Schedule of Benefits

The HPHC Insurance Company Tiered-Copayment PPO Massachusetts

Services listed below are covered when Medically Necessary. Please see your Benefit Handbook for details.

Member Cost Sharing Summary

In-Network Cost Sharing

Copayments

A Copayment is a dollar amount that is payable by the Member 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.

There are two types of Copayments that apply to your Plan. A lower Copayment, known as "Copayment Level 1," applies to some outpatient services, including most primary care, obstetrical care, gynecological care, mental health care (including the treatment of substance abuse disorders). Most outpatient specialty care requires payment of a higher Copayment, known as "Copayment Level 2." The Level 1 and Level 2 Copayments that apply to your Plan are listed below.

Copayment Level 1: Your Plan has a $20 Copayment per visit.

Copayment Level 2: Your Plan has a $40 Copayment per visit.

Please refer to the table below for the Copayment amounts that apply to specific In-Network services.

You have a **Hospital Inpatient Copayment** of $300 per admission. $200 per visit for Day Surgery. Please see the table below for the services to which the Hospital Inpatient Copayment applies.

Out-of-Network Cost Sharing

Deductible

Your Plan has an Out-of-Network Deductible of **$250** per Member or **$500** per family per calendar year.

Please refer to the table below for the Copayments and Coinsurance amounts that apply to specific Out-of-Network services.

Out-of-Pocket Maximum

Your Plan has an Out-of-Network Out-of-Pocket Maximum of **$1,500** per Member or **$3,000** per family per calendar year.

Copayment Level 1

Special Level 1 Services: Copayment Level 1 always applies to the following outpatient services regardless of the provider or location of service:

- Routine well physical examinations (including well child care, vision and auditory screening for children, nutrition counseling and health education)
- Immunizations
- Annual preventive gynecological examinations
- Voluntary termination of pregnancy
- Voluntary sterilization
- Mental health services (including treatment of substance abuse disorders)
- Early intervention services
- Physical therapy
- Occupational therapy
- Speech therapy
- Routine annual eye examinations
- Artificial insemination
- Advanced reproductive technologies

In addition to the Special Level 1 list, Copayment Level 1 applies to covered outpatient professional services, other than services received at a professional office operated by a hospital, from the following types of providers:

- All Primary Care Physicians. The term "Primary Care Physician" (PCP) includes the following specialties: Internal Medicine, Family Practitioner, General Practitioner and Pediatrician
- Obstetricians and Gynecologists
- Certified Nurse Midwives
- Nurse Practitioners who bill independently

Copayment Level 2

Copayment Level 2 applies to the following outpatient professional services:

- Any covered services or provider not listed under Copayment Level 1
- Any service provided in a hospital operated doctor's office, except the Special Level 1 Services listed above.

If a provider is categorized as both a Copayment Level 1 provider and a Copayment Level 2 provider, Copayment Level 1 applies. For example, if a provider is both a PCP and a cardiologist, you will be responsible for Copayment Level 1.

A Copayment applies to all services except where specifically noted below.

Please note: Occasionally the Copayment may exceed the contract rate payable by the Plan for a service. If the Copayment is greater than the contract rate, you are responsible for the full Copayment, and the provider keeps the entire Copayment.

Please refer to the section titled "Member Cost Sharing" at the end of this document for detailed information on the Copayments, Deductibles, Coinsurance and Out-of-Pocket Maximums that apply to your Plan.

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Inpatient Acute Hospital Services (including Day Surgery)		
All covered services, including the following: ▪ Coronary care ▪ Hospital services ▪ Intensive care ▪ Physicians' and surgeons' services including consultations ▪ Semi-private room and board	Subject to the Hospital Inpatient Copayment.	20% Coinsurance after the Deductible has been met.
▪ Colonoscopy	Covered in full.	20% Coinsurance after the Deductible has been met.
Hospital Outpatient Department Services		
All covered services, including the following: ▪ Anesthesia services ▪ Chemotherapy ▪ Endoscopic procedures ▪ Laboratory tests and x-rays ▪ Physicians' and surgeons' services ▪ Radiation therapy	Covered in full. (Unless otherwise listed under a specific benefit below.)	20% Coinsurance after the Deductible has been met.
Emergency Room Care		
▪ Hospital emergency room treatment You are always covered in a Medical Emergency. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. If you are hospitalized, you must call the Plan within 48 hours, or as soon as you can. If an attending emergency physician gives notice of hospitalization to the Plan, no further notice is required.	$100 Copayment per visit. (This Copayment is waived if you are admitted directly to the hospital from the emergency room.)	$100 Copayment per visit. (This Copayment is waived if you are admitted directly to the hospital from the emergency room.)
Emergency Admission Services		
▪ Inpatient services which are required immediately following the rendering of emergency room treatment	Subject to the Hospital Inpatient Copayment.	Subject to the Hospital Inpatient Copayment.

