Schedule of Benefits

MEDICARE ENHANCE

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 Copayments 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 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 only designed to help you understand the Plan. 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. Here are some phone numbers to help you get additional Medicare information: For information on Medicare Part A - 1-800-252-5533; For information on Medicare Part B - 1-800-882-1228.

SECTION 1: PREVENTIVE CARE SERVICES

Medicare and the Plan cover a wide range of preventive care, including physical examinations, diagnostic tests and immunizations. (Your Benefit Handbook lists these services on page 20.) Preventive services are covered by the Plan minus any coverage provided by Medicare and any Copayments that apply. Please refer to the "Outpatient Services" Section under "Physicians and other Medicare covered professionals (including mental health and substance abuse care)" and "Diagnostic Tests and Procedures" for the Copayments that apply to these services.

SECTION 2: INPATIENT SERVICES

Service	Medicare Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Hospital Care (including acute, rehabilitation and psychiatric hospitalizations)				10-11
Days 1-60 in Benefit Period	All but Medicare Deductible amount	Medicare Deductible amount	Nothing	
Days 61-90 in Benefit Period	All but Medicare Coinsurance amount	Medicare Coinsurance amount	Nothing	
Up to 60 Lifetime Reserve Days (if any)	All but Reserve Days Daily Coinsurance amount	Medicare Lifetime Reserve Days Daily Coinsurance amount	Nothing	
After your 60 Lifetime Reserve Days are exhausted **Note**: Additional coverage may be available for mental health and substance abuse services Please see Section 4 of this Schedule of Benefits.	Nothing	Full benefits to the extent Medically Necessary	Nothing	

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

Service	Medicare Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Rehabilitation Hospital Care	Nothing	Full Benefits	Nothing	11
After your 60 Lifetime Reserve Days are exhausted: Benefits are provided up to 100 days per calendar year for Medically Necessary rehabilitation				
Skilled Nursing Facility Care (SNF)				11
Days 1-20	Medicare allowable amount	Nothing	Nothing	
Days 21-100	Medicare allowable amount minus SNF Daily Coinsurance amount	The SNF Daily Coinsurance amount	Nothing	
Days 100 +	Nothing	Nothing	All Charges	
Religious Nonmedical Health Care Institutions	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	11
Physician and Other Professionals	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	11
Private Duty Nursing **Note**: Only inpatient coverage is provided	Nothing	Nothing	Nothing	18
Blood Transfusions				11
First 3 pints of blood per calendar year	Nothing	Medicare Blood Deductible	Nothing	
Beyond 3 pints per calendar year	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	
Human Organ Transplants (including bone marrow transplants)	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	10, 17

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

SECTION 3: OUTPATIENT SERVICES

Service	Medicare Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Emergency Services				11
Within the US	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less Emergency room Copayment per visit	$30 Emergency Room Copayment per visit, waived if admitted to a Hospital	
Outside the US and its Territories	Nothing	All covered services, less Emergency room Copayment per visit	$30 Emergency Room Copayment per visit, waived if admitted to a Hospital	14
Physicians and other Medicare 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	$5 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.)	11
House Calls by a physician	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	$15 Copayment per visit	11
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	11
Medical Therapies including Outpatient Surgery	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	12
Chiropractic Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$5 Copayment per visit	11

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

Service	Medicare Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Podiatric Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$5 Copayment per visit	12
Physical and Occupational Therapy	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$5 Copayment per visit	13
Speech Language and Hearing Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$5 Copayment per visit	13, 14
Dental Care and Oral Surgery Services	Very limited coverage provided. See your Benefit Handbook	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit if Medicare coverage is provided	$5 Copayment per visit	13
Hospice Care (including inpatient Respite Care)	100% of Medicare allowable amount and 95% of the cost of outpatient drugs and respite care	Medicare Deductible and the Hospice Coinsurance amount	Nothing	13, 18
Diagnostic Tests and Procedures	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	Nothing (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.)	12, 14
Ambulance	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts.	Nothing	12

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

Service	Medicare 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	Nothing	12
Home Health Care Services	Medicare allowable amount	Nothing	Nothing	12
Home Infusion Therapy	Very limited coverage provided. See your Benefit Handbook	Full benefits minus any coverage by Medicare	Nothing	18
Consultations Concerning Contraception and Hormone Replacement Therapy	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	17
Kidney Dialysis	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	13

SECTION 4: MASSACHUSETTS MANDATED MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

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

Service	Medicare Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Inpatient Mental Health Care				
For all Mental and Emotional disorders: Benefits are provided up to 60 days per calendar year	Nothing	Full benefits	Nothing	15-16
For Biologically-Based and Rape Related Mental and Emotional Disorders: Benefits are provided for the same number of days as the coverage provided for a physical illness.	Nothing	Full benefits	Nothing	

