HPHC Insurance Company

2020 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 must make Plan "A" available. Some plans may not be available in your State.

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

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

* 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 $2,340 deductible. Benefits for high deductible Plan F will not begin until out-of-pocket expenses exceed $2,340. 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 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

HPHC Insurance Company

2020 Outline of Medicare Supplement Coverage

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 $5,880 paid at 100% after limit is reached	Out-of-pocket limit $2,940 paid at 100% after limit is reached		

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

* 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 $2,340 deductible. Benefits for high deductible Plan F will not begin until out-of-pocket expenses exceed $2,340. 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 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 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	$186.00	$233.00	$218.00	$189.00	$165.00

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.
1600 Crown Colony Drive
ATTN: Enrollment/Billing Quincy, MA 02169.
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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	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[3]	✓	✓
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)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2020[2]					$5,880[2]	$2,940[2]				

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

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2,340 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] 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.

[3] 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.

PLAN A
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 have 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			
First 60 days	All but $1,408	$0	$1,408 (Part A Deductible)
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after - While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	 $0 $0	 100% of Medicare eligible expenses $0	 $0** All Costs

** 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 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN A
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 have 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* 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 $176 a day	$0	Up to $176 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

The deductible and coinsurance amounts listed above reflect the 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN A
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $198 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.

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 out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment			
First $198 of Medicare approved amounts*	$0	$0	$198 (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 $198 of Medicare approved amounts*	$0	$0	$198 (Part B Deductible)
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 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN A
MEDICARE (PARTS A & B)

* Once you have been billed $198 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.

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 $198 of Medicare approved amounts*	$0	$0	$198 (Part B Deductible)
- Remainder of Medicare approved amounts	80%	20%	$0

The deductible and coinsurance amounts listed above reflect the 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN F
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 have 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			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $704 a day	$704 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

** 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 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN F
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 have 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* 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 $176 a day	Up to $176 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

The deductible and coinsurance amounts listed above reflect the 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 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 $198 of Medicare approved amounts	$0	$198 (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 $198 of Medicare approved amounts	$0	$198 (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 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 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 $198 of Medicare approved amounts	$0	$198 (Part B Deductible)	$0
- Remainder of Medicare approved amounts	80%	20%	$0

The deductible and coinsurance amounts listed above reflect the 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN F
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

PLAN G
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 have 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			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $704 a day	$704 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

** 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 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN G
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 have 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* 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 $176 a day	Up to $176 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

The deductible and coinsurance amounts listed above reflect the 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $198 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.

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 $198 of Medicare approved amounts*	$0	$0	$198 (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 $198 of Medicare approved amounts*	$0	$0	$198 (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

The deductible and coinsurance amounts listed above reflect the 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN G
MEDICARE (PARTS A & B)

* Once you have been billed $198 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.

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 $198 of Medicare approved amounts*	$0	$0	$198 (Part B Deductible)
- Remainder of Medicare approved amounts	80%	20%	$0

The deductible and coinsurance amounts listed above reflect the 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN G
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

PLAN M
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 have 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			
First 60 days	All but $1,408	$704 (50% of Part A Deductible)	$704 (50% of Part A Deductible)
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after - While using 60 lifetime reserve days	All but $704 a day	$704 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

** 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 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN M
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 have 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* 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 $176 a day	Up to $176 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

The deductible and coinsurance amounts listed above reflect the 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN M
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $198 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.

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 $198 of Medicare approved amounts*	$0	$0	$198 (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 $198 of Medicare approved amounts*	$0	$0	$198 (Part B Deductible)
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 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN M
MEDICARE (PARTS A & B)

* Once you have been billed $198 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.

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 $198 of Medicare approved amounts*	$0	$0	$198 (Part B Deductible)
- Remainder of Medicare approved amounts	80%	20%	$0

The deductible and coinsurance amounts listed above reflect the 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN M
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

PLAN N
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 have 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			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after - While using 60 lifetime reserve days	All but $704 a day	$704 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

** 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 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN N
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 have 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* 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 $176 a day	Up to $176 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

The deductible and coinsurance amounts listed above reflect the 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $198 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.

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 $198 of Medicare approved amounts*	$0	$0	$198 (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

The deductible and coinsurance amounts listed above reflect the 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN N
MEDICARE (PARTS A & B)

* Once you have been billed $198 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First three pints	$0	All Costs	$0
Next $198 of Medicare approved amounts*	$0	$0	$198 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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 $198 of Medicare approved amounts*	$0	$0	$198 (Part B Deductible)
- Remainder of Medicare approved amounts	80%	20%	$0

The deductible and coinsurance amounts listed above reflect the 2020 Medicare deductible and coinsurance amounts. Beginning 1/1/21, these amounts will be replaced with the 2021 Medicare deductible and coinsurance amounts.

PLAN N
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

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HPHC Insurance
Company