OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

Humana Medicare Supplement Plans

for California residents Medicare supplement benefit plans: A, B, C, F, High Deductible F, G, High Deductible G, K, L and N

THE POLICYHOLDER SHALL HAVE THE RIGHT TO RETURN THIS POLICY VIA REGULAR MAIL, WITHIN 30 DAYS OF RECEIVING IT, AND TO HAVE FULL PREMIUM REFUNDED IF AFTER EXAMINATION OF THE POLICY, THE INSURED PERSON IS NOT SATISFIED FOR ANY REASON. THE RETURN SHALL VOID THE POLICY FROM THE BEGINNING, AND THE PARTIES SHALL BE IN THE SAME POSITION AS IF NO POLICY HAD BEEN ISSUED.

Insured by Humana Insurance Company

CA81077M20-1

Humana®

Humana Insurance Company offers Plans A, B, C, F, High Deductible F, G, High Deductible G, K, L and N
Benefit Chart of Medicare Supplement Plans Sold on or After January 1, 2020

This 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]**				

[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.

Premium Rating Area Classification

Use this page to identify your rating area for assistance in determining your monthly premium. Please locate your county below.

Area 1: (Premium rates begin on page 3)
Alpine, Lake, Los Angeles, Napa, Orange, Shasta

Area 2: (Premium rates begin on page 5)
Alameda, Calaveras, Contra Costa, Kern, Marin, Monterey, Plumas, Riverside, San Benito, San Bernardino, San Diego, Trinity, Ventura, Yuba

Area 3: (Premium rates begin on page 7)
Amador, Butte, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kings, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Nevada, Placer, Sacramento, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Yolo

Humana Medicare Supplement Area 1 Monthly Premiums

Effective Date: 07-01-2024

* Members who enroll prior to age 65 will remain in the same age category for the duration of the policy, as these policies are issue-age rated.

Attained Age & Gender	Premium Type	Plan A	Plan B	Plan C	Plan F	High Deductible Plan F	Plan G	High Deductible Plan G	Plan K	Plan L	Plan N
<65*-Unisex	Preferred	$451.68	$484.93	$604.33	$613.11	$152.90	$513.72	$137.36	$247.87	$359.68	$379.31
	Standard	$674.11	$723.80	$902.25	$915.36	$227.55	$766.84	$204.30	$369.49	$536.59	$565.92
65-Unisex	Preferred	$245.94	$267.50	$332.32	$339.06	$83.86	$279.60	$75.43	$135.89	$196.05	$206.68
	Standard	$366.61	$398.82	$495.70	$505.77	$124.36	$416.91	$111.74	$202.13	$292.01	$307.91
66-Unisex	Preferred	$254.24	$276.52	$343.54	$350.52	$86.65	$289.05	$77.93	$140.45	$202.63	$213.64
	Standard	$379.00	$412.32	$512.49	$522.90	$128.52	$431.02	$115.49	$208.93	$301.87	$318.32
67-Unisex	Preferred	$264.33	$287.51	$357.21	$364.46	$90.03	$300.53	$80.96	$145.99	$210.66	$222.11
	Standard	$394.09	$428.73	$532.90	$543.74	$133.58	$448.18	$120.02	$217.21	$313.87	$330.99
68-Unisex	Preferred	$274.82	$298.92	$371.41	$378.94	$93.55	$312.46	$84.12	$151.75	$219.00	$230.91
	Standard	$409.76	$445.78	$554.12	$565.39	$138.84	$466.02	$124.73	$225.81	$326.33	$344.13
69-Unisex	Preferred	$284.10	$309.02	$383.97	$391.77	$96.67	$323.02	$86.91	$156.83	$226.39	$238.70
	Standard	$423.63	$460.88	$572.91	$584.56	$143.49	$481.80	$128.91	$233.43	$337.36	$355.76
70-Unisex	Preferred	$293.72	$319.49	$397.01	$405.06	$99.90	$333.97	$89.81	$162.13	$234.03	$246.77
	Standard	$438.01	$476.54	$592.38	$604.44	$148.32	$498.17	$133.24	$241.32	$348.80	$367.84
71-Unisex	Preferred	$303.66	$330.30	$410.45	$418.79	$103.23	$345.27	$92.80	$167.57	$241.94	$255.10
	Standard	$452.86	$492.69	$612.48	$624.94	$153.30	$515.06	$137.71	$249.47	$360.61	$380.30
72-Unisex	Preferred	$313.94	$341.50	$424.38	$433.01	$106.68	$356.99	$95.90	$173.22	$250.12	$263.73
	Standard	$468.24	$509.43	$633.31	$646.19	$158.47	$532.56	$142.34	$257.91	$372.85	$393.20
73-Unisex	Preferred	$324.57	$353.07	$438.78	$447.69	$110.25	$369.08	$99.09	$179.06	$258.58	$272.65
	Standard	$484.13	$526.72	$654.82	$668.15	$163.79	$550.65	$147.12	$266.64	$385.49	$406.53
74-Unisex	Preferred	$335.60	$365.07	$453.71	$462.93	$113.95	$381.63	$102.42	$185.11	$267.35	$281.91
	Standard	$500.60	$544.66	$677.14	$690.92	$169.33	$569.40	$152.09	$275.67	$398.59	$420.36

Note: If you are going to have a birthday within the month of your requested coverage effective date, please use the age you will be turning on that birthday to determine your plan premium rate.

