

State: Arkansas **Filing Company:** Humana Insurance Company
TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010
Product Name: 2010 Individual Medicare Supplement Plans
Project Name/Number: 2012 HH Discount Forms w Supporting Rates/AR-16-2012

Filing at a Glance

Company: Humana Insurance Company
Product Name: 2010 Individual Medicare Supplement Plans
State: Arkansas
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010
Sub-TOI: MS08I.012 Multi-Plan 2010
Filing Type: Form/Rate
Date Submitted: 08/13/2012
SERFF Tr Num: HUMA-128624065
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: AR-16-2012

Implementation: On Approval
Date Requested:
Author(s): Michele Zabel, Paula Williamson, Bettina Ponds, Tiffany Turner, Chi Dang, Shawn Farnsley
Reviewer(s): Stephanie Fowler (primary)
Disposition Date: 08/16/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Humana Insurance Company
TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010
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General Information

Project Name: 2012 HH Discount Forms w Supporting Rates Status of Filing in Domicile: Not Filed
Project Number: AR-16-2012 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: WI is the state of domicile.
Explanation for Combination/Other: Market Type: Individual
Submission Type: Resubmission Previous Filing Number: HUMA-128552483
Individual Market Type: Overall Rate Impact:
Filing Status Changed: 08/16/2012
State Status Changed: 08/16/2012 Deemer Date:
Created By: Michele Zabel Submitted By: Tiffany Turner
Corresponding Filing Tracking Number:

Filing Description:

Re: Humana Insurance Company/NAIC 119, 73288
Humana Individual Medicare Supplement Plans - Household Discount Forms with Supporting Rates

This filings is a resubmission of a previously disapproved filing. Per objection received on filing HUMA-128552319, Humana would like to proceed with offering a household discount on the below policy forms. Actuarial support is provided for this discount. Please find enclosed for your review and approval the forms necessary to implement the household premium discounting. We intend to mail the enclosed amendment to current policyholders advising them of the available household discount. The amendment will be added to the policy forms and included with all new issues once approved. The Outline of Coverage and application forms have been revised to disclose and capture necessary information during the application process.

Policy forms impacted by this filing: ARMESM10A, ARMESM10B, ARMESM10C, ARMESM10F, ARMESM10F(HD), ARMESM10K, ARMESM10L and ARMESM10N.

- 1) AR81077PDN - Outline of Coverage
- 2) GN85026PDN - Application
- 3) GN85026PDNEE - Fulfillment Application
- 4) ARGHHH40IHH1 - Policy Form Amendment

Please contact me via SERFF, at (502) 580-1570 or by email at tturner2@humana.com, if you have questions or require additional information relative to this filing.

Company and Contact

Filing Contact Information

Tiffany Turner, Compliance Analyst tturner2@humana.com
500 W Main 502-580-0837 [Phone]
NCT 29
Louisville, KY 40202

State: Arkansas **Filing Company:** Humana Insurance Company
TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010
Product Name: 2010 Individual Medicare Supplement Plans
Project Name/Number: 2012 HH Discount Forms w Supporting Rates/AR-16-2012

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	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

Company	Amount	Date Processed	Transaction #
Humana Insurance Company	\$50.00	08/13/2012	61630415
Humana Insurance Company	\$150.00	08/14/2012	61652776

SERFF Tracking #:

HUMA-128624065

State Tracking #:

Company Tracking #:

AR-16-2012

State: Arkansas

Filing Company:

Humana Insurance Company

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Product Name: 2010 Individual Medicare Supplement Plans

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	08/16/2012	08/16/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	08/15/2012	08/15/2012

Response Letters

Responded By	Created On	Date Submitted
Tiffany Turner	08/16/2012	08/16/2012

State: Arkansas **Filing Company:** Humana Insurance Company
TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010
Product Name: 2010 Individual Medicare Supplement Plans
Project Name/Number: 2012 HH Discount Forms w Supporting Rates/AR-16-2012

Disposition

Disposition Date: 08/16/2012

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Humana Insurance Company	0.970%	0.970%	\$12,044	744	\$1,241,654	0.970%	0.970%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Fulfillment Application	Approved-Closed	Yes
Form	Policy Form Amendment	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Rate	Proposed Base Rates	Approved-Closed	Yes

State: Arkansas **Filing Company:** Humana Insurance Company
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Product Name: 2010 Individual Medicare Supplement Plans
Project Name/Number: 2012 HH Discount Forms w Supporting Rates/AR-16-2012

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/15/2012
Submitted Date	08/15/2012
Respond By Date	09/17/2012

Dear Tiffany Turner,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Application, GN85026PDN (Form)

Comments: R&R 27, Sec. 11.D. requires a statement above health questions on the application that "Under Open Enrollment, health questions are not required to be answered." Questions regarding tobacco use should have the same statement unless the question is in the health section.

