HPHC Insurance Company

“I am ready for a plan with predictable costs and the freedom to see the doctors I want”

Harvard Pilgrim’s Medicare Supplement Plan

Massachusetts

The individual shown is representative only. The comment is a composite of sentiments often expressed by our members.

Form No.: 2024MA003

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"My grandkids keep me healthy."

Contact your local licensed Agent/Broker for more information

HPHC Insurance Company

Dear Friend:

We're delighted that you're interested in Harvard Pilgrim's Medicare Supplement Plan. The enclosed materials will explain how our plan options can cover you for the unexpected gaps and any out-of-pocket costs you may experience with Original Medicare only.

We offer three Medicare Supplement Plan options, which feature:

- Predictable costs with no copayments
- The ability to see any Medicare participating provider or hospital anywhere in the country
- No need for referrals
- Continuous open enrollment
- Up to $150 annual Fitness Reimbursement Benefit
- And more

Our Medicare Supplement Plan is offered by HPHC Insurance Company, an affiliate of Harvard Pilgrim Health Care.

To learn more about Harvard Pilgrim's Medicare Supplement Plan, we invite you to review the enclosed materials or call your local licensed Agent/Broker for additional information so they can further explain the Plan options and or answer your questions.

Thank you for considering Harvard Pilgrim's Medicare Supplement Plan.

Sincerely,

Patty Blake
President, Senior Products

HPHC Insurance Company

When it comes to health coverage for Medicare beneficiaries, we make it simple.

Harvard Pilgrim is excited to present our Medicare Supplement Plan that's easy to use and helps to fill in the gaps in your Medicare coverage. Our Plan options will give you the very best Harvard Pilgrim has to offer—the coverage you need at a predictable price.

And with more than 40 years of experience in providing health care coverage for Medicare beneficiaries, we know how to make things simple for you.

"I like having a choice of plan options"

Call or visit us online for more information: 1-877-909-4742 (TTY: 711)

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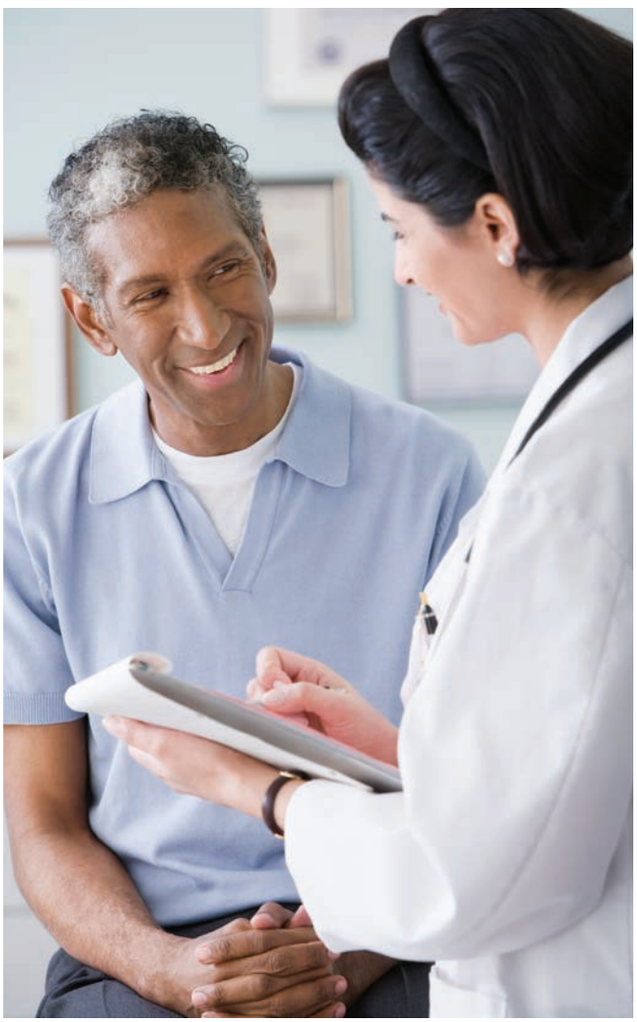
Why Medicare Supplement?

Often people believe that Original Medicare pays for all hospitalization and doctor costs. When first enrolled in Medicare, people are surprised to learn that there are gaps in their coverage and that they're responsible for paying for services that Medicare doesn't completely cover. That's how Harvard Pilgrim can help you. Our Medicare Supplement Plan options help fill in the gaps, and you decide the level of coverage you want.

