Schedule of Benefits

The HPHC Insurance Company Best Buy HSA PPO Massachusetts

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

Member Cost Sharing Summary

In-Network Cost Sharing

Your Plan has the following **In-Network** Member Cost Sharing responsibilities.

In-Network Deductible: $1,500 per Member or $3,000 per family per calendar year.

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

In-Network Out-of-Pocket Maximum: $3,000 per Member or $6,000 per family per calendar year.

Out-of-Network Cost Sharing

Your Plan has the following **Out-of-Network** Member Cost sharing responsibilities.

Out-of-Network Deductible: $3,000 per Member or $6,000 per family per calendar year.

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

Out-of-Network Out-of-Pocket Maximum: $6,000 per Member or $12,000 per family per calendar year.

Out-of-Network Lifetime Benefit Maximum

Out-of-Network Lifetime Benefit Maximum: $1,000,000 per Member per lifetime.

Please refer to the section titled “Member Cost Sharing” at the end of this document for detailed information on the Member Cost Sharing 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	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
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	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
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. The emergency room cost sharing is waived if you are admitted immediately from the emergency room.	In-Network Deductible, then no charge.	Same as In-Network.
Emergency Admission Services		
▪ Inpatient services which are required immediately following the rendering of emergency room treatment	In-Network Deductible, then no charge.	Same as In-Network.

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Professional Office Visit Services		
▪ Office visits for illness or injury ▪ See below for Preventive Care Services	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
Preventive Care Services - the In-Network Deductible and Out-of-Network Deductible do not apply to the special services listed below		
The following professional services: ▪ Routine physical examinations ▪ Annual gynecological examinations ▪ Routine annual eye examinations ▪ Routine hearing examinations ▪ Pediatric preventive dental ▪ Nutritional counseling	$20 Copayment per visit.	20% Coinsurance.
▪ Routine prenatal care ▪ Home care for mother and newborn following delivery ▪ Inpatient physician care for healthy newborn	No charge.	20% Coinsurance.

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Preventive Care Services (Continued)		
The following tests and procedures: ▪ Immunizations ▪ Flu shots ▪ Mammograms ▪ Pap smears ▪ Prostate-specific antigen (PSA) screening ▪ Total cholesterol tests ▪ Screenings for STDs ▪ HIV testing ▪ Hepatitis C testing ▪ Routine urinalysis ▪ Lead level testing ▪ Fecal occult blood test ▪ Tuberculosis skin testing ▪ Routine hemoglobin tests ▪ Hemoglobin A1c ▪ Microalbuminuria test ▪ Fetal ultrasounds	No charge.	20% Coinsurance.

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Skilled Nursing Facility Care Services		
▪ Covered up to 100 days per calendar year	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
Inpatient Rehabilitation Services		
▪ Covered up to 60 days per calendar year	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
Dental Services		
▪ Extraction of unerupted teeth impacted in bone ▪ Initial emergency treatment - within 72 hours of injury (Please see your Benefit Handbook for details on your coverage) ▪ Please refer to "Preventive Care Services" for preventive dental care for children	In-Network Deductible, then no charge. If Inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.	Out-of-Network Deductible, then 20% Coinsurance. If Inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.
Maternity Care Services		
▪ Postpartum care	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
▪ All hospital services for mother	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Mental Health and Drug and Alcohol Rehabilitation Services		
Please note that no day or visit limits apply to inpatient or outpatient mental health treatment for biologically-based mental disorders, rape-related mental or emotional disorders and non-biologically-based mental, behavioral or emotional disorders for children and adolescents. No day or visit limits apply to inpatient or outpatient drug and alcohol rehabilitation services that are authorized by a Plan mental health clinician in conjunction with treatment of mental disorders. (Please see your Benefit Handbook for details.)		
▪ Inpatient mental health services - up to 60 days per calendar year [1] ▪ Inpatient drug and alcohol rehabilitation - up to 30 days per calendar year [1] ▪ Inpatient detoxification	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
▪ Outpatient mental health services - up to 24 visits per calendar year		
Group therapy	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
Individual therapy	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
▪ Outpatient drug and alcohol rehabilitation services - up to 20 visits or $500 in benefit value, whichever is greater, per calendar year		
Group therapy	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
Individual therapy visits	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.

[1] Partial hospitalization services are available up to a maximum of 120 days per calendar year in place of inpatient mental health services. Partial hospitalization services are available up to a maximum of 60 days per calendar year in place of inpatient drug and alcohol rehabilitation services.

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Mental Health and Drug and Alcohol Rehabilitation Services (Continued)		
▪ Outpatient drug and alcohol rehabilitation services in conjunction with the treatment of mental disorders		
Group therapy	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
Individual therapy	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
▪ Outpatient detoxification	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
▪ Psychological testing	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
Home Health Care Services		
▪ Home care services ▪ Intermittent skilled nursing care	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
No benefit limit applies to durable medical equipment, physical therapy or occupational therapy received as part of authorized home health care.		

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Durable Medical Equipment including Prosthetics		
Durable medical equipment (DME) including prosthetics - up to a maximum of $1,500 per calendar year for all covered equipment. Coverage includes, but is not limited to: ▪ Durable medical equipment ▪ Prosthetic devices (the DME benefit limit does not apply to artificial arms and legs) ▪ Breast prostheses, including replacements and mastectomy bras (the DME benefit limit does not apply) ▪ 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 ▪ Oxygen and respiratory equipment (the DME benefit limit does not apply)	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
Hypodermic Syringes and Needles		
▪ Hypodermic syringes and needles to the extent Medically Necessary, as required by Massachusetts law	Subject to the applicable prescription drug Copayment listed on your ID card, if your Plan includes 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 Plan includes 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.

