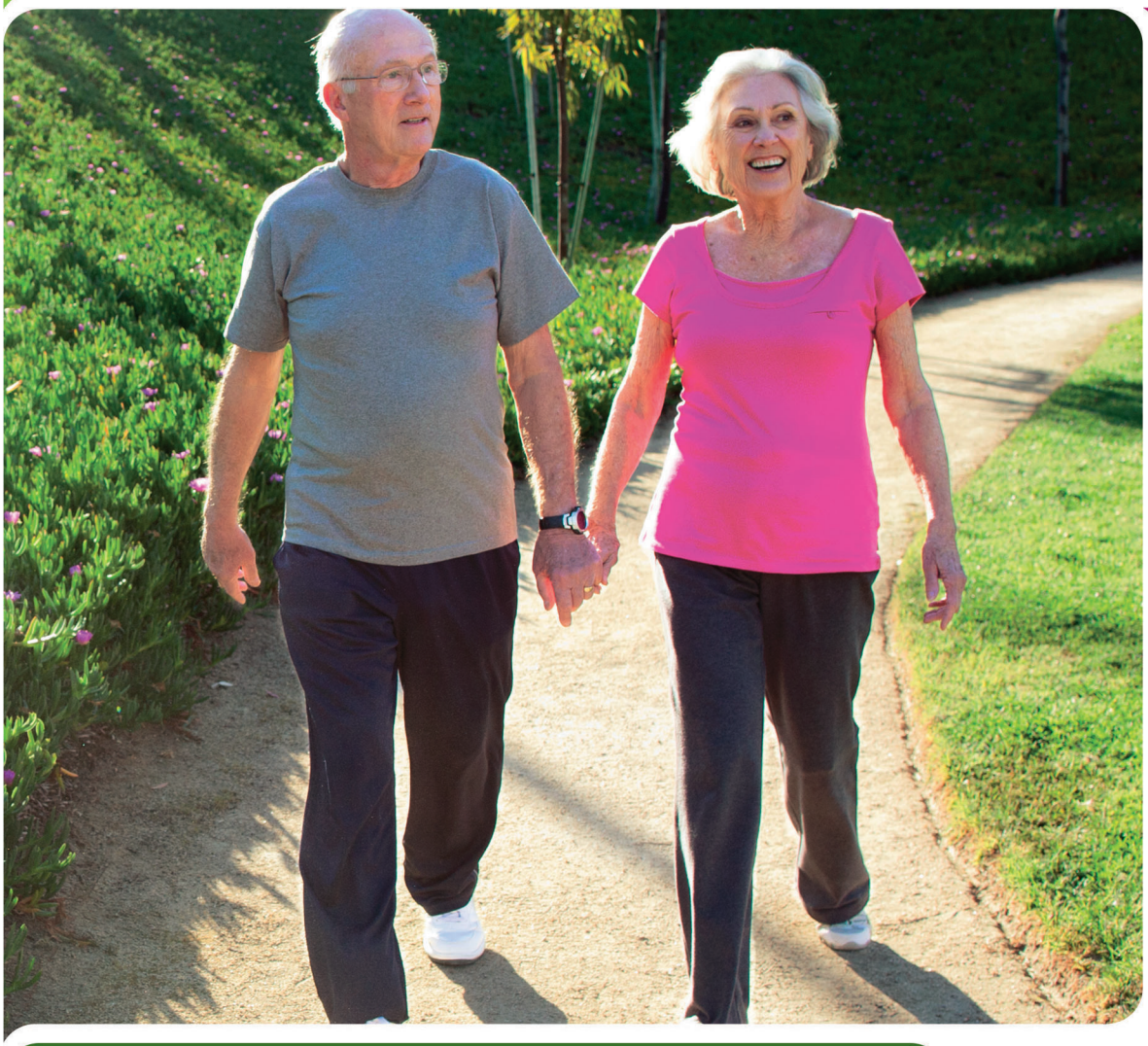
Outline of Medicare Supplement Coverage

for **Arkansas** residents Medicare supplement benefit plans with Dental and Vision: A, F, High Deductible F, K, and N



Humana Healthy Living Medicare Supplement Plans

Humana®

AR81077HLPD1

Humana Insurance Company offers Plans A, F, High Deductible F, K, and N
Benefit Chart of Medicare Supplement Plans Sold 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

A	B	C	D	F F*	G	K	L	M	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	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 for ER
		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	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%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
Innovative Benefits				Innovative Benefits		Innovative Benefits			Innovative Benefits
						Out-of-pocket limit $5,560; paid at 100% after limit reached	Out-of-pocket limit $2,780; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,300. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Humana Healthy Living Medicare Supplement Monthly Premiums Community Rates