(Continued on next page)

Humana Medicare Supplement Area 1 Monthly Premiums

Effective Date: 07-01-2024

Attained Age & Gender	Premium Type	Plan A	Plan B	Plan C	Plan F	High Deductible Plan F	Plan G	High Deductible Plan G	Plan K	Plan L	Plan N
75-Unisex	Preferred	$347.02	$377.50	$469.17	$478.70	$117.78	$394.62	$105.86	$191.37	$276.43	$291.48
	Standard	$517.66	$563.23	$700.24	$714.48	$175.06	$588.81	$157.22	$285.05	$412.16	$434.67
76-Unisex	Preferred	$358.81	$390.32	$485.13	$494.98	$121.74	$408.04	$109.40	$197.84	$285.80	$301.37
	Standard	$535.28	$582.40	$724.09	$738.83	$180.97	$608.87	$162.52	$294.71	$426.18	$449.45
77-Unisex	Preferred	$370.99	$403.59	$501.63	$511.83	$125.83	$421.90	$113.07	$204.53	$295.49	$311.61
	Standard	$553.51	$602.23	$748.76	$764.00	$187.08	$629.60	$168.00	$304.72	$440.67	$464.74
78-Unisex	Preferred	$382.07	$415.65	$516.64	$527.14	$129.55	$434.52	$116.41	$210.62	$304.31	$320.90
	Standard	$570.06	$620.26	$771.19	$786.88	$192.64	$648.44	$172.99	$313.80	$453.85	$478.64
79-Unisex	Preferred	$391.29	$425.69	$529.13	$539.89	$132.65	$445.01	$119.18	$215.68	$311.65	$328.64
	Standard	$583.86	$635.25	$789.85	$805.93	$197.27	$664.14	$177.14	$321.37	$464.81	$490.20
80-Unisex	Preferred	$400.73	$435.95	$541.89	$552.91	$135.81	$455.74	$122.02	$220.85	$319.14	$336.55
	Standard	$597.94	$650.59	$808.93	$825.39	$201.99	$680.16	$181.38	$329.10	$476.01	$502.03
81-Unisex	Preferred	$410.43	$446.29	$555.02	$564.22	$139.06	$466.78	$124.94	$226.18	$326.86	$344.69
	Standard	$612.45	$666.06	$828.57	$842.31	$206.85	$696.67	$185.75	$337.06	$487.55	$514.19
82-Unisex	Preferred	$420.34	$455.08	$567.10	$575.35	$142.39	$478.07	$127.93	$231.62	$334.75	$353.01
	Standard	$627.27	$679.20	$846.59	$858.94	$211.83	$713.53	$190.20	$345.20	$499.33	$526.63
83-Unisex	Preferred	$430.53	$463.99	$578.20	$586.62	$145.81	$489.66	$130.99	$237.19	$342.86	$361.56
	Standard	$642.50	$692.52	$863.20	$875.79	$216.94	$730.85	$194.79	$353.54	$511.45	$539.41
84-Unisex	Preferred	$440.67	$473.01	$589.45	$598.04	$149.31	$501.54	$134.13	$241.79	$351.16	$370.32
	Standard	$657.69	$706.00	$880.01	$892.85	$222.18	$748.62	$199.49	$360.39	$523.87	$552.50
85+-Unisex	Preferred	$451.68	$484.93	$604.33	$613.11	$152.90	$513.72	$137.36	$247.87	$359.68	$379.31
	Standard	$674.11	$723.80	$902.25	$915.36	$227.55	$766.84	$204.30	$369.49	$536.59	$565.92

Note: If you are going to have a birthday within the month of your requested coverage effective date, please use the age you will be turning on that birthday to determine your plan premium rate.

Humana Medicare Supplement Area 2 Monthly Premiums

Effective Date: 07-01-2024

* Members who enroll prior to age 65 will remain in the same age category for the duration of the policy, as these policies are issue-age rated.

Attained Age & Gender	Premium Type	Plan A	Plan B	Plan C	Plan F	High Deductible Plan F	Plan G	High Deductible Plan G	Plan K	Plan L	Plan N
<65*-Unisex	Preferred	$385.35	$413.69	$515.48	$522.97	$130.64	$438.24	$117.39	$211.60	$306.92	$323.65
	Standard	$574.96	$617.33	$769.45	$780.63	$194.28	$654.01	$174.46	$315.28	$457.73	$482.74
65-Unisex	Preferred	$209.95	$228.33	$283.59	$289.34	$71.79	$238.65	$64.60	$116.14	$167.42	$176.49
	Standard	$312.82	$340.29	$422.87	$431.46	$106.31	$355.70	$95.56	$172.61	$249.23	$262.79
66-Unisex	Preferred	$217.03	$236.03	$293.16	$299.11	$74.16	$246.70	$66.73	$120.03	$173.04	$182.42
	Standard	$323.39	$351.79	$437.18	$446.06	$109.86	$367.73	$98.75	$178.41	$257.64	$271.66
67-Unisex	Preferred	$225.63	$245.39	$304.81	$310.99	$77.05	$256.49	$69.31	$124.75	$179.88	$189.64
	Standard	$336.25	$365.78	$454.59	$463.82	$114.17	$382.36	$102.61	$185.46	$267.87	$282.46
68-Unisex	Preferred	$234.58	$255.12	$316.92	$323.34	$80.05	$266.66	$72.01	$129.66	$186.99	$197.14
	Standard	$349.61	$380.32	$472.68	$482.28	$118.66	$397.57	$106.63	$192.80	$278.49	$293.66
69-Unisex	Preferred	$242.49	$263.73	$327.62	$334.27	$82.70	$275.67	$74.38	$133.99	$193.29	$203.78
	Standard	$361.43	$393.19	$488.69	$498.62	$122.62	$411.02	$110.19	$199.29	$287.89	$303.58
70-Unisex	Preferred	$250.69	$272.66	$338.74	$345.61	$85.46	$285.00	$76.86	$138.51	$199.81	$210.66
	Standard	$373.70	$406.54	$505.29	$515.57	$126.74	$424.98	$113.88	$206.02	$297.65	$313.88
71-Unisex	Preferred	$259.16	$281.87	$350.20	$357.31	$88.30	$294.63	$79.40	$143.15	$206.55	$217.77
	Standard	$386.35	$420.31	$522.43	$533.04	$130.98	$439.38	$117.69	$212.97	$307.71	$324.49
72-Unisex	Preferred	$267.92	$291.42	$362.08	$369.43	$91.24	$304.62	$82.05	$147.96	$213.52	$225.12
	Standard	$399.46	$434.58	$540.18	$551.17	$135.38	$454.30	$121.64	$220.16	$318.14	$335.50
73-Unisex	Preferred	$276.99	$301.28	$374.35	$381.95	$94.28	$314.93	$84.77	$152.94	$220.73	$232.73
	Standard	$413.01	$449.32	$558.52	$569.88	$139.93	$469.72	$125.71	$227.60	$328.92	$346.86
74-Unisex	Preferred	$286.39	$311.51	$387.08	$394.94	$97.43	$325.63	$87.60	$158.10	$228.20	$240.62
	Standard	$427.05	$464.61	$577.55	$589.29	$144.65	$485.70	$129.95	$235.30	$340.09	$358.65
75-Unisex	Preferred	$296.12	$322.11	$400.26	$408.38	$100.70	$336.70	$90.54	$163.44	$235.95	$248.78
	Standard	$441.60	$480.44	$597.24	$609.38	$149.53	$502.25	$134.32	$243.29	$351.66	$370.84
76-Unisex	Preferred	$306.17	$333.04	$413.86	$422.26	$104.07	$348.14	$93.56	$168.95	$243.94	$257.21
	Standard	$456.62	$496.78	$617.57	$630.14	$154.57	$519.35	$138.84	$251.53	$363.61	$383.45

Note: If you are going to have a birthday within the month of your requested coverage effective date, please use the age you will be turning on that birthday to determine your plan premium rate.

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Humana Medicare Supplement Area 2 Monthly Premiums

Effective Date: 07-01-2024

Attained Age & Gender	Premium Type	Plan A	Plan B	Plan C	Plan F	High Deductible Plan F	Plan G	High Deductible Plan G	Plan K	Plan L	Plan N
77-Unisex	Preferred	$316.56	$344.35	$427.93	$436.63	$107.56	$359.96	$96.69	$174.66	$252.20	$265.94
	Standard	$472.15	$513.69	$638.61	$651.60	$159.78	$537.02	$143.52	$260.06	$375.96	$396.48
78-Unisex	Preferred	$326.00	$354.63	$440.72	$449.68	$110.73	$370.71	$99.53	$179.85	$259.71	$273.86
	Standard	$486.27	$529.06	$657.72	$671.10	$164.52	$553.08	$147.77	$267.81	$387.19	$408.33
79-Unisex	Preferred	$333.87	$363.19	$451.37	$460.54	$113.38	$379.66	$101.90	$184.16	$265.98	$280.46
	Standard	$498.03	$541.84	$673.64	$687.34	$168.47	$566.46	$151.31	$274.26	$396.54	$418.19
80-Unisex	Preferred	$341.91	$371.94	$462.25	$471.65	$116.07	$388.81	$104.31	$188.56	$272.36	$287.20
	Standard	$510.03	$554.91	$689.90	$703.93	$172.49	$580.12	$154.92	$280.85	$406.09	$428.27
81-Unisex	Preferred	$350.18	$380.75	$473.44	$481.29	$118.84	$398.22	$106.81	$193.11	$278.94	$294.14
	Standard	$522.40	$568.10	$706.64	$718.36	$176.64	$594.20	$158.64	$287.64	$415.92	$438.63
82-Unisex	Preferred	$358.63	$388.25	$483.74	$490.77	$121.68	$407.84	$109.35	$197.75	$285.67	$301.23
	Standard	$535.03	$579.31	$722.00	$732.53	$180.88	$608.57	$162.44	$294.57	$425.97	$449.24
83-Unisex	Preferred	$367.31	$395.84	$493.20	$500.38	$124.60	$417.72	$111.97	$202.50	$292.58	$308.52
	Standard	$548.01	$590.66	$736.16	$746.89	$185.23	$623.34	$166.35	$301.68	$436.30	$460.13
84-Unisex	Preferred	$375.96	$403.53	$502.80	$510.11	$127.58	$427.85	$114.64	$206.42	$299.65	$315.98
	Standard	$560.97	$602.15	$750.49	$761.44	$189.70	$638.49	$170.35	$307.53	$446.88	$471.30
85+-Unisex	Preferred	$385.35	$413.69	$515.48	$522.97	$130.64	$438.24	$117.39	$211.60	$306.92	$323.65
	Standard	$574.96	$617.33	$769.45	$780.63	$194.28	$654.01	$174.46	$315.28	$457.73	$482.74

Note: If you are going to have a birthday within the month of your requested coverage effective date, please use the age you will be turning on that birthday to determine your plan premium rate.

Humana Medicare Supplement Area 3 Monthly Premiums

Effective Date: 07-01-2024

* Members who enroll prior to age 65 will remain in the same age category for the duration of the policy, as these policies are issue-age rated.

Attained Age & Gender	Premium Type	Plan A	Plan B	Plan C	Plan F	High Deductible Plan F	Plan G	High Deductible Plan G	Plan K	Plan L	Plan N
<65*-Unisex	Preferred	$321.33	$344.94	$429.73	$435.96	$109.16	$365.38	$98.12	$176.60	$256.00	$269.93
	Standard	$479.28	$514.57	$641.28	$650.60	$162.17	$545.13	$145.66	$262.96	$381.62	$402.45
65-Unisex	Preferred	$175.23	$190.54	$236.56	$241.35	$60.13	$199.13	$54.15	$97.08	$139.80	$147.35
	Standard	$260.92	$283.79	$352.58	$359.74	$88.89	$296.64	$79.93	$144.12	$207.94	$219.23
66-Unisex	Preferred	$181.12	$196.94	$244.54	$249.49	$62.11	$205.84	$55.92	$100.32	$144.47	$152.29
	Standard	$269.72	$293.37	$364.51	$371.90	$91.85	$306.65	$82.59	$148.95	$214.95	$226.63
67-Unisex	Preferred	$188.28	$204.74	$254.24	$259.39	$64.51	$213.99	$58.07	$104.25	$150.17	$158.30
	Standard	$280.43	$305.03	$379.00	$386.70	$95.44	$318.84	$85.81	$154.82	$223.47	$235.62
68-Unisex	Preferred	$195.74	$212.85	$264.33	$269.68	$67.01	$222.46	$60.32	$108.34	$156.10	$164.55
	Standard	$291.56	$317.14	$394.07	$402.07	$99.17	$331.51	$89.16	$160.93	$232.32	$244.95
69-Unisex	Preferred	$202.33	$220.02	$273.24	$278.78	$69.23	$229.96	$62.29	$111.95	$161.34	$170.08
	Standard	$301.40	$327.86	$407.41	$415.69	$102.48	$342.71	$92.12	$166.34	$240.15	$253.22
70-Unisex	Preferred	$209.16	$227.46	$282.50	$288.22	$71.52	$237.74	$64.36	$115.71	$166.77	$175.81
	Standard	$311.62	$338.98	$421.24	$429.80	$105.91	$354.34	$95.20	$171.95	$248.27	$261.79
71-Unisex	Preferred	$216.21	$235.13	$292.05	$297.97	$73.89	$245.76	$66.48	$119.58	$172.39	$181.73
	Standard	$322.16	$350.45	$435.52	$444.36	$109.44	$366.34	$98.37	$177.73	$256.66	$270.64
72-Unisex	Preferred	$223.51	$243.09	$301.94	$308.07	$76.34	$254.08	$68.68	$123.58	$178.20	$187.86
	Standard	$333.08	$362.34	$450.30	$459.45	$113.11	$378.76	$101.66	$183.73	$265.35	$279.80
73-Unisex	Preferred	$231.07	$251.30	$312.17	$318.49	$78.87	$262.67	$70.95	$127.73	$184.20	$194.20
	Standard	$344.37	$374.62	$465.58	$475.04	$116.89	$391.61	$105.05	$189.92	$274.32	$289.27
74-Unisex	Preferred	$238.90	$259.82	$322.77	$329.32	$81.50	$271.58	$73.31	$132.03	$190.43	$200.77
	Standard	$356.07	$387.35	$481.43	$491.22	$120.83	$404.92	$108.58	$196.34	$283.63	$299.09
75-Unisex	Preferred	$247.01	$268.65	$333.75	$340.51	$84.22	$280.80	$75.75	$136.48	$196.88	$207.57
	Standard	$368.18	$400.54	$497.83	$507.95	$124.89	$418.71	$112.22	$203.00	$293.27	$309.25
76-Unisex	Preferred	$255.38	$277.76	$345.08	$352.08	$87.03	$290.33	$78.27	$141.07	$203.54	$214.59
	Standard	$380.69	$414.15	$514.77	$525.24	$129.09	$432.95	$115.99	$209.86	$303.22	$319.75

Note: If you are going to have a birthday within the month of your requested coverage effective date, please use the age you will be turning on that birthday to determine your plan premium rate.

(Continued on next page)

Humana Medicare Supplement Area 3 Monthly Premiums

Effective Date: 07-01-2024

Attained Age & Gender	Premium Type	Plan A	Plan B	Plan C	Plan F	High Deductible Plan F	Plan G	High Deductible Plan G	Plan K	Plan L	Plan N
77-Unisex	Preferred	$264.03	$287.18	$356.80	$364.04	$89.93	$300.18	$80.88	$145.82	$210.42	$221.86
	Standard	$393.64	$428.24	$532.29	$543.11	$133.43	$447.67	$119.88	$216.97	$313.51	$330.60
78-Unisex	Preferred	$271.89	$295.74	$367.45	$374.91	$92.57	$309.14	$83.24	$150.15	$216.68	$228.46
	Standard	$405.39	$441.04	$548.22	$559.36	$137.38	$461.05	$123.43	$223.42	$322.87	$340.47
79-Unisex	Preferred	$278.44	$302.87	$376.32	$383.96	$94.78	$316.59	$85.21	$153.74	$221.89	$233.96
	Standard	$415.19	$451.69	$561.47	$572.89	$140.67	$472.20	$126.37	$228.79	$330.65	$348.68
80-Unisex	Preferred	$285.14	$310.16	$385.39	$393.21	$97.02	$324.21	$87.23	$157.41	$227.21	$239.57
	Standard	$425.19	$462.58	$575.02	$586.71	$144.02	$483.57	$129.38	$234.28	$338.61	$357.08
81-Unisex	Preferred	$292.03	$317.50	$394.71	$401.25	$99.33	$332.05	$89.30	$161.19	$232.69	$245.35
	Standard	$435.49	$473.56	$588.96	$598.72	$147.47	$495.30	$132.48	$239.93	$346.80	$365.72
82-Unisex	Preferred	$299.07	$323.74	$403.29	$409.14	$101.69	$340.06	$91.42	$165.06	$238.29	$251.26
	Standard	$446.02	$482.89	$601.76	$610.53	$151.01	$507.27	$135.65	$245.71	$355.17	$374.55
83-Unisex	Preferred	$306.31	$330.07	$411.17	$417.15	$104.13	$348.29	$93.60	$169.02	$244.05	$257.33
	Standard	$456.83	$492.35	$613.55	$622.49	$154.63	$519.57	$138.90	$251.63	$363.77	$383.63
84-Unisex	Preferred	$313.51	$336.47	$419.16	$425.26	$106.61	$356.73	$95.83	$172.28	$249.94	$263.55
	Standard	$467.62	$501.92	$625.49	$634.61	$158.35	$532.19	$142.24	$256.50	$372.59	$392.92
85+-Unisex	Preferred	$321.33	$344.94	$429.73	$435.96	$109.16	$365.38	$98.12	$176.60	$256.00	$269.93
	Standard	$479.28	$514.57	$641.28	$650.60	$162.17	$545.13	$145.66	$262.96	$381.62	$402.45

Note: If you are going to have a birthday within the month of your requested coverage effective date, please use the age you will be turning on that birthday to determine your plan premium rate.

Premium Information

We, Humana Insurance Company, can only change the renewal premium for your policy if we also change the renewal premium for all policies that we issue like yours in this State. No change in premium will be made because of the number of claims you file, nor because of a change in your health or your type of work.

If you are rated as age 65 or older, this is an attained age rated policy, which means that your premiums will increase based on age. Your attained age premium increase will go into effect on the first monthly renewal date which falls on or follows the policy annual anniversary date. The premium increase will be based on your age attained on or before the last day of the renewal calendar month. A premium change will not be made more than once in a 12-month period.

However, if you enroll prior to age 65, you will remain in the same age category for the duration of your policy.

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 your insurance company.

Right to return policy

If you find that you are not satisfied with your policy for any reason, you shall have the right to return this policy via regular mail to:

Humana Insurance Company
Attn: Medicare Enrollments
P.O. Box 14168
Lexington, KY 40512-4168

If you send the policy back to us within 30 days of receiving it, and have full premium refunded if after examination of the policy, the return shall void the policy from the beginning, and the parties shall be in the same position as if no policy had been issued.

If you choose to cancel your policy, coverage will end on the last day of the month in which we receive your cancelation request. If you have paid premiums for months after your plan's end date, we will refund your premium for those months. Your refund will not be processed on a pro-rated basis.

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.

Disclosure

This policy may not fully cover all of your medical costs. Neither this company nor any of 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 the "Medicare & You" handbook for more details. For additional information concerning policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, 1-800-434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California.

Complete answers are very important

When you fill out the application for the new policy, be sure to truthfully and completely answer 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.

Guaranteed Issue Guidelines

Open Enrollment – You are eligible for Guaranteed Issue if you apply for a Humana Medicare Supplement Plan policy prior to or during the six-month period beginning with the first day of the first month in which you are enrolled for benefits under Part B of Medicare.

Annual Open Enrollment – You are entitled to an annual open enrollment period lasting 60 days, commencing with your birthday, during which time you may purchase any Medicare Supplement policy that offers benefits equal to or lesser than those provided by the previous coverage.

Other Situations – You are eligible for Guaranteed Issue if you apply for the policy no later than 63 days after the date of termination of enrollment described below, you submit evidence of the date of termination or disenrollment with the Enrollment Application, and you meet one of the following conditions:

1. You are enrolled in an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates or ceases to provide such supplemental health benefits; or you are enrolled in an employee welfare benefit plan that is primary to Medicare and the plan terminates, or ceases to provide health benefits because you left the plan.
2. You are enrolled with a Medicare Advantage organization under a Medicare Advantage Plan (the “Plan”) under Part C of Medicare and any of the following apply; or you are 65 years of age or older and are enrolled with a Program of All-Inclusive Care for Elderly (PACE), and there are circumstances similar to those described as follows that would permit discontinuance of your enrollment with the provider if you were enrolled in a Medicare Advantage Plan:
    - The Medicare Advantage organization or Plan's certification under this part has been terminated or the Medicare Advantage organization or Plan has notified you of an impending termination of certification; or
    - The Medicare Advantage organization has terminated or otherwise discontinued providing the Plan in the area in which you reside, or has notified you of an impending termination or discontinuance of the plan; or
    - You are no longer eligible to elect the Plan because:
        i) of a change in your place of residence or other change in circumstances specified by the Secretary of the Department of Health and Human Services (the "Secretary"), excluding those circumstances where you were disenrolled from the Plan for any of the reasons described in Section1851(g)(3)(B) of the federal Social Security Act (e.g., where you have not paid premiums on a timely basis, or you have engaged in disruptive behavior as
        ii) the Plan is terminated for all enrollees residing within a particular residential service area; or
    - The Medicare Advantage Plan in which you've been enrolled reduces any of its benefits or increases the amount of cost sharing or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to you. If any of these circumstances occur, you're eligible for a Medicare supplement policy issued by the same issuer through which you were enrolled at the time the benefit reduction, premium increase, or provider discontinuance occurs or for one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer.

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If no Medicare supplement policy is available to you from the same issuer of your Medicare Advantage Plan, a subsidiary of the parent company of that issuer, or a network that contracts with the parent company of that issuer, you're eligible for a Medicare supplement policy during the Medicare Advantage Annual Enrollment Period if your Medicare Advantage Plan:

- Increases your premium by more than 15 percent
- Increases physician, hospital, or drug copayments by 15 percent
- Reduces any benefits under the plan
- Discontinues, for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to you

Note: In the case the Medicare Advantage Plan discontinues its relationship with a provider providing services to you, your eligibility for a Medicare supplement policy is not restricted to during the Medicare Advantage Annual Enrollment Period.

