Schedule of Benefits

HPHC Insurance Company, Inc.

THE HPHC INSURANCE COMPANY BEST BUY HSA PPO PLAN
MASSACHUSETTS

This Schedule of Benefits summarizes your benefits under The HPHC Insurance Company Best Buy HSA PPO Plan (the Plan) and states the Member Cost Sharing amounts that you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook and Prescription Drug Brochure (if you have the Plan's outpatient pharmacy coverage) for detailed information on benefits covered by the Plan and the terms and conditions of coverage.

There are two levels of coverage - In-Network and Out-of-Network

In-Network coverage applies when you use a Plan Provider for Covered Benefits. When using Plan Providers, coverage is based on the contracted rate between HPHC and the Provider.

Out-of-Network coverage applies when you use a Non-Plan Provider for Covered Benefits. When using Non-Plan Providers, the Plan pays only a percentage of the cost of the care you receive up to the Allowed Amount for the service. In most cases, this will be higher than the HPHC contracted rate. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount. Please refer to section I.E.6., titled "Member Cost Sharing" in your Benefit Handbook for additional information about Out-of-Network Charges in excess of the Allowed Amount.

In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Member Cost Sharing is listed below under the heading "Emergency Room Care."

Member Responsibility for Notification and Prior Approval

Members must contact HPHC for coverage of a number of services. These are listed below.

Mental Health Care (Including the Treatment of Substance Abuse Disorders). Notification must be provided before the start of any planned inpatient admission to a Non-Plan mental health or drug and alcohol rehabilitation facility. Prior Approval must be obtained before receiving certain mental health services from Non-Plan Providers. This requirement also applies to treatment of substance abuse disorders. Please refer to our internet site, **www.harvardpilgrim.org**, or contact the Member Services Department at **1-888-333-4742** for a list of services. To obtain provide Notification or Prior Approval for mental health or substance abuse services, please call the Behavioral Health Access Center at **1-888-777-4742**.

Medical Services. Members are required to notify HPHC before the start of any planned inpatient admission to a Non-Plan Medical Facility. Members are also required to obtain Prior Approval from HPHC for certain services. Before you receive services from a Non-Plan Provider, please refer to our Internet site, **www.harvardpilgrim.org**, or contact the Member Services Department at **1-888-333-4742** for a list of Out-of-Network services that require Prior Approval.

If you do not provide Notification or obtain Prior Approval when required, you will be responsible for paying the Penalty amount stated in this Schedule of Benefits in addition to any applicable Member Cost Sharing. No coverage will be provided if HPHC determines that the service is not Medically Necessary, and you will be responsible for the entire cost of the service.

Emergency Care. You do not need to contact HPHC before receiving care in a Medical Emergency. In the event of an emergency hospital admission to a Non-Plan Provider, you must notify HPHC within 48 hours of the admission, unless notification is not possible because of your condition. If notice is given to HPHC by an attending emergency physician, no further notification is required. However, if notification is not received when the Member's condition permits it, the Member is responsible for the Penalty amount stated in this Schedule of Benefits. Please call **1-800-708-4414** to notify us of an emergency admission to a Non-Plan facility.

Clinical Review Criteria

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **1-888-888-4742 ext. 38723**.

COPAYMENTS

A Copayment is a dollar amount that is payable by the Member for certain Covered Benefits. The Copayment is due at the time services are rendered or when billed by the provider. Different Copayments apply depending on the type of service, the specialty of the provider and the location of service.

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.

COVERED BENEFITS

Your Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at **1-888-333-4742**.

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and other Copayments	
	See Covered Benefits below
Out-of-Network Coinsurance and Copayments	
	See Covered Benefits below
Deductible	
Your Plan Deductible can be met by any combination of eligible In-Network and Out-of-Network expenses.	$1,500 for Individual Coverage per Plan Year $3,000 for Family Coverage per Plan Year
Important Notice: If you have Family Coverage, the Deductible may be met by any combination of covered family Members. The individual Deductible does not apply. No Member in the family is eligible for benefits subject to the Deductible until the Family Coverage Deductible is met.	

General Cost Sharing Features:	Member Cost Sharing:
Out-of-Pocket Maximum	
Includes all In-Network and Out-of-Network Member Cost Sharing except: – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers	$3,000 for Individual Coverage per Plan Year $6,000 for Family Coverage per Plan Year
Important Notice: If you have Family Coverage, the Out-of-Pocket Maximum may be met by any combination of covered family Members. The individual Out-of-Pocket Maximum does not apply. Once the Out-of-Pocket Maximum has been reached, no additional Member Cost Sharing will be applied for the remainder of the Plan Year.	
Out-of-Network Penalty Payment	
– Does not count toward the Deductible or Out-of-Pocket Maximum	$500
Deductible Rollover	
– None	