Our easy-to-use Plan options feature:

- 15% savings off your monthly premium your first year of coverage by enrolling when initially eligible for Medicare
- The choice to go to any Medicare participating provider or hospital anywhere in the country
- The ability to keep the doctor you currently have if they are a Medicare participating physician
- No need for referrals
- Continuous open enrollment – no need to wait for the Medicare Open Enrollment Period
- Choice of Medical Plan options – Medicare Supplement Core Plan, Medicare Supplement 1 Plan or Medicare Supplement 1A Plan
- No copayments for physician services (a Part B deductible applies to the Medicare Supplement Core Plan and Medicare Supplement 1A Plan)
- Worldwide travel emergency coverage
- Fitness Benefit – Up to $150 yearly reimbursement
- Outstanding customer service

We offer three different Medicare Supplement Plan choices: Medicare Supplement Core Plan, Medicare Supplement 1 Plan and Medicare Supplement 1A Plan, with varying levels of premiums and coverage. Please review the enclosed Outline of Coverage and the benefit highlight chart to pick the plan that works best for you.



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What kinds of coverage gaps need to be filled?

When Medicare covers a service, you usually have to pay for a portion of the cost, called a deductible or coinsurance. A deductible is the amount you are responsible for paying before Medicare begins to pay.

After your deductible is paid, you may also have to pay a coinsurance, which is usually 20% of the cost of the service. If you have Original Medicare and Harvard Pilgrim's Medicare Supplement Plan, Medicare will pay its share of the Medicare approved amounts for covered health care costs first. Then Harvard Pilgrim has plan options to cover the rest.

What is Medicare?

Medicare is a Federal government health insurance program that was created in 1965 by the Social Security Administration. It's health insurance for people 65 or older, under 65 with certain disabilities, and any age with End-Stage Renal Disease (ESRD).

Different Parts of Medicare

Medicare Part A
(Hospital Insurance)

- Helps cover inpatient care in hospitals
- Helps cover skilled nursing facility, hospice and home health care

Medicare Part B
(Medical Insurance)

- Helps cover doctors' services and outpatient care
- Helps cover some preventive services to help maintain your health

Medicare Part C
(Medicare Advantage Plans)

- Health plans that are offered by private companies approved by the Centers for Medicare & Medicaid Services (CMS)

Medicare Part D
(Medicare Prescription Drug Coverage)

- A prescription drug option offered by private insurance companies approved by and under contract with the Centers for Medicare & Medicaid Services (CMS)
- Helps cover the cost of prescription drugs

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Medicare Supplement Plan Eligibility

How do I know if I'm eligible to join?

You're eligible to join if:

- You reside in Massachusetts
- You are entitled to Medicare Part A (hospital), enrolled in Medicare Part B (medical) and you continue to pay Medicare Part B premiums. You also may be eligible if you are under 65 and have a disability other than End-Stage Renal Disease
- Medicare Supplement 1 Plan will not be offered to individuals newly eligible for Medicare on or after January 1, 2020

Note: If you are already covered by both Medicare and Medicaid, you most likely do not need the additional coverage that Harvard Pilgrim's Medicare Supplement Plan options would provide.

When do I enroll?

If you are eligible, you can enroll anytime!

However, the best time to enroll in Harvard Pilgrim's Medicare Supplement Plan is during your Medicare Supplement initial open enrollment period since you can save money on your premiums when you're initially eligible for Medicare. This period lasts for six months and begins on the first day of the month in which you are 65 or older and enrolled in Medicare Part B.

If you have group health coverage through an employer because either you or your spouse is currently working, you may want to wait to enroll in Part B. When your employer coverage ends, you will be able to enroll in Part B and take advantage of the discount if you enroll within six months.

You can send in your enrollment application for our plan before your Medicare Supplement open enrollment period starts. This may be important if you currently have coverage that will end when you turn 65, as it allows you to have continuous coverage.

Save money!

To qualify for these premium discounts you must be at least age 65 and apply for coverage within six months of your Part B effective date.

- 15% in the first 12 months of enrollment
- 10% in the second 12 months of enrollment
- 5% in the third 12 months of enrollment

There are no discounts after the third year.

For more information about initial eligibility premium discounts, please refer to the enclosed Monthly Premium Rate Sheet.

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How do I enroll?

