

SERFF Tracking Number: HUMA-126779971 State: Arkansas  
 Filing Company: Humana Insurance Company State Tracking Number: 46574  
 Company Tracking Number: AR-14-2010  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.011 Plan N 2010  
 Standard Plans 2010  
 Product Name: 2010 Individual Medicare Supplement Plans  
 Project Name/Number: Product Filing - Plan N/AR-14-2010

## Filing at a Glance

Company: Humana Insurance Company  
 Product Name: 2010 Individual Medicare Supplement Plans  
 TOI: MS08I Individual Medicare Supplement - Standard Plans 2010  
 Sub-TOI: MS08I.011 Plan N 2010  
 Filing Type: Form/Rate

SERFF Tr Num: HUMA-126779971 State: Arkansas  
 SERFF Status: Closed-Approved- Closed State Tr Num: 46574  
 Co Tr Num: AR-14-2010 State Status: Approved-Closed  
 Reviewer(s): Stephanie Fowler  
 Disposition Date: 09/07/2010  
 Authors: Michele Zabel, Paula Williamson, Bettina Ponds, Tammy House, Tiffany Turner  
 Date Submitted: 08/23/2010 Disposition Status: Approved-Closed  
 Implementation Date Requested: On Approval Implementation Date: 09/07/2010  
 State Filing Description:

## General Information

Project Name: Product Filing - Plan N  
 Project Number: AR-14-2010  
 Requested Filing Mode: Review & Approval  
 Explanation for Combination/Other:  
 Submission Type: New Submission  
 Overall Rate Impact:  
 Filing Status Changed: 09/07/2010

Status of Filing in Domicile: Not Filed  
 Date Approved in Domicile:  
 Domicile Status Comments:  
 Market Type: Individual  
 Group Market Size:  
 Group Market Type:  
 Explanation for Other Group Market Type:  
 State Status Changed: 09/07/2010  
 Created By: Bettina Ponds  
 Corresponding Filing Tracking Number:

Deemer Date:  
 Submitted By: Bettina Ponds  
 Filing Description:  
 RE: Humana Insurance Company/NAIC # 119, 73288  
 2010 Individual Medicare Supplement Plan N

Humana Insurance Company is filing the below captioned forms for your consideration and approval.

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The policy form is a standardized individual Medicare supplement policy which is designed in accordance with the new Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

We intend to sell the new Medicare supplement plan with effective dates beginning January 1, 2011 and thereafter.

1. Policy Form: ARMESM10N
2. Outline of Coverage: AR81077M10N
3. Enrollment Application: GN85030M10N
4. Actuarial Memorandum - Rates

The Outline of Coverage and Enrollment Application were recently approved as part of the initial product filings submitted for June 1, 2010. These forms are being submitted as revised forms and a reference to the prior approved filing number will be provided. The only changes that have been made are revisions necessary to add Plan N to the Humana current plan lineup. For example the only revision to the Enrollment Application is the adding of Plan N to the selection option for the applicant.

Please feel free to contact me at (502) 580-0964 or through e-mail at [bponds@humana.com](mailto:bponds@humana.com), if you have any questions about this submission or require further information relative to this filing.

## Company and Contact

### Filing Contact Information

Bettina Ponds, Regulatory Compliance Analyst [bponds@humana.com](mailto:bponds@humana.com)  
500 W. Main St. 502-580-0964 [Phone]  
Louisville, KY 40202

### Filing Company Information

Humana Insurance Company	CoCode: 73288	State of Domicile: Wisconsin
1100 Employers Boulevard	Group Code: 119	Company Type: Life & Health
Green Bay, WI 54344	Group Name:	State ID Number:
(800) 558-4444 ext. [Phone]	FEIN Number: 39-1263473	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$150.00
Retaliatory?	Yes

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Fee Explanation: 3 x \$50 for policy, application and rates = \$150  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	\$150.00	08/23/2010	38955660

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	09/07/2010	09/07/2010

*SERFF Tracking Number:* HUMA-126779971      *State:* Arkansas  
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## **Disposition**

Disposition Date: 09/07/2010

Implementation Date: 09/07/2010

Status: Approved-Closed

Comment: This approval is subject to the following:

- Increases will not be given more frequently than once in a twelve-month period;
- The insured shall be notified by the insurer of its intention to increase the rate for renewal not less than thirty (30) days prior to the effective date of the renewal.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Form	Individual Medicare Supplement Policy Plan N	Approved	Yes
Form	Outline of Coverage	Approved	Yes
Form	Enrollment Application	Approved	Yes
Rate	Proposed base rates plan N	Approved	Yes

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## Form Schedule

### Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 09/07/2010	ARMESM1 0N	Policy/Cont ract/Fratern al	Individual Medicare Supplement Policy Plan N Certificate	Initial		43.200	ARMESM10N .pdf
Approved 09/07/2010	AR81077M 10N	Outline of Coverage	Outline of Coverage	Revised	Replaced Form #: AR81077M10 Previous Filing #: HUMA-126375307		AR81077M10 N (Outline of Coverage).pdf
Approved 09/07/2010	GN85030M 10N	Application/ Enrollment Form	Enrollment Application	Revised	Replaced Form #: GN85026M10 Previous Filing #: HUMA-126375307		GN85026M10 N (Enrollment Application).p df

**HUMANA INSURANCE COMPANY**  
**Administrative Office: 1100 Employers Boulevard, DePere, WI 54115**

**MEDICARE SUPPLEMENT POLICY**  
**PLAN N**

**Notice to Buyer:** This Policy may not cover all of Your medical expenses.

In this Policy, “We”, “Us”, or “Our” refers to Humana Insurance Company “You” or “Your” means an eligible person who becomes insured under this Policy.

This Policy establishes that You are insured for the benefits set forth in this Policy.

This Policy describes all the benefits, important provisions, exclusions and limitations of Your coverage. This Policy is the insurance contract. Insurance under this Policy is effective only if You become and remain insured. **READ YOUR POLICY CAREFULLY.**

**NOTICE OF THIRTY (30) DAY RIGHT TO EXAMINE POLICY**

We want You to fully understand and be satisfied with Your Policy. If for any reason You are not satisfied, return it to Your agent or mail it to Humana Insurance Company, Attn: Medicare Enrollments, [P.O. Box 14168, Lexington, KY 40512-4168] within 30 days of its delivery. If You do so, the Policy will be void from the effective date. We will refund Your premium to You less any claims paid.

**GUARANTEED RENEWABLE**

You may renew this Policy for as long as You live by paying the renewal premium. It must be paid on or before the renewal date or during the 31 days that follow. We cannot refuse to renew this Policy or place any restrictions on it if You pay the premium on time.

**PREMIUM RATES SUBJECT TO CHANGE**

We can change the renewal premium for Your Policy but only if We also change the renewal premium for all policies that We issue like Yours on a Class basis. We will give You a written notice before any premium increase becomes effective. No change in premium will be made because of the number of claims You file, or because of a change in Your health or Your type of work.



[Michael B. McAllister, President]

## **POLICYHOLDER INFORMATION**

**POLICYHOLDER:** [John Doe]

**EFFECTIVE DATE:** [date]

**POLICY NUMBER:** [MS Policy Number]

**INITIAL PREMIUM:** [\$]

**RENEWAL DATE:** First Day of the Month

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## **BASIC CORE BENEFITS**

Your Policy is designed to coordinate with benefits provided by the federal Medicare program. Unless specifically stated otherwise, this Policy does not cover any service or portion of a service that is not a Medicare-Eligible Expense. When You receive services for Medicare-Eligible Expenses, We will pay the basic core benefits as follow:

### **Inpatient Hospital Confinement Benefits (Medicare Part A)**

**Coinsurance Benefit:** We will pay 100% of the Part A Medicare-Eligible Expenses for each day of Inpatient Hospital Confinement You incur from the 61<sup>st</sup> day through the 90<sup>th</sup> day in each Medicare Benefit Period to the extent not covered by Medicare.

**Lifetime Reserve Days Benefit:** We will pay 100% of the Part A Medicare-Eligible Expenses for each Lifetime Reserve Day of Inpatient Hospital Confinement You incur to the extent not covered by Medicare. Lifetime Reserve Days are nonrenewable and limited to 60 days during Your lifetime.

