Schedule of Benefits

MEDICARE ENHANCE
HPHC INSURANCE COMPANY, INC.
Services are covered when Medically Necessary. Please see your Benefit Handbook for the details of your coverage.

INTRODUCTION

This Schedule of Benefits summarizes your coverage under Medicare Enhance (the Plan) and states the Subscriber cost sharing amounts you must pay for Covered Services. However, it is only a summary of your benefits. Please consult your *Benefit Handbook* and *Prescription Drug Brochure* (if you have the Plan's prescription coverage) 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 program handbook, *Medicare and You* or contact the Centers for Medicare and Medicaid Services (CMS), for information on your Medicare benefits. You may call CMS for information on Medicare Parts A and B at: 1-800-MEDICARE (1-800-633-4227).

SECTION 1: SUBSCRIBER COST SHARING (WHAT YOU PAY)

Subscribers are required to share the cost of the benefits provided under the Plan. The following is a summary of the cost sharing amounts under your 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. Please see the tables below for a detailed list of the Copayments that apply to your Employer Group's Plan.

*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.

SECTION 2: PREVENTIVE CARE SERVICES

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

Medicare coverage includes a one-time "Welcome to Medicare" physical examination received within the first 12 months a beneficiary is covered by Medicare Part B. HPHC recommends that Subscribers utilize this benefit if available. After being enrolled in Medicare Part B for one year, Medicare also covers a yearly physical exam, known as a "Wellness" visit. The first yearly physical exam must take place at least 12 months after the "Welcome to Medicare" physical examination, if a beneficiary has had one.

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 and (5) bone mass measurements; (6) glaucoma testing; (7) medical nutrition therapy; (8) counseling to stop smoking; (9) colorectal cancer screening, including fecal occult blood tests, flexible sigmoidoscopy, colonoscopy and barium enema examinations; and (10) immunizations for flu, pneumonia and hepatitis B. Coverage for mammograms includes a baseline mammogram for women between ages 35 and 39 and an annual mammogram for women 40 years of age and older

Please refer to Section III. D.2. of your Benefit Handbook for detailed information on additional preventive care services covered by the Plan. Please consult with your doctor and refer to the Medicare publication, *Medicare and You*, for additional information on preventive care services that may benefit you.

SECTION 3: COVERAGE OUTSIDE OF THE UNTED STATES

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

*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.

SECTION 4: INPATIENT SERVICES

Service	Medicare Parts A or B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Hospital Care (including acute, rehabilitation and psychiatric hospitalizations)				
Days 1-60 in Benefit Period	All but Medicare Deductible amount	Medicare Deductible amounts	No Copayment	9
Days 61-90 in Benefit Period	All but Medicare Coinsurance amounts	Medicare Coinsurance amounts	No Copayment	9
Up to 60 Lifetime Reserve Days (if any)	All but Reserve Days Daily Coinsurance amounts	Medicare Lifetime Reserve Days Daily Coinsurance amounts	No Copayment	9
After your 60 Lifetime Reserve Days are exhausted your Plan covers unlimited days	Nothing	All charges to the extent Medically Necessary	No Copayment	9
Rehabilitation Hospital Care				
After your 60 Lifetime Reserve Days are exhausted: Benefits are provided up to 100 days per calendar year for Medically Necessary rehabilitation	Nothing	All charges	No Copayment	9

*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.
** Page numbers refer to your Medicare Enhance Benefit Handbook.

Service	Medicare Parts A or B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Skilled Nursing Facility Care (SNF)				
Days 1-20	Medicare allowable amount	Nothing	No Copayment	10
Days 21-100	Medicare allowable amount minus SNF Daily Coinsurance amounts	The Medicare SNF Daily Coinsurance amounts	No Copayment	10
Days 100 +	Nothing	Nothing	All Charges	10
Religious Nonmedical Health Care Institutions	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	10
Physician and Other Professionals (inpatient services only)	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	9
Blood Transfusions				
First 3 pints of blood per calendar year	Nothing	Medicare Blood Deductible	No Copayment	9
Beyond 3 pints per calendar year	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	9
Human Organ Transplants (Including bone marrow transplants)	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	9

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any cost sharing that applies.