It's easy to enroll in Harvard Pilgrim's Medicare Supplement Plan. Compare our Medicare Supplement Plan options from the enclosed Outline of Coverage and Benefit Highlight Chart.

Once you've found a Plan option that works for you, simply complete the Medicare Supplement Plan application included in this package.

Ensure you've read and answered all the questions.

Sign the completed enrollment application and mail it to us. Please do not send your premium payment with the enrollment application; you will receive a bill after your enrollment application has been processed.

Money-back guarantee!

Every plan comes with a 30-day "guarantee" period. This means that you have 30 days after receiving your policy to decide whether or not to keep your policy.

What could be easier?

When will my coverage begin?

Your coverage is effective on the first day of the month following the month in which we received your signed, completed enrollment application. For example, if we received your signed, completed enrollment application on January 15, your coverage will be effective February 1.

Feel confident we're there for you

Harvard Pilgrim has a highly experienced team of Member Service Representatives dedicated to answering your questions once you enroll as a member. They understand that you want a hassle-free experience and will answer your questions in a friendly and knowledgeable way.

HPHC Insurance Company

Discounts and savings programs

Many ways to save on healthy products and services

The advantages of being a Harvard Pilgrim member go beyond the high-quality care, reliability and personal support that distinguishes us.

Our discounts and savings program will help you save on health-related products and services that can enhance your quality of life. Here are some examples:

- Universal Dental Plan membership – provides dental discounts of 20% to 50% on all procedures from a network of participating dentists.
- Free eyewear and eyewear savings programs
  - Get 35% off frames with purchase of a complete pair of eyeglasses at participating EyeMed affiliated providers.
- Savings on Hearing Aids
  - Significant savings off hearing aids and complimentary after-care from select providers.
- Daily Burn – get a 30-day free trial followed by 25% off your monthly membership.
- Save up to 40% on Ompractice membership.
- Get 20% off Lively Products
- Save 10% at Vigorous Minds
- Get 25% savings at award winning meal planning services from The Dinner Daily.
- 20% discount for services such as relocating and downsizing with Life Cycle Transitions.
- Savings on Massage Therapy
- Savings on Acupuncture & Chiropractic Care

Visit us at **www.harvardpilgrim.org/public/discounts-savings**

These savings programs are not insurance products. Rather, they are discount programs and services designed to help keep members healthy and active. All programs subject to change without advance notice.

HPHC Insurance Company

Why join Harvard Pilgrim's Medicare Supplement Plan?

- We make it simple and easy to get the coverage you need at a predictable price
- You have choice and flexibility – a choice of Plan options and the flexibility to go to any Medicare Participating provider or hospital anywhere in the country, with no need for referrals
- You can continue to see your current provider* if he or she is a Medicare participating physician
- You'll enjoy discounts on a wide range of health-related products and services

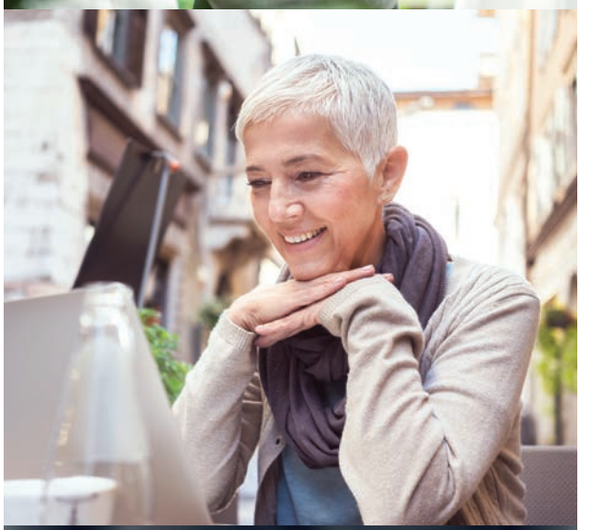
All this from a name you know and trust. So, when you are looking for a supplement to your Medicare coverage, look no further than Harvard Pilgrim.

Call us for more information at 1-(877) 909-4742 or visit us online at **kit.hpforlife.org**

Or You Can Easily Enroll Now!

Enroll over the phone at 1-(877) 906-4742 or online at **kit.hpforlife.org**

It's that Simple!