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

Service	Medicare Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Outpatient Mental Health Care				15-16
For all Mental and Emotional disorders: Benefits are provided up to 24 visits per calendar year	Nothing	Full benefits, less applicable Copayment per visit	$5 Copayment per visit	
For Biologically-Based and Rape Related Mental and Emotional Disorders: Benefits are provided for unlimited visits	Nothing	Full benefits, less applicable Copayment per visit (for unlimited) visits.	$5 Copayment per visit	
Inpatient Substance Abuse Care				15-16
For all Substance Abuse Rehabilitation needs: Benefits are provided for 30 days per calendar year	Nothing	Full benefits	Nothing	
For Substance Abuse Rehabilitation provided in conjunction with treatment for a mental disorder: Benefits are provided for the same number of days as the coverage provided for a physical illness.	Nothing	Full benefits	Nothing	
Outpatient Substance Abuse Care				
For all Substance Abuse Rehabilitation needs: Benefits are provided up to $500 dollars per calendar year	Nothing	Full benefits, less applicable Copayment per visit	$5 Copayment per visit	15-16
For Substance Abuse Rehabilitation provided in conjunction with treatment for a mental disorder: Benefits are provided for unlimited visits	Nothing	Full benefits, less applicable Copayment per visit	$5 Copayment per visit	

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

Service	Medicare 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	Nothing	13
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	$5 Copayment per visit	16

SECTION 5: ADDITIONAL COVERED SERVICES

Service	Medicare Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Scalp Hair Prosthesis (Wigs)	Nothing	Up to $350 per calendar year	All charges in excess of $350	17
Low Protein Foods	Nothing	Up to $2,500 per calendar year	All charges in excess of $2,500	17
Special Formulas for Malabsorption	Nothing	Full benefits	Nothing	17
Cardiac Rehabilitation Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$5 Copayment per visit	17
Diabetes Treatment	Covered less Medicare Deductible and Coinsurance amounts for Medicare covered items	Medicare Deductible and Coinsurance amounts for Medicare covered items. Full benefits for non-Medicare covered items. Less applicable Copayment per visit	$5 Copayment per visit If you have prescription drug coverage you pay the Copayments listed on your ID card. If you do not have prescription drug coverage, you pay the following Copayments; $5 Generic items, $10 Select Brand items, and $25 for Non-Select Brand items	17
Medicare Covered Clinical Trials	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	13

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

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

Service	Medicare Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Page**
Human Leukocyte Antigen Testing	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	Nothing	17
Dental Services Inpatient or Surgical Day Care 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 hart disease	Nothing	All charges	Nothing	13, 18

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

SECTION 6: WHAT THE PLAN DOES NOT COVER

The Plan does not cover the following:

1. Any product or service that is not covered by Medicare unless specifically listed as a Covered Service in your *Benefit Handbook*, this *Schedule of Benefits* or the *Prescription Drug Brochure* (if any).
2. Any product or service that is not Medically Necessary.
3. 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.
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 for inpatient care over the semi-private room rate, except when a private room is Medically Necessary.
6. Any product or service for which no charge would be made in the absence of insurance.
7. 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.
8. Any product or service that is Experimental or Unproven. (Please see the Glossary for the definition of "Experimental or Unproven.")
9. Private duty nursing unless as specifically listed as a Covered Service in this *Schedule of Benefits*.
10. Chiropractic care, except for manual manipulation of the spine to correct a subluxation, unless specifically listed as a Covered Service in this *Schedule of Benefits*.
11. Cosmetic surgery except for: (1) services covered by Medicare and (2) any additional services required to be covered under the Women's Health and Cancer Rights Act of 1998.
12. Rest or Custodial Care.
13. Eyeglasses and contact lenses, or examinations to prescribe, fit, or change eyeglasses or contact lenses, except when covered by Medicare after cataract surgery.
14. Hearing aids unless specifically listed as a Covered Service in this *Schedule of Benefits*.
15. 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.
16. Foot orthotics, except as required for the treatment of severe diabetic foot disease.
17. Any form of hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. (Please see your *Benefit Handbook* for the coverage provided for wigs)

SECTION 6: WHAT THE PLAN DOES NOT COVER (continued)

18. 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 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 Dental Services, such coverage will be listed in your Schedule of Benefits. (Please see the Glossary for the definition of "Dental Services.")

19. 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.")

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

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

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

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

24. 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.)

25. 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 or (3) coverage for the drug or medication is mandated by Massachusetts law.

26. 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.

27. Planned home births.

28. Transsexual surgery or any related drugs and procedures.

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

30. 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 your *Benefit Handbook*.

31. Acupuncture, aromatherapy, or alternative medicine unless specifically listed in this S*chedule of Benefits*

32. 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.

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

34. Any charges for a liver, lung, heart or heart-lung transplant that is not provided at a Hospital approved by Medicare for the type of transplant required.

35. Abortions, unless continuing the pregnancy would be life-threatening to the mother.

SECTION 7: IMPORTANT NOTICES

Medical Emergency: You are always covered for care you need in a medical emergency. 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.