Schedule of Benefits

HPHC Insurance Company, Inc.

Medicare Enhance
MASSACHUSETTS

This Schedule of Benefits summarizes your coverage under Medicare Enhance ("the Plan") and states the Subscriber cost-sharing amounts that you must pay for Covered Services. However, it is only a summary of your benefits. Please see your *Benefit Handbook* for detailed information on the benefits covered by the Plan and the terms and conditions of coverage.

Please note that the information on Medicare benefits in this document is provided for informational purposes only. HPHC Insurance Company, Inc. (HPIC) is not responsible for Medicare benefits. Please refer to the Medicare handbook *Medicare & You* or contact the Centers for Medicare and Medicaid Services (CMS) at **1-800-MEDICARE (1-800-633-4227)** or **www.medicare.gov** for information on your Medicare benefits.

Section 1: Subscriber Cost Sharing (What You Pay)

Subscribers are required to share the cost of the benefits provided under the Plan. Please see the tables below for a detailed list of the cost sharing that applies to your Employer Group's plan.

A Copayment is a dollar amount that is payable by the Subscriber for certain Covered Services. The Copayment is due at the time services are rendered or when billed by the Provider. Your identification card contains the Copayment amounts that apply to the Plan's most frequently used services.

Payment Maximum: The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any Subscriber cost-sharing amounts that apply under your Plan. If your Plan provides coverage for a service that is not covered by Medicare, the Plan will pay all charges up to the Payment Maximum minus the applicable cost sharing.

Section 2: Preventive Care Services

Medicare covers a number of preventive care services at no cost to Subscribers. The Plan will pay the Medicare Deductible and Coinsurance amounts, if any, for Medicare-covered preventive care services.

Medicare coverage includes a one-time "Welcome to Medicare" preventive visit received within the first 12 months a beneficiary is covered by Medicare Part B. HPIC recommends that Subscribers utilize this benefit if available. After being enrolled in Medicare Part B for one year, Medicare also covers a yearly "Wellness" visit. Your first yearly "Wellness" visit must occur 12 months after your Part B enrollment or your "Welcome to Medicare" preventive visit.

When specific Medicare coverage criteria are met, Medicare also provides coverage for preventive services including, but not limited to: (1) Pap tests, pelvic and breast exams; (2) Mammograms; (3) Prostate cancer screenings; (4) Diabetes screenings; (5) Bone mass measurements; (6) Glaucoma tests; (7) Medical nutrition therapy services; (8) Counseling to prevent tobacco use & tobacco-caused disease; (9) Colorectal cancer screenings, including fecal occult blood tests, flexible sigmoidoscopy, colonoscopy and barium enema; and (10) Immunizations for flu, pneumococcal shots and hepatitis B shots.

The Plan will also provide coverage, less any payments by Medicare, for the following preventive care services: annual routine physical exams, annual routine eye exams, and annual routine hearing exams. Please refer to Section III.D.2. of your Benefit Handbook for detailed information on additional preventive care services covered by the Plan.

Section 3: Emergency Coverage Outside of the United States

Your Plan provides limited emergency coverage for Subscribers traveling outside of the United States. Please refer to Section III.D.3. of your Benefit Handbook for details of your coverage.

Section 4: Inpatient Services Covered by Medicare

Benefit Period: The way that Original Medicare measures a Subscriber's use of Hospital and Skilled Nursing Facility services. A Medicare Benefit Period begins the first day of a Medicare-covered stay at an inpatient Hospital or Skilled Nursing Facility. It ends when you have not received any inpatient Hospital care or Skilled Nursing Facility care for 60 days in a row. If you go into a Hospital or a Skilled Nursing Facility after one Benefit Period has ended, a new Benefit Period begins. Medicare puts no limit on the number of Benefit Periods covered by Medicare during your lifetime.

Medicare Inpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Hospital Care (including acute, nonmedical health care institutions, psychiatric and rehabilitation hospitalization)			
First 60 days of a Benefit Period	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
61st through 90th day of a Benefit Period	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
91st day and after of a Benefit Period – up to 60 Lifetime Reserve Days (if any)	Covered less Lifetime Reserve Days Daily Coinsurance	Medicare Lifetime Reserve Days Daily Coinsurance	No charge
Non-Medicare Covered Services			
After your 60 Lifetime Reserve Days are exhausted, your plan covers unlimited days	Nothing	All charges	No charge
Skilled Nursing Facility Care (SNF)			
First 20 days of a Benefit Period	Medicare allowable amount	Nothing	No charge
21st through 100th day of a Benefit Period	Medicare allowable amount minus SNF Daily Coinsurance	The Medicare SNF Daily Coinsurance	No charge
101st day and after of a Benefit Period	Nothing	Nothing	All charges

Medicare Inpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Physicians and Other Health Professionals (inpatient services)			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Human Organ Transplants (including bone marrow transplants)			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Blood Transfusions			
First three pints per calendar year	Nothing	Medicare Blood Deductible	No charge
Beyond 3 pints per calendar year	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge

Section 5: Outpatient Services Covered by Medicare

Medicare Outpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Acupuncture Treatment			
Note: Limited coverage provided by Medicare. See your Benefit Handbook for details.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Administration of Allergy Injections			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Ambulance Services			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Cardiac Rehabilitation Services			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Chiropractic Services			
Note: Limited coverage provided by Medicare. See your Benefit Handbook for details.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge

Medicare Outpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Dental Care and Oral Surgery			
Note: Limited coverage provided by Medicare. See your Benefit Handbook for details.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Diagnostic Tests and Procedures			
Diagnostic tests and procedures	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Durable Medical Equipment (DME) and Prosthetic Devices			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Emergency Room Care			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Home Health Care			
	Medicare allowable amount	Nothing	No charge
Home Infusion Therapy			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Hospice Care (including inpatient Respite Care)			
Additional Hospice benefits may apply. See "Section 6: State Mandated Benefits" below.	100% of the Medicare allowable amount; and 95% of the cost of outpatient drugs and respite care (Medicare Hospice Coinsurance) Benefits are covered less Medicare Deductible	Medicare Deductible and Hospice Coinsurance	No charge
House Calls			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge

Medicare Outpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Kidney Dialysis			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Medical Therapies			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Outpatient Methadone Maintenance			
	Nothing	All charges	No charge
Outpatient Surgery			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Physical, Occupational and Speech Therapy			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Physicians and Other Health Professionals (including mental health and substance use disorder treatment)			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Podiatrist Services			
Note: Limited coverage provided by Medicare. See your Benefit Handbook for details.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Telemedicine Virtual Visits			
Additional Telemedicine Virtual Visits benefits may apply. See "Section 6: State Mandated Benefits" below.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Urgent Care Services			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge

Section 6: STATE-MANDATED BENEFITS

This section lists additional Plan benefits that are required by Massachusetts law, which may not be covered by Medicare.

HPIC Plan Benefits	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Applied Behavioral Analysis			
	Nothing	All charges	No charge
COVID-19			
– Testing, treatment, and vaccines See your Benefit Handbook for details.	Nothing	All charges	No charge
Hospice Care (including inpatient Respite Care)			
	Nothing	All charges	No charge
Low Protein Foods			
– Up to $5,000 per calendar year	Nothing	All charges	All charges in excess of $5,000
Mental Health Care and Substance Use Disorder Treatment Services			
Inpatient Services – Benefits are provided for the same number of days as the coverage provided for a physical illness	Nothing	All charges	No charge
Outpatient Services – Benefits are provided for unlimited visits	Nothing	All charges	No charge
Detoxification and Psychopharmacological Services, Psychological Testing and Neuropsychological Assessment Services	Nothing	All charges	No charge
Partial Hospitalization	Nothing	All charges	No charge
Scalp Hair Prosthetics (Wigs)			
– Up to $350 per calendar year	Nothing	All charges	All charges in excess of $350
Special Formulas for Malabsorption			
	Nothing	All charges	No charge
Speech Language and Hearing Services			
	Nothing	All charges	No charge
Telemedicine Virtual Visits			
	Nothing	All charges	No charge

Section 7: Additional Covered Services

The Plan will cover the benefits in this section when not covered by Medicare.

HPIC Plan Benefits	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Emergency Services received outside of the United States			
Note: See your Benefit Handbook for details.	Nothing	All charges	No charge
Inpatient Dental Services or Outpatient Oral Surgery			
The removal of 7 or more permanent teeth, removal of one or more impacted teeth, excision of radicular cysts involving the roots of three or more teeth, gingivectomies (including osseous surgery) of two or more gum quadrants. Benefits are only provided for the above procedures when the Subscriber has a serious medical condition that makes it Medically necessary that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease.	Nothing	All charges	No charge
Routine Eye Exam			
– Limited to 1 exam per calendar year	Nothing	All charges	No charge
Routine Hearing Exam			
– Limited to 1 exam per calendar year	Nothing	All charges	No charge
Routine Physical Exam			
	Nothing	All charges	No charge

Section 8: What The Plan Does Not Cover

A. No benefits will be provided by the Plan for any of the following:

- Any product or service that is not covered by Medicare unless specifically listed as a Covered Service in the Benefit Handbook, Schedule of Benefits or (if applicable) the Prescription Drug Brochure.
- Any charges for products or services covered by a Medicare Advantage plan operated under Medicare Part C or a Prescription Drug Plan (PDP) under Medicare Part D.
- Any product or service obtained at an unapproved facility if Medicare requires that the product or service be provided at a Medicare-approved facility. This exclusion applies to liver, lung, heart and heart-lung transplants; and any other services Medicare determines must be obtained at a Medicare-approved facility.
- Any product or service provided after the date on which your enrollment in the Plan has ended.
- Any charges that exceed the Payment Maximum.
- Any product or services received in a hospital not certified to provide services to Medicare beneficiaries, unless (1) the hospital is outside the United States, (2) the Subscriber's Plan

includes benefits for emergency services outside of the United States, and (3) coverage is available under that benefit.

- Any product or service for which no charge would be made in the absence of insurance.