** Page numbers refer to your Medicare Enhance Benefit Handbook.

SECTION 5: OUTPATIENT SERVICES

Service	Medicare Parts A or B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Emergency Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Emergency room Copayment per visit	$50 Emergency Room Copayment per visit, waived if admitted to a Hospital	10
Physicians and other covered Professionals (including mental health and substance abuse care)	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit (Please note: No Copayment applies to diagnostic tests, x-rays, and immunizations if billed without a professional office visit and no additional services are provided)	10
House Calls by a physician	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$25 Copayment per visit	10
Administration of Allergy Injections	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$5 Copayment per visit	10
Medical Therapies including Outpatient Surgery	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	11
Chiropractic Services **Note:** Very limited coverage provided. See your *Benefit Handbook*	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit (if Medicare coverage is provided)	$15 Copayment per visit	10

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any cost sharing that applies.

** Page numbers refer to your Medicare Enhance Benefit Handbook.

Service	Medicare Parts A or B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Podiatric Services **Note:** Limited coverage provided. See your *Benefit Handbook*	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit (if Medicare coverage is provided)	$15 Copayment per visit	10
Physical and Occupational Therapy	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	12
Speech Language and Hearing Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	12
Dental Care and Oral Surgery Services **Note:** Limited coverage provided. See your *Benefit Handbook*	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit (if Medicare coverage is provided)	$15 Copayment per visit	11
Hospice Care (including inpatient Respite Care)	100% of the Medicare allowable amount; and 95% of the cost of outpatient drugs and respite care (Medicare Hospice Coinsurance). Benefits are covered less the Medicare Deductible	Medicare Deductible and the Hospice Coinsurance amount	No Copayment	12
Diagnostic Tests and Procedures	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment (Please note: No Copayment applies to diagnostic tests, x-rays, and immunizations if billed without a professional office visit and no additional services are provided)	11
Ambulance	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	11

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any cost sharing that applies.

** Page numbers refer to your Medicare Enhance Benefit Handbook.

Service	Medicare Parts A or B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Durable Medical Equipment and Prosthetic Devices	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	11
Home Health Care Services	Medicare allowable amount	Nothing	No Copayment	11
Home Infusion Therapy **Note:** Very limited coverage provided. See your *Benefit Handbook*	Generally None	All charges minus any coverage by Medicare	No Copayment	17
Kidney Dialysis	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	12
Cardiac Rehabilitation Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	10

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any cost sharing that applies.

** Page numbers refer to your Medicare Enhance Benefit Handbook.

SECTION 6: STATE MANDATED BENEFITS

The plan will cover the benefits in this section when Medicare coverage is not available:

Service	Medicare Parts A or B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Inpatient Mental Health Care				
For all Mental and Emotional disorders. **Note:** Benefits are provided up to 60 days per calendar year	Nothing	All charges	No Copayment	14
For Biologically-Based and Rape Related Mental and Emotional Disorders **(including Substance Abuse Disorders).** **Note:** Benefits are provided for the same number of days as the coverage provided for a physical illness.	Nothing	All charges	No Copayment	14
Outpatient Mental Health Care				
For all Mental and Emotional disorders. Benefits are provided up to 24 visits per calendar year	Nothing	All charges, less applicable Copayment per visit	$15 Copayment per visit	14
For Biologically-Based and Rape Related Mental and Emotional Disorders **(including Substance Abuse Disorders).** Benefits are provided for unlimited visits	Nothing	All charges, less applicable Copayment per visit (for unlimited) visits	$15 Copayment per visit	14

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any cost sharing that applies.

