year max per modality; 36 max for cardiac therapy.
Physical Rehabilitation	100% limited to 60 days of inpatient stay for restorative physical therapy.
Physician Services for Surgery	100%
Podiatry	100% after \$45 co-payment; PCP referral not required.
Preventive health services	100% after \$25 co-payment.
Primary Care Physician (PCP) office visit	100% after \$25 co-pay; only by your designated PCP. 100% for office surgery.
Prosthetic Devices	100% limited to one prosthetic per loss of limb or eye.
Skilled nursing facility	100% after deductible for up to 120 days per calendar year or spell of illness; custodial care is not covered.
Specialist office visits	100% after \$45 co-payment; PCP referral required unless direct access is allowed, as indicated. 100% for office surgery.
Sterilization	100% for outpatient tubal ligation or vasectomy; Inpatient: 100% after deductible.
Urgent Care Center	\$50 co-payment per visit.
Vision screening <i>(children through age 17)</i>	100% when performed by PCP, to determine need for vision correction; one exam per Calendar Year.

* For coverage to begin at date of birth for newborn children, a completed and signed enrollment form must be received by the Plan within 30 days of birth and no additional premium will be charged for such 30 day period. This notice period is extended to 60 days from the date of birth with no waiver of premium for the first 30 days. If the enrollment form is not received within 60 days of birth, the newborn child will be a Late Enrollee under the Plan. You must enroll your newborn within these time periods regardless of whether your coverage is family coverage.

A full list and description of benefits are in your Member Handbook.

Your Member Handbook also lists the Exclusions, Limitations and Restrictions which apply.

You have coverage for Prescription Drugs only if your Employer/Group has elected to obtain a Prescription Drug Rider.

EXCLUSIONS

For a Complete List and Description of Exclusions, Please Consult The Member Handbook

NO BENEFITS WILL BE PROVIDED FOR THE FOLLOWING SERVICES:

- Any services not authorized by your Primary Care Physician
- Any services which are not medically necessary
- Non-emergency care outside the NHP service area
- Any stay in a hospital or skilled nursing facility longer than authorized
- Conditions for which reimbursement is available from a government agency or program
- Television, newspaper, telephone, or other personal conveniences during a hospital stay
- Custodial Care or services relating to self care
- Cosmetic items, services or surgery
- Autopsy
- Dental evaluation or treatment
- Family or marital counseling services
- Treatment for learning disabilities, mental retardation, and other developmental disorders
- Hearing aids, eyeglasses, or contact lenses
- Services determined to be investigational, experimental or obsolete
- Examinations for insurance, employment screening, or licenses
- Services paid by or received from Workers' Compensation or any occupational or disease law
- Reversal of voluntary sterilization
- Artificial insemination and related services, including in-vitro fertilization or similar assisted fertilization services
- Treatment or surgery for infertility conditions
- Termination of pregnancy unless medically necessary for the physical health of the mother or for documented fetal abnormalities
- Long term physical (including chest physiotherapy), respiratory, occupational, cardiac or speech therapy
- Corsets, shoes (including orthopedic shoes), splints, orthotics and similar items
- Air conditioners, humidifiers, dehumidifiers, whirlpools, jacuzzis, swimming pools, or other similar items
- Services provided to evaluate scholastic and/or occupational ability, performance, or potential
- Educational or vocational training and supplies, unless otherwise stated
- Treatment and/or evaluation of complications arising from any non-covered service
- Any service not listed as a Covered Service
- Treatment for Illness or Injury relating to war or due to service in the armed forces
- Keloid removal
- Genetic testing or counseling, except when there is suspected fetal abnormality
- Any items or services related to or ordered by a court of law unless otherwise a Covered Service
- Services to treat wounds, injuries, or illness acquired while committing a crime
- Vision screening for members over the age of 17
- Vision exams for eyeglasses or contact lenses
- Hearing exams for members over the age of 17
- Acupressure, acupuncture, hypnosis, biofeedback or other complementary/alternative healing methods
- Medical or surgical treatment resulting from willfully failing to follow your physician's treatment plan
- Services for routine foot care
- Services for the treatment of obesity, or Morbid Obesity
- Smoking cessation
- Pre-natal or child birth classes
- Services provided by a member of household or relation by blood or marriage
- Inpatient Hospital Services for alcohol/chemical dependency, except for detoxification or acute symptoms
- Treatment for sexual dysfunction or sex change operations
- Charges or fees incurred from any non-Member of Neighborhood Health Partnership
- Private duty nurses
- Emergency room visits for an illness or injury that is not an emergency
- Charges which exceed usual, customary and reasonable charges for non-contracted Providers
- Treatment of a condition or complication resulting from being under the influence of alcohol or due to illegal drug use
- Prescriptions for outpatient medications, over the counter drugs and other medical supplies and equipment
- Illness or Injury resulting from participation in hazardous recreational activities
- Weight control, weight loss, health and fitness programs or nutritional consultants
- Circumcision, except within 30 days of birth or when Medically Necessary
- Treatment for erectile dysfunction, including penile implants
- Wigs or cranial prosthetics

See your Member Handbook for a complete list and description of Exclusions and other Limitations.