**Medicare Exhaustion Benefit:** After all Medicare Inpatient Hospital Confinement benefits are exhausted, including Your Lifetime Reserve Days, We will pay 100% of the Part A Medicare-Eligible Expenses You incur for Inpatient Hospital Confinement. Benefits are payable at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment. Medicare exhaustion benefits are limited to a maximum of 365 days of Inpatient Hospital Confinement payable during Your lifetime.

### **Blood Benefit (Medicare Parts A and B)**

We will pay the reasonable cost under Medicare Parts A and B for the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

### **Medicare Part B Coinsurance Benefit**

After the Medicare Part B Calendar Year Deductible has been satisfied, We will pay the Coinsurance Amount not paid by Medicare applicable to Part B Medicare-Eligible Expenses regardless of Hospital Confinement. The Coinsurance Amount is generally 20% of the total amount approved by Medicare for medical services. In the case of Hospital Outpatient department services under a prospective payment system, We will pay the copayment amount.

This plan requires a copayment of up to [\$20] for each office visit, and a copayment of up to [\$50] for each emergency room visit. The emergency room copayment will be waived if you are admitted to any Hospital as an inpatient and the emergency room visit is then covered as a Part A Medicare Eligible Expense.

### **Hospice Care Benefit**

We will pay the cost sharing of all Part A Medicare-Eligible Hospice Care and Respite Care expenses.

## **ADDITIONAL BENEFITS**

We will pay the additional benefits as follow when You receive services for Medicare-Eligible Expenses. These additional benefits are subject to the same terms and conditions as Basic Core Benefits.

### **Inpatient Hospital Confinement Deductible Benefit (Medicare Part A)**

When You are confined in a Hospital as an Inpatient, We will pay 100% of the Medicare Part A Inpatient Hospital Deductible Amount due for each Benefit Period.

### **Skilled Nursing Facility Confinement Benefit (Medicare Part A)**

When You are confined in a Skilled Nursing Facility for post-Hospital care eligible under Medicare Part A, We will pay the actual billed charges, up to the daily Coinsurance Amount, for each day of confinement from the 21<sup>st</sup> day through the 100<sup>th</sup> day, during each Medicare Benefit Period.

### **Emergency Care in a Foreign Country Benefit**

If You receive Emergency Care while in a foreign country, We will pay 80% of the billed Medicare-Eligible Expenses incurred for Hospital, physician and medical services to the extent such expenses are not covered by Medicare, after a \$250 Calendar Year Deductible has been satisfied by You. Benefits are payable only for Emergency Care that would have been covered by Medicare to the extent such Emergency Care would have been covered by Medicare if provided in the United States. Benefits are limited to:

- a. Emergency Care which begins during the first 60 days in a row of each trip You make outside of the United States; and
- b. A maximum payable of \$50,000 during Your lifetime.

## **ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE**

### **PERSONS ELIGIBLE FOR COVERAGE**

To be eligible for coverage under the Policy, You must be:

1. eligible for Medicare; and
2. enrolled in both Medicare Parts A and B.

### **EFFECTIVE DATE OF COVERAGE**

The effective date of Your coverage will be the effective date shown on the Policyholder Information page.

You are not eligible for coverage under the Policy if You have assigned Your Medicare benefits to another plan, such as participation in a Medicare Advantage or Medicare Cost Plan.

## **BENEFIT AND RENEWAL PREMIUM CHANGES**

The benefits provided by this Policy are intended to cover the Deductible and Copayment/Coinsurance Amounts imposed by Medicare. This Policy does not duplicate benefits provided by Medicare.

- Any change in the Part A Deductible or the Part B Deductible or Copayment/Coinsurance Amounts or any other benefits covered under Medicare that are also covered under this Policy will result in a corresponding change in the benefits provided by this Policy.
- Any such change in benefits will take effect at the same time that the change in the Medicare program takes effect. A notification will be sent to You of any Medicare benefit changes as soon as practicable, but no later than 30 days prior to the annual effective date of such changes.
- When such a change in benefits occurs, a corresponding change in the Policy's premium may be made. This change in premium is subject to approval by the State.
- We can only change the renewal premium for your Policy if We also change the renewal premium for all policies that We issue like Yours on a Class basis. A change in premium is subject to approval by the 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.

## **DISCOUNT PROGRAMS AND EXTRA SERVICES**

We may offer or provide access to discount programs and extra services to You. In addition, We may arrange for third party service providers, such as pharmacies, optometrists, and/or fitness centers, to provide discounts on goods and services to You. Some of these third party service providers may make payments to Us when covered persons take advantage of these discount programs and health and wellness services. These payments offset the cost to Us of making these programs available and may help reduce the costs of Your plan administration.

Although We have arranged for third parties to offer discounts on these goods and services, these discount programs and services are not insured benefits under this Policy. The third party service providers are solely responsible to You for the provision of any such goods and/or services. We are not responsible for any such goods and/or services, nor are We liable if vendors refuse to honor such discounts and services. Further, We are not liable to covered persons for the negligent provision of such goods and/or services by third party service providers. Discount programs and extra services may not be available to persons who “opt out” of marketing communications and where otherwise restricted by law.

## **PRE-EXISTING CONDITION LIMITATIONS**

This Policy will not cover expenses due to a Pre-existing Condition unless the expense is incurred 90 days or more after the Effective Date.

- If, as of the date of application, You had a Continuous Period of Creditable Coverage or had prior coverage under a Medicare Supplement policy for at least 90 days, we will not exclude benefits based on a Pre-existing Condition.
- If, as of the date of application, You had a Continuous Period of Creditable Coverage or had prior coverage under a Medicare Supplement policy for less than 90 days, we will reduce the period of the pre-existing condition limitation by the time covered under such prior coverage.

**NOTE:** The above does not apply if You applied for and were issued this Policy under guaranteed issue status.

## **TERMINATION OF COVERAGE**

Your Policy will terminate:

1. On the date You fail to pay the required premium within the time allowed to keep Your Policy in force, including the grace period.
2. At the end of the month following the date We receive written notice that You wish to terminate Your coverage.
3. At the end of the month following the date of Your death.

**NOTE:** If We discover a fraudulent misstatement on Your application, Your Policy will terminate on the original effective date.

If We terminate coverage for You, it will not affect any pending claim, which includes those medical services and supplies rendered or furnished prior to the date coverage ends.

If We accept a premium for a time period after coverage is to cease, then coverage will continue to the end of the term for which the premium was paid.

## **SUSPENSION/REINSTITUTION OF COVERAGE**

### **Suspension:**

Benefits and premiums under this Policy shall be suspended at Your request for a period, not to exceed 24 months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within 90 days after You become entitled to such assistance.

Benefits and premiums under this Policy shall be suspended at Your request, (for the period provided by federal regulation), if You are entitled to benefits under Section 226 (b) of the Social Security Act; and are covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act, as amended).

Upon receipt of timely notice, We will return that portion of the premium for the period of time Your coverage is suspended. Your refunded premiums will be reduced by the amount of claims paid for the period You are eligible.

**Reinstitution:**

If You lose entitlement to medical assistance during a period of suspension, this Policy will be automatically reinstated (effective the date of such termination of entitlement). You must provide Us with notice of the loss of the entitlement within 90 days after the date of the loss and pay the premium attributed to the period effective as of the date of termination of entitlement.

If Your group health plan terminates during a period of suspension, this Policy will be automatically reinstated (effective the date of such termination). You must provide Us with notice of the termination within 90 days after the date of such termination; and pay the premium attributable to the period, effective as of the date of termination of Your group health plan.

Upon reinstatement:

- (a) there will be no additional waiting period with respect to treatment of pre-existing conditions;
- (b) coverage will be substantially equivalent to coverage in effect before the date of the suspension; and
- (c) premiums will be classified on terms that are at least as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

## **POLICY PROVISIONS**

### **ENTIRE CONTRACT**

This Policy, including the application and any attachments, is the entire contract of insurance.

### **CHANGES IN THIS CONTRACT**

No agent has the authority to change or waive any part of this Policy. To be valid, any change must be in writing, approved by one of Our officers, and attached to this Policy.

### **CONFORMITY WITH STATE LAW**

Any part of this Policy which is in conflict with the laws of the state where You live on Your effective date is amended to meet the minimum requirements of those laws.