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	Same as Durable Medical and Prosthetic Equipment.	Same as Durable Medical and Prosthetic Equipment.
▪ Blood glucose monitors, infusion devices, including insulin pumps and insulin pump supplies	In-Network Deductible, then no charge.	Same as In-Network.
▪ 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 In-Network Deductible, then the applicable prescription drug cost sharing listed on your ID card, if your Plan includes prescription drug coverage. If prescription drug coverage is not available, you will pay the In-Network Deductible, then a $10 Copayment for Tier 1 items, a $25 Copayment for Tier 2 items, and a $40 Copayment for Tier 3 items.	Same as In-Network.

Service	In-Network Participating Providers Cost to Member	Out-of-Network Non-Participating Providers Cost to Member
Other Health Services		
▪ Cardiac rehabilitation ▪ Dialysis ▪ Early intervention services - up to $5,200 per calendar year and a lifetime maximum of $15,600 ▪ Second opinion ▪ Physical and occupational therapies - combined up to 20 visits per condition per calendar year ▪ Speech-language and hearing services, including therapy	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
▪ House calls	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
▪ Emergency ambulance services	In-Network Deductible, then no charge.	Same as In-Network.
▪ Ambulance services ▪ Low protein foods ($2,500 per calendar year) ▪ State mandated formulas	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.
▪ Hospice services	In-Network Deductible, then no charge. If Inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.	Out-of-Network Deductible, then 20% Coinsurance. If Inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.
▪ Vision hardware for special conditions (please see your Benefit Handbook for details and limits on your coverage)	In-Network Deductible, then no charge.	Out-of-Network Deductible, then 20% Coinsurance.

Special Enrollment Rights

For Subscribers enrolled through an Employer Group:

If the Subscriber declines enrollment for himself or herself and Dependents (including spouse) because of other health insurance coverage, the Subscriber may be able to enroll in this plan in the future along with the Dependents, provided that enrollment is requested within 30 days after other coverage ends. In addition, if the Subscriber has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the Subscriber may be able to enroll along with the new Dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption.

Member Cost Sharing

Deductible

A Deductible is a specific dollar amount that is payable by the Member for Covered Benefits received each calendar year before any benefits are payable by the Plan. An exception may apply to specific preventive care services listed in this *Schedule of Benefits*. Deductible amounts are incurred as of the date of service.

Your Plan has two separate Deductibles, one that applies to In-Network services and one that applies to Out-of-Network services. Expenses incurred for In-Network services, (including prescription drugs) apply only to the In-Network Deductible. Expenses incurred for Out-of-Network services apply only to the Out-of-Network Deductible.

You must meet the In-Network Deductible before coverage is provided for any In-Network service that is subject to the Deductible. The In-Network Deductible applies to all In-Network services except those for which only a fixed dollar Copayment is payable by the Member. (Please see the table above for a list of services requiring payment of a Copayment or services subject to the In-Network Deductible.)

You must meet the Out-of-Network Deductible before coverage is provided for any Out-of-Network service that is subject to the Deductible. You must meet the Out-of-Network Deductible before any Out-of-Network service is covered by the Plan. (Please see the table above for a list of services subject to the Out-of-Network Deductible.)

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, the Deductible is met when any number of Members in a covered family meet the family Deductible, then all Members of the covered family receive coverage for services subject to that Deductible for the remainder of the calendar year. These rules apply to the separate Deductibles for In-Network and Out-of-Network services under the Plan.

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. Please refer to the table above for the specific Copayments that apply to your Plan. Your identification card also indicates the Copayment amounts for the Plan's most frequently used services.

Please note: Occasionally the Copayment may exceed the contract rate payable by HPHC Insurance Company 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.

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 In-Network Providers, Covered Charges are based on the contracted rate between HPHC Insurance Company and the Provider. 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, one that applies to In-Network services and one that applies to Out-of-Network services. Only expenses incurred for covered In-Network services apply to the In-Network Out-of-Pocket Maximum. Only expenses incurred for covered Out-of Network services apply to the Out-of-Network Out-of Pocket Maximums.

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

- Any expenses above the Usual, Customary and Reasonable Charge for a service
- Any penalty for failure to receive Prior Approval when required

Lifetime Benefit Maximum

- Your Plan has an Out-of-Network Lifetime Benefit Maximum. The Out-of-Network Lifetime Benefit Maximum is the total amount payable by HPHC Insurance Company for Covered Benefits per Member per lifetime.

Member Responsibility when using Non-Participating Providers

Services Requiring Prior Approval

Members are responsible for obtaining Prior Approval from HPHC Insurance Company before receiving any service requiring prior approval listed in Section A.5 of the *Benefit Handbook*. 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.

To request Prior Approval, please call one of the following telephone numbers:

- For all medical services, call 1-800-708-4414
- For all Mental Health and Drug and Alcohol Rehabilitation Services, call 1-888-777-4742

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 the Out-of-Network Deductible or Out-of-Pocket Maximum.

Maternity Care

If you are pregnant and using a Non-Participating Provider, you may call the Brighter Infant Beginnings Program, at 1-800-742-2423, after the first prenatal visit.

Exclusions From Coverage

In addition to the coverage exclusions listed in your *Benefit Handbook*, your Plan does not cover the following:

- Chiropractic services, including osteopathic manipulation
- Eyeglasses, contact lenses and fittings, except as listed in your *Benefit Handbook* and this *Schedule of Benefits*
- Hearing aids
- Foot orthotics, except for the treatment of severe diabetic foot disease