HPHC Insurance Company

If you are a prospective member and have questions, please call your local licensed Agent/Broker

Massachusetts
Monthly Premium Rates
Effective January 1, 2024 - December 31, 2024

If you are at least age 65 and apply for coverage within six months of your Part B effective date, you may qualify for a discounted premium rate for the first 3 years of enrollment in our plan.

- **15 % in the first 12 months of enrollment;**
- **10% in the second 12 months of enrollment;**
- **5% in the third 12 months of enrollment.**

There are no discounts after the third year.

Medicare Supplement 1 Plan will not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

	Rate without discount	15% discount Year 1	10% discount Year 2	5% discount Year 3
Core Plan	**$150.00**	**$127.50**	**Amount based on 2025 rates**	**Amount based on 2026 rates**
Supplement 1A Plan	**$215.00**	**$182.75**	**Amount based on 2025 rates**	**Amount based on 2026 rates**
Supplement 1 Plan	**$266.50**	**$226.52**	**Amount based on 2025 rates**	**Amount based on 2026 rates**

HPHC Insurance Company

Visit us online at **www.hpforlife.org**
or call **1 (877) 909-4742, TTY 711** for more information.

HPHC's Medicare Supplement Plan
HPHC Insurance Company, Inc.

Outline of Medicare Supplement Coverage – Cover Page:
Benefit Plans Medicare Supplement Core, Medicare Supplement 1 and Medicare Supplement 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.

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.
	Skilled Nursing coinsurance	Skilled Nursing coinsurance
	Part A deductible	Part A deductible
	Part B deductible	
	Foreign Travel	Foreign Travel
Additional Benefits	**Additional Benefits**	**Additional Benefits**
Foreign Travel		
Fitness Reimbursement Program	Fitness Reimbursement Program	Fitness Reimbursement Program
Premium Rate Effective 1/1/24	**Premium Rate Effective 1/1/24**	**Premium Rate Effective 1/1/24**
Billed Monthly: $150.00	**Billed Monthly: $266.50**	**Billed Monthly: $215.00**

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. 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 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.

Massachusetts Medicare Supplement Insurance

Outline of Coverage

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 **(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.

Massachusetts Medicare Supplement Insurance

Outline of Coverage

THE BENEFITS TO PREMIUM RATIO FOR MEDICARE SUPPLEMENT CORE IS 80.4%.

This means that during the anticipated life of your Policy and others just like it, the company expects to pay out $80.40 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 82.5%.

This means that during the anticipated life of your Policy and others just like it, the company expects to pay out $82.50 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 85.4%.

This means that during the anticipated life of your Policy and others just like it, the company expects to pay out $85.40 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 (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 (617) 521-7794.

MEDICARE SUPPLEMENT CORE

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, 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 $1,632	$0	$1,632 (Part A Deductible)
61st through 90th day of a benefit period	All but $408 a day	$408 a day	$0
91st day and after of a benefit period:			
- While using 60 lifetime reserve days	All but $816 a day	$816 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 $1,632	$1,632 (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

*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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

MEDICARE SUPPLEMENT CORE

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

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 $1,632	$1,632 (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 $204 a day	$0	Up to $204 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 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.

*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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

MEDICARE SUPPLEMENT CORE

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 $240 of Medicare-approved amounts**	$0	$0	$240 (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 $240 of Medicare-approved amounts**	$0	$0	$240 (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
Outpatient treatment for other mental health disorders (for services covered by Medicare)			
First $240 of Medicare-approved amounts**	$0	$0	$240 (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

**Once you have been billed $240 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.

The deductible and coinsurance amounts listed above reflect the 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

MEDICARE SUPPLEMENT CORE

MEDICARE (PART B) MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First three pints	$0	All Costs	$0
Next $240 of Medicare-approved amounts**	$0	$0	$240 (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 $240 of Medicare-approved amounts**	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Not covered by Medicare	$0	All allowed charges	Balance

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 $240 of Medicare-approved amounts**	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

**Once you have been billed $240 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.

The deductible and coinsurance amounts listed above reflect the 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

MEDICARE SUPPLEMENT CORE

MEDICARE (PART B) – MEDICAL SERVICES PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS – NOT COVERED BY MEDICARE			
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Only the services listed above while traveling outside of 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

MEDICARE SUPPLEMENT 1

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, 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 $1,632	$1,632 (Part A Deductible)	$0
61st through 90th day of a benefit period	All but $408 a day	$408 a day	$0
91st day of a benefit period and after:			
- While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve 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

*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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

