HPHC Insurance Company

2026 Outline of Medicare Supplement Coverage

Maine

BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS SOLD FOR EFFECTIVE DATES ON OR AFTER JUNE 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company shall make Plan "A" available. Some plans may not be available in your state.

The Deductible and Coinsurance amounts listed below 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.

Note: The Plans shaded in grey are currently available for sale.

BASIC BENEFITS:

- **Hospitalization**—Part A Coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses**—Part B Coinsurance (generally 20% of Medicare approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B Coinsurance or copayments.
- **Blood**—First three pints of blood each year.
- **Hospice**—Part A Coinsurance.

Plan A	Plan B	Plan C	Plan D	Plan F	High Deductible Plan F*	Plan G	Plan K	Plan L	Plan M	Plan N
Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER

*Plan F also has an option called a High Deductible Plan F. This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2,950 deductible. Benefits for high deductible Plan F will not begin until out-of-pocket expenses exceed $2,950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A and Part B but do not include the plan's separate foreign travel emergency deductible.

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2026 Outline of Medicare Supplement Coverage

Maine

Note: The Plans shaded in grey are currently available for sale

Plan A	Plan B	Plan C	Plan D	Plan F	High Deductible Plan F*	Plan G	Plan K	Plan L	Plan M	Plan N
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit $8,000; paid at 100% after limit is reached	Out-of-pocket limit $4,000; paid at 100% after limit is reached		

*Plan F also has an option called a High Deductible Plan F. This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2,950 deductible. Benefits for high deductible Plan F will not begin until out-of-pocket expenses exceed $2,950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A and Part B but do not include the plan's separate foreign travel emergency deductible.

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.

Premium Information

We, HPHC Insurance Company, Inc. can only raise your premium if we raise the premium for all Policies like yours in this State.

Plan Type	Plan A	Plan F	Plan G	Plan M	Plan N
Billed Monthly	$306.00	$382.00	$361.00	$311.00	$273.00

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 of the rights and duties of both you and HPHC Insurance Company, Inc.

Right to Return Policy

If you find that you are not satisfied with your Policy, you may return it to:

HPHC Insurance Company, Inc.
Attn: Enrollment/Billing
1 Wellness Way
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 of 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.

Notice

This Policy may not fully cover all of your medical costs. HPHC Insurance Company, Inc. is not 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 about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

The chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid. The Plans shaded in grey are currently available for sale

	Plans Available to All Applicants								Medicare first eligible before 2020 only	
Benefits	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[2]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			80%	80%			80%	80%	80%	80%
Out-of-pocket limit in 2026[3]					$8,000[3]	$4,000[3]				

[1]Plans F and G also have a high deductible option which require first paying a plan deductible of $2,950 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2]Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

[3]Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

Plan A

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

Services	Medicare Pays:	Plan Pays:	You Pay:
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.			
First 60 days	All but $1,736	$0	$1,736 (Part A Deductible)
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
• 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

*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 have not received skilled care in any other facility for 60 days in a row.

**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.

Plan A

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

Services	Medicare Pays:	Plan Pays:	You Pay:
SKILLED NURSING FACILITY CARE* 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 leaving 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
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited Copayment/ Coinsurance for outpatient drugs and inpatient respite care	Medicare Copayment/Coinsurance	$0

*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 have not received skilled care in any other facility for 60 days in a row.

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.

Plan A

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	$0	$283 (Part B Deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$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			
Tests for Diagnostic Services	100%	$0	$0

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

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.

Plan A

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	$0	$283 (Part B Deductible)
• Remainder of Medicare approved amounts	80%	20%	$0

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

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.

Plan F

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

Services	Medicare Pays:	Plan Pays:	You Pay:
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
• 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

*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 have not received skilled care in any other facility for 60 days in a row.