B. Unless covered by Medicare Parts A and B, no Benefits will be provided by the Plan for any of the following:

- Any product or service that is not Medically Necessary.
- Any product or service (1) for which you are legally entitled to treatment at government expense or (2) for which payment is required to be made by a Workers' Compensation plan or an employer under state or federal law.
- Any charges for inpatient care over the semi-private room rate, except when a private room is Medically Necessary.
- Any product or service received outside of the United States that is: (1) related to the provision of routine or preventive care of any kind; (2) a service that was, or could have been, scheduled before leaving the United States, even if such scheduling would have delayed travel plans; (3) a form of transportation, including transportation back to the United States, except road ambulance to the nearest hospital; or (4) a service that would not be a covered by Medicare or the Plan in the United States.
- Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven or Investigational.
- Cosmetic services or products, including, but not limited to, cosmetic surgery, except for services required to be covered under the Women's Health and Cancer Rights Act of 1998.
- Custodial Care.
- Recovery programs including rest or domiciliary care, sober houses, transitional support services and therapeutic communities.
- Eyeglasses, contact lenses, fittings or examinations . (Note that Medicare provides limited benefits for eyeglasses or contact lenses after cataract surgery).
- Refractive eye surgery, including but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.
- Hearing aids unless specifically listed as a Covered Service in the Schedule of Benefits.
- Hearing aid batteries.
- Biofeedback.
- Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Service. Aromatherapy, treatment with crystals and alternative medicine. Any of the following types of programs: health resorts, spas recreational programs, camps, outdoor residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs), massage therapy and myotherapy.
- Routine foot care services such as the trimming of corns and bunions, removal of calluses, unless such care is Medically Necessary due to circulatory system disease such as diabetes. Foot orthotics, except as required for the treatment of severe diabetic foot disease or systemic circulatory diseases.
- Any form of hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. (Please see Section III.C.3. for the coverage provided for wigs.)

- Dental Services, including, but not limited to, restorative, periodontal, orthodontic, endodontic, prosthodontic services (including any services related to dentures), or any Dental Services relative to the treatment of temporomandibular joint dysfunction (TMJ), except that (1) the Plan will cover the Medicare Deductible and Coinsurance amount for any Dental Service that has been covered by Medicare and (2) the Plan will cover additional Dental Services if such coverage is purchased by an Employer Group. If your Employer Group has purchased coverage for additional Inpatient Dental Services or Outpatient Oral Surgery, such coverage will be listed in the Schedule of Benefits.
- Infertility services or any related services, supplies, or drugs, including, but not limited to, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intra-cytoplasmic sperm injection, donor egg procedures (including related egg and inseminated egg procurement), the preservation of eggs or sperm, voluntary sterilization or the reversal of voluntary sterilization.
- Any form or Surrogacy or services for a gestational carrier.
- Ambulance services except as specified in the Benefit Handbook. No benefits will be provided for transportation other than by ambulance.
- Exercise equipment; or personal comfort or convenience items such as radios, telephone, television, or haircutting services.
- Any product or service provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
- Any product or service related to diet plans or weight loss programs, including diet foods, drinks or drugs of any kind. (However, the Plan will cover Medicare Deductible and Coinsurance amounts for professional services or surgery covered by Medicare for the treatment of obesity.)
- Drugs or medications that can be self-administered unless (1) the Employer Group has purchased prescription drug coverage on behalf of the Subscriber, and coverage for such drug or medication is provided for in the Prescription Drug Brochure, (2) the drug or medication is covered by Medicare Parts A or B; or (3) coverage for the drug or medication is mandated by Massachusetts law.
- Educational services or testing; services for problems of school performance; sensory integrative praxis tests, vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation.
- Planned home births.
- Devices or special equipment needed for sports or occupational purposes.
- Charges for any product or service, including, but not limited to, professional fees, medical equipment, drugs, and Hospital or other facility charges, that are related to any care that is not a Covered Service under this Benefit Handbook.
- Mental health services that are (1) provided to Subscribers who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.
- Telemedicine services involving e-mail, fax or non-secure texting.
- Any service or supply (with the exception of contact lenses) purchased from the internet.
- Services provided by a doula.

Section 9: Important Notices

Medical Emergency: You are always covered for care you need in a medical emergency within the United States. In the event of a medical emergency, you should go to the nearest emergency facility or call 911 or the local emergency number.

Coverage will be subject to the terms, conditions, exclusions and limitations of Medicare-eligible services and supplies, and is subject to change pursuant to Medicare guidelines.

This Plan is only available to Subscribers enrolled through Employer Groups. Coverage under the Plan is effective on the first day of the month chosen by your Employer and renews each year on your Employer's anniversary date unless terminated in accordance with the terms of the Employer Agreement. Premiums are subject to change as set forth in the Employer Agreement between HPIC and your Employer Group as permitted by law. Please refer to your Benefit Handbook for information about your eligibility and continuation of coverage rights under this Plan. To be eligible to enroll, or continue enrollment, in the Plan, an individual must be enrolled in Medicare Part A and Part B and pay any premium required for continued enrollment at all times.