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

Maine

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

Form No.: 2024ME005

HPHC Insurance Company

"My grandkids keep me healthy."

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

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 five Medicare Supplement Plan options, which feature:

- Variable levels of premiums and coverage
- 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 us for additional information and we can further explain the plan or answer your questions. Call us at at 1-877-909-4742. For TTY service, call 711.

Hours of operation are:

- October 1 - March 31, 8 a.m. – 8 p.m. 7 days a week
- April 1 - September 30, 8 a.m. – 8 p.m. Monday through Friday

You can also visit us online at **kit.hpforlife.org**.

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

Sincerely,

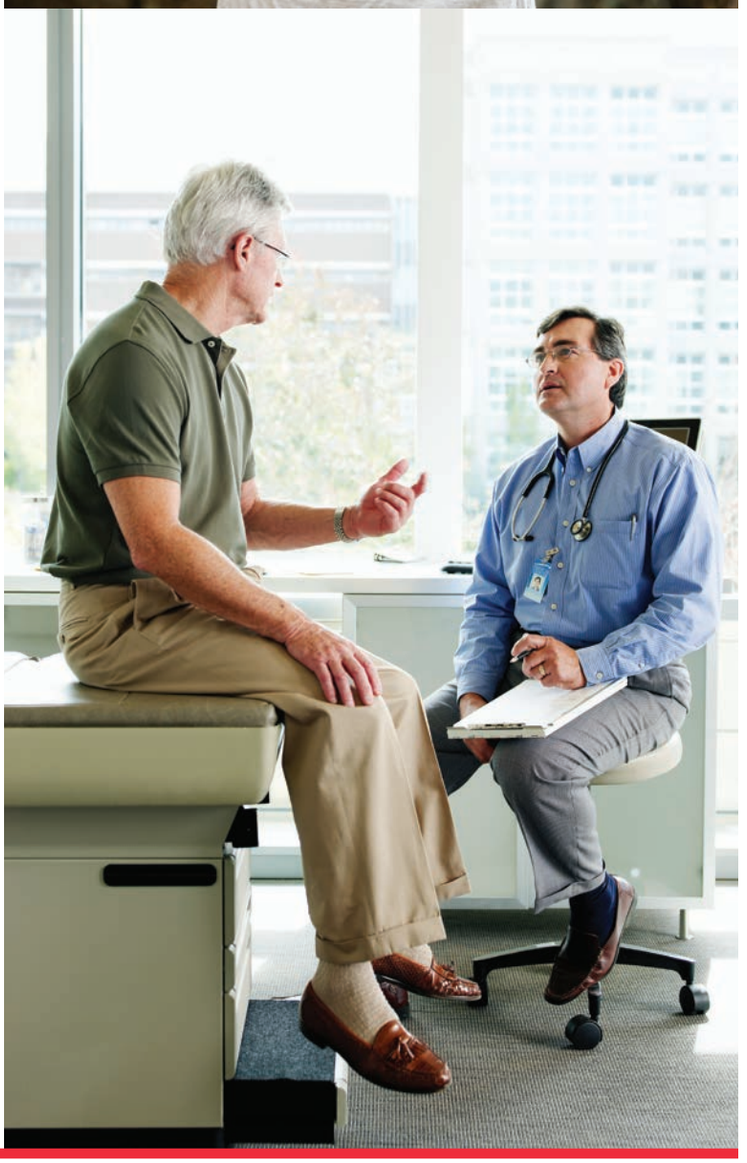
Patty Blake
President, Senior Products

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)