MEDICARE SUPPLEMENT 1

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

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 and after 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 $204 a day	Up to $204 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

*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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

MEDICARE SUPPLEMENT 1

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

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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 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 $240 of Medicare-approved amounts	$0	$240 (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 $240 of Medicare-approved amounts	$0	$240 (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 $240 of allowed charges	$0	$240 (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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 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 $240 of Medicare-approved amounts	$0	$240 (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 $240 of Medicare-approved amounts	$0	$240 (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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 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 $240 of Medicare-approved amounts	$0	$240 (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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

MEDICARE SUPPLEMENT 1A

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, 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 $1,632	$1,632 (Part A Deductible)	$0
61st through 90th day of a benefit period	All but $408 a day	$408 a day	$0
91st day of a benefit period and after:			
- While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserves 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

*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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

MEDICARE SUPPLEMENT 1A

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

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 and after of a benefit period	$0	100% of Medicare eligible expenses	$0
61st through 120th day and after of a benefit period	$0	100% of Medicare eligible expenses	$0
- Beyond the additional 365 days	$0	$0	All Costs
- Days 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 $204 a day	Up to $204 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

*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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

MEDICARE SUPPLEMENT 1A

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

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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

MEDICARE SUPPLEMENT 1A

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 $240 of Medicare-approved amounts**	$0	$0	$240 (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 $240 of Medicare-approved amounts**	$0	$0	$240 (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 $240 of allowed charges	$0	$0	$240 (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

**Once you have been billed $240 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.

The deductible and coinsurance amounts listed above reflect the 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

MEDICARE SUPPLEMENT 1A

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First three pints	$0	All Costs	$0
Next $240 of Medicare-approved amounts**	$0	$0	$240 (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 $240 of Medicare-approved amounts**	$0	$0	$240 (Part B Deductible)
- Remainder of Medicare-approved amounts	80%	20%	$0
(Not covered by Medicare)	$0	All allowed charges	Balance

**Once you have been billed $240 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.

The deductible and coinsurance amounts listed above reflect the 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

MEDICARE SUPPLEMENT 1A

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 $240 of Medicare-approved amounts**	$0	$0	$240 (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 of 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

**Once you have been billed $240 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.

The deductible and coinsurance amounts listed above reflect the 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

NOTES

HPHC Insurance Company

Instructions to help you complete your enrollment application for the HPHC Medicare Supplement Plan

Thank you for applying for membership to HPHC's Medicare Supplement plan.

There are 3 ways to enroll:

1. Enroll online.
2. Enroll over the phone with a plan representative, please call **1-877-906-HPHC (4742)**.
3. Complete a paper enrollment application.

Prior to submitting your enrollment application for processing, please take the time to complete the entire enrollment application. If the enrollment application received is incomplete, it may be returned to you for additional information.

You are eligible to apply for HPHC's Medicare Supplement plan if you meet all of the following requirements:

- Your legal residence is in the state of Massachusetts.
- You are eligible for Medicare Part A and Medicare Part B and enrolled in Medicare Part B.
- If you are under age 65 and qualify for Medicare coverage because of disability, the disability that qualifies you for Medicare is not solely End Stage Renal Disease (ESRD).
- You are eligible for Medicare Supplement 1 if you have attained age 65 before January 1, 2020 or first became eligible for Medicare before January 1, 2020.

Instructions:

1. Please choose a plan and effective date for coverage to begin (i.e. MM/01/YYYY). Your effective date begins the 1st of the month and cannot be prior to the date we receive your application.
2. Please fill in your personal information.
3. Your Medicare information: In order for your enrollment to be complete, you must copy information from your Medicare card, or attach a copy of your letter of Verification from the Social Security Administration or Railroad Retirement Board. If you don't have your Medicare information or have not been assigned a Medicare claim number at this time, call your local Social Security Office to enroll or to obtain proof of enrollment.
4. Read and answer all questions.
5. Read "Important Information" in Section 5.
6. Sign and date the enrollment application.

Detach the yellow copy of this application for your legal records and mail the white enrollment application to:

Harvard Pilgrim Health Care
Medicare Supplement Plan
1 Wellness Way, Canton, MA 02021

If you need assistance or have questions, please call us at:
Prospective Members: 1-877-909-HPHC (4742), TTY 711
Current Members: 1-877-907-HPHC (4742), TTY 711

Massachusetts
❒ New Enrollment
❒ Change to Enrollment

HPHC Medicare Supplement Enrollment Application

The Plan is underwritten by HPHC Insurance Company, an affiliate of Harvard Pilgrim Health Care.

