

FREEDOM 2500 SELECT PLAN

(No PCP Required, No Referral Required, No Network Required*)

SUMMARY OF BENEFITS

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

The Summary of Benefits, although a helpful tool, is only a summary. Always refer to your member handbook and riders for a detailed explanation of your coverage or call Member Services at 305-715-2500, 1-800-354-0222 (outside Miami-Dade) or for the hearing impaired please use (TTY) 305-715-2322, when you have a question about your plan. In the event of a conflict between this Summary of Benefits and the member handbook and riders, the member handbook and riders will control.

Features	Coverage												
Co-payments for in-network physician & urgent care visits	Type	New patient co-pay	Established patient co-pay										
	Provider 1	\$100	\$65										
	All other providers	\$150	\$90										
	Annual Routine Physical (age 2 and up)	\$45	\$45										
	Well-woman Visit	\$45	\$45										
	<i>see page 4 for details on provider categories</i>												
	Urgent Care Centers	\$145											
Deductible	All benefits not subject to a co-payment are subject to a calendar year deductible of \$2,500 per member, or \$5,000 per family, whichever comes first.												
Co-insurance	All benefits not subject to a co-payment are covered 100% once the calendar year deductible is met.												
Out-of-pocket maximums	There is no out-of-pocket maximum for co-payments.												
Out-of-network coverage	<p>Except for services listed in the Network-only coverage section below, this plan will process out-of-network claims at the following levels:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>Benefit</u></th> <th style="text-align: right;"><u>Reimbursement Level</u> <i>(As a % of Medicare Allowable Fee Schedule)</i></th> </tr> </thead> <tbody> <tr> <td>Hospital, Skilled Nursing Facility, Ambulatory Surgery Center, Urgent Care Center</td> <td style="text-align: right; vertical-align: top;">100%</td> </tr> <tr> <td>Physician</td> <td style="text-align: right; vertical-align: top;">80%</td> </tr> <tr> <td>Diagnostic Services</td> <td style="text-align: right; vertical-align: top;">50%</td> </tr> <tr> <td>All other covered benefits**</td> <td style="text-align: right; vertical-align: top;">100%</td> </tr> </tbody> </table> <p>**For ambulance services, ordinance rates will apply where required by law.</p> <p>The member will be responsible for any amount that the provider bills in excess of the plan reimbursement level. Any out-of-network claims that are applied to the deductible will be applied at the level of Medicare Allowable Fee Schedule indicated above.</p>			<u>Benefit</u>	<u>Reimbursement Level</u> <i>(As a % of Medicare Allowable Fee Schedule)</i>	Hospital, Skilled Nursing Facility, Ambulatory Surgery Center, Urgent Care Center	100%	Physician	80%	Diagnostic Services	50%	All other covered benefits**	100%
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Network-only coverage	<p>You must use network providers to receive coverage for the following services:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>Benefit</u></th> <th></th> </tr> </thead> <tbody> <tr> <td>Mental Health/Substance Abuse/Alcoholism</td> <td>Podiatry</td> </tr> <tr> <td>Laboratory Services</td> <td>Chiropractic</td> </tr> <tr> <td>Home Health, DME, Infusion</td> <td>Rehabilitative Therapy</td> </tr> <tr> <td></td> <td>Diabetes Supplies & Equipment</td> </tr> </tbody> </table> <p><i>Call Member Services for access to these providers</i></p>			<u>Benefit</u>		Mental Health/Substance Abuse/Alcoholism	Podiatry	Laboratory Services	Chiropractic	Home Health, DME, Infusion	Rehabilitative Therapy		Diabetes Supplies & Equipment
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Mental Health/Substance Abuse/Alcoholism	Podiatry												
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*Other than services listed in the Network only coverage section.

YOUR NHP PLAN COVERAGE

IMPORTANT NOTICE: Unless otherwise stated, care, services or treatment, not medically necessary, or not prior authorized by NHP are not covered services. *You must check your member handbook and riders for further details relating to your coverage. In the event of a conflict between this Summary of Benefits and the member handbook and riders, the member handbook and riders will control.*