HPHC Insurance Company

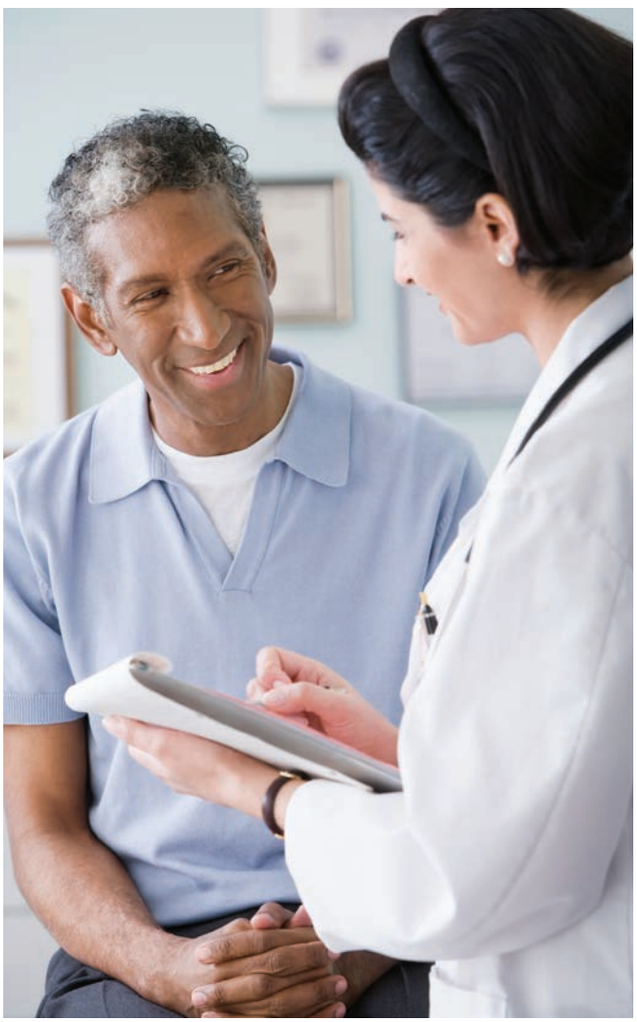
Why Medicare Supplement?

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:

- 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
- Choice of Medical Plan options – A, F, G, M, & N
- No copayments for physician services (Exception Plan N)
- Worldwide travel emergency coverage (Exception Plan A)
- Outstanding customer service

We offer five different Medicare Supplement Plan choices: Plan A, Plan F, Plan G, Plan M, and Plan N, 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.



HPHC Insurance Company

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 Maine
- You are entitled to Medicare Part A (hospital), enrolled in Medicare Part B (medical) and you continue to pay Medicare Part B premiums
- Medicare Supplement Plans are available to all individuals, regardless of age, who are entitled to Medicare benefits due to disability. This policy may not cover all of your medical expenses.
- Medicare Supplement benefit Plan F, 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. 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.

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.

You are eligible for "Open Enrollment" if:

- You have enrolled in Medicare Part B within the last 6 months
- You are under age 65, disabled and enrolled in Medicare Part B within the last 6 months
- You were enrolled in Medicare Part B prior to age 65 based upon disability and turned 65 within the last 6 months
- Your Medicare Part B will become effective within the next 60 days

Guaranteed Issue:

You are eligible for "Annual one month guaranteed issue" if:

- You are applying for Plan "A" during the month of December for a January 1st effective date

You are eligible for "Guaranteed Issue" if:

- You have been involuntarily terminated or lost coverage from a Medicare Advantage plan, employer retiree plan, COBRA coverage, Medicare Select, PACE, Demonstration or Medicare Supplement plan in the past 90 days

For more information or to see if you qualify under Maine guaranteed issue laws, please contact Harvard Pilgrim at 1-(877) 909-4742.

HPHC Insurance Company

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 enrollment 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.

Enroll over the phone at
1-(877) 906-4742
Monday-Friday,
8:30 a.m. - 5:00 p.m.

If you would like to enroll over the telephone with a Plan representative, please call 1-(877) 906-4742 (Monday–Friday 8:30 a.m.-5:00 p.m.). You can also enroll online at **kit.hpforlife.org**

Our Sales Executives are available to help you with any questions you may have about our Plan options and how to enroll. Please call our knowledgeable team at

1-(877) 909-4742, October 1 – March 31, 8 a.m. – 8 p.m. 7 days a week,
April 1 – September 30, 8 a.m. – 8 p.m. Monday through Friday.

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're 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 providers or hospital anywhere in the country, with no need for referrals
- You can continue to see your current doctor if he or she is a Medicare participating physician
- You'll enjoy discounts on a wide range of health-related products and services

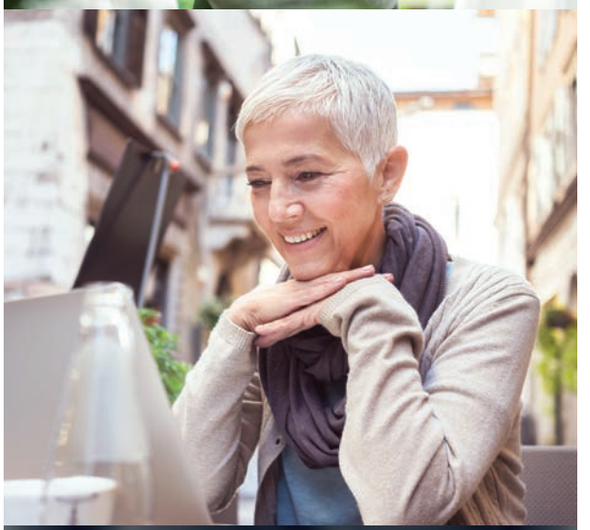
All this from a name you know and trust. So, when you are looking for a supplement to your Medicare coverage, look no further than Harvard Pilgrim.

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 **1 - (877) 909 - 4742**
TTY 711

October 1 - March 31, 8 a.m. – 8 p.m.
7 days a week,

April 1 - September 30, 8 a.m. – 8 p.m.
Monday through Friday

Or visit us online:
kit.hpforlife.org

1 Wellness Way, Canton, MA 02021

11/23

Maine
Monthly Premium Rates

Effective January 1, 2024 - December 31, 2024

Plan Type	Plan A	Plan F	Plan G	Plan M	Plan N
Billed Monthly	$254.00	$319.00	$299.00	$258.00	$226.00

HPHC Insurance Company

Visit us online at **hpforlife.org**
or call **1-877-909-4742, TTY 711** for more information.
October 1-March 31, 8 a.m. – 8 p.m. 7 days a week,
April 1-September 30, 8 a.m. – 8 p.m. Monday through Friday.

Medicare Supplement Plans are available to all individuals, regardless of age, who are entitled to Medicare benefits due to disability. This Policy may not cover all of your medical expenses. Not connected with or endorsed by the U.S. Government or the Federal Medicare Program. This is a solicitation of insurance. An agent/producer may contact you.

HPHC Insurance Company

2024 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 $2,800 deductible. Benefits for high deductible Plan F will not begin until out-of-pocket expenses exceed $2,800. 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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

HPHC Insurance Company

2024 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 $7,060 paid at 100% after limit is reached	Out-of-pocket limit $3,530 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 $2,800 deductible. Benefits for high deductible Plan F will not begin until out-of-pocket expenses exceed $2,800. 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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 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	$254.00	$319.00	$299.00	$258.00	$226.00

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 2024[2]					$7,060[2]	$3,530[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 $2,800 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 $1,632	$0	$1,632 (Part A Deductible)
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after - While using 60 lifetime reserve days	All but $816 a day	$816 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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 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 $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 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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

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

* Once you have been billed $240 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 $240 of Medicare approved amounts*	$0	$0	$240 (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 $240 of Medicare approved amounts*	$0	$0	$240 (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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

PLAN A
MEDICARE (PARTS A & B)

* Once you have been billed $240 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 $240 of Medicare approved amounts*	$0	$0	$240 (Part B Deductible)
- Remainder of Medicare approved amounts	80%	20%	$0

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.

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 $1,632	$1,632 (Part A Deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after			
- 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

** 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.

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 $204 a day	Up to $204 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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 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 $240 of Medicare approved amounts	$0	$240 (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 $240 of Medicare approved amounts	$0	$240 (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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 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 $240 of Medicare approved amounts	$0	$240 (Part B Deductible)	$0
- Remainder of Medicare approved amounts	80%	20%	$0

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.

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 $1,632	$1,632 (Part A Deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after			
- 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

** 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.

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 $204 a day	Up to $204 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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

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

* Once you have been billed $240 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 $240 of Medicare approved amounts*	$0	$0	$240 (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 $240 of Medicare approved amounts*	$0	$0	$240 (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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

PLAN G
MEDICARE (PARTS A & B)

* Once you have been billed $240 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 $240 of Medicare approved amounts*	$0	$0	$240 (Part B Deductible)
- Remainder of Medicare approved amounts	80%	20%	$0

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.

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 $1,632	$816 (50% of Part A Deductible)	$816 (50% of Part A Deductible)
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after - 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

** 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.

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 $204 a day	Up to $204 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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

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

* Once you have been billed $240 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 $240 of Medicare approved amounts*	$0	$0	$240 (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 $240 of Medicare approved amounts*	$0	$0	$240 (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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

PLAN M
MEDICARE (PARTS A & B)

* Once you have been billed $240 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 $240 of Medicare approved amounts*	$0	$0	$240 (Part B Deductible)
- Remainder of Medicare approved amounts	80%	20%	$0

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.

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 $1,632	$1,632 (Part A Deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after - 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

** 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.

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 $204 a day	Up to $204 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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

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

* Once you have been billed $240 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 $240 of Medicare approved amounts*	$0	$0	$240 (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 2024 Medicare deductible and coinsurance amounts. Beginning 1/1/25, these amounts will be replaced with the 2025 Medicare deductible and coinsurance amounts.

PLAN N
MEDICARE (PARTS A & B)

* Once you have been billed $240 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 $240 of Medicare approved amounts*	$0	$0	$240 (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 $240 of Medicare approved amounts*	$0	$0	$240 (Part B Deductible)
- Remainder of Medicare approved amounts	80%	20%	$0

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.

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

NOTES

NOTES


HPHC Insurance
Company

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

Maine

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 Maine.
- 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.
- Medicare Supplement benefit Plan F, will not be offered to individuals newly eligible for Medicare on or after 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: 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, call your local Social Security Office to obtain proof of enrollment.
4. Read and answer all questions in Section 4.
5. **Determine your Eligibility.**

   Open Enrollment
   - You have enrolled in Medicare Part B within the last 6 months.
   - You were enrolled in Medicare Part B prior to age 65 and turned 65 within the last 6 months.
   - Your Medicare Part B will become effective within the next 60 days.

   Guaranteed Issue
   - You have been involuntarily terminated or lost coverage from a Medicare Advantage Plan, employer retiree plan, COBRA coverage, Medicare Select, PACE, Demonstration or Medicare Supplement plan in the past 90 days.
   - The Harvard Pilgrim Medicare Supplement plan you are choosing is of equal or lesser coverage than your current Medicare Supplement policy and you have not had a gap in coverage of more than 90 days. **(Please be sure to answer question 4 completely or HPHC may request proof of coverage)**.
   - You left your employer retiree plan and are applying within 90 days of your disenrollment date.
   - You voluntarily disenrolled from your Medicare Advantage, Medicare Select or PACE plan within the first 36 months of enrollment, and are applying for Medicare Supplement within 90 days of termination.

   Annual One Month Guaranteed Issue
   - You are applying for Plan "A" during the month of December for a January 1st effective date for coverage - Section 5 is **NOT** required.

   Continuous Open Enrollment
   - You are applying for Plans A, F, G, M and N at anytime-Section 5 must be completed with all "NO" responses.
6. Read "Important Information" in Section 6.
7. Sign and date the enrollment application.
8. If you 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, please include a copy.

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

Maine
❒ 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: ❒ Plan A ❒ Plan F ❒ Plan G ❒ Plan M ❒ Plan N 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. 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

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 90 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. If your previous coverage before this Medicare plan was a different Medicare plan of the same type, your "START" date is the day you began your **first** plan of this type.