SECTION 1.
Plan Choice: ❒ Core Plan ❒ Supplement 1 Plan ❒ Supplement 1A Plan Plan Effective Date _____

SECTION 2.
Personal Information:

First Name Middle Initial Last Name

Permanent Address *(Number & Street)*

City/State/Zip Code

Billing Address *(if different from your permanent address)*

City/State/Zip Code

Current Insurance Carrier

Social Security Number
___ __ ___ __ ____

Gender ❒ Male ❒ Female

Date of Birth Month Day Year
___ ___ ___

Telephone Number
( ) -

Email Address

SECTION 3.
Medicare Information
Please take out your red, white & blue Medicare Card to complete this section.

Name (as it appears on your Medicare card):

Medicare Number: _____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Supplement plan.

SECTION 4.
Replacement or other Coverage

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement Insurance Policy, or that you had certain rights to buy such a Policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. If you were involuntarily terminated for nonpayment of premium, please also include documentation demonstrating payment of outstanding premiums.

SECTION 4. continued
Please Answer All Questions Please check Yes or No

To the best of your knowledge,

1. (a) Did you turn age 65 in the last six months? ❒ Yes ❒ No
   (b) Did you enroll in Medicare Part B in the last six months? ❒ Yes ❒ No
   (c) If yes, what is the effective date? _____

2. If you are age 65 skip this question and continue to question #3. If you are not yet age 65 you may be eligible if you can answer "No" to the following question: Are you eligible for coverage under Medicare due solely to End Stage Renal disease? ❒ Yes ❒ No

3. Are you covered for medical assistance through the state Medicaid program?
   NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question. ❒ Yes ❒ No
   If yes,
   (a) Will Medicaid pay your premiums for this Medicare Supplement Insurance Policy? ❒ Yes ❒ No
   (b) Do you receive any benefits from Medicaid OTHER THAN payments Toward your Medicare Part B premium? ❒ Yes ❒ No

4. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

   START ____/____/_____ END ____/____/_____
   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement Insurance Policy? ❒ Yes ❒ No
   (c) Was this your first time in this type of Medicare plan? ❒ Yes ❒ No
   (d) Did you drop a Medicare Supplement Insurance Policy to enroll in the Medicare plan? ❒ Yes ❒ No

5. (a) Do you have another Medicare Supplement Insurance Policy in force? ❒ Yes ❒ No
   (b) If so, with what company, and what plan do you have? _____
   _____
   (c) If so, do you intend to replace your current Medicare Supplement Insurance Policy with this policy? ❒ Yes ❒ No

6. Have you had coverage under any other health insurance within the past 63 days? ❒ Yes ❒ No
   (For example , an employer, union, or individual plan)
   (a) If so, with what company and what kind of policy? _____
   _____
   (b) What are your dates of coverage under the other policy? START ___/____/_____ END ____/____/_____
   (If you are still covered under this plan, leave "END" blank.)

SECTION 5.

IMPORTANT INFORMATION

A. You do not need more than one Medicare Supplement Insurance Policy.

B. If you newly enroll in a Medicare Supplement 1 plan, you are not permitted to switch within the same company into a Medicare Supplement 1A plan until you have been covered by the company's Medicare Supplement 1 plan for a period of at least a 12-month period.

C. If you purchase this Policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

D. You may be eligible for Medicaid benefits and may not need a Medicare Supplement Insurance Policy.

E. The benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested,during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your Policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

   If the Medicare Supplement Insurance Policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your Policy was suspended, the reinstituted Policy will not have outpatient prescription drug coverage, as you will be enrolled in the most comparable plan without outpatient prescription drug coverage.

F. If you are eligible for, and have enrolled in a Medicare Supplement Insurance Policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement Insurance Policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement Insurance Policy (or, if that is no longer available, a substantially equivalent Policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.

   If the Medicare Supplement Insurance Policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your Policy was suspended, the reinstituted Policy will not have outpatient prescription drug coverage, as you will be enrolled in the most comparable plan without outpatient prescription drug coverage.