** Page numbers refer to your Medicare Enhance Benefit Handbook.

Service	Medicare Parts A or B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Partial Hospitalization for Mental Health and Substance abuse	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	No Copayment	14
Detoxification, Psychopharmacological, Psychological Testing, and Neuropsychological Assessment Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	15
Scalp Hair Prosthesis (Wigs)	Nothing	Up to $350 per calendar year	All charges in excess of $350	15
Low Protein Foods	Nothing	Up to $5,000 per calendar year	All charges in excess of $5,000	15
Special Formulas for Malabsorption	Nothing	Full benefits	No Copayment	15
Hypodermic Needles and Syringes	Nothing	Full benefits, less applicable Copayment	If you have the Plan's prescription drug coverage, your Copayment is listed on your ID card. If you do not have the Plan's prescription drug coverage, then you will pay the lower of the pharmacy's retail price or a $10 Copayment.	15

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any cost sharing that applies.
** Page numbers refer to your Medicare Enhance Benefit Handbook.

SECTION 7: WHAT THE PLAN DOES NOT COVER

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

1. Any product or service that is not covered by Medicare unless specifically listed as a Covered Service in this *Benefit Handbook*, the *Schedule of Benefits* or the *Prescription Drug Brochure (if applicable).*

2. 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.

3. Any product or service obtained at an unapproved hospital (or other facility) if Medicare requires that a service be provided at a hospital (or other facility) specifically approved for that service. This exclusion applies to weight loss (bariatric) surgery; liver, lung, heart and heart-lung transplants; and any other services Medicare determines must be obtained at a hospital (or other facility) that has been specifically approved for a specific service to be eligible for coverage by Medicare.

4. Any product or service that is provided to you after the date on which your enrollment in the plan has ended.

5. Any charges that exceed the Payment Maximum. (Please see the Glossary for the definition of "Payment Maximum.")

6. Any products 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 services outside of the United States, and (3) coverage is available under that benefit.

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

B. No Benefits will be provided by the Plan for any of the following unless covered by Medicare Parts A or B:

1. Any product or service that is not Medically Necessary.

2. 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 laws of similar purpose.

3. Any charges for inpatient care over the semi-private room rate, except when a private room is Medically Necessary.

4. 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.

5. Any product or service that is Experimental or Unproven. (Please see the Glossary for the definition of "Experimental or Unproven.")

6. Private duty nursing.

7. 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.

8. Rest or Custodial Care.

9. Eyeglasses and contact lenses, or examinations to prescribe, fit, or change eyeglasses or contact lenses unless specifically listed as a Covered Service in your *Schedule of Benefits*. (Note that Medicare provides limited benefits for eye glasses or contact lenses after cataract surgery.).

10. Hearing aids.

11. Biofeedback, massage therapy (including myotherapy), sports medicine clinics, treatment with crystals or 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.

12. Foot orthotics, except as required for the treatment of severe diabetic foot disease.

13. 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)

14. 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 coinsurance and deductible amount for any Dental Service that has been covered by Medicare. (Please see the Glossary for the definition of "Dental Services.")

15. 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, or any form or Surrogacy. (Please see the Glossary for the definition of "Surrogacy.")

16. Ambulance services except as specified in this *Benefit Handbook* or the *Schedule of Benefits*. No benefits will be provided for transportation other than by ambulance.

17. Exercise equipment; or personal comfort or convenience items such as radios, telephone, television, or haircutting services.

18. Any product or service provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

19. Refractive eye surgery, including laser surgery, orthokeratology or lens implantation for correction of myopia, hyperopia and astigmatism.

20. Any products or services related to diet plans or weight loss programs, including diet foods, drinks or drugs of any kind. (However, the Plan will cover Medicare Coinsurance and Deductible amounts for professional services or surgery covered by Medicare for the treatment of obesity.)

21. 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.

22. 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.

23. Planned home births.

24. Gender reassignment surgery or any related drugs and procedures.

25. Devices or special equipment needed for sports or occupational purposes.

26. Charges for any products or services, 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*.

27. Acupuncture, aromatherapy, or alternative medicine

28. 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.

SECTION 8: 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 limitation of Medicare eligible services and supplies, and is subject to change pursuant to Medicare guidelines. This brochure is not intended as an explanation of Medicare benefits. Information and guidelines as established by the Centers for Medicare and Medicaid Services (CMS) regarding Medicare, may be obtained by contacting your local Social Security office.

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 year to 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.