   START ____/____/_____ END ____/____/_____

   (b) If you have been covered by more than one Medicare plan of this type, have you been covered continuously by these plans, with no break in coverage and no period of original Medicare (Part A or B) between the first plan and your current plan? ❒ Yes ❒ No
   (c) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ❒ Yes ❒ No
   (d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ❒ Yes ❒ No

4. (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

5. Have you had coverage under any other health insurance within the past 90 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.
IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEED ISSUE (SEE #5 ON THE INSTRUCTION PAGE TO DETERMINE WHETHER THIS SECTION APPLIES TO YOU), DO NOT ANSWER THE QUESTIONS IN THIS SECTION.

If the answer to any question in this section is YES the Applicant is not eligible for coverage. This does not apply to applicants applying for Medicare Supplement coverage under Plan A.

- Height _____ (feet/inches)
- Weight _____ (pounds)
- Are you now confined in a hospital or nursing home, or, within the past 60 days, have you been advised by a doctor to seek medical care or treatment in a hospital or in a nursing home? ❒ Yes ❒ No
- Are you bedridden? ❒ Yes ❒ No
- Do you require the use of a wheelchair? (if "YES," please give details) ❒ Yes ❒ No

_____

_____

- Are you receiving kidney dialysis? ❒ Yes ❒ No
- Have you, due to mental or physical disability, authorized any person or institution to legally act in your behalf and take over your personal transactions? ❒ Yes ❒ No
- In the past 12 months, have you been advised to have surgery but it has not yet been done? ❒ Yes ❒ No
- In the past 12 months, have you been hospitalized three or more times? ❒ Yes ❒ No
- Do you routinely visit the same medical provider more than monthly for medical advice or treatment? ❒ Yes ❒ No
- Do you now have any of the following conditions diagnosed by a member of the medical profession or have you received medical advice or treatment for the following conditions within the past 12 months?

  ❒ Cancer (except skin) or Leukemia

  ❒ Chronic Lung Disease

  ❒ Cirrhosis of the Liver

  ❒ Diabetes (insulin dependent)

  ❒ Stroke

  ❒ Angina Pectoris, Heart Attack, Congestive Heart Failure, or Valvular Heart Disease

  ❒ Alzheimer's Disease, memory loss or impairment, dementia or cognitive impairment

  ❒ Parkinson's Disease

  ❒ Multiple Sclerosis

  ❒ Chronic Kidney Disease

  ❒ Any form of Arthritis or Degenerative Bone Disease which causes crippling, fractures, limitation of motion or requiring joint replacement

SECTION 6.

IMPORTANT INFORMATION

A. You do not need more than one Medicare Supplement policy.

B. If you purchase this policy you may want to evaluate your existing health coverage and decide if you need multiple coverages.

C. You may be eligible for Medicaid benefits and may not need a Medicare Supplement policy.

D. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement 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 suspended Medicare Supplement policy or, if that is no longer available, a substantially equivalent policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

   If the Medicare Supplement 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, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

E. If you are eligible for, and have enrolled in a Medicare Supplement 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 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 policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement 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 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, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

F. Counseling services may be available in your state 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).

SECTION 7.

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. Benefits under this Plan will be explained under a separate document.

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 application.

The subrogation provision outlined in the Policy, permits subrogation payments on a just and equitable basis. This authorization is valid through the term of coverage under the plan or any renewals thereof. You may revoke this authorization at any time by contacting the Plan at the above address or telephone number, provided that such revocation may be a basis for denying benefits under the Plan. All statements and information in this application shall be deemed representations and not warranties. I understand that a copy of this application will be given to me, or my authorized representative, upon request.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. Failure to sign this application may impair the Plan's ability to evaluate or process an application or claim and may be a basis for denying an application or a claim for benefits.

_____ _____

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 8.

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 9.
NOTE: THIS SECTION IS ONLY TO BE COMPLETED IF YOU ARE WORKING WITH AN INDEPENDENT INSURANCE AGENT AND ARE REPLACING AN EXISTING MEDICARE PLAN.

NOTE: 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 should review this 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 _____

  _____

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 material 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.

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).