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Physician Services		
Services include but are not limited to the following: ▪ Administration of injections ▪ Allergy tests and treatments ▪ Changes and removal of casts, dressings or sutures ▪ Chemotherapy ▪ Diabetes self-management, including education and training ▪ Diagnostic screening and tests, including blood tests and screenings mandated by state law ▪ Family planning services ▪ Health education, including nutritional counseling ▪ Infertility services ▪ Lead screening and other screenings and tests for children ▪ Medical treatment of temporomandibular joint dysfunction (TMD) ▪ Sick and well office visits including psychopharmacological services ▪ Preventive care office visits, including routine physical examinations, immunizations, annual eye examinations, school, camp, sports and premarital examinations, ▪ Vision and hearing screening ▪ Consultations concerning contraception and hormone replacement therapy	Copayment Level 1: $20 Copayment per visit. Copayment Level 1 applies to all primary care, obstetrical care and gynecological care services. Copayment Level 2: $40 Copayment per visit. Copayment Level 2 applies to all care provided by a specialist. Please note: diagnostic tests, mammograms, x-rays and immunizations will be covered in full if billed without an office visit and no other services are provided.	20% Coinsurance after the Deductible has been met.
▪ Administration of allergy injections	$5 Copayment per visit.	20% Coinsurance after the Deductible has been met.
▪ Please note that Copayment Level 2 applies to physicians' services rendered in a hospital operated physician's office, except for the Special Level 1 Services listed at the beginning of this document. Please see the Section titled "Member Cost Sharing" at the beginning of this document for detailed information on Copayments and Special Level 1 Services.		
Skilled Nursing Care and Inpatient Rehabilitation		
▪ Room and board, special services and physicians' services - up to 100 days per calendar year for skilled nursing care and 100 days per calendar year for inpatient rehabilitation services at a semi-private rate for each benefit	Subject to the Hospital Inpatient Copayment.	20% Coinsurance after the Deductible has been met.

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Dental Services		
▪ Initial emergency treatment - within 72 hours of injury (Please see your Benefit Handbook for details on your coverage)	Copayment Level 2: $40 Copayment per visit. If inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.	20% Coinsurance per visit after the Deductible has been met.
Maternity Care		
▪ Prenatal and postpartum care	Covered in full.	20% Coinsurance after the Deductible has been met.
▪ All hospital services for mother, including inpatient physician services	Subject to the Hospital Inpatient Copayment.	20% Coinsurance after the Deductible has been met.
▪ Routine nursery charges for newborn care	Covered in full.	20% Coinsurance after the Deductible has been met.

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Mental Health Care (Including the Treatment of Substance Abuse Disorders)		
Inpatient Services		
▪ Mental health care services	Subject to the Hospital Inpatient Copayment.	20% Coinsurance after the Deductible has been met.
Intermediate Care Services		
▪ Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization ▪ Intensive outpatient programs, partial hospitalization and day treatment programs	Covered in full.	20% Coinsurance after the Deductible has been met.
Outpatient Services		
▪ Mental health care services Group therapy Individual therapy	 $10 Copayment per visit. Copayment Level 1: $20 Copayment per visit.	20% Coinsurance after the Deductible has been met.
▪ Detoxification	Copayment Level 1: $20 Copayment per visit.	20% Coinsurance after the Deductible has been met.
▪ Medication management	Copayment Level 1: $20 Copayment per visit.	20% Coinsurance after the Deductible has been met.
▪ Psychological testing and neuropsychological assessment	Copayment Level 1: $20 Copayment per visit.	20% Coinsurance after the Deductible has been met.

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Home Health Care Services		
▪ Home care services ▪ Intermittent skilled nursing care	Covered in full.	20% Coinsurance after the Deductible has been met.
No benefit limit applies to durable medical equipment or physical therapy, occupational therapy and speech therapy received as part of authorized home health care.		
Durable Medical Equipment including Prosthetics		
Durable medical equipment (DME) including prosthetics – covered up to a maximum of $5,000 in equipment costs per Member per calendar year, except as stated below. Coverage includes, but is not limited to: ▪ Durable medical equipment ▪ Prosthetic devices ▪ Ostomy supplies ▪ Wigs – up to $350 per calendar year when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury ▪ Breast prostheses, including replacements and mastectomy bras	20% Copayment of equipment cost to HPHC, not to exceed a Member's total expense of $1,000. There is no coverage after the $5,000 in equipment cost has been paid, including Member Copayments.	20% Coinsurance after the Deductible has been met.