### **TIME PERIOD**

All periods begin and end at 12:01 A.M., Standard Time, at Your residence.

### **TIME LIMIT ON CERTAIN DEFENSES**

Three years from the effective date of Your Policy, only fraudulent misstatements on Your application may be used to void Your Policy or deny any claim for loss incurred or disability that starts after the three year period.

### **MISSTATEMENT OF AGE**

If Your age is misstated on Your application, the coverage provided will be that which the premium submitted would have purchased at Your correct age. If Your correct age as of the effective date of Your Policy would have caused Us to refuse coverage to You, We will only be responsible for the return of all premiums paid, less the amount of any claims which have been paid.

### **LEGAL ACTION**

No legal action may be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action may be brought after three years from the time written proof of loss is required to be furnished.

### **ASSIGNMENT**

No change of assignment of interest under the Policy will be binding upon Us unless and until the original or duplicate thereof is received at Our Administrative Office, which does not assume any responsibility for the validity thereof.

## **NOTICE OF CLAIM**

Notice of a claim for benefits must be given to Us. The notice must be in writing. Any claim will be based on the written notice.

The notice must be received by Us within 60 days after the start of the loss on which the claim is based. If notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the 60 day period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

## **CLAIM FORMS**

When We receive written notice of claim, We will send You forms for filing proof of loss. These forms should be furnished within 15 days after We receive written notice.

If We fail to furnish these forms within 15 days, You can meet the time period shown below for submitting proof of loss by submitting written proof which explains the reasons for the claim. Written proof should establish facts about the claim such as occurrence, nature and extent of the loss involved.

## **PROOF OF LOSS**

Written proof of loss must be given to Us within 90 days after the date of the loss for which claim is made.

Failure to provide the proof of loss within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof of loss must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of a legal incapacity.

## **EXTENSION OF TIME LIMITS**

If the time limit We allow for giving notice of claim or submitting proof of loss is less than the law permits in the state where You live, We will extend Our time limits to agree with the minimum period specified by Your state's laws. The law must exist at the time Your Policy is issued.

## **RIGHT TO REQUIRE MEDICAL EXAMS**

We have the right to require that a medical exam be performed on any claimant for whom a claim is pending as often as We may reasonably require. If We require a medical exam, it will be performed at Our expense.

## **TIME OF PAYMENT OF CLAIMS**

Benefits will be paid immediately when We receive proper written proof of loss.

## **PAYMENT OF CLAIMS**

If You die while benefits remain due and unpaid, We may choose to pay those benefits, up to \$1,000.00, or the amount required by state law, to:

1. any person related to You by blood or marriage who appears to be entitled to the benefits; or
2. the executors or administrators of Your estate.

We will be discharged for further responsibility to the extent of any payment made in good faith.

## **PAYMENT OF PREMIUM**

The initial premium is due on or before the effective date of Your Policy. Each premium after the initial one is due at the end of the period for which the preceding premium was paid.

Your Policy will lapse on the last day of the period for which the premium is paid. If the premium is not paid by that date, the grace period will begin.

## **REFUND OF UNEARNED PREMIUMS**

Upon the death of the insured, premiums paid for this Policy for any period beyond the end of the policy month in which the death occurred shall be refunded. Unearned premiums shall be paid in lump sum on a date no later than 30 days after the proof of the insured's death has been furnished to Humana.

## **GRACE PERIOD**

A grace period of 31 days is allowed for the late payment of any premium except the initial premium. The coverage will continue in force during the grace period. If the premium is not paid during the grace period, the Policy will terminate as of the initial due date for that premium, which is the last day before the grace period begins.

## **REINSTATEMENT**

The coverage may be reinstated if it has terminated because the premium was not paid before the end of the grace period. It will be reinstated on the first of the month after the premium due is paid if We do not require an application for reinstatement.

If We do require an application for reinstatement, a conditional receipt will be given. If We approve the application for reinstatement, the Policy will be reinstated on the first of the month after the approval. If We do not give written approval or disapproval of Your application within 45 days after the date of the conditional receipt, the coverage will be automatically reinstated on the 45th day.

The reinstated coverage will cover only Injuries or Sicknesses which occur after the date of reinstatement.

We have the right to make changes to this coverage as a condition for reinstatement. In all other respects, You and We will have the same rights as before the coverage terminated.

**NOTICE:**

This Notice is to advise You that should any complaints arise regarding this insurance, You may contact Your servicing agent or the following:

Humana Insurance Company  
[P.O. Box 14601  
Lexington, KY 40512  
800-866-0581]

If We at Humana Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department  
Consumer Services Division  
[1200 West Third Street  
Little Rock, AR 72201  
501-371-2640 or 800-852-5494]

## DEFINITIONS

This section provides an alphabetical list of certain terms and their meanings as used in this Policy. Defined terms are capitalized wherever they occur in the Policy.

**ADMISSION** means entry into a facility as a registered Inpatient according to the rules and regulations of that facility. An Admission ends when you are discharged or released from the facility.

**BENEFIT PERIOD** means an interval of time during which you are confined in a Hospital or Skilled Nursing Facility as an Inpatient. The Confinement may be continuous or intermittent. A Benefit Period begins on the day You are admitted to a Hospital or Skilled Nursing Facility as an Inpatient. It does not end until You have been free of Confinement for 60 consecutive days.

**CALENDAR YEAR** means the twelve-month period that begins on January 1 and ends with December 31. When You first become covered under this Policy, the first Calendar Year begins for You on the effective date of Your Policy and ends on the following December 31.

**CLASS** means a grouping of individuals based on current geographic residence.

**CONFINEMENT** means the number of days spent as an Inpatient following each Admission to a facility. If seven or more days have not elapsed between the date of discharge from a facility and the date of the next Admission, the days will be counted as one Confinement. This occurs whether or not We provided benefits during the Confinement. One Confinement may consist of several Admissions.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which You were covered by Creditable Coverage, if during the period of coverage, You had no breaks in coverage greater than 63 days.

**COPAYMENT OR COINSURANCE AMOUNT** means that predetermined amount, whether a fixed dollar or a percentage, You must pay to receive a specific service or benefit.

**CREDITABLE COVERAGE** means (a) a group health plan; (b) health insurance coverage; (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare); (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928; (e) Chapter 55 of Title 10 United States Code (CHAMPUS); (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); (i) a public health plan as defined in federal regulation; or (j) a health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

**DEDUCTIBLE** means the amount of covered expenses which You must pay before benefits will be paid.

**HOSPICE CARE** means a program of palliative care approved for payment by Medicare that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family.

**HOSPITAL** means an institution which meets all of the following requirements.

1. It must provide, for a fee, medical care and treatment of Sick or Injured persons on an Inpatient basis.
2. It must provide or operate, either on its premises or in facilities available to the Hospital on a pre-arranged basis, medical, diagnostic and major surgical facilities.
3. Care and treatment must be given by or supervised by physicians. Nursing services must be provided on a 24 hour basis and must be given by or supervised by graduate Registered Nurses.
4. It must be licensed by the laws of the jurisdiction where it is located. It must be run as a Hospital as defined by those laws.
5. It must not be primarily a:
  - a. convalescent, rest or nursing home;
  - b. facility providing custodial, educational or rehabilitative care; or
  - c. facility for drug abusers and/or alcoholics.

The term Hospital also includes licensed psychiatric Hospitals which are properly accredited to provide psychiatric, diagnostic and therapeutic services for the treatment of patients who have mental illnesses. In addition, if services specifically for the treatment of a physical disability are provided in a licensed Hospital, benefits will not be denied solely because that Hospital is primarily of a rehabilitative nature and lacks major surgical facilities. However, the Hospital must be accredited by one of the following:

1. The Joint Commission on Accreditation of Healthcare Organizations;
2. The American Osteopathic Hospital Association; or
3. The Commission on the Accreditation of Rehabilitative Facilities.

**INJURY** means a non-occupational bodily harm which is the direct result of an accident.

**INPATIENT** means a registered bed patient in a facility for whom a Room and Board charge is made.

**LIFETIME RESERVE DAYS** means the 60 additional days of Hospital Confinement benefits provided by Part A of Medicare which You may use after the first 90 days of Hospital Confinement benefits during a Medicare Benefit Period. Lifetime Reserve Days may be used only once during Your lifetime.

**MEDICARE** means “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,” or “Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act.

**MEDICARE-ELIGIBLE EXPENSES** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

**MEDICARE PART A** means insurance to cover Hospital expenses, such as Room and Board and other Inpatient Hospital services.

**MEDICARE PART B** means insurance to cover medical expenses, such as physicians' services, Outpatient Hospital services and a number of other non-Hospital medical services and supplies.

**NURSE** means one of the following licensed professionals:

1. Registered Nurse (R.N.);
2. Licensed Practical Nurse (L.P.N.); or
3. Licensed Vocational Nurse (L.V.N.).

**OUTPATIENT** means someone who receives medical services or supplies while not Hospital confined.

**PRE-EXISTING CONDITION** means a condition for which medical advice was given or treatment was recommended by or received from a physician within six months prior to Your Effective Date.

**RESPIRE CARE** means Hospice Care services provided by the Hospice Care program to give temporary relief to a Hospice patient's family or other care givers.

**SICKNESS** means a non-occupational disease or illness which first begins after You become covered by this Policy.

**SKILLED NURSING FACILITY** means an institution which meets all of the following requirements.

1. It must primarily and continuously provide, for a fee, skilled nursing care and related services to persons recovering from an Injury or Sickness. Such care must be provided on an Inpatient basis.
2. It must provide 24-hours-a-day nursing services by or under the supervision of graduate Registered Nurses.
3. It must maintain a daily medical record of each Inpatient.
4. It must provide each patient with a planned program of medical care and treatment by or under the supervision of a physician.
5. It must be approved as a Skilled Nursing Facility under the Medicare program, or be qualified to receive such approval, if requested.

**YOU** or **YOUR** means the person insured under this Policy.

**WE, US,** or **OUR** means Humana Insurance Company.

# Outline of Medicare Supplement Coverage

for **Arkansas** residents Medicare supplement benefit plans: [A, B, C, F, High Deductible F, K, L, and N]



[Sample Photo]

**HUMANA**<sup>®</sup>  
Guidance when you need it most

Humana Medicare Supplement plans

AR81077M10N

# Humana Insurance Company offers Plans A, B, C, F, High Deductible F, K, L, 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. Plans E, H, I, and J are no longer available for sale.

**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		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						
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Part B Excess (100%)	Part B Excess (100%)			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit [\$4,620]; paid at 100% after limit reached	Out-of-pocket limit [\$2,310]; 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 [\$2,000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2,000]. 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 MEDICARE SUPPLEMENT MONTHLY PREMIUMS COMMUNITY RATES - (AGE 65 AND OVER)

[Effective Date: 06-01-2010]

Area 1 includes the following county: Pulaski

Plan	Preferred	Standard
Plan A	[\$152.77]	[\$227.35]
Plan B	[\$166.09]	[\$247.26]
Plan C	[\$191.19]	[\$284.77]
Plan F	[\$195.05]	[\$290.54]
High Deductible Plan F	[\$74.40]	[\$110.21]
Plan K	[\$90.42]	[\$134.15]
Plan L	[\$127.68]	[\$189.83]
Plan N	[\$100.00]	[\$100.00]

## HUMANA MEDICARE SUPPLEMENT MONTHLY PREMIUMS COMMUNITY RATES - (AGE 65 AND OVER)

[Effective Date: 06-01-2010]

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	[\$146.56]	[\$218.06]
Plan B	[\$159.33]	[\$237.16]
Plan C	[\$183.39]	[\$273.12]
Plan F	[\$187.10]	[\$278.65]
High Deductible Plan F	[\$71.42]	[\$105.75]
Plan K	[\$86.78]	[\$128.71]
Plan L	[\$122.50]	[\$182.09]
Plan N	[\$100.00]	[\$100.00]

## HUMANA MEDICARE SUPPLEMENT MONTHLY PREMIUMS COMMUNITY RATES - (AGE 65 AND OVER)

[Effective Date: 06-01-2010]

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	[\$135.10]	[\$200.93]
Plan B	[\$146.86]	[\$218.51]
Plan C	[\$169.01]	[\$251.63]
Plan F	[\$172.43]	[\$256.72]
High Deductible Plan F	[\$65.91]	[\$97.52]
Plan K	[\$80.06]	[\$118.66]
Plan L	[\$112.95]	[\$167.82]
Plan N	[\$100.00]	[\$100.00]

## **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.

## **Disclosure**

Use this outline to compare benefits and premiums among policies. This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

## **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.

## **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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	\$0	[\$1,100] (Part A deductible)
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 [\$137.50] a day	\$0	Up to [\$137.50] a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 [\$155] 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0  Generally 80%	\$0  Generally 20%	[\$155] (Part B deductible)  \$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First three pints Next [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$155] (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100%  \$0 80%	\$0  \$0 20%	\$0  [\$155] (Part B deductible) \$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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	[\$1,100] (Part A deductible)	\$0
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 [\$137.50] a day	\$0	Up to [\$137.50] a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 [\$155] 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0  Generally 80%	\$0  Generally 20%	[\$155] (Part B deductible)  \$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First three pints Next [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$155] (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100%  \$0 80%	\$0  \$0 20%	\$0  [\$155] (Part B deductible) \$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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	[\$1,100] (Part A deductible)	\$0
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 [\$137.50] a day	Up to [\$137.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 [\$155] 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0  Generally 80%	[\$155] (Part B deductible)  Generally 20%	\$0  \$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First three pints Next [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs [\$155] (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100%  \$0 80%	\$0  [\$155] (Part B deductible) 20%	\$0  \$0 \$0

# PLAN C

## Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	[\$1,100] (Part A deductible)	\$0
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 [\$137.50] a day	Up to [\$137.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 [\$155] 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0  Generally 80%	[\$155] (Part B deductible)  Generally 20%	\$0  \$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First three pints Next [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs [\$155] (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100%  \$0 80%	\$0  [\$155] (Part B deductible) 20%	\$0  \$0 \$0

# PLAN F

## Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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 one has paid a calendar year [\$2,000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,000]. 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 [\$2,000] Deductible,** Plan Pays	In Addition To [\$2,000] Deductible,** You Pay
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	[\$1,100] (Part A deductible)	\$0
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 [\$137.50] a day	Up to [\$137.50] 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 [\$2,000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,000]. 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 [\$2,000] Deductible,** Plan Pays	In Addition To [\$2,000] Deductible,** You Pay
<b>BLOOD</b> First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 [\$155] 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 [\$2,000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,000]. 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 [\$2,000] Deductible,** Plan Pays	In Addition To [\$2,000] Deductible,** You Pay
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [\$155] of Medicare-approved amounts*	\$0	[\$155] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First three pints	\$0	All costs	\$0
Next [\$155] of Medicare-approved amounts*	\$0	[\$155] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

# HIGH DEDUCTIBLE PLAN F

## MEDICARE (PARTS A AND B)

\*Once you have been billed [\$155] 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 [\$2,000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,000]. 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 [\$2,000] Deductible,** Plan Pays	In Addition To [\$2,000] Deductible,** You Pay
<b>HOME HEALTH CARE</b>			
MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$155] of Medicare-approved amounts*	\$0	[\$155] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

### Other Benefits - Not Covered By Medicare

Services	Medicare Pays	After You Pay [\$2,000] Deductible,** Plan Pays	In Addition To [\$2,000] Deductible,** You Pay
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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 [\$4,620] 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*
<b>HOSPITALIZATION**</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	[\$550] (50% of Part A deductible)	[\$550] (50% of Part A deductible)◆
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE**</b>			
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 [\$137.50] a day	Up to [\$68.75] a day	Up to [\$68.75] 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*
<b>BLOOD</b> First three pints	\$0	50%	50% ♦
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> 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 [\$155] 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*
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$155] of Medicare-approved amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare-approved amounts	\$0  Generally 75% or more of Medicare approved amounts  Generally 80%	\$0  Remainder of Medicare approved amounts  Generally 10%	[\$155] (Part B deductible)****◆ All costs above Medicare approved amounts Generally 10%◆
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4,620])*
<b>BLOOD</b> First three pints Next [\$155] of Medicare-approved amounts**** Remainder of Medicare-approved amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50%◆ [\$155] (Part B deductible)****◆ Generally 10%◆
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

\*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [\$4,620] 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 & B

Services	Medicare Pays	Plan Pays	You Pay*
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$155] of Medicare-approved amounts*****	\$0	\$0	[\$155] (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 [\$2,310] 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*
<b>HOSPITALIZATION**</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	[\$825] (75% of Part A deductible)	[\$275] (25% of Part A deductible)♦
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE**</b>			
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 [\$137.50] a day	Up to [\$103.13] a day	Up to [\$34.37] 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*
<b>BLOOD</b> First three pints Additional amounts	\$0 100%	75% \$0	25% ♦ \$0
<b>HOSPICE CARE</b> 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 [\$155] 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*
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$155] of Medicare-approved amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare-approved amounts	\$0  Generally 75% or more of Medicare approved amounts  Generally 80%	\$0  Remainder of Medicare approved amounts  Generally 15%	[\$155] (Part B deductible)****◆ All costs above Medicare approved amounts  Generally 5%◆
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2,310])*
<b>BLOOD</b> First three pints Next [\$155] of Medicare-approved amounts**** Remainder of Medicare-approved amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25%◆ [\$155] (Part B deductible)****◆ Generally 5%◆
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

\*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [\$2,310] 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 L

## Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay*
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$155] of Medicare-approved amounts*****	\$0	\$0	[\$155] (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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	[\$1,100] (Part A deductible)	\$0
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 [\$137.50] a day	Up to [\$137.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 [\$135] 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
<p><b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b>, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment</p> <p>First [\$135] of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p>	<p>\$0</p> <p>Generally 80%</p>	<p>\$0</p> <p>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.</p>	<p>[\$135] (Part B deductible)</p> <p>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.</p>
<p><b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)</p>	\$0	\$0	All costs
<p><b>BLOOD</b></p> <p>First three pints</p> <p>Next [\$135] of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$0</p> <p>20%</p>	<p>\$0</p> <p>[\$135] (Part B deductible)</p> <p>\$0</p>
<p><b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b></p>	100%	\$0	\$0

# PLAN N

## Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$135] of Medicare-approved amounts*	\$0	\$0	[\$135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

## Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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



# ENROLLMENT APPLICATION

Follow these easy steps to apply for a Humana Medicare Supplement insurance policy.

**① Have Your Medicare Card Ready**

Please print legibly and complete the entire form. You will need to fill in the information exactly as it appears on your Medicare card. Each person must complete a separate application.

**② Read and Complete Other Coverage Information**

Be sure you read and understand the information before completing this section. If you intend to replace your current Medicare Supplement policy or Medicare Advantage plan with this policy, be sure to complete the enclosed form titled Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage.

**③ Complete Guaranteed Acceptance**

Please fill out this section if you are eligible for guaranteed acceptance.

**④ Read and Complete Medical Questions**

**⑤ Determine Your Monthly Premium**

**⑥ Be Sure to Include Your Initial Premium Payment**

Your first month's premium payment must be included. This is necessary even if you choose our Automatic Bank Withdrawal or Auto Credit Card Charge options for future premium payments.

**⑦ Sign and Date the Enrollment Application**

**⑧ Keep Member Copy For Your Records**

Return the original copy of your completed Enrollment Application, first month's premium and any additional required forms.

GN85026M10N

**HUMANA**<sup>®</sup>  
*Guidance when you need it most*

# MARKING INSTRUCTIONS

- Please print clearly and press hard.

- Use blue or black ink only.

- Completely fill the ovals.

## Correct Mark



## Incorrect Marks



- Print legible numbers and capital block letters in the boxes.

## Correct Numbers and Letters

1 2 3 A B C

- Print only one character per box.

- If you make a mistake, correct it by crossing out the box and writing the letter/number above or below the box as shown.

S M I ~~R~~ H  
                  T

- When filling out dates, such as effective dates or birth dates, be sure dates appear in the MMDDYYYY format. No dashes or spaces are necessary.

0 3 2 4 2 0 1 0

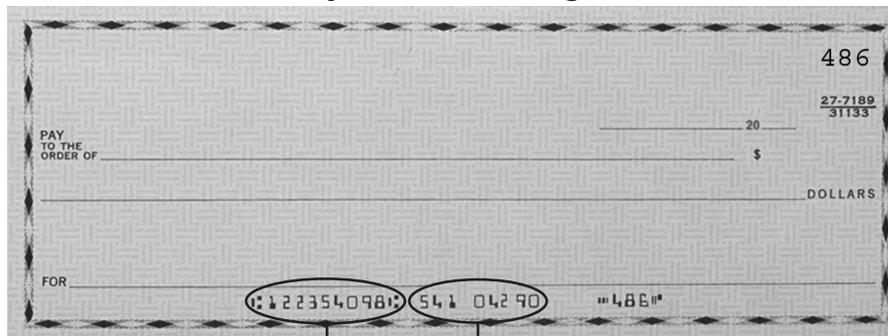
## Required Fields Must Be Completed



## Optional Fields



## SAMPLE CHECK (if you are choosing the auto bank withdrawal)



Routing  
Number

Account  
Number

1

LAST NAME FIRST NAME MI

ADDRESS APT OR STE#

ADDRESS (continued) COUNTY

CITY STATE ZIP CODE

TELEPHONE DATE OF BIRTH

GENDER M F HEIGHT FT IN WEIGHT LBS

MAILING ADDRESS (only if different from above street ADDRESS) APT OR STE#

CITY STATE ZIP CODE

E-MAIL ADDRESS (optional)

(E-mail address, if available, will be used as a means to communicate only coverage information.)

Select the policy you are applying for:

- Plan A Plan K
Plan B Plan L
Plan C Plan N
Plan F
High Deductible Plan F

PROPOSED EFFECTIVE DATE

Please complete the information below as it appears on your Medicare card.
MEDICARE CLAIM NUMBER
IS ENTITLED TO EFFECTIVE DATE
HOSPITAL INSURANCE (PART A)
MEDICAL INSURANCE (PART B)

PERSON TO NOTIFY IN AN EMERGENCY (optional):

LAST NAME FIRST NAME MI

RELATIONSHIP TO APPLICANT TELEPHONE

□□□□ - □□ - □□□□□□□□

2 OTHER COVERAGE INFORMATION

- You do not need more than one Medicare Supplement policy.
If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).

Yes or No answers are required to the following questions. If you have lost, or you are losing or replacing, other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

- 1. a. Did you turn age 65 in the last six months? Yes No
b. Did you enroll in Medicare Part B in the last six months? Yes No
If yes, what is the effective date? MM/DD/YYYY
2. Are you covered for medical assistance through the State Medicaid program? Yes No
(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)
a. If yes, will Medicaid pay your premiums for this Medicare Supplement policy? Yes No
b. Do you receive any benefits from Medicaid OTHER THAN payments toward Your Medicare Part B premium? Yes No
3. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START MM/DD/YYYY END MM/DD/YYYY
a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? Yes No
b. Was this your first time in this type of Medicare plan? Yes No
c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes No
4. Do you have another Medicare Supplement policy in force? Yes No
a. If so, with what company? □□□□□□□□□□□□□□□□□□□□
What plan do you have? □□□□□□□□□□□□□□□□□□□□
b. If so, do you intend to replace your current Medicare Supplement policy with this policy? Yes No
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) Yes No
a. If so, with what company? □□□□□□□□□□□□□□□□□□□□
What policy do you have? □□□□□□□□□□□□□□□□□□□□
b. What are your dates of coverage under this policy? (If you are still covered under this policy, leave "END" blank.)
START MM/DD/YYYY END MM/DD/YYYY
6. Do you intend to replace your current healthcare coverage with this Medicare Supplement policy? Yes No

-   -

**③ GUARANTEED ACCEPTANCE**

**PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.**

1. Are you applying for coverage during your Medicare Supplement Open Enrollment Period?  Yes  No  
If yes, please go directly to Section 6.
2. Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed acceptance?  Yes  No  
If yes, please go directly to Section 6.

If you answered yes to either question in this section, you qualify for the Preferred rates.

**④ MEDICAL QUESTIONS**

**Yes or No answers are required to the following questions, unless you indicated that you are applying for coverage during your Medicare Supplement Open Enrollment Period or qualify for guaranteed acceptance.**

**PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.**

1. In the last year, have you been hospitalized, confined to a nursing facility; or are you bedridden or confined to a wheelchair?  Yes  No
2. In the past 90 days have you received Home Health care?  Yes  No
3. Do you now have or within the last two years have you had or been advised by a physician that you need treatment or surgery for:
  - a. Heart, Coronary, or Carotid Artery Disease (not including high blood pressure), Peripheral Vascular Disease, Congestive Heart Failure or any other type of Heart Failure, Enlarged Heart, Stroke, Transient Ischemic Attacks (TIA), or Heart Rhythm disorders?  Yes  No
  - b. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other Chronic Pulmonary disorders? Have you used supplementary oxygen in the last year?  Yes  No
  - c. Parkinson’s Disease, Multiple or Lateral Sclerosis, Huntington’s Disease, Muscular Dystrophy, Lupus, Hepatitis, or Lou Gehrig’s Disease?  Yes  No
  - d. Alzheimer’s Disease, senile dementia, organic brain disorders, senility disorder, schizophrenia, other major depressive disorders, mental or nervous disorders, cirrhosis, alcoholism or drug abuse?  Yes  No
  - e. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection?  Yes  No
  - f. Kidney disease requiring dialysis or diabetes requiring more than 50 units of insulin daily?  Yes  No
  - g. Internal cancer, leukemia or melanoma?  Yes  No
  - h. Amputation caused by disease or trauma or neuralgic or poor circulation that has caused an ulcer on the skin? Do you have any paralytic conditions?  Yes  No
  - i. Rheumatoid arthritis, Paget’s Disease, degenerative bone disease, crippling arthritis, vertebral or hip fractures/dislocations, spinal cord disorders/injuries?  Yes  No
  - j. Organ transplantation?  Yes  No
4. Please list any prescription drugs (full medication name) you are currently taking or have taken within the past 12 months:

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**⑤ MONTHLY PREMIUM DETERMINATION**

All applicants must answer these questions, unless applying during a Medicare Supplement Open Enrollment Period or qualify for guaranteed acceptance as indicated in Section 3.

1. Did you have Medicare coverage prior to age 65?  Yes  No
2. Have you used tobacco products within the last 12 months?  Yes  No

If your application is accepted, and you answered **No** to both questions, you qualify for the Preferred rates. To determine your monthly premium, refer to your Outline of Coverage.

**⑥ PAYMENT OPTIONS**

**MONTHLY PREMIUM**

.   In order for us to process your application, you must submit your first month's premium.

**INITIAL PAYMENT**

.   Initial Premium Payment, if you are submitting more than your first month's premium.

**CHECK NUMBER**

**MONEY ORDER**

**CREDIT CARD NAME**

- MasterCard  Visa  Discover

**CREDIT CARD NUMBER**

**EXPIRATION DATE**

**Future Payment options:**  Automatic Withdrawal  Coupon Book  Auto Credit Card Charge

I hereby authorize Humana to initiate debit/credit entries to my checking/savings account or my credit card account, as indicated below, in amounts appropriate to my coverage; and authorize the bank named below to debit/credit the same to such account. I authorize Humana to change the amount of the debit/credit, provided that I am given advance written notice. This authorization is to remain effective until I give Humana and the bank reasonable notice of termination.

**I have included a voided check/savings withdrawal slip from the bank account I want debited.**

**DEPOSITORY BANK NAME**

**ROUTING NUMBER**

**ACCOUNT NUMBER**

- Checking  Savings

If you choose the auto credit card charge option, complete the following:  MasterCard  Visa  Discover

**CREDIT CARD NUMBER**

**EXPIRATION DATE**

I understand that if my application is not submitted during an open enrollment or guaranteed issue period, Humana has the right to reject my application and any premiums paid will be refunded. I also understand that the policy will not pay benefits for stays beginning or medical expenses incurred during the first three months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within six months prior to the insurance effective date. Coverage is not limited if you enroll during an open enrollment or guaranteed issue period or satisfy the creditable coverage requirements.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement may be subject to prosecution for fraud.

The undersigned applicant certifies that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. The applicant further acknowledges receipt of the currently available Outline of Coverage and the "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" publication.



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Insured by Humana Insurance Company

**Humana.com**

SERFF Tracking Number: HUMA-126779971 State: Arkansas  
 Filing Company: Humana Insurance Company State Tracking Number: 46574  
 Company Tracking Number: AR-14-2010  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.011 Plan N 2010  
 Standard Plans 2010  
 Product Name: 2010 Individual Medicare Supplement Plans  
 Project Name/Number: Product Filing - Plan N/AR-14-2010

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved 09/07/2010 plan N	Proposed base rates	ARMESM10N	New		Proposed Base Rates Plan N.pdf

**Exhibit 4  
Humana Insurance Company  
Medicare Supplement Rates [1] [4]**

**State:** Arkansas  
**Form #s:** ARMESM10N  
**Effective Date:** October 1, 2010  
**Proposed Base Rates**

	Plan N			
	Preferred [3]		Standard [2]	
	Male	Female	Male	Female
<b>Community</b>	\$108.99	\$108.99	\$162.90	\$162.90

- [1] Base rates presented are discounted rates based on monthly ACH/credit card payment modes. For monthly coupon book payment mode there is an additional \$2 per month. Other fees or discounts may apply in the future, including non-monthly modes and policy issue.
- [2] Standard Rate applies to tobacco users and beneficiaries originally eligible due to disability.
- [3] Preferred Rates are for non-tobacco users not originally eligible due to disability. For issues during open enrollment, the Preferred rates will apply.
- [4] Geographic area factors are also applied.

SERFF Tracking Number: HUMA-126779971 State: Arkansas  
 Filing Company: Humana Insurance Company State Tracking Number: 46574  
 Company Tracking Number: AR-14-2010  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.011 Plan N 2010  
 Standard Plans 2010  
 Product Name: 2010 Individual Medicare Supplement Plans  
 Project Name/Number: Product Filing - Plan N/AR-14-2010

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b>	Flesch Certification	Accepted for Informational Purposes	<b>Date:</b> 09/07/2010

**Comments:**

**Attachment:**

Certification of Flesch Reading Ease Test.pdf

		<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b>	Application	Approved	<b>Date:</b> 09/07/2010

**Comments:**

**Attachment:**

GN85026M10N (Enrollment Application).pdf

		<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b>	Outline of Coverage	Approved	<b>Date:</b> 09/07/2010

**Comments:**

**Attachment:**

AR81077M10N (Outline of Coverage).pdf

# Certification of Flesch Reading Ease Test

**RE: Humana Insurance Company**

This is to certify that the form listed below is in compliance with the readability requirements of the Flesch Reading ease test.

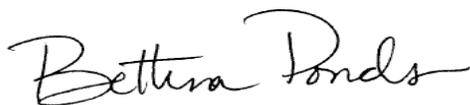
The Flesch test was applied to this form in its entirety

The Flesch reading ease test score is:

## Medicare Supplement Policy

Form Number: ARMESM10N

Flesch Score: 43.2

A handwritten signature in cursive script that reads "Bettina Ponds".

---

(Signature)

Bettina A. Ponds  
Compliance Analyst

Date: August 20, 2010

# ENROLLMENT APPLICATION

Follow these easy steps to apply for a Humana Medicare Supplement insurance policy.

**① Have Your Medicare Card Ready**

Please print legibly and complete the entire form. You will need to fill in the information exactly as it appears on your Medicare card. Each person must complete a separate application.

**② Read and Complete Other Coverage Information**

Be sure you read and understand the information before completing this section. If you intend to replace your current Medicare Supplement policy or Medicare Advantage plan with this policy, be sure to complete the enclosed form titled Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage.

**③ Complete Guaranteed Acceptance**

Please fill out this section if you are eligible for guaranteed acceptance.

**④ Read and Complete Medical Questions**

**⑤ Determine Your Monthly Premium**

**⑥ Be Sure to Include Your Initial Premium Payment**

Your first month's premium payment must be included. This is necessary even if you choose our Automatic Bank Withdrawal or Auto Credit Card Charge options for future premium payments.

**⑦ Sign and Date the Enrollment Application**

**⑧ Keep Member Copy For Your Records**

Return the original copy of your completed Enrollment Application, first month's premium and any additional required forms.

GN85026M10N

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*Guidance when you need it most*

# MARKING INSTRUCTIONS

- Please print clearly and press hard.

- Use blue or black ink only.

- Completely fill the ovals.

## Correct Mark



## Incorrect Marks



- Print legible numbers and capital block letters in the boxes.

## Correct Numbers and Letters

1 2 3 A B C

- Print only one character per box.

- If you make a mistake, correct it by crossing out the box and writing the letter/number above or below the box as shown.

S M I ~~R~~ H  
                  T

- When filling out dates, such as effective dates or birth dates, be sure dates appear in the MMDDYYYY format. No dashes or spaces are necessary.

0 3 2 4 2 0 1 0

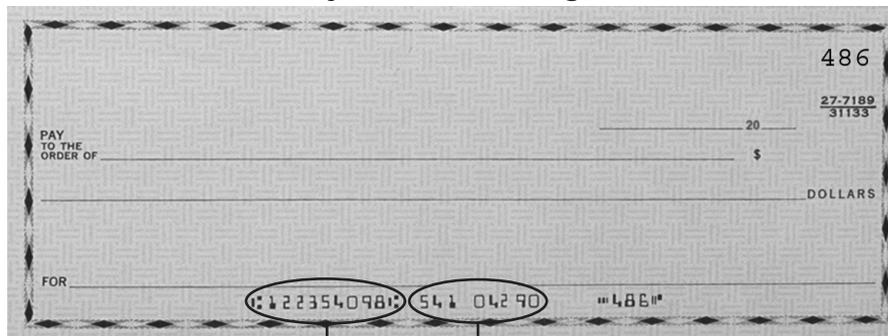
## Required Fields Must Be Completed



## Optional Fields



## SAMPLE CHECK (if you are choosing the auto bank withdrawal)



Routing  
Number

Account  
Number

1

LAST NAME FIRST NAME MI

ADDRESS APT OR STE#

ADDRESS (continued) COUNTY

CITY STATE ZIP CODE

TELEPHONE DATE OF BIRTH

GENDER M F HEIGHT FT IN WEIGHT LBS

MAILING ADDRESS (only if different from above street ADDRESS) APT OR STE#

CITY STATE ZIP CODE

E-MAIL ADDRESS (optional)

(E-mail address, if available, will be used as a means to communicate only coverage information.)

Select the policy you are applying for:

- Plan A Plan K
Plan B Plan L
Plan C Plan N
Plan F
High Deductible Plan F

PROPOSED EFFECTIVE DATE

Please complete the information below as it appears on your Medicare card.
MEDICARE CLAIM NUMBER
IS ENTITLED TO EFFECTIVE DATE
HOSPITAL INSURANCE (PART A)
MEDICAL INSURANCE (PART B)

PERSON TO NOTIFY IN AN EMERGENCY (optional):

LAST NAME FIRST NAME MI

RELATIONSHIP TO APPLICANT TELEPHONE

□□□□ - □□ - □□□□□□□□

2 OTHER COVERAGE INFORMATION

- You do not need more than one Medicare Supplement policy.
If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).

Yes or No answers are required to the following questions. If you have lost, or you are losing or replacing, other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

- 1. a. Did you turn age 65 in the last six months? Yes No
b. Did you enroll in Medicare Part B in the last six months? Yes No
If yes, what is the effective date? MM/DD/YYYY
2. Are you covered for medical assistance through the State Medicaid program? Yes No
(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)
a. If yes, will Medicaid pay your premiums for this Medicare Supplement policy? Yes No
b. Do you receive any benefits from Medicaid OTHER THAN payments toward Your Medicare Part B premium? Yes No
3. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START MM/DD/YYYY END MM/DD/YYYY
a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? Yes No
b. Was this your first time in this type of Medicare plan? Yes No
c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes No
4. Do you have another Medicare Supplement policy in force? Yes No
a. If so, with what company?
What plan do you have?
b. If so, do you intend to replace your current Medicare Supplement policy with this policy? Yes No
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) Yes No
a. If so, with what company?
What policy do you have?
b. What are your dates of coverage under this policy? (If you are still covered under this policy, leave "END" blank.)
START MM/DD/YYYY END MM/DD/YYYY
6. Do you intend to replace your current healthcare coverage with this Medicare Supplement policy? Yes No

□□□ - □□ - □□□□□□□□

③ GUARANTEED ACCEPTANCE

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

- 1. Are you applying for coverage during your Medicare Supplement Open Enrollment Period?
2. Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed acceptance?

If you answered yes to either question in this section, you qualify for the Preferred rates.

④ MEDICAL QUESTIONS

Yes or No answers are required to the following questions, unless you indicated that you are applying for coverage during your Medicare Supplement Open Enrollment Period or qualify for guaranteed acceptance.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

- 1. In the last year, have you been hospitalized, confined to a nursing facility; or are you bedridden or confined to a wheelchair?
2. In the past 90 days have you received Home Health care?
3. Do you now have or within the last two years have you had or been advised by a physician that you need treatment or surgery for:
a. Heart, Coronary, or Carotid Artery Disease...
b. Emphysema, Chronic Obstructive Pulmonary Disease (COPD)...
c. Parkinson's Disease, Multiple or Lateral Sclerosis...
d. Alzheimer's Disease, senile dementia...
e. Acquired Immune Deficiency Syndrome (AIDS)...
f. Kidney disease requiring dialysis or diabetes requiring more than 50 units of insulin daily?
g. Internal cancer, leukemia or melanoma?
h. Amputation caused by disease or trauma...
i. Rheumatoid arthritis, Paget's Disease...
j. Organ transplantation?

4. Please list any prescription drugs (full medication name) you are currently taking or have taken within the past 12 months:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

-   -

**⑤ MONTHLY PREMIUM DETERMINATION**

All applicants must answer these questions, unless applying during a Medicare Supplement Open Enrollment Period or qualify for guaranteed acceptance as indicated in Section 3.

1. Did you have Medicare coverage prior to age 65?  Yes  No
2. Have you used tobacco products within the last 12 months?  Yes  No

If your application is accepted, and you answered **No** to both questions, you qualify for the Preferred rates. To determine your monthly premium, refer to your Outline of Coverage.

**⑥ PAYMENT OPTIONS**

**MONTHLY PREMIUM**

.   In order for us to process your application, you must submit your first month's premium.

**INITIAL PAYMENT**

.   Initial Premium Payment, if you are submitting more than your first month's premium.

**CHECK NUMBER**

**MONEY ORDER**

**CREDIT CARD NAME**

- MasterCard  Visa  Discover

**CREDIT CARD NUMBER**

**EXPIRATION DATE**

**Future Payment options:**  Automatic Withdrawal  Coupon Book  Auto Credit Card Charge

I hereby authorize Humana to initiate debit/credit entries to my checking/savings account or my credit card account, as indicated below, in amounts appropriate to my coverage; and authorize the bank named below to debit/credit the same to such account. I authorize Humana to change the amount of the debit/credit, provided that I am given advance written notice. This authorization is to remain effective until I give Humana and the bank reasonable notice of termination.

**I have included a voided check/savings withdrawal slip from the bank account I want debited.**

**DEPOSITORY BANK NAME**

**ROUTING NUMBER**

⑆         ⑆

**ACCOUNT NUMBER**

- Checking  Savings

If you choose the auto credit card charge option, complete the following:  MasterCard  Visa  Discover

**CREDIT CARD NUMBER**

**EXPIRATION DATE**

I understand that if my application is not submitted during an open enrollment or guaranteed issue period, Humana has the right to reject my application and any premiums paid will be refunded. I also understand that the policy will not pay benefits for stays beginning or medical expenses incurred during the first three months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within six months prior to the insurance effective date. Coverage is not limited if you enroll during an open enrollment or guaranteed issue period or satisfy the creditable coverage requirements.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement may be subject to prosecution for fraud.

The undersigned applicant certifies that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. The applicant further acknowledges receipt of the currently available Outline of Coverage and the "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" publication.



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**Humana.com**

# Outline of Medicare Supplement Coverage

for **Arkansas** residents Medicare supplement benefit plans: [A, B, C, F, High Deductible F, K, L, and N]



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Humana Medicare Supplement plans

AR81077M10N

# Humana Insurance Company offers Plans A, B, C, F, High Deductible F, K, L, 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. Plans E, H, I, and J are no longer available for sale.

**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		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						
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Part B Excess (100%)	Part B Excess (100%)			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit [\$4,620]; paid at 100% after limit reached	Out-of-pocket limit [\$2,310]; 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 [\$2,000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2,000]. 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 MEDICARE SUPPLEMENT MONTHLY PREMIUMS COMMUNITY RATES - (AGE 65 AND OVER)

[Effective Date: 06-01-2010]

Area 1 includes the following county: Pulaski

Plan	Preferred	Standard
Plan A	[\$152.77]	[\$227.35]
Plan B	[\$166.09]	[\$247.26]
Plan C	[\$191.19]	[\$284.77]
Plan F	[\$195.05]	[\$290.54]
High Deductible Plan F	[\$74.40]	[\$110.21]
Plan K	[\$90.42]	[\$134.15]
Plan L	[\$127.68]	[\$189.83]
Plan N	[\$100.00]	[\$100.00]

## HUMANA MEDICARE SUPPLEMENT MONTHLY PREMIUMS COMMUNITY RATES - (AGE 65 AND OVER)

[Effective Date: 06-01-2010]

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	[\$146.56]	[\$218.06]
Plan B	[\$159.33]	[\$237.16]
Plan C	[\$183.39]	[\$273.12]
Plan F	[\$187.10]	[\$278.65]
High Deductible Plan F	[\$71.42]	[\$105.75]
Plan K	[\$86.78]	[\$128.71]
Plan L	[\$122.50]	[\$182.09]
Plan N	[\$100.00]	[\$100.00]

## HUMANA MEDICARE SUPPLEMENT MONTHLY PREMIUMS COMMUNITY RATES - (AGE 65 AND OVER)

[Effective Date: 06-01-2010]

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	[\$135.10]	[\$200.93]
Plan B	[\$146.86]	[\$218.51]
Plan C	[\$169.01]	[\$251.63]
Plan F	[\$172.43]	[\$256.72]
High Deductible Plan F	[\$65.91]	[\$97.52]
Plan K	[\$80.06]	[\$118.66]
Plan L	[\$112.95]	[\$167.82]
Plan N	[\$100.00]	[\$100.00]

## **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.

## **Disclosure**

Use this outline to compare benefits and premiums among policies. This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

## **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.

## **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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	\$0	[\$1,100] (Part A deductible)
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 [\$137.50] a day	\$0	Up to [\$137.50] a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 [\$155] 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0  Generally 80%	\$0  Generally 20%	[\$155] (Part B deductible)  \$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First three pints Next [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$155] (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100%  \$0 80%	\$0  \$0 20%	\$0  [\$155] (Part B deductible) \$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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	[\$1,100] (Part A deductible)	\$0
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 [\$137.50] a day	\$0	Up to [\$137.50] a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 [\$155] 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0  Generally 80%	\$0  Generally 20%	[\$155] (Part B deductible)  \$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First three pints Next [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$155] (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100%  \$0 80%	\$0  \$0 20%	\$0  [\$155] (Part B deductible) \$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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	[\$1,100] (Part A deductible)	\$0
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 [\$137.50] a day	Up to [\$137.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 [\$155] 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0  Generally 80%	[\$155] (Part B deductible)  Generally 20%	\$0  \$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First three pints Next [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs [\$155] (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100%  \$0 80%	\$0  [\$155] (Part B deductible) 20%	\$0  \$0 \$0

# PLAN C

## Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	[\$1,100] (Part A deductible)	\$0
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 [\$137.50] a day	Up to [\$137.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 [\$155] 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0  Generally 80%	[\$155] (Part B deductible)  Generally 20%	\$0  \$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First three pints Next [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs [\$155] (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$155] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100%  \$0 80%	\$0  [\$155] (Part B deductible) 20%	\$0  \$0 \$0

# PLAN F

## Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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 one has paid a calendar year [\$2,000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,000]. 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 [\$2,000] Deductible,** Plan Pays	In Addition To [\$2,000] Deductible,** You Pay
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	[\$1,100] (Part A deductible)	\$0
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 [\$137.50] a day	Up to [\$137.50] 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 [\$2,000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,000]. 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 [\$2,000] Deductible,** Plan Pays	In Addition To [\$2,000] Deductible,** You Pay
<b>BLOOD</b> First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 [\$155] 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 [\$2,000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,000]. 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 [\$2,000] Deductible,** Plan Pays	In Addition To [\$2,000] Deductible,** You Pay
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [\$155] of Medicare-approved amounts*	\$0	[\$155] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First three pints	\$0	All costs	\$0
Next [\$155] of Medicare-approved amounts*	\$0	[\$155] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

# HIGH DEDUCTIBLE PLAN F

## MEDICARE (PARTS A AND B)

\*Once you have been billed [\$155] 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 [\$2,000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,000]. 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 [\$2,000] Deductible,** Plan Pays	In Addition To [\$2,000] Deductible,** You Pay
<b>HOME HEALTH CARE</b>			
MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$155] of Medicare-approved amounts*	\$0	[\$155] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

### Other Benefits - Not Covered By Medicare

Services	Medicare Pays	After You Pay [\$2,000] Deductible,** Plan Pays	In Addition To [\$2,000] Deductible,** You Pay
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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 [\$4,620] 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*
<b>HOSPITALIZATION**</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	[\$550] (50% of Part A deductible)	[\$550] (50% of Part A deductible)◆
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE**</b>			
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 [\$137.50] a day	Up to [\$68.75] a day	Up to [\$68.75] 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*
<b>BLOOD</b> First three pints	\$0	50%	50% ♦
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> 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 [\$155] 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*
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$155] of Medicare-approved amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare-approved amounts	\$0  Generally 75% or more of Medicare approved amounts  Generally 80%	\$0  Remainder of Medicare approved amounts  Generally 10%	[\$155] (Part B deductible)****◆ All costs above Medicare approved amounts Generally 10%◆
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4,620])*
<b>BLOOD</b> First three pints Next [\$155] of Medicare-approved amounts**** Remainder of Medicare-approved amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50%◆ [\$155] (Part B deductible)****◆ Generally 10%◆
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

\*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [\$4,620] 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 & B

Services	Medicare Pays	Plan Pays	You Pay*
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$155] of Medicare-approved amounts*****	\$0	\$0	[\$155] (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 [\$2,310] 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*
<b>HOSPITALIZATION**</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	[\$825] (75% of Part A deductible)	[\$275] (25% of Part A deductible)♦
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE**</b>			
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 [\$137.50] a day	Up to [\$103.13] a day	Up to [\$34.37] 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*
<b>BLOOD</b> First three pints	\$0	75%	25% ♦
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> 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 [\$155] 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*
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$155] of Medicare-approved amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare-approved amounts	\$0  Generally 75% or more of Medicare approved amounts  Generally 80%	\$0  Remainder of Medicare approved amounts  Generally 15%	[\$155] (Part B deductible)****◆ All costs above Medicare approved amounts Generally 5%◆
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2,310])*
<b>BLOOD</b> First three pints Next [\$155] of Medicare-approved amounts**** Remainder of Medicare-approved amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25%◆ [\$155] (Part B deductible)****◆ Generally 5%◆
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

\*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [\$2,310] 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 L

## Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay*
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$155] of Medicare-approved amounts*****	\$0	\$0	[\$155] (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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,100]	[\$1,100] (Part A deductible)	\$0
61st through 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$550] a day	[\$550] 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 [\$137.50] a day	Up to [\$137.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 [\$135] 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
<p><b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b>, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment</p> <p>First [\$135] of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p>	<p>\$0</p> <p>Generally 80%</p>	<p>\$0</p> <p>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.</p>	<p>[\$135] (Part B deductible)</p> <p>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.</p>
<p><b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)</p>	\$0	\$0	All costs
<p><b>BLOOD</b></p> <p>First three pints</p> <p>Next [\$135] of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$0</p> <p>20%</p>	<p>\$0</p> <p>[\$135] (Part B deductible)</p> <p>\$0</p>
<p><b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b></p>	100%	\$0	\$0

# PLAN N

## Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$135] of Medicare-approved amounts*	\$0	\$0	[\$135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

## Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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