**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.

Plan F

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

Services	Medicare Pays:	Plan Pays:	You Pay:
SKILLED NURSING FACILITY CARE* 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 leaving 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 and after	$0	$0	All Costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited Copayment/ Coinsurance for outpatient drugs and inpatient respite care	Medicare Copayment/Coinsurance	$0

*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 have not received skilled care in any other facility for 60 days in a row.

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.

Plan F

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
Part B Excess Charges (Above Medicare approved amounts)	$0	100%	$0
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			
Tests for Diagnostic Services	100%	$0	$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.

Plan F

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			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
• First $250 each calendar year	$0	$0	$250
• Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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.

Plan G

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

Services	Medicare Pays:	Plan Pays:	You Pay:
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
• 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

*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 have not received skilled care in any other facility for 60 days in a row.

**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.

Plan G

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

Services	Medicare Pays:	Plan Pays:	You Pay:
SKILLED NURSING FACILITY CARE* 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 leaving 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 and after	$0	$0	All Costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited Copayment/ Coinsurance for outpatient drugs and inpatient respite care	Medicare Copayment/Coinsurance	$0

*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 have not received skilled care in any other facility for 60 days in a row.

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.

Plan G

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	$0	$283 (Unless Part B Deductible has been met)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First three pints	$0	All Costs	$0
Next $283 of Medicare approved amounts*	$0	$0	$283 (Unless Part B Deductible has been met)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for Diagnostic Services	100%	$0	$0

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

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.

Plan G

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	$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			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
• First $250 each calendar year	$0	$0	$250
• Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

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.

Plan M

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

Services	Medicare Pays:	Plan Pays:	You Pay:
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.			
First 60 days	All but $1,736	$868 (50% of Part A Deductible)	$868 (50% of Part A Deductible)
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
• 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

*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 have not received skilled care in any other facility for 60 days in a row.

**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.

Plan M

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

Services	Medicare Pays:	Plan Pays:	You Pay:
SKILLED NURSING FACILITY CARE* 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 leaving 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 and after	$0	$0	All Costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited Copayment/ Coinsurance for outpatient drugs and inpatient respite care	Medicare Copayment/Coinsurance	$0

*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 have not received skilled care in any other facility for 60 days in a row.

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.

Plan M

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	$0	$283 (Part B Deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$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			
Tests for Diagnostic Services	100%	$0	$0

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

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.

Plan M

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	$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			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
• First $250 each calendar year	$0	$0	$250
• Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

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.

Plan N

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

Services	Medicare Pays:	Plan Pays:	You Pay:
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
• 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

*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 have not received skilled care in any other facility for 60 days in a row.

**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.

Plan N

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

Services	Medicare Pays:	Plan Pays:	You Pay:
SKILLED NURSING FACILITY CARE* 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 leaving 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 and after	$0	$0	All Costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited Copayment/ Coinsurance for outpatient drugs and inpatient respite care	Medicare Copayment/Coinsurance	$0

*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 have not received skilled care in any other facility for 60 days in a row.

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.

Plan N

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	$0	$283 (Part B Deductible)
Remainder of Medicare approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare approved amounts)	$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			
Tests for Diagnostic Services	100%	$0	$0

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

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.

Plan N

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	$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			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
• First $250 each calendar year	$0	$0	$250
• Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

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. يرجىالاتصال 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 કાડ 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 ननःशिुल्क उपलब्ध हैं। कृ पया 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 កនិយាយភាសាបសងេបបា្តីភាសាអ្ង់បលេ ស បសវាកម្មជំនួ យភាសា ដលែឥតលិតថ្លេ លើអាចរកហានសបា្រអ្ន ក។ សូ ម្បាបាកាន់ បលេខបាបលើ 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 ນ່ມນພາສາ ອັງິກດ, ທ່ານສາມາດໃຊ້ບໍລການ້ດ້ານພາສາໄ ດ້ ໂດຍ່ໍບເສຍ ຄ່າ. ກະລຸນາໂທຫາເບີ່ທ່ຢູ່ໃນ 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.

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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**