G. Counseling services are available in Massachusetts to provide advice concerning your purchase of Medicare Supplement Insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). You may call the Massachusetts Executive Office of Elder Affairs insurance counseling program at **1-800-243-4636** (**TTY 1-800-439-2370**) or write to that office at the following address for more information: One Ashburton Place, 5th Floor, Boston, MA 02108.

SECTION 6.

I or my authorized representative certify that the statements made and answers given are complete and true. I or my authorized representative have read and carefully considered all of the information on this application. I or my authorized representative also certify that I received the "Outline of Medicare Supplement Coverage." I or my authorized representative understand that no employer, former employer, health care provider, or private or government agency may sponsor, purchase or contribute to the cost of this Harvard Pilgrim Medicare Supplement Plan. I or my authorized representative understand that to enroll in coverage, and for as long as I am covered, I must be entitled to Medicare Part A and enrolled in Medicare Part B. I or my authorized representative understand that membership will become effective upon the first day of the month following acceptance by the Plan.

I or my authorized representative authorize all of my health care providers, other health plans, and insurance companies to release all of my medical records and other information to the Plan or to Plan affiliated health care providers for the purpose of determining my coverage and administering my benefits.

I or my authorized representative authorize the use by the Plan and its agents, of any information obtained hereunder for the delivery of health service, to determine eligibility and entitlement to benefits (including reimbursement by third parties) for education and research in accordance with government regulations and for the other plan professional activities such as utilization review, quality assurance, case management, referral and authorization, disease management, fraud detection, and certain oversight activities, such as accreditation and regulatory audits.

I or my authorized representative understand that the benefits for which I am eligible are those described in the applicable subscriber policy. I or my authorized representative understand that HPHC's Medicare Supplement Insurance premium rates are subject to change as allowed by state law. I or my authorized representative understand that enrollment in this plan is contingent upon payment of premium. I or my authorized representative is entitled to receive a copy of this authorization form.

_____ _____

Signature of Applicant or Authorized Representative (if applicable)* Date

*If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to the application (such as a Power of Attorney).

SECTION 7.

NOTE: THIS SECTION IS ONLY TO BE COMPLETED IF YOU ARE WORKING WITH AN INDEPENDENT INSURANCE AGENT. PLEASE FAX ENROLLMENT FORM TO 1-617-509-4262.

I, or my authorized representative, acknowledge receipt of "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" at the time of my application for coverage in Harvard Pilgrim Health Care's Medicare Supplement Plan.

Please Print:

Applicant Name: _____

Applicant Address: _____

_____

Medicare Number : _____

_____ _____

Signature of Applicant, or Authorized Representative (if applicable)* Date

*If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to the application (such as a Power of Attorney).

Please Print:

Agent/Broker Name _____

Agent /Broker ID _____

_____ _____

Agent /Broker Signature Date

SECTION 8.

NOTE: THIS SECTION IS ONLY TO BE COMPLETED IF YOU ARE WORKING WITH AN INDEPENDENT INSURANCE AGENT AND ARE REPLACING AN EXISTING MEDICARE PLAN

Notice to Applicant Regarding Replacement of
Medicare Supplement Insurance or Medicare Advantage

HPHC Insurance Company

1 Wellness Way, Canton, MA 02021

Save this Notice! It May be Important to you in the future.

According to the information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by HPHC Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. You have 30 days to review your policy and decide whether to keep it. Except that if you are newly enrolling in a Medicare Supplement 1 Plan, then you are not permitted to switch within the same company into a Medicare Supplement 1A plan until you have been covered by the company's Medicare Supplement 1 plan for a period of at least 12 months. You should review your new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, INSURANCE PRODUCER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- ❒ Additional benefits
- ❒ Fewer benefits and lower premiums
- ❒ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ❒ Other (please specify) _____
- ❒ No change in benefits, but lower premiums
- ❒ Disenrollment from a Medicare Advantage plan.
  Please explain reason for disenrollment. Optional only for Direct Mailers _____
  _____

State law provides that your replacement Policy may not contain any preexisting conditions, waiting periods, elimination periods or probationary periods.

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

continued

SECTION 8. continued

Do not cancel your present policy until you have received your new policy and are sure that 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.

_____

Signature of Agent, Broker, or Other Representative*

_____

Typed Name and Address of Issuer, Agent, or Broker

Please Print:
Applicant Name _____

Applicant Address _____

_____

_____

_____ _____

Signature of Applicant or Authorized Representative (if applicable)* Date

* If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to the application (such as a Power of Attorney).