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Acupuncture Treatment for Injury or Illness		
– Limited to 20 visits per Plan Year	Deductible, then no charge	Deductible, then 20% Coinsurance
Ambulance Transport		
– Emergency ambulance transport	Deductible, then no charge	Same as In-Network
– Non-emergency ambulance transport	Deductible, then no charge	Deductible, then 20% Coinsurance
Autism Spectrum Disorders Treatment		
– Applied behavior analysis	Deductible, then no charge	Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Dental Services		
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.		
– Emergency Dental Care **Please Note:** Services must be received within 3 days of injury	Deductible, then no charge	Deductible, then 20% Coinsurance
– Extraction of teeth impacted in bone	Deductible, then no charge	Deductible, then 20% Coinsurance
– Preventive Dental Care for children (up to the age of 13) – limited to 2 preventive dental exams per Plan Year, only the following services are included: – Cleaning	$25 Copayment per visit	20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Dental Services (Continued)		
– Fluoride treatment – Teaching plaque control – X-rays		
Dialysis		
– Dialysis services	Deductible, then no charge	Deductible, then 20% Coinsurance
– Installation of home equipment	Deductible, then no charge	Deductible, then 20% Coinsurance
Durable Medical Equipment		
– Durable medical equipment	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
– Blood glucose monitors, infusion devices and insulin pumps (including supplies)	Deductible, then no charge	Same as In-Network
– Oxygen and respiratory equipment	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Early Intervention Services		
	Deductible, then no charge **Please Note:** The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health	Deductible, then 20% Coinsurance **Please Note:** The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health
Emergency Admission		
	Deductible, then no charge	Same as In-Network
Emergency Room Care		
	Deductible, then no charge	Same as In-Network
Hearing Aids (for Members up to the age of 22)		
– Limited to $2,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then no charge	Deductible, then 20% Coinsurance
Home Health Care		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Please Note: If your Home Health Care services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		
Hospice - Outpatient		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Hospital – Inpatient Services		
– Acute hospital care	Deductible, then no charge	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Hospital – Inpatient Services (Continued)		
– Inpatient maternity care	Deductible, then no charge	Deductible, then 20% Coinsurance
– Inpatient routine nursery care, including prophylactic medication to prevent gonorrhea	No charge	20% Coinsurance
– Home care for mother and newborn following delivery	No charge	20% Coinsurance
– Inpatient rehabilitation – limited to 60 days per Plan Year	Deductible, then no charge	Deductible, then 20% Coinsurance
– Skilled nursing facility – limited to 100 days per Plan Year	Deductible, then no charge	Deductible, then 20% Coinsurance
Hypodermic Syringes and Needles		
	Subject to the applicable pharmacy Member Cost Sharing in your Outpatient Prescription Drug Schedule of Benefits and listed on your ID Card. If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy's retail price or a Copayment of $5 for Tier 1 drugs or supplies, $10 for Tier 2 drugs or supplies and $25 for Tier 3 drugs or supplies. All Copayments are based on a 30 day supply.	
	For information on the different drug tiers, please visit our website at **www.harvardpilgrim.org/members** and select **"pharmacy/drug tier look up"**or contact our Member Services Department at **1-888-333-4742**.	
Infertility Services and Treatments (see the Benefit Handbook for details)		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Laboratory and Radiology Services		
– Laboratory and x-rays	Deductible, then no charge	Deductible, then 20% Coinsurance
Advanced radiology – CT scans – PET scans – MRI – MRA – Nuclear medicine services	Deductible, then no charge	Deductible, then 20% Coinsurance
Please Note: No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org**		
Low Protein Foods		
– Limited to $5,000 per Plan Year	Deductible, then no charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Maternity Care - Outpatient		
– Routine outpatient prenatal and postpartum care **Note:** Member cost sharing **may** apply to prenatal ultrasounds when billed as a specialized or non-routine service. See "Laboratory and Radiology Services" for your applicable Member Cost Sharing.	No charge The Deductible does not apply to prenatal and postpartum care provided in a physician's office. All other care is covered as stated in this Schedule of Benefits.	20% Coinsurance
Please Note: Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, for services provided by another physician or specialist, see "Physician and Other Professional Office Visits" for your applicable Member Cost Sharing. Please see your Benefit Handbook for more information on maternity care.		
Medical Drugs (drugs that cannot be self-administered)		
– Medical drugs received in a doctor's office or other outpatient facility	Deductible, then no charge Coverage may also be provided under the Specialty Pharmacy Program. Please see your Prescription Drug Brochure for details.	Deductible, then 20% Coinsurance
– Medical drugs received in the home	Deductible, then no charge Coverage may also be provided under the Specialty Pharmacy Program. Please see your Prescription Drug Brochure for details.	Deductible, then 20% Coinsurance
Please Note: You may also have the Plan's outpatient prescription drug coverage. That benefit provides coverage for most prescription drugs purchased at an outpatient pharmacy. Some medical drugs received in a physician's office or outpatient facility may be provided by the Specialty Pharmacy Program under your outpatient prescription drug benefit. If you have outpatient prescription drug coverage, your Member Cost Sharing will be listed on your ID Card. Please see the Prescription Drug Brochure for a detailed explanation of your benefits.		