- You demonstrate, in accordance with guidelines established by the Secretary, that:
  - i) the Medicare Advantage organization offering the Plan substantially violated a material provision of the organization's contract with the Centers for Medicare & Medicaid Services in relation to you, including the failure to provide you, on a timely basis, with medically necessary care for which benefits are available under the Plan, or the failure to provide such covered care in accordance with applicable quality standards; or
  - ii) the Medicare Advantage organization or agent or other entity acting on the Medicare Advantage organization's behalf, materially misrepresented the plan's provisions in marketing the Plan to you; or
- You meet such other exceptional conditions as the Secretary may provide.

3. Your enrollment ceases under the same circumstances that would permit discontinuance under Section 2, and you are enrolled with one the following:
   - An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost); or
   - A similar organization operating under demonstration project authority, effective for periods before April 1,1999; or
   - An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
   - An organization under a Medicare Select policy.
4. You are enrolled in a Medicare Supplement policy and the enrollment ceases because:
   - Of the insolvency of the issuer or bankruptcy of the non-issuer organization, or of other involuntary termination of coverage or enrollment under the policy; or
   - The issuer of the policy substantially violated a material provision of the policy; or
   - The issuer or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to you.
5. You were enrolled under a Medicare supplement policy and you terminate enrollment and subsequently enroll, for the first time, with (1) any Medicare Advantage organization under a Medicare Advantage Plan under Part C of Medicare, (2) any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), (3) any similar organization operating under demonstration project authority, (4) any PACE program under Section 1894 of the Social Security Act, or (5) a Medicare Select policy, and enrollment under this section is terminated by you during any period within the first 12 months

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of such subsequent enrollment (during which you are permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act).

6. You upon first becoming enrolled for benefits under Medicare Part A and Part B, enroll in a Medicare Advantage Plan under Part C of Medicare, or in a PACE program under Section 1894 of the Social Security Act, and disenroll from the plan or program within 12 months of the effective date of enrollment.
7. You qualify for a 6 month open enrollment period if you lose Military Health Coverage because:
    - A military base closes; or
    - A military base no longer offers health care services; or
    - You move away from a military base; or
    - You lose access to health care services at a military base.
8. You qualify for a 6 month open enrollment period if you lose your eligibility for full Medi-Cal benefits due to an increase in your income or assets.

"Note to individuals under the age of 65: An issuer shall make available Medicare supplement benefit plans A, B, C, F, and G, if currently available, to an applicant who qualifies for Guaranteed Issue, is 64 years of age or younger and who does not have end-stage renal disease. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement plan K or L and the selection between Medicare supplement benefit plan M or N is made at the issuer's discretion."

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 once lifetime reserve days are used:	All but $816 a day	$816 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0**
• beyond the additional 365 days	$0	$0	All costs
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

****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.

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 outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, 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 (subject to any applicable State or Federal restrictions on such charges)
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 and 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

Plan B

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 once lifetime reserve days are used:	All but $816 a day	$816 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0**
• beyond the additional 365 days	$0	$0	All costs
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

****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.

Plan B

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, 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 (subject to any applicable State or Federal restrictions on such charges)
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 and 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

Plan C

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 once lifetime reserve days are used:	All but $816 a day	$816 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0**
• beyond the additional 365 days	$0	$0	All costs
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

****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.

Plan C

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, 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	$0	All costs (subject to any applicable State or Federal restrictions on such charges)
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

Medicare (Parts A and 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

Plan C

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 of 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 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 once lifetime reserve days are used:	All but $816 a day	$816 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0**
• beyond the additional 365 days	$0	$0	All costs
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

****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.

Plan F

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, 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

Medicare (Parts A and 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

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 of 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

High Deductible 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.

** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2,800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay $2,800 Deductible,** Plan Pays	In Addition To $2,800 Deductible,** 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 once lifetime reserve days are used:	All but $816 a day	$816 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0***
• beyond the additional 365 days	$0	$0	All costs
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

***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.

High Deductible Plan F

Medicare (Part A) - Hospital Services - Per Benefit Period *(Continued)*

** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2,800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay $2,800 Deductible,** Plan Pays	In Addition To $2,800 Deductible,** You Pay
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

High Deductible Plan F

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.

** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2,800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay $2,800 Deductible,** Plan Pays	In Addition To $2,800 Deductible,** 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, 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

High Deductible Plan F

Medicare (Parts A and 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.

** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2,800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay $2,800 Deductible,** Plan Pays	In Addition To $2,800 Deductible,** 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	After You Pay $2,800 Deductible,** Plan Pays	In Addition To $2,800 Deductible,** You Pay
Foreign Travel **Not covered by Medicare** Medically necessary emergency care services beginning during the first 60 days of each trip outside of 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 once lifetime reserve days are used:	All but $816 a day	$816 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0**
• beyond the additional 365 days	$0	$0	All costs
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

****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.

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, 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	100%	$0
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 and 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

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 of 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

High Deductible 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.

** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,800 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay $2,800 Deductible,** Plan Pays	In Addition To $2,800 Deductible,** 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 once lifetime reserve days are used:	All but $816 a day	$816 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0***
• beyond the additional 365 days	$0	$0	All costs
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

***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.

High Deductible Plan G

Medicare (Part A) - Hospital Services - Per Benefit Period *(Continued)*

** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,800 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay $2,800 Deductible,** Plan Pays	In Addition To $2,800 Deductible,** You Pay
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

High Deductible 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.

** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,800 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay $2,800 Deductible,** Plan Pays	In Addition To $2,800 Deductible,** 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, 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

High Deductible Plan G

Medicare (Parts A and 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.

** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,800 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay $2,800 Deductible,** Plan Pays	In Addition To $2,800 Deductible,** 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 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	After You Pay $2,800 Deductible,** Plan Pays	In Addition To $2,800 Deductible,** You Pay
Foreign Travel **Not covered by Medicare** Medically necessary emergency care services beginning during the first 60 days of each trip outside of 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 K

* You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $7,060 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service subject to any applicable State or Federal restrictions on such charges.**

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 once lifetime reserve days are used:	All but $816 a day	$816 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0***
• beyond the additional 365 days	$0	$0	All costs
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 $102 a day	Up to $102 a day◆
101st day and after	$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.

Plan K

Medicare (Part A) - Hospital Services - Per Benefit Period *(Continued)*

Services	Medicare Pays	Plan Pays	You Pay*
Blood			
First three pints	$0	50%	50%◆
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	50% of coinsurance or copayments	50% of coinsurance or copayments◆

Plan K

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, durable medical equipment			
First $240 of Medicare-approved amounts****	$0	$0	$240 (Part B deductible)****◆
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
Part B Excess Charges			
(above Medicare-approved amounts)	$0	$0	All costs (subject to any applicable State or Federal restrictions on such charges and they do not count toward annual out-of-pocket limit of $7,060)*
Blood			
First three pints	$0	50%	50%◆
Next $240 of Medicare-approved amounts****	$0	$0	$240 (Part B deductible)****◆
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $7,060 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service subject to any applicable State or Federal restrictions on such charges.**

Plan K

Medicare (Parts A and 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%	10%	10%◆

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Plan L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $3,530 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service subject to any applicable State or Federal restrictions on such charges.**

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	$1,224 (75% of Part A deductible)	$408 (25% 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 once lifetime reserve days are used:	All but $816 a day	$816 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0***
• beyond the additional 365 days	$0	$0	All costs
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 $153 a day	Up to $51 a day◆
101st day and after	$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.

Plan L

Medicare (Part A) - Hospital Services - Per Benefit Period *(Continued)*

Services	Medicare Pays	Plan Pays	You Pay*
Blood			
First three pints	$0	75%	25%◆
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	75% of coinsurance or copayments	25% of coinsurance or copayments◆

Plan L

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, durable medical equipment			
First $240 of Medicare-approved amounts****	$0	$0	$240 (Part B deductible)****◆
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%◆
Part B Excess Charges			
(above Medicare-approved amounts)	$0	$0	All costs (subject to any applicable State or Federal restrictions on such charges and they do not count toward annual out-of-pocket limit of $3,530)*
Blood			
First three pints	$0	75%	25%◆
Next $240 of Medicare-approved amounts****	$0	$0	$240 (Part B deductible)****◆
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%◆
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $3,530 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service subject to any applicable State or Federal restrictions on such charges.**

Plan L

Medicare (Parts A and 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%	15%	5%◆

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

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 once lifetime reserve days are used:	All but $816 a day	$816 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0**
• beyond the additional 365 days	$0	$0	All costs
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

****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.

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, 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 (subject to any applicable State or Federal restrictions on such charges)
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

Plan N

Medicare (Parts A and 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** Medically necessary emergency care services beginning during the first 60 days of each trip outside of 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

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**.

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our customer service number at 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m. Eastern time.

Español (Spanish): Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711)**. Horas de operación: 8 a.m. a 8 p.m. hora del este.

繁體中文 (Chinese): 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235（聽障專線：711）**。辦公時間：東部時間上午 8 時至晚上 8 時。


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