Features		Requirements
Authorizations	<p>Your provider must obtain pre-certification 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. If these services are not pre-certified, a 20% reduction of benefit level will apply.</p> <p><i>Contact Medical Management at 305-715-2600 (Miami-Dade) or 1-800-550-5568.</i></p>	
Diagnostic Services	<p>In order to qualify for network-level benefits, the following services must be performed by a provider in the DMS network or in the office of an in-network physician: MRIs, MRAs, CT scans, PET scans, nuclear stress tests, diagnostic non-obstetrical ultrasounds, and echocardiograms including doppler studies.</p>	
Services & supplies		Coverage
Hospital services	<ul style="list-style-type: none"> • Inpatient care (medical, surgical, maternity and physical rehabilitation admissions) • Outpatient non-surgical care • Outpatient surgical care • Emergency room services • Diabetes outpatient self-management training and educational services 	100% after \$2,500 deductible Urgent Care Centers
Physician Office Visit	<p>Covered services include:</p> <ul style="list-style-type: none"> • Physical exams • X-ray • Laboratory Services • Well-child care • Hearing exams (children through age 17; one exam per calendar year) • Vision screening (children through age 17 to determine need for vision correction; one exam per calendar year) • Preventive health services • Intrauterine birth-control devices • Immunizations <p>Note: Services other than those listed above may be subject to additional co-payments and deductible as listed herein.</p>	100% after applicable co-payment per visit
Allergy Testing & Treatment	Performed in a Physicians Office	100% after \$40 co-payment
Urgent Care Centers	All available services	100% after \$145 co-payment
Mental health <i>(Services must be provided through Psych/Care, Inc.)</i>	<ul style="list-style-type: none"> • Inpatient (maximum benefit period of 30 days per calendar year) • Outpatient professional office visit (maximum of 20 visits per calendar year) 	<p>100% after \$2,500 deductible</p> <p>100% after co-payment per schedule</p>

Services & supplies		Coverage
Alcohol, drug, chemical dependency <i>(Services must be provided through Psych/Care, Inc.)</i>	<ul style="list-style-type: none"> Inpatient (limited to crisis intervention for medical detoxification only) Outpatient professional office visit <i>Maximum benefit of \$2000 per calendar year</i>	<p>100% after \$2,500 deductible</p> <p>100% after co-payment per schedule</p>
Rehabilitative Therapy	<ul style="list-style-type: none"> Physical, respiratory, speech, cardiac, and occupational therapy (up to 60 visits per calendar year for all services combined) 	100% after \$55 co-payment per visit
Other medical services	<ul style="list-style-type: none"> Chiropractic services (limited to 12 treatments per year) Prenatal physician office services, including one OB ultrasound between weeks 13 and 24 of pregnancy (co-payment applies for initial OB visit only) Podiatry 	100% after co-payment per schedule
	<ul style="list-style-type: none"> Injections (Chemotherapy, Pain Management & other Provider administered injections) Transplants Cancer Radiation Treatments Skilled nursing facility (up to 120 days per calendar year or spell of illness; custodial care is not covered) Ambulance Diabetes supplies & equipment (available through Express Scripts Inc. only) Sterilization (not performed in physician office) Office Surgery Cardiac testing included but not limited to: EKG, Stress Tests, catheterization High Cost Diagnostic Services; MRIs, MRAs, CT scans, PET scans, nuclear stress tests, diagnostic non-obstetrical ultrasounds, and echocardiograms including doppler studies. X-rays and other diagnostic services (not performed in physicians office) Physician services for maternity delivery 	100% after \$2,500 deductible
	<ul style="list-style-type: none"> Hospice services (up to lifetime maximum benefit of 180 days) Prosthetic devices (limited to one prosthetic per loss of limb or eye) Mammograms (includes 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) Home healthcare (up to 20 visits per calendar year or spell of illness; custodial care not included) Home infusion services (up to 20 visits per calendar year or spell of illness) Durable medical equipment and disposable medical supplies (limited to a lifetime medical maximum benefit of \$2,500) Laboratory services obtained through Quest Diagnostics or performed in the physician office. 	<p>100%</p> <p>(not subject to deductible)</p>

PROVIDER 1 PHYSICIANS

Dermatologist
Family Practitioner
General Practitioner
General Pediatrician
Internal Medicine
Mental Health/Substance
Abuse Counselors

In order to enroll a newborn child, the plan must receive a completed and signed enrollment form within 60 days of the date of birth. If the child is enrolled within 30 days of birth, no additional premium will be charged for the first 30 days of coverage. If the child is enrolled between 31 and 60 days of birth, additional premium for the child will be charged from the date of birth. For newborn children timely enrolled within 60 days of the date of birth, coverage shall be effective as of the date of birth. If the newborn child is not enrolled within 60 days of birth, the newborn child will not be eligible to enroll until the next open enrollment period. 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 and riders.

Your member handbook and riders lists the exclusions, limitations and restrictions which apply.



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305-715-2500 • 1-800-354-0222 (outside Miami-Dade)

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