Medical Formulas		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Mental Health Care (Including the Treatment of Substance Abuse Disorders)		
Inpatient services – Mental health services – Drug and Alcohol Rehabilitation Services – Detoxification	Deductible, then no charge	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Mental Health Care (Including the Treatment of Substance Abuse Disorders) (Continued)		
Intermediate Mental Health Care Services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs for mental health and drug and alcohol rehabilitation services	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient services – Mental health services – Drug and alcohol rehabilitation services	**Group therapy** – Deductible, then no charge **Individual therapy** – Deductible, then no charge	**Group therapy** – Deductible, then 20% Coinsurance **Individual therapy** – Deductible, then 20% Coinsurance
– Detoxification	Deductible, then no charge	Deductible, then 20% Coinsurance
– Medication management	Deductible, then no charge	Deductible, then 20% Coinsurance
– Methadone maintenance	Deductible, then no charge	Deductible, then 20% Coinsurance
– Psychological testing and neuropsychological assessment	Deductible, then no charge	Deductible, then 20% Coinsurance
Ostomy Supplies		
	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits)		
– Consultations, evaluations, sickness, and injury care	Deductible, then no charge	Deductible, then 20% Coinsurance
Treatments and procedures, including but not limited to: – Administration of injections – Allergy treatments – Casting, suturing and the application of dressings – Genetic counseling – Non-routine foot care – Pregnancy testing – Surgical procedures	Deductible, then no charge	Deductible, then 20% Coinsurance
– Administration of allergy injections	Deductible, then no charge	Deductible, then 20% Coinsurance
Preventive Care Services – the Deductible does not apply to the preventive services listed below		
– Routine examinations for preventive care, including immunizations	No charge	20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Preventive Services and Tests – the Deductible does not apply to the preventive services and tests listed below		
Preventive care services, including all FDA approved contraceptive devices. Under the federal health care reform law, many preventive services and tests are covered with no Member Cost Sharing. For a list of covered preventive services, please see the Preventive Services notice on our website at: **www.harvardpilgrim.org**. You may also get a copy of the Preventive Services notice by calling the Member Services Department at **1–888–333–4742**.	No charge	20% Coinsurance
Under federal law the list of preventive services and tests may change periodically based on the recommendations of the following agencies: a. Grade "A" and "B" recommendations of the United States Preventive Services Task Force; b. With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and c. With respect to services for women, infants, children and adolescents, the Health Resources and Services Administration. Information on the recommendations of these agencies may be found on the web site of the U.S. Department of Health and Human Services at: **https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with changes in the recommendations of the agencies listed above. You can find a list of the current recommendations for preventive care on Harvard Pilgrim's web site at **www.harvardpilgrim.org**.		
Additional Preventive Services and Tests – Fetal ultrasound – Hepatitis C testing – Lead level testing – Prostate-specific antigen (PSA) screening – Routine hemoglobin tests – Routine urinalysis	No charge	20% Coinsurance
Prosthetic Devices		
	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Rehabilitation and Habilitation Services - Outpatient		
– Cardiac rehabilitation	Deductible, then no charge	Deductible, then 20% Coinsurance
– Pulmonary rehabilitation therapy	Deductible, then no charge	Deductible, then 20% Coinsurance
– Speech-language and hearing services	Deductible, then no charge	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Rehabilitation and Habilitation Services - Outpatient (Continued)		
– Occupational therapy – limited to 60 visits per Plan Year – Physical therapy – limited to 60 visits per Plan Year **Please Note:** Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.	Deductible, then no charge	Deductible, then 20% Coinsurance
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
– Colonoscopy, endoscopy and sigmoidoscopy	Deductible, then no charge	Deductible, then 20% Coinsurance
Please Note: No In-Network Member Cost Sharing applies to certain preventive care services, including screening colonoscopies. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org**.		
Spinal Manipulative Therapy (including care by a chiropractor)		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Surgery – Outpatient		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Urgent Care Services		
– Convenience care clinic	Deductible, then no charge	Deductible, then 20% Coinsurance
– Urgent care clinic (including hospital urgent care clinic)	Deductible, then no charge	Deductible, then 20% Coinsurance
Please Note: Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefit. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory and Radiology Services."		
Vision Services		
– Routine eye examinations – limited to 1 exam per Plan Year	$25 Copayment per visit	20% Coinsurance
– Vision hardware for special conditions	Deductible, then no charge	Deductible, then 20% Coinsurance
Voluntary Sterilization		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Please Note: No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org**.		
Voluntary Termination of Pregnancy		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Wigs and Scalp Hair Prostheses as required by law		
– Limited to $350 per Plan Year (see the Benefit Handbook for details)	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance