HPHC Insurance Company

Massachusetts 2026

Outline of Medicare Supplement Coverage

Medicare Supplement Core
Medicare Supplement 1
Medicare Supplement 1A

Outline of Medicare Supplement Coverage—Cover Page:

Benefit Plans Medicare Supplement Core, 1, and 1A

Medicare Supplement Insurance can be sold in only standard plans. This chart shows the benefits included in each plan. Every company must make available the "Core" plan. For persons who became Medicare Eligible prior to January 1, 2020, companies which make Medicare Supplement 1A plans available are to also make Medicare Supplement 1 plans available. For persons who became Medicare Eligible after January 1, 2020, companies may make Medicare Supplement 1A plans available, but they are not permitted to make Medicare Supplement 1 plans available. Companies may add certain benefits to the standard benefits, if approved by the Commissioner. Look at each company's materials to find out what benefits, if any, the company has added to the standard benefits for each plan it offers.

Basic Benefits:	Included in all plans.
Hospitalization:	Part A Coinsurance coverage for the first 90 days per Benefit Period (not including the Medicare Part A Deductible) and the 60 Medicare lifetime reserve days, plus coverage for 365 additional days after Medicare benefits end. This shall also include benefits for biologically-based mental disorders.
Medical Expenses:	Part B Coinsurance (generally 20% of Medicare-approved expenses), or, in the case of Hospital outpatient department services under a prospective payment system, the applicable copayments. This shall also include benefits for biologically-based mental disorders.
Blood:	First three pints of blood each year.

Massachusetts Medicare Supplement Insurance Outline Of Coverage

HPHC Insurance Company, Inc.
Policy Category: Medicare Supplement Insurance

NOTICE TO BUYER: This Policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

PREMIUM INFORMATION

We, HPHC Insurance Company, Inc. can only raise your premium if we raise the premium for all Policies like yours in Massachusetts, and if approved by the Commissioner of Insurance. If you choose to pay your premium on a monthly basis, upon your death, we will refund the unearned portion of the premium paid. If you choose to pay your premium on a monthly basis and you cancel your Policy, we will refund the unearned portion of the premium paid. In the case of death the unearned portion of the premium will be refunded on a pro-rata basis.

DISCLOSURES

Use this outline to compare benefits and premiums among Policies

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your Policy's most important features. The Policy is your insurance contract. You must read the Policy itself to understand all the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your Policy, you may return it to HPHC Insurance Company, Inc. 1 Wellness Way, ATTN Enrollment/Billing Canton, MA 02021. If you send the Policy back to us within 30 days after you receive it, we will treat the Policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

If you are replacing another health insurance Policy, do NOT cancel it until you have actually received your new Policy and are sure you want to keep it. If you cancel your present Policy and then decide that you do not want to keep your new Policy, it may not be possible to get back the coverage of the present Policy.

If you newly enroll in a Medicare Supplement 1 plan and you became Medicare Eligible before January 1, 2020, you will not be able to switch into the same company's Medicare Supplement 1A plan until you have been covered under the Medicare Supplement 1 plan for a period of at least 12 months.

NOTICE

This Policy may not fully cover all your medical costs. Neither HPHC Insurance Company, Inc. nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new Policy, be sure to answer truthfully and completely all questions. The company may cancel your Policy and refuse to pay any claims if you leave out or falsify important information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

MASSACHUSETTS SUMMARY

The Commissioner of Insurance has set standards for the sale of Medicare Supplement Insurance Policies. Such Policies help you pay hospital and doctor bills, and some other bills, that are not covered in full by Medicare. Please note that the benefits provided by

Medicare and this Medicare Supplement Insurance Policy may not cover all the costs associated with your treatment. It is important that you become familiar with the benefits provided by Medicare and your Medicare Supplement Insurance Policy. This Policy summary outlines the different coverage you have if, in addition to this Policy, you are also covered by Part A (hospital bills, mainly) and Part B (doctors' bills, mainly) of Medicare.

Under M.G.L. c. 112, §.2, no physician who agrees to treat a Medicare beneficiary may charge to or collect from that beneficiary any amount in excess of the reasonable charge for that service as determined by the United States Secretary of Health and Human Services. This prohibition is commonly referred to as the ban on balance billing. A physician is allowed to charge you or collect from your insurer a copayment or coinsurance for Medicare-Covered Services. However, if your physician charges you or attempts to collect from you an amount which together with your copayment or coinsurance is greater than the Medicare-approved amount, please contact the Board of Registration in Medicine at **1-781-876-8200**.

We cannot explain everything here. Massachusetts law requires that personal insurance Policies be written in easy-to-read language. So, if you have questions about your coverage not answered here, read your Policy. If you still have questions, ask your agent or company. You may also wish to get a copy of "Medicare & You", a small book put out by Medicare that describes Medicare benefits.

THE BENEFITS TO PREMIUM RATIO FOR MEDICARE SUPPLEMENT CORE IS 85.6%.

This means that during the anticipated life of your Policy and others just like it, the company expects to pay out $85.60 in claims made by you and all other Policyholders for every $100 it collects in premiums. The minimum ratio allowed for Policies of this type is 65%. A higher ratio is to your advantage as long as it allows the company a reasonable return so that the product remains available.

THE BENEFITS TO PREMIUM RATIO FOR MEDICARE SUPPLEMENT 1 IS 88.5%.

This means that during the anticipated life of your Policy and others just like it, the company expects to pay out $88.50 in claims made by you and all other Policy holders for every $100 it collects in premiums. The minimum ratio allowed for Policies of this type is 65%. A higher ratio is to your advantage as long as it allows the company a reasonable return so that the product remains available.

THE BENEFITS TO PREMIUM RATIO FOR PLAN MEDICARE SUPPLEMENT 1A IS 88.7%.

This means that during the anticipated life of your Policy and others just like it, the company expects to pay out $88.70 in claims made by you and all other Policyholders for every $100 it collects in premiums. The minimum ratio allowed for Policies of this type is 65%. A higher ratio is to your advantage as long as it allows the company a reasonable return so that the product remains available.

COMPLAINTS

If you have a complaint, call us at **1-877-907-4742** or your agent. If you are not satisfied, you may write or call the Massachusetts Division of Insurance, Consumer Service Department 1000 Washington St. Suite 810 Boston, MA 02118, Consumer Services Unit at **1-617-521-7794**.

Medicare Supplement Core	Medicare Supplement 1	Medicare Supplement 1A
STANDARD BENEFITS BASIC BENEFITS	**STANDARD BENEFITS BASIC BENEFITS**	**STANDARD BENEFITS BASIC BENEFITS**
Hospitalization: For biologically-based mental disorders, stays in a licensed mental hospital, less Part A deductibles; for other mental disorders: stays in a licensed mental hospital for at least 60 days per calendar year less days covered by Medicare or already covered by plan in that calendar year for the other mental disorders, less Part A deductibles.	**Hospitalization:** For biologically-based mental disorders, stays in a licensed mental hospital; for other mental disorders: stays in a licensed mental hospital for a minimum of 120 days per benefit period (at least 60 days per calendar year) less days covered by Medicare or already covered by plan in that calendar year for the other mental disorders.	**Hospitalization:** For biologically-based mental disorders, stays in a licensed mental hospital; for other mental disorders: stays in a licensed mental hospital for a minimum of 120 days per benefit period (at least 60 days per calendar year) less days covered by Medicare or already covered by plan in that calendar year for the other mental disorders.
N/A	Skilled Nursing coinsurance	Skilled Nursing coinsurance
N/A	Part A Deductible	Part A Deductible
N/A	Part B Deductible	N/A
N/A	Foreign Travel	Foreign Travel
ADDITIONAL BENEFITS	**ADDITIONAL BENEFITS**	**ADDITIONAL BENEFITS**
Foreign Travel	N/A	N/A
Fitness Reimbursement Program	Fitness Reimbursement Program	Fitness Reimbursement Program
PREMIUM RATE EFFECTIVE 1/1/26	**PREMIUM RATE EFFECTIVE 1/1/26**	**PREMIUM RATE EFFECTIVE 1/1/26**
Billed monthly: $177.10	Billed monthly: $315.15	Billed monthly: $254.10

Medicare Supplement Core

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies, and licensed mental hospital stays for biologically based mental disorders or other mental disorders prior to the 190-day Medicare lifetime maximum			
First 60 days of a benefit period	All but $1,736	$0	$1,736 (Part A Deductible)
61st through 90th day of a benefit period	All but $434	$434 a day	$0
91st day and after of a benefit period:			
• While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0
– Beyond the additional 365 days	$0	$0	All Costs
LICENSED MENTAL HOSPITAL STAYS not covered by Medicare for biologically based mental disorders			
First 60 days of a benefit period	$0	All but $1,736	$1,736 (Part A Deductible)
61st through 90th day of a benefit period	$0	100% of Medicare eligible expenses	$0
91st day and after of a benefit period:			
• While using 60 lifetime reserve days	$0	100% of Medicare eligible expenses	$0
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0
– Beyond the additional 365 days	$0	$0	All Costs

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement Core

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
LICENSED MENTAL HOSPITAL STAYS not covered by Medicare for other mental disorders			
First 60 days per calendar year less days covered by Medicare or already covered by the plan in that calendar year for other mental disorders	$0	All but $1,736	$1,736 (Part A Deductible)
61st day and after of a benefit period	$0	100% of Medicare eligible expenses	$0
Days after 60 days per calendar year less days covered by Medicare or plan in that calendar year	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* (Participating with Medicare) You must meet Medicare's requirements including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after having left the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $217 a day	$0	Up to $217 a day
101st day and after	$0	$0	All Costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the Policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement Core

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for outpatient drugs and inpatient respite care	Coinsurance	$0

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment			
First $283 of Medicare-approved amounts**	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
OUTPATIENT TREATMENT FOR BIOLOGICALLY BASED MENTAL DISORDERS (For services covered by Medicare)			
First $283 of Medicare-approved amounts**	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
OUTPATIENT TREATMENT FOR BIOLOGICALLY BASED MENTAL DISORDERS (For services not covered by Medicare)			
	$0	100% of expenses	$0

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement Core

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
OUTPATIENT TREATMENT FOR OTHER MENTAL HEALTH DISORDERS (for services covered by Medicare)			
First $283 of Medicare-approved amounts**	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
OUTPATIENT TREATMENT FOR OTHER MENTAL HEALTH DISORDERS (for services not covered by Medicare)			
First 24 visits per calendar year	$0	100%	$0
Visits 25 and after	$0	$0	All Costs
BLOOD			
First three pints	$0	All Costs	$0
Next $283 of Medicare-approved amounts**	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Blood tests for diagnostic services	100%	$0	$0
SPECIAL MEDICAL FORMULAS MANDATED BY LAW (Covered by Medicare)			
First $283 of Medicare-approved amounts**	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Not covered by Medicare	$0	All allowed charges	Balance

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement Core

MEDICARE (PARTS A & B)

**Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE (Medicare-approved services)			
Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT			
First $283 of Medicare-approved amounts**	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS (NOT COVERED BY MEDICARE)

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL (Not covered by Medicare) Only the services listed above while traveling outside the United States			
	$0	Remainder of charges (including portion normally paid by Medicare)	$0
OUTPATIENT PRESCRIPTION DRUGS (Not covered by Medicare)			
	$0	$0	All Costs
FITNESS REIMBURSEMENT PROGRAM (Not covered by Medicare)			
	$0	Up to $150	All charges after $150

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement 1

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies, and licensed mental hospital stays for biologically based mental disorders or other mental disorders prior to the 190-day Medicare lifetime maximum			
First 60 days of a benefit period	All but $1,736	$1,736 (Part A Deductible)	$0
61st through 90th day of a benefit period	All but $434 a day	$434 a day	$0
91st day and after of a benefit period:			
• While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0
– Beyond the additional 365 days	$0	$0	All Costs
LICENSED MENTAL HOSPITAL STAYS for biologically based mental disorders not covered by Medicare			
First 60 days of a benefit period	$0	100% of Medicare eligible expenses	$0
61st through 90th day of a benefit period	$0	100% of Medicare eligible expenses	$0
91st day and after of a benefit period:			
• While using 60 lifetime reserve days	$0	100% of Medicare eligible expenses	$0
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0
– Beyond the additional 365 days	$0	$0	All Costs

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement 1

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
LICENSED MENTAL HOSPITAL STAYS not covered by Medicare for other mental disorders			
First 120 days per benefit period (at least 60 days per calendar year) less days covered by Medicare or already covered by the plan in that calendar year for other mental disorders			
• First 60 days of a benefit period	$0	100% of Medicare eligible expenses	$0
• 61st through 120th day of a benefit period	$0	100% of Medicare eligible expenses	$0
Beyond the additional 365 days	$0	$0	All Costs
Days after 120 days per benefit period (or 60 days per calendar year) less days covered by Medicare or plan in that calendar year	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* (Participating with Medicare) You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after having left the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $217 a day	Up to $217 a day	$0
101st day through 365th day of a benefit period	$0	$10 a day	Balance
Beyond the 365th day of a benefit period	$0	$0	All Costs
(Not Participating with Medicare) You must meet Medicare's requirements including having been in a hospital for at least three days and transferred to the facility within 30 days after having left the hospital			
1st day through 365th day of a benefit period	$0	$8 a day	Balance
Beyond the 365th day of a benefit period	$0	$0	All Costs

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement 1

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for outpatient drugs and inpatient respite care	Coinsurance	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement 1

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment			
First $283 of Medicare-approved amounts	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
OUTPATIENT TREATMENT FOR BIOLOGICALLY BASED MENTAL DISORDERS (for services covered by Medicare)			
First $283 of Medicare-approved amounts	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
OUTPATIENT TREATMENT FOR BIOLOGICALLY BASED MENTAL DISORDERS (for services not covered by Medicare)			
	$0	100%	$0
OUTPATIENT TREATMENT FOR OTHER MENTAL HEALTH DISORDERS (for services covered by Medicare)			
First $283 of Medicare-approved amounts	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
OUTPATIENT TREATMENT FOR OTHER MENTAL HEALTH DISORDERS (for services not covered by Medicare)			
First 24 visits per calendar year	$0	100%	$0
Visits 25 and after	$0	$0	All Costs

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement 1

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

Services	Medicare Pays	Plan Pays	You Pay
BLOOD			
First three pints	$0	All Costs	$0
Next $283 of Medicare-approved amounts	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Blood tests for diagnostic services	100%	$0	$0
SPECIAL MEDICAL FORMULAS MANDATED BY LAW (Covered by Medicare)			
First $283 of Medicare-approved amounts	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Not covered by Medicare	$0	All allowed charges	Balance

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement 1

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE (Medicare-approved services)			
Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT			
First $283 of Medicare-approved amounts	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS (NOT COVERED BY MEDICARE)

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL (Not covered by Medicare) Only the services listed above while traveling outside the United States			
	$0	Remainder of charges (including portion normally paid by Medicare)	$0
OUTPATIENT PRESCRIPTION DRUGS (Not covered by Medicare)			
	$0	$0	All Costs
FITNESS REIMBURSEMENT PROGRAM (Not covered by Medicare)			
	$0	Up to $150	All charges after $150

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement 1A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies, and licensed mental hospital stays for biologically based mental disorders or other mental disorders prior to the 190-day Medicare lifetime maximum			
First 60 days of a benefit period	All but $1,736	$1,736 (Part A Deductible)	$0
61st through 90th day of a benefit period	All but $434 a day	$434 a day	$0
91st day and after of a benefit period:			
• While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0
– Beyond the additional 365 days	$0	$0	All Costs
LICENSED MENTAL HOSPITAL STAYS for biologically based mental disorders not covered by Medicare			
First 60 days of a benefit period	$0	100% of Medicare eligible expenses	$0
61st through 90th day of a benefit period	$0	100% of Medicare eligible expenses	$0
91st day and after of a benefit period:			
• While using 60 lifetime reserve days	$0	100% of Medicare eligible expenses	$0
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0
– Beyond the additional 365 days	$0	$0	All Costs

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement 1A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
LICENSED MENTAL HOSPITAL STAYS not covered by Medicare for other mental disorders			
First 120 days per benefit period (at least 60 days per calendar year) less days covered by Medicare or already covered by the plan in that calendar year for other mental disorders			
• First 60 days of a benefit period	$0	100% of Medicare eligible expenses	$0
• 61st through 120th day of a benefit period	$0	100% of Medicare eligible expenses	$0
Beyond the additional 365 days	$0	$0	All Costs
Days after 120 days per benefit period (or 60 days per calendar year) less days covered by Medicare or plan in that calendar year	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* (Participating with Medicare) You must meet Medicare's requirements including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after having left the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $217 a day	Up to $217 a day	$0
101st day through 365th day of a benefit period	$0	$10 a day	Balance
Beyond the 365th day of a benefit period	$0	$0	All Costs

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement 1A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
SKILLED NURSING FACILITY CARE* (Not Participating with Medicare) You must meet Medicare's requirements including having been in a hospital for at least three days and transferred to the facility within 30 days after having left the hospital			
1st day through 365th day of a benefit period	$0	$8 a day	Balance
Beyond the 365th day of a benefit period	$0	$0	All Costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for outpatient drugs and inpatient respite care	Coinsurance	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement 1A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment			
First $283 of Medicare-approved amounts**	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
OUTPATIENT TREATMENT FOR BIOLOGICALLY BASED MENTAL DISORDERS (for services covered by Medicare)			
First $283 of Medicare-approved amounts**	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
OUTPATIENT TREATMENT FOR BIOLOGICALLY BASED MENTAL DISORDERS (for services not covered by Medicare)			
	$0	100%	$0
OUTPATIENT TREATMENT FOR OTHER MENTAL HEALTH DISORDERS (for services covered by Medicare)			
First $283 of Medicare-approved amounts**	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
OUTPATIENT TREATMENT FOR OTHER MENTAL HEALTH DISORDERS (for services not covered by Medicare)			
First 24 visits per calendar year	$0	100%	$0
Visits 25 and after	$0	$0	All Costs

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement 1A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
BLOOD			
First three pints	$0	All Costs	$0
Next $283 of Medicare-approved amounts**	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Blood tests for diagnostic services	100%	$0	$0
SPECIAL MEDICAL FORMULAS MANDATED BY LAW (Covered by Medicare)			
First $283 of Medicare-approved amounts**	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Not covered by Medicare	$0	All allowed charges	Balance

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Medicare Supplement 1A

MEDICARE (PARTS A & B)

**Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE (Medicare-approved services)			
Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT			
First $283 of Medicare-approved amounts**	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS (NOT COVERED BY MEDICARE)

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL (Not covered by Medicare)			
Only the services listed above while traveling outside the United States	$0	Remainder of charges (including portion normally paid by Medicare)	$0
OUTPATIENT PRESCRIPTION DRUGS (Not covered by Medicare)			
	$0	$0	All Costs
FITNESS REIMBURSEMENT PROGRAM (Not covered by Medicare)			
	$0	Up to $150	All charges after $150

The deductible and coinsurance amounts listed above reflect the 2026 Medicare deductible and coinsurance amounts. Beginning 1/1/27, these amounts will be replaced with the 2027 Medicare deductible and coinsurance amounts.

Notes

HPHC Insurance Company

Harvard Pilgrim Health Care

a Point32Health company

Language Assistance Services

Arabic (العربية) انتباه: إذا كنت تتحدث لغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. يرجى الاتصال بالرقم الموجود على بطاقة هوية العضو الخاصة بك.

French (Français) ATTENTION : Si vous parlez une langue autre que l'anglais, des services d'assistance linguistique gratuits sont à votre disposition. Veuillez appeler le numéro indiqué sur votre carte d'adhérent.

Greek (Ελληνικά) ΠΡΟΣΟΧΗ: Εάν μιλάτε κάποια άλλη γλώσσα πέρα από τα αγγλικά, γλωσσικές υπηρεσίες χωρίς χρέωση είναι στη διάθεσή σας. Καλέστε τον αριθμό στην κάρτα μέλους σας.

Gujarati (ગુજરાતી) ધ્યાન આપો: જો તમે અંગ્રેજી સિવાય બીજી ભાષા બોલો છો, તો ભાષા હિાય વિાઓ, તમારા માટે મફત ઉપલબ્ધ છે. કૃપા કરીને તમારા ભિ્ય આઈડી કાડ્ડ પરના નંબર પર કૉલ કરો.

Haitian Creole (Kreyòl Ayisyen) ATANSYON: Si w pale yon lang ki pa Anglè, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri rele nimewo ki sou kat ID manm ou a.

Hindi (हिंदी) ध्यान दें: अगर आप अंग्रेजी के अलावा कोई दूसरी भाषा बोलते हैं, तो भाषा सहायता सेवाएं आपके ललए ननःशुल्क उपलब्ध हैं। कृपया अपने सदस्य आईडी काडड पर ददए गए नंबर पर कॉल करें।

Italian (Italiano) ATTENZIONE: se parli una lingua diversa dall'inglese, sono disponibili gratuitamente servizi di assistenza linguistica. Chiama il numero indicato sulla tua tessera membro identificativa.

Khmer (ភាសាខ្មែរ) ប្រសិនបរអ្ន កនិយាយភាសាបសងេបហ្ាពីភាសាអ្ង់បលេ ស បសវាកម្មជំនួ យភាសា ដលែឥតលិតថ្លេ លីអាចរកហានសហ្ារអ្ន ក។ សូ ម្ហ្ាហ្ាកាន់បលខហ្ាបលី ID កាតសាជិកររស់អ្ន ក។

Korean (한국어) 알림: 영어 이외의 언어를 사용하신다면 언어 지원 서비스를 무료로 제공해 드립니다. 가입자 ID 카드에 명시된 번호로 전화하시기 바랍니다.

Lao (ພາສາລາວ) ກະລຸນາ ຮັບຊາບ: ຖ້າ ທ່ານເວົ້າພາສາອື່ນີ່ທ່ໍບແ ່ມນພາສາ ອັງິກດ, ທ່ານສາມາດໃຊ້ບໍລການ້ດ້ານພາສາໄ ດ້ ໂດຍ່ໍ່ບເສຍ ່ຄາ. ກະລຸນາໂທຫາເບີ່ທ່ໍ ຢໃນ ບັດປະຈໍາ ຕົວສະມາຊິກຂອງ ທ່ານ.

Polish (polski) UWAGA: Jeśli posługujesz się językiem innym niż angielski, możesz bezpłatnie korzystać z usług pomocy językowej. Zadzwoń pod numer podany na Twojej karcie członkowskiej.

Portuguese (Português) ATENÇÃO: caso fale outro idioma que não o inglês, são-lhe disponibilizados gratuitamente serviços de assistência linguística. Ligue para o número no seu cartão de identificação de membro.

Russian (Русский) ВНИМАНИЕ! Если вы не говорите на английском языке, то можете бесплатно воспользоваться услугами языковой поддержки. Позвоните по номеру, указанному на вашей идентификационной карте участника.

Spanish (Español) ATENCIÓN: Si usted habla un idioma que no sea inglés, están disponibles para usted, sin costo, servicios de asistencia en otros idiomas. Llame al número que figura en su tarjeta de identificación de miembro.

Traditional Chinese (繁體中文) 注意事項：如果您講非英語的其他語言，我們可以為您提供免費的語言協助服務。請撥打您會員 ID 卡上的電話號碼。

Vietnamese (Tiếng Việt) LƯU Ý: Nếu quý vị nói ngôn ngữ khác không phải tiếng Anh, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi đến số điện thoại trên thẻ ID hội viên của quý vị.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Please call the number on your member ID card.

Continued on next page

General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity).

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer (see below for contact information).

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity) you can file a grievance with:

Point32Health Civil Rights Legal Coordinator
1 Wellness Way
Canton, MA 02021-1166

866-750-2074, TTY service: 711
Fax: 617-668-2754
Email: **OCRCoordinator@point32health.org**

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
www.hhs.gov/ocr/office/file/index.html

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.