Effective Date: 05-01-2019

Area 1 includes the following county: Pulaski

Plan	Preferred	Standard
***Plan A <65**	$593.03	$880.42
Plan A	$205.68	$301.48
Plan F	$260.75	$383.79
High Deductible Plan F	$97.01	$139.07
Plan K	$130.18	$188.63
Plan N	$184.84	$270.35

*Plan A <65 Effective 07-01-2018

Humana Healthy Living Medicare Supplement Monthly Premiums Community Rates

Effective Date: 05-01-2019

Area 2 includes the following counties: Arkansas, Clark, Conway, Faulkner, Garland, Grant, Hot Spring, Jackson, Lonoke, Monroe, Montgomery, Perry, Pike, Polk, Prairie, Saline, Van Buren, White, Woodruff

Plan	Preferred	Standard
***Plan A <65**	$569.09	$844.64
Plan A	$197.70	$289.55
Plan F	$250.50	$368.47
High Deductible Plan F	$93.51	$133.83
Plan K	$125.31	$181.35
Plan N	$177.72	$259.70

*Plan A <65 Effective 07-01-2018

Humana Healthy Living Medicare Supplement Monthly Premiums Community Rates

Effective Date: 05-01-2019

Area 3 includes the following counties: Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Chicot, Clay, Cleburne, Cleveland, Columbia, Craighead, Crawford, Crittenden, Cross, Dallas, Desha, Drew, Franklin, Fulton, Greene, Hempstead, Howard, Independence, Izard, Jefferson, Johnson, Lafayette, Lawrence, Lee, Lincoln, Little River, Logan, Madison, Marion, Miller, Mississippi, Nevada, Newton, Ouachita, Phillips, Poinsett, Pope, Randolph, St. Francis, Scott, Searcy, Sebastian, Sevier, Sharp, Stone, Union, Washington, Yell

Plan	Preferred	Standard
***Plan A <65**	$524.93	$778.63
Plan A	$182.98	$267.55
Plan F	$231.59	$340.21
High Deductible Plan F	$87.05	$124.17
Plan K	$116.32	$167.93
Plan N	$164.58	$240.06

*Plan A <65 Effective 07-01-2018

Medicare Supplement Discounts*

ACH Discount

Save $2 on your monthly premium by electing to make payments electronically. If you wish to take advantage of this discount be sure to select an automatic payment option in Section 7 of your enrollment application.

Household Discount**

Save 5% on your monthly premium when more than one member of your household enrolls or is enrolled in a Humana Medicare Supplement plan. This discount is only applicable to policyholders with effective dates of June 1, 2010 or after. To apply for the discount, please include the name and Medicare claim number of the person enrolled or enrolling in a Humana Medicare Supplement policy living at your address in Section 6 of your enrollment application.

Calculate Your Premium

Base monthly premium (please refer to page 2): _____

ACH Discount (applied to base premium): _____

Household Discount (applied to base premium): _____

Premium Quote (base premium minus discounts): _____

* We reserve the right to make changes to the premium discount structure. If a change to the discount structure occurs to your policy, it will affect all policies we issue like yours.

** The household premium discount will be removed if the other Medicare supplement policyholder whose policy status entitles you to the discount no longer resides with you. However, if that person becomes deceased, your discount will still apply. This premium change will occur on the billing cycle following the date we learn your eligibility has ended. Household is defined as a condominium unit, a single family home, or an apartment unit within an apartment complex.

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.

Premium discounts may be applied or discontinued based on eligibility.

Disclosure

Use this outline to compare benefits and premiums among policies.

Read your policy very carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all 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, you may return it 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 after you receive it, we will treat the policy as if it had never been issued and return all of your payments less any claims paid.

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.

Neither Humana Insurance Company nor its agents are connected with Medicare.

This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

Humana offers Medicare Supplement Insurance plans that do not contain innovative benefits. For more information, please contact Humana at 1-888-310-8482.

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.

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 $1,364	$0	$1,364 (Part A deductible)
61st through 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
while using 60 lifetime reserve days once lifetime reserve days are used:	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 $185 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 $185 of Medicare-approved amounts*	$0	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Plan A

Innovative Benefits

Services	Medicare Pays	Plan Pays	You Pay
Dental In-Network			
Preventive Services			
• Cleaning, up to 2 per calendar year	$0	100%	$0
• Oral Exams, up to 2 per calendar year	$0	100%	$0
• Dental X-Ray, up to 1 per calendar year	$0	100%	$0
Oral Cancer Screening, up to 1 per calendar year	$0	100%	$0
Extractions (Unlimited)	$0	75%	25%
Restorative (fillings), up to 1 per calendar year	$0	50%	50%
Dental Out-of-Network			
Preventive Services			
• Cleaning, up to 2 per calendar year	$0	50%	50%
• Oral Exams, up to 2 per calendar year	$0	50%	50%
• Dental X-Ray, up to 1 per calendar year	$0	50%	50%
Oral Cancer Screening, up to 1 per calendar year	$0	50%	50%
Extractions (Unlimited)	$0	50%	50%
Restorative (fillings), up to 1 per calendar year	$0	45%	55%
Vision			
Routine examination with dilation, once every 12 months	$0	100%*	$0
Eye glasses or contact lenses - conventional and disposable	$0	$100 allowance	Remaining Balance

*** up to $75 allowance provided for Out-of-Network**

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 $1,364	$1,364 (Part A deductible)	$0
61st through 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
while using 60 lifetime reserve days once lifetime reserve days are used:	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $185 of Medicare-approved amounts*	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$185 (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

Plan F

Innovative Benefits

Services	Medicare Pays	Plan Pays	You Pay
Dental In-Network			
Preventive Services			
• Cleaning, up to 2 per calendar year	$0	100%	$0
• Oral Exams, up to 2 per calendar year	$0	100%	$0
• Dental X-Ray, up to 1 per calendar year	$0	100%	$0
Oral Cancer Screening, up to 1 per calendar year	$0	100%	$0
Extractions (Unlimited)	$0	75%	25%
Restorative (fillings), up to 1 per calendar year	$0	50%	50%
Dental Out-of-Network			
Preventive Services			
• Cleaning, up to 2 per calendar year	$0	50%	50%
• Oral Exams, up to 2 per calendar year	$0	50%	50%
• Dental X-Ray, up to 1 per calendar year	$0	50%	50%
Oral Cancer Screening, up to 1 per calendar year	$0	50%	50%
Extractions (Unlimited)	$0	50%	50%
Restorative (fillings), up to 1 per calendar year	$0	45%	55%
Vision			
Routine examination with dilation, once every 12 months	$0	100%*	$0
Eye glasses or contact lenses - conventional and disposable	$0	$100 allowance	Remaining Balance

*** up to $75 allowance provided for Out-of-Network**

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 one has paid a calendar year $2,300 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,300. 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 $2,300 Deductible,** Plan Pays	In Addition To $2,300 Deductible,** You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0
61st through 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
while using 60 lifetime reserve days	All but $682 a day	$682 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
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 $170.50 a day	Up to $170.50 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 one has paid a calendar year $2,300 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,300. 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 $2,300 Deductible,** Plan Pays	In Addition To $2,300 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 $185 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 one has paid a calendar year $2,300 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,300. 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 $2,300 Deductible,** Plan Pays	In Addition To $2,300 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 $185 of Medicare-approved amounts*	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$185 (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 $185 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 one has paid a calendar year $2,300 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,300. 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 $2,300 Deductible,** Plan Pays	In Addition To $2,300 Deductible,** You Pay
Home Health Care MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $185 of Medicare-approved amounts*	$0	$185 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	After You Pay $2,300 Deductible,** Plan Pays	In Addition To $2,300 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

High Deductible Plan F

Innovative Benefits

Dental and vision coverage is not subject to the high deductible for this Plan.

Services	Medicare Pays	Plan Pays	You Pay
Dental In-Network			
Preventive Services			
• Cleaning, up to 2 per calendar year	$0	100%	$0
• Oral Exams, up to 2 per calendar year	$0	100%	$0
• Dental X-Ray, up to 1 per calendar year	$0	100%	$0
Oral Cancer Screening, up to 1 per calendar year	$0	100%	$0
Extractions (Unlimited)	$0	75%	25%
Restorative (fillings), up to 1 per calendar year	$0	50%	50%
Dental Out-of-Network			
Preventive Services			
• Cleaning, up to 2 per calendar year	$0	50%	50%
• Oral Exams, up to 2 per calendar year	$0	50%	50%
• Dental X-Ray, up to 1 per calendar year	$0	50%	50%
Oral Cancer Screening, up to 1 per calendar year	$0	50%	50%
Extractions (Unlimited)	$0	50%	50%
Restorative (fillings), up to 1 per calendar year	$0	45%	55%
Vision			
Routine examination with dilation, once every 12 months	$0	100%*	$0
Eye glasses or contact lenses - conventional and disposable	$0	$100 allowance	Remaining Balance

*** up to $75 allowance provided for Out-of-Network**

Plan K

* You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $5,560 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.**

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 $1,364	$682 (50% of Part A deductible)	$682 (50% of Part A deductible)◆
61st through 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
while using 60 lifetime reserve days once lifetime reserve days are used:	All but $682 a day	$682 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 $170.50 a day	Up to $85.25 a day	Up to $85.25 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 $185 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 $185 of Medicare-approved amounts****	$0	$0	$185 (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 (and they do not count toward annual out-of-pocket limit of $5,560)*
Blood			
First three pints	$0	50%	50%◆
Next $185 of Medicare-approved amounts****	$0	$0	$185 (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 $5,560 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.**

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 $185 of Medicare-approved amounts*****	$0	$0	$185 (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 K

Innovative Benefits

Services	Medicare Pays	Plan Pays	You Pay
Dental In-Network			
Preventive Services			
• Cleaning, up to 2 per calendar year	$0	100%	$0
• Oral Exams, up to 2 per calendar year	$0	100%	$0
• Dental X-Ray, up to 1 per calendar year	$0	100%	$0
Oral Cancer Screening, up to 1 per calendar year	$0	100%	$0
Extractions (Unlimited)	$0	75%	25%
Restorative (fillings), up to 1 per calendar year	$0	50%	50%
Dental Out-of-Network			
Preventive Services			
• Cleaning, up to 2 per calendar year	$0	50%	50%
• Oral Exams, up to 2 per calendar year	$0	50%	50%
• Dental X-Ray, up to 1 per calendar year	$0	50%	50%
Oral Cancer Screening, up to 1 per calendar year	$0	50%	50%
Extractions (Unlimited)	$0	50%	50%
Restorative (fillings), up to 1 per calendar year	$0	45%	55%
Vision			
Routine examination with dilation, once every 12 months	$0	100%*	$0
Eye glasses or contact lenses - conventional and disposable	$0	$100 allowance	Remaining Balance

*** up to $75 allowance provided for Out-of-Network**

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 $1,364	$1,364 (Part A deductible)	$0
61st through 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
while using 60 lifetime reserve days once lifetime reserve days are used:	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $185 of Medicare-approved amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges			
(above Medicare-approved amounts)	$0	$0	All costs
Blood			
First three pints	$0	All costs	$0
Next $185 of Medicare-approved amounts*	$0	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$0	$185 (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

Plan N

Innovative Benefits

Services	Medicare Pays	Plan Pays	You Pay
Dental In-Network			
Preventive Services			
• Cleaning, up to 2 per calendar year	$0	100%	$0
• Oral Exams, up to 2 per calendar year	$0	100%	$0
• Dental X-Ray, up to 1 per calendar year	$0	100%	$0
Oral Cancer Screening, up to 1 per calendar year	$0	100%	$0
Extractions (Unlimited)	$0	75%	25%
Restorative (fillings), up to 1 per calendar year	$0	50%	50%
Dental Out-of-Network			
Preventive Services			
• Cleaning, up to 2 per calendar year	$0	50%	50%
• Oral Exams, up to 2 per calendar year	$0	50%	50%
• Dental X-Ray, up to 1 per calendar year	$0	50%	50%
Oral Cancer Screening, up to 1 per calendar year	$0	50%	50%
Extractions (Unlimited)	$0	50%	50%
Restorative (fillings), up to 1 per calendar year	$0	45%	55%
Vision			
Routine examination with dilation, once every 12 months	$0	100%*	$0
Eye glasses or contact lenses - conventional and disposable	$0	$100 allowance	Remaining Balance

*** up to $75 allowance provided for Out-of-Network**

Notes

Discrimination is against the law

Humana Inc. and its subsidiaries ("Humana") comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Humana does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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.

• Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call **1-800-866-0581 (TTY: 711)**.

If you believe that Humana has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call **1-800-866-0581 (TTY: 711)**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800–368–1019. If you use a TTY, call **1-800-537-7697**.
Complaint Forms are available at www.hhs.gov/ocr/office/file/index.html.

Humana®

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-866-0581 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-866-0581 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-866-0581 （TTY: 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-866-0581 (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-800-866-0581 (TTY: 711)번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-866-0581 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-866-0581 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-866-0581 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-866-0581 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-866-0581 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-866-0581 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-866-0581 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-866-0581 (TTY: 711).

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-866-0581 (رقم هاتف الصم والبكم: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-866-0581 （TTY：711）まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-866-0581 (TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-866-0581 (TTY: 711).

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