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Diabetes Equipment and Supplies		
▪ Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids	Subject to the applicable cost sharing for durable medical and prosthetic equipment benefit.	Subject to the applicable cost sharing for durable medical and prosthetic equipment benefit.
▪ Blood glucose monitors, insulin pumps and supplies and infusion devices	Covered in full.	Covered in full.
▪ Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips	Subject to the applicable prescription drug Copayment listed on your ID card, if your Employer has selected prescription drug coverage. If prescription drug coverage is not available, then you will pay a $5 Copayment for Tier 1 items, a $10 Copayment for Tier 2 items and a $25 Copayment for Tier 3 items.	Subject to the applicable prescription drug Copayment listed on your ID card, if your Employer has selected prescription drug coverage. If prescription drug coverage is not available, then you will pay a $5 Copayment for Tier 1 items, a $10 Copayment for Tier 2 items and a $25 Copayment for Tier 3 items.

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Hypodermic Syringes and Needles		
▪ Hypodermic syringes and needles to the extent Medically Necessary, as required by Massachusetts law (the DME benefit limit does not apply)	Subject to the applicable prescription drug Copayment listed on your ID card, if your Employer has selected prescription drug coverage. If prescription drug coverage is not available, then you will pay the lower of the pharmacy's retail price or a $5 Copayment for Tier 1 items, $10 Copayment for Tier 2 items and a $25 Copayment for Tier 3 items.	Subject to the applicable prescription drug Copayment listed on your ID card, if your Employer has selected prescription drug coverage. If prescription drug coverage is not available, then you will pay the lower of the pharmacy's retail price or a $5 Copayment for Tier 1 items, $10 Copayment for Tier 2 items and a $25 Copayment for Tier 3 items.
Other Health Services		
▪ Dialysis	Covered in full.	20% Coinsurance after the Deductible has been met.
▪ Psychopharmacological services ▪ Cardiac rehabilitation ▪ Early intervention services ▪ Physical and occupational therapies – 90 consecutive days per condition ▪ Speech-language and hearing services, including therapy	Copayment Level 1: $20 Copayment per visit.	20% Coinsurance after the Deductible has been met.
▪ House calls	Copayment Level 1: $20 Copayment per visit. Copayment Level 2: $40 Copayment per visit	20% Coinsurance after the Deductible has been met.

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Other Health Services (continued)		
▪ Second opinion	Copayment Level 1: $20 Copayment per visit. Copayment Level 2: $40 Copayment per visit.	20% Coinsurance per visit after the Deductible has been met.
▪ Vision hardware for special conditions (please see your Benefit Handbook for details on your coverage)	Covered in full up to the benefit limit	20% Coinsurance after the Deductible has been met, up to the benefit limit.
▪ Low protein foods ($2,500 per Member per calendar year) ▪ Ambulance services ▪ State mandated formulas	Covered in full.	20% Coinsurance after the Deductible has been met.
▪ Hospice services	Covered in full per outpatient visit. If inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.	20% Coinsurance per visit after the Deductible has been met.

Special Enrollment Rights

For Subscribers enrolled through an Employer Group:

If an employee declines enrollment for the employee and his or her Dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll himself or herself, along with his or her Dependents in this Plan if the employee or his or her Dependents lose eligibility for that other coverage (or if the employer stops contributing toward the employee's or Dependents' other coverage). However, enrollment must be requested within 30 days after other coverage ends (or after the employer stops contributing toward the employee's or Dependents' other coverage). In addition, if an employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll himself or herself and his or her Dependents. However, enrollment must be requested within 30 days after the marriage, birth, adoption or placement for adoption.

Special enrollment rights may also apply to persons who lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. An employee or Dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this Plan, if enrollment is requested within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan if enrollment is requested within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.

Member Cost Sharing

Deductible

A Deductible is a specific dollar amount that is payable by the Member for covered services each calendar year before benefits subject to the Deductible are available under the Plan. Deductible amounts are incurred as of the date of service.

You must meet the Out-of-Network Deductible before any Out-of-Network service is covered by the Plan, except for care in a hospital emergency room.

Unless a family Deductible applies, each Member is responsible for the Member Deductible for covered services each calendar year. For Members who have family coverage there are two options for meeting the Deductible:

- If a Member of a covered family meets an individual Deductible, then that Member receives coverage for services subject to that Deductible for the remainder of the calendar year.
- If any number of Members in a covered family meet a family Deductible, then all Members of the covered family receive coverage for services subject to that Deductible for the remainder of the calendar year.

Deductible Carryover

A Deductible carryover allows you to apply any Deductible amount incurred for covered services during the last three (3) months of a calendar year (October, November, and December) toward the Deductible for the next calendar year. In order for a Deductible carryover to apply, the Member (or family) must have had continuous coverage under the Plan through the same Employer Group at the time the Deductible amounts for the prior year were incurred.