Objection 2

- Fulfillment Application , GN85026PDNEE (Form)

Comments: R&R 27, Sec. 11.D. requires a statement above health questions on the application that "Under Open Enrollment, health questions are not required to be answered." Questions regarding tobacco use should have the same statement unless the question is in the health section.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

State: Arkansas **Filing Company:** Humana Insurance Company
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Product Name: 2010 Individual Medicare Supplement Plans
Project Name/Number: 2012 HH Discount Forms w Supporting Rates/AR-16-2012

Response Letter

Response Letter Status Submitted to State
Response Letter Date 08/16/2012
Submitted Date 08/16/2012

Dear Stephanie Fowler,

Introduction:

Per your review,

Response 1

Comments:

Under Section 4 - Medical Questions it reads

"IF YOU ARE APPLYING FOR COVERAGE DURING YOUR MEDICARE SUPPLEMENT OPEN ENROLLMENT PERIOD OR QUALIFY FOR GUARANTEED ACCEPTANCE, YOU ARE NOT REQUIRED TO ANSWER THE FOLLOWING QUESTIONS."

Under Section 5 - Premium Determination it reads

"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."

Related Objection 1

Applies To:

- Application, GN85026PDN (Form)

Comments: R&R 27, Sec. 11.D. requires a statement above health questions on the application that "Under Open Enrollment, health questions are not required to be answered." Questions regarding tobacco use should have the same statement unless the question is in the health section.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments:

Under Section 4 - Medical Questions it reads

"IF YOU ARE APPLYING FOR COVERAGE DURING YOUR MEDICARE SUPPLEMENT OPEN ENROLLMENT PERIOD OR QUALIFY FOR GUARANTEED ACCEPTANCE, YOU ARE NOT REQUIRED TO ANSWER THE FOLLOWING QUESTIONS."

Under Section 5 - Premium Determination it reads

"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."

Related Objection 2

Applies To:

- Fulfillment Application , GN85026PDNEE (Form)

Comments: R&R 27, Sec. 11.D. requires a statement above health questions on the application that "Under Open Enrollment, health questions are not required to be answered." Questions regarding tobacco use should have the same statement unless the question is in the health section.

Changed Items:

State: Arkansas **Filing Company:** Humana Insurance Company
TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010
Product Name: 2010 Individual Medicare Supplement Plans
Project Name/Number: 2012 HH Discount Forms w Supporting Rates/AR-16-2012

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

I feel the statements listed above should suffice for this requirement.

If you have additional questions or concerns, please do not hesitate to contact me.

Sincerely,

Tiffany Turner

State: Arkansas

Filing Company:

Humana Insurance Company

TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010

Product Name: 2010 Individual Medicare Supplement Plans

Project Name/Number: 2012 HH Discount Forms w Supporting Rates/AR-16-2012

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 08/16/2012	GN85026PDN	AEF	Application	Revised: Replaced Form #: GN85026M10 Previous Filing #: HUMA- 126375307		GN85026PDN.pdf
2	Approved-Closed 08/16/2012	GN85026PDNE E	AEF	Fulfillment Application	Initial:		GN85026PDNEE.pdf
3	Approved-Closed 08/16/2012	ARGHHH40IHH 1	POL	Policy Form Amendment	Initial:		ARGHHH40IHH1.pdf
4	Approved-Closed 08/16/2012	AR81077PDN	OUT	Outline of Coverage	Revised: Replaced Form #: AR81077M10 Previous Filing #: HUMA- 126375307		AR81077PDN.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate

SERFF Tracking #:

HUMA-128624065

State Tracking #:

Company Tracking #:

AR-16-2012

State: Arkansas

Filing Company: Humana Insurance Company

TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010

Product Name: 2010 Individual Medicare Supplement Plans

Project Name/Number: 2012 HH Discount Forms w Supporting Rates/AR-16-2012

POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages
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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 Premium

⑥ Determine Your Discount

⑦ 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.

⑧ Sign and Date the Enrollment Application

⑨ Keep Member Copy For Your Records

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

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.



- 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

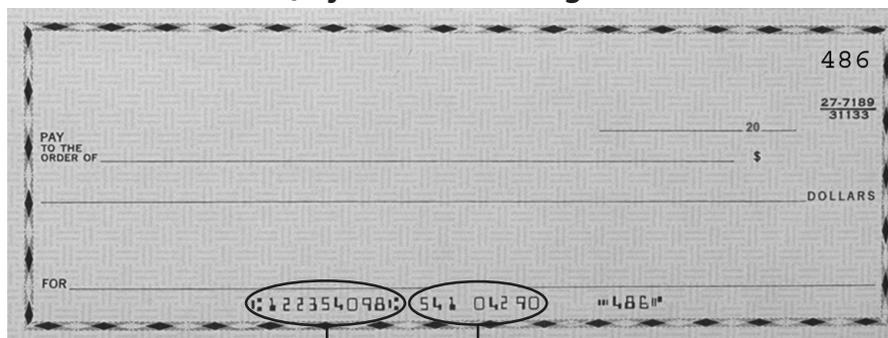
Required Fields Must Be Completed



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 HOSPITAL INSURANCE (PART A) EFFECTIVE DATE

MEDICAL INSURANCE (PART B) EFFECTIVE DATE

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
c. 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

IF YOU ARE APPLYING FOR COVERAGE DURING YOUR MEDICARE SUPPLEMENT OPEN ENROLLMENT PERIOD OR QUALIFY FOR GUARANTEED ACCEPTANCE, YOU ARE NOT REQUIRED TO ANSWER THE FOLLOWING QUESTIONS.

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:

□□□□ - □□□ - □□□□□□□□

5 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 premium, refer to your Outline of Coverage.

6 DISCOUNT DETERMINATION

If you qualify for the Household Discount disclosed in your Outline of Coverage, please provide the name and Medicare claim number of the individual living at your current address.

LAST NAME FIRST NAME MI
MEDICARE CLAIM NUMBER

7 PAYMENT OPTIONS

PREMIUM QUOTE INITIAL PAYMENT CHECK NUMBER MONEY ORDER DEPOSITORY BANK NAME ROUTING NUMBER ACCOUNT NUMBER CREDIT CARD NAME CREDIT CARD NUMBER EXPIRATION DATE

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

DEPOSITORY BANK NAME ROUTING NUMBER ACCOUNT NUMBER CREDIT CARD NUMBER EXPIRATION DATE

I hereby authorize Humana to initiate debit/credit entries to my checking/savings account or my credit card account, as indicated above, in amounts appropriate to my coverage; and authorize the bank named above to debit/credit the same to such account.

HUMANA[®]

Insured by Humana Insurance Company

Humana.com

MEDICARE SUPPLEMENT ENROLLMENT APPLICATION

Please review the following copy of your application. If any of the information contained in your application, including that which is related to your medical history (when applying outside of guaranteed acceptance periods), is incorrect or incomplete, please contact Humana within 10 days by calling [1-800-866-0581]. If you are speech or hearing impaired and use a TTY, please call [711]. You can also contact us by mail at Humana, [P.O. Box 14168, Lexington, KY 40512-4168]. Depending upon the circumstances of your enrollment, you may not have been asked all of the questions contained in this application. Questions which you were not required to answer appear blank or do not display a Yes or No response.

This application is a part of the policy and the policy was issued on the basis that the answers to all questions and the information provided are correct and complete.

SECTION 1 – PERSONAL INFORMATION

LAST NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS 1: _____

ADDRESS 2: _____

CITY: _____ STATE: __ ZIP CODE: _____ COUNTY: _____

PHONE: (____) ____ - ____ DATE OF BIRTH: __/__/____ GENDER: M F

HEIGHT ____ (FT) ____ (IN) WEIGHT ____ (LBS) BMI ____

MAILING ADDRESS (Only if different from Street Address):

ADDRESS 1: _____

ADDRESS 2: _____

CITY: _____ STATE: __ ZIP CODE: _____

E-MAIL ADDRESS: _____

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

Select the policy you are applying for:

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

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: _____

MIDDLE INITIAL: ____ RELATIONSHIP TO APPLICANT: _____ PHONE: (____) ____ - ____

SECTION 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. A copy of the notice from your prior insurer may be requested.

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? ___/___/___

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 ___/___/___ END ___/___/___

- 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 ___/___/___ END ___/___/___

- c. Do you intend to replace your current healthcare coverage with this Medicare Supplement policy? Yes No

SECTION 3 – GUARANTEED ACCEPTANCE DETERMINATION

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.

SECTION 4 – MEDICAL QUESTIONS

IF YOU ARE APPLYING FOR COVERAGE DURING YOUR MEDICARE SUPPLEMENT OPEN ENROLLMENT PERIOD OR QUALIFY FOR GUARANTEED ACCEPTANCE, YOU ARE NOT REQUIRED TO ANSWER THE FOLLOWING QUESTIONS. 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:

SECTION 5 - 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.

SECTION 6 - DISCOUNT DETERMINATION

If you qualify for the Household Discount disclosed in your Outline of Coverage, please provide the name and Medicare claim number of the individual living at your current address.

Last Name: _____

First Name: _____ Middle Initial: _____

Medicare Claim Number: _____

SECTION 7 - PAYMENT OPTIONS

PREMIUM PAYMENT INFORMATION HAS BEEN INTENTIONALLY REMOVED FROM THIS COPY OF YOUR COMPLETED ENROLLMENT APPLICATION IN ORDER TO SAFEGUARD YOUR PERSONAL FINANCIAL INFORMATION.

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.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility.*

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

*If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

SECTION 8 – SIGNATURE & DATE

APPLICANT'S SIGNATURE: _____ **SIGNATURE DATE:** ____ / ____ / ____

AGENT'S SIGNATURE: _____ **SIGNATURE DATE:** ____ / ____ / ____

Sales Agent - Please list: All health insurance policies sold to the applicant which are still in force and all health insurance policies sold to the applicant within the past five years which are no longer in force (if none or not applicable, write NONE.)

COMPANY: _____ **TYPE:** _____

COMPANY: _____ **TYPE:** _____

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

AMENDMENT TO MEDICARE SUPPLEMENT POLICIES
PLANS A, B, C, F, HIGH DEDUCTIBLE PLAN F, K, & L

This amendment is attached to and made a part of Your Policy. Except as modified below, all Policy terms, conditions, and limitations apply.

The following section is amended in its entirety to read as follows:

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. For premium changes related to the household premium discount, refer to that section in this Policy.

The following is added to Your Policy:

HOUSEHOLD PREMIUM DISCOUNT

You are eligible for a premium discount if in Your household You have resided with at least one other Medicare-eligible person for the past year and that person owns or is issued a Medicare Supplement insurance Policy by Us. The discount will be effective the billing cycle following notice to Us of Your eligibility.

Household is defined as a condominium unit, a single family home, or an apartment unit within an apartment complex.

We reserve the right to make changes to the premium discount structure. If a change to the discount structure occurs to Your Policy, it will affect all Policies We issue like Yours.

The household premium discount will be removed if the other Medicare Supplement insurance policyholder whose Policy status entitles You to the discount no longer resides with You. However, if that person becomes deceased, Your discount will still apply. This premium change will occur on the billing cycle following the date We learn Your eligibility has ended.



[Michael B. McCallister, President]

Outline of Medicare Supplement Coverage

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



Humana Medicare Supplement plans

AR81077PDN

HUMANA[®]

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.

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						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit [\$4,660]; paid at 100% after limit reached	Out-of-pocket limit [\$2,330]; 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 [\$2,070] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2,070]. 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: [11-01-2011]

Area 1 includes the following county: [Pulaski]

Plan	Preferred	Standard
Plan A	[\$100.00]	[\$100.00]
Plan B	[\$100.00]	[\$100.00]
Plan C	[\$100.00]	[\$100.00]
Plan F	[\$100.00]	[\$100.00]
High Deductible Plan F	[\$100.00]	[\$100.00]
Plan K	[\$100.00]	[\$100.00]
Plan L	[\$100.00]	[\$100.00]
Plan N	[\$100.00]	[\$100.00]

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

Effective Date: [11-01-2011]

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	[\$100.00]	[\$100.00]
Plan B	[\$100.00]	[\$100.00]
Plan C	[\$100.00]	[\$100.00]
Plan F	[\$100.00]	[\$100.00]
High Deductible Plan F	[\$100.00]	[\$100.00]
Plan K	[\$100.00]	[\$100.00]
Plan L	[\$100.00]	[\$100.00]
Plan N	[\$100.00]	[\$100.00]

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

Effective Date: [11-01-2011]

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	[\$100.00]	[\$100.00]
Plan B	[\$100.00]	[\$100.00]
Plan C	[\$100.00]	[\$100.00]
Plan F	[\$100.00]	[\$100.00]
High Deductible Plan F	[\$100.00]	[\$100.00]
Plan K	[\$100.00]	[\$100.00]
Plan L	[\$100.00]	[\$100.00]
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.

Premium discounts may be applied or discontinued based on eligibility.

Disclosure

Use this outline to compare benefits and premiums among policies.

Read your policy very carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right to return policy

If you find that you are not satisfied with your policy, you may return it to:

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

If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments less any claims paid.

Policy replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

This policy may not fully cover all of your medical costs.

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

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

Complete answers are very important

When you fill out the application for the new policy, be sure to truthfully and completely answer all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	\$0	[\$1,156] (Part A deductible)
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	\$0	Up to [\$144.50] a day
101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

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

*Once you have been billed [\$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	[\$140] (Part B deductible) \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First three pints Next [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$140] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$140] (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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	[\$1,156] (Part A deductible)	\$0
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	\$0	Up to [\$144.50] a day
101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

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

*Once you have been billed [\$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	[\$140] (Part B deductible) \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First three pints Next [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$140] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$140] (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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	[\$1,156] (Part A deductible)	\$0
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	Up to [\$144.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

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

*Once you have been billed [\$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	[\$140] (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First three pints Next [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs [\$140] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 [\$140] (Part B deductible) 20%	\$0 \$0 \$0

PLAN C

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN F

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	[\$1,156] (Part A deductible)	\$0
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	Up to [\$144.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

*Once you have been billed [\$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	[\$140] (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	100%	\$0
BLOOD First three pints Next [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs [\$140] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 [\$140] (Part B deductible) 20%	\$0 \$0 \$0

PLAN F

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN F

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,070] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,070]. 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 [\$2,070] Deductible,** Plan Pays	In Addition To [\$2,070] Deductible,** You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	[\$1,156] (Part A deductible)	\$0
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	Up to [\$144.50] 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 [\$2,070] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,070]. 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 [\$2,070] Deductible,** Plan Pays	In Addition To [\$2,070] Deductible,** You Pay
BLOOD First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed [\$140] 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 [\$2,070] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,070]. 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 [\$2,070] Deductible,** Plan Pays	In Addition To [\$2,070] Deductible,** You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [\$140] of Medicare-approved amounts*	\$0	[\$140] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	100%	\$0
BLOOD			
First three pints	\$0	All costs	\$0
Next [\$140] of Medicare-approved amounts*	\$0	[\$140] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

HIGH DEDUCTIBLE PLAN F

MEDICARE (PARTS A AND B)

*Once you have been billed [\$140] 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 [\$2,070] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,070]. 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 [\$2,070] Deductible,** Plan Pays	In Addition To [\$2,070] Deductible,** You Pay
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$140] of Medicare-approved amounts*	\$0	[\$140] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	After You Pay [\$2,070] Deductible,** Plan Pays	In Addition To [\$2,070] Deductible,** You Pay
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN K

*You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [\$4,660] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	[\$578] (50% of Part A deductible)	[\$578] (50% of Part A deductible)◆
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare’s requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	Up to [\$72.25] a day	Up to [\$72.25] a day◆
101st day and after	\$0	\$0	All costs

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD *(Continued)*

Services	Medicare Pays	Plan Pays	You Pay*
BLOOD First three pints	\$0	50%	50% ♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments ♦

PLAN K

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

****Once you have been billed [\$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay*
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$140] of Medicare-approved amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare-approved amounts	\$0 Generally 80% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 10%	[\$140] (Part B deductible)****◆ All costs above Medicare approved amounts Generally 10%◆
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4,660])*
BLOOD First three pints Next [\$140] of Medicare-approved amounts**** Remainder of Medicare-approved amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50%◆ [\$140] (Part B deductible)****◆ Generally 10%◆
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [\$4,660] 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*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$140] of Medicare-approved amounts*****	\$0	\$0	[\$140] (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 [\$2,330] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	[\$867] (75% of Part A deductible)	[\$289] (25% of Part A deductible)♦
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	Up to [\$108.38] a day	Up to [\$36.12] a day♦
101st day and after	\$0	\$0	All costs

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD *(Continued)*

Services	Medicare Pays	Plan Pays	You Pay*
BLOOD First three pints	\$0	75%	25% ♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments ♦

PLAN L

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

****Once you have been billed [\$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay*
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$140] of Medicare-approved amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare-approved amounts	\$0 Generally 80% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 15%	[\$140] (Part B deductible)****◆ All costs above Medicare approved amounts Generally 5%◆
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2,330])*
BLOOD First three pints Next [\$140] of Medicare-approved amounts**** Remainder of Medicare-approved amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25%◆ [\$140] (Part B deductible)****◆ Generally 5%◆
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [\$2,330] 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*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$140] of Medicare-approved amounts*****	\$0	\$0	[\$140] (Part B deductible)◆
Remainder of Medicare-approved amounts	80%	15%	5%◆

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

PLAN N

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	[\$1,156] (Part A deductible)	\$0
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	Up to [\$144.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

*Once you have been billed [\$140] 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>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment</p> <p>First [\$140] 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>[\$140] (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>PART B EXCESS CHARGES (above Medicare-approved amounts)</p>	\$0	\$0	All costs
<p>BLOOD</p> <p>First three pints</p> <p>Next [\$140] 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>[\$140] (Part B deductible)</p> <p>\$0</p>
<p>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</p>	100%	\$0	\$0

PLAN N

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$140] of Medicare-approved amounts*	\$0	\$0	[\$140] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

HUMANA®

SERFF Tracking #:

HUMA-128624065

State Tracking #:

Company Tracking #:

AR-16-2012

State: Arkansas

Filing Company:

Humana Insurance Company

TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010

Product Name: 2010 Individual Medicare Supplement Plans

Project Name/Number: 2012 HH Discount Forms w Supporting Rates/AR-16-2012

Rate Information

Rate data applies to filing.

Filing Method: SERFF

Rate Change Type: Increase

Overall Percentage of Last Rate Revision: 4.000%

Effective Date of Last Rate Revision: 11/11/2011

Filing Method of Last Filing: SERFF

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Humana Insurance Company	0.970%	0.970%	\$12,044	744	\$1,241,654	0.970%	0.970%

SERFF Tracking #:

HUMA-128624065

State Tracking #:

Company Tracking #:

AR-16-2012

State: Arkansas

Filing Company:

Humana Insurance Company

TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010

Product Name: 2010 Individual Medicare Supplement Plans

Project Name/Number: 2012 HH Discount Forms w Supporting Rates/AR-16-2012

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action*	Rate Action Information		Attachments
1	Approved-Closed 08/16/2012	Proposed Base Rates	ARMESM10A, ARMESM10B, ARMESM10C, ARMESM10F, ARMESM10F(HD), ARMESM10L, ARMESM10K	Revised	Previous State Filing Number:	HUMA- 127285905	Proposed Base Rates - HH Discount.pdf
					Percent Rate Change Request:	0.970	

Exhibit 5 (continued)
Humana Insurance Company
Medicare Supplement Rates [1] [4]

State: **Arkansas**
Form #s: **ARMESM10A, ARMESM10B, ARMESM10C, ARMESM10F, ARMESM10F(HD), ARMESM10K, ARMESM10L, ARMESM10N**
Effective Date: **November 1, 2012**
Proposed Base Rates

	Plan A				Plan B				Plan C				Plan F			
	Preferred [3]		Standard [2]		Preferred [3]		Standard [2]		Preferred [3]		Standard [2]		Preferred [3]		Standard [2]	
	Male	Female	Male	Female												
Community	\$144.98	\$144.98	\$216.69	\$216.69	\$157.79	\$157.79	\$235.84	\$235.84	\$181.92	\$181.92	\$271.92	\$271.92	\$185.64	\$185.64	\$277.46	\$277.46

	Plan F(HD)				Plan K				Plan L				Plan N			
	Preferred [3]		Standard [2]		Preferred [3]		Standard [2]		Preferred [3]		Standard [2]		Preferred [3]		Standard [2]	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Community	\$69.61	\$69.61	\$104.04	\$104.04	\$85.02	\$85.02	\$127.08	\$127.08	\$120.85	\$120.85	\$180.62	\$180.62	\$114.44	\$114.44	\$171.06	\$171.06

- [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 and guaranteed acceptance, the Preferred rates will apply.
- [4] Geographic area factors are also applied.

Exhibit 6
Humana Insurance Company
Medicare Supplement Area Factors and Classification

State: Arkansas

Form #s: ARMESM10A, ARMESM10B, ARMESM10C, ARMESM10F, ARMESM10F(HD), ARMESM10K, ARMESM10L, ARMESM10N

Effective Date: November 1, 2012

Area	Rate Factor
1