Copayments

As a Member of the Plan, you are responsible for a portion of the cost of certain benefits through Copayments. Copayments are payable to the Provider at the time of service. This is a Tiered-Copayment Plan, so please refer to page 1 for a description on how Copayments work under this Plan. To identify specific Copayment amounts that apply to your Plan, please refer to the table above. Your identification card also indicates the Copayment amounts for the Plan's most frequently used services.

Member Cost Sharing Continued

Coinsurance

Coinsurance is a percentage of Covered Charges that is payable by the Member for certain covered services. Coinsurance amounts apply after the Deductible has been met. When using Out-of-Network Providers, Covered Charges are based on the Provider's charge for the service. In most cases, this will be higher than HPHC Insurance Company's contracted rate.

Out-of-Pocket Maximums

Your Plan has two separate Out-of-Pocket Maximums that apply to Out-of-Network services. Only expenses incurred for covered Out-of Network services apply to the Out-of-Network Out-of Pocket Maximum.

The Out-of-Network Out-of-Pocket Maximums are limits on the cost sharing amounts you will be required to pay for Covered Benefits per calendar year. The following expenses do not apply to the Out-of-Pocket Maximums:

- Cost sharing for prescription drugs
- Out-of-Network Coinsurance for DME, prosthetic devices and vision hardware for special conditions
- Any expenses above the Usual, Customary and Reasonable Charge for a service
- Any penalty for failure to receive Prior Approval when required

Member Responsibility when using Non-Participating Providers

Required Approvals

Hospital Admissions

Members are responsible for obtaining Prior Approval from HPHC Insurance Company before any hospital admission when either the physician or facility is a Non-Participating Provider (this includes Day Surgery and day hospitalization for mental health care (including the treatment of substance abuse disorders)). If you do not obtain the required Prior Approval, one of the following will occur:

- You will be denied coverage and be responsible for all charges if HPHC Insurance Company determines the hospitalization was not Medically Necessary.
- You will be subject to a $500 penalty payment in addition to any applicable Deductible, Copayments and Coinsurance amounts, if HPHC Insurance Company determines the hospitalization was Medically Necessary.

Please call 1-800-708-4414 for Prior Approval.

Specialized Services

When using Non-Participating Providers for the specialized services listed below, it is the Member's responsibility to obtain Prior Approval from HPHC Insurance Company before any costs are incurred. If you do not get Prior Approval you are responsible for a $500 penalty payment. Please call 1-800-708-4414 to obtain Prior Approval for the following services:

- All inpatient services
- Physical, speech, and occupational therapies
- Advanced reproductive technologies
- All services provided in the Member's home
- Human organ transplants

Member Responsibility when using Non-Participating Providers Continued

48 Hour Emergency Notification

In cases of an emergency hospital admission to a Non-Participating Provider, you must notify HPHC Insurance Company within 48 hours of the admission, unless notification is not possible because of your condition. If notification is not received when the Member's condition permits it, the Member is responsible for the $500 penalty payment. Please call 1-800-708-4414 to notify HPHC Insurance Company of an emergency admission to a Non-Participating facility.

Penalty Payments

Penalty payments do not count toward any Deductible or Out-of-Pocket Maximum.

Exclusions

- Cosmetic procedures
- Commercial diet plans or weight loss programs
- Transsexual surgery, including related procedures
- Dental services, including periodental, restorative or orthodontic services
- Services that are not medically necessary or procedures which are experimental or unproven
- Eyeglasses, contact lenses, and fittings, unless your employer group has purchased the VisionCare Rider
- Refractive eye surgery
- Transportation other than by ambulance
- Cost for any services for which you are entitled to treatment at government expense, including military service disabilities
- Cost for services covered by workers' compensation, third party liability, other insurance coverage, or an employer under state or federal law
- Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy
- Chiropractic services, including osteopathic manipulation, routine foot care, biofeedback, pain management programs, massage therapy, acupuncture, alternative medicine and sports medicine clinics
- Education services (including problems of school performance) or testing for developmental, educational or behavioral problems
- Sensory integrative praxis test
- Physical examinations for insurance, licensing, or employment
- Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation
- Rest or custodial care
- Personal comfort or convenience items
- Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services
- Reversal of voluntary sterilization (including procedures necessary for conception as a result of voluntary sterilization)
- Any form of surrogacy
- Infertility treatment for Members who are not medically infertile
- Special equipment needed for sports or occupational purposes
- Services for which no charge would be made in the absence of insurance
- Services after termination of membership or for non-members
- Services or supplies given to you 1) by anyone related to you by blood, marriage, or adoption, or 2) anyone who ordinarily lives with you
- Services for which no coverage is provided in the Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure
- Hearing aids and dentures
- Foot orthotics, except as required for treatment of severe diabetic foot disease
- Methadone maintenance
- Private duty nursing
- Pediatric preventive dental
- Extraction of teeth impacted in bone
- Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs.
- Services for any condition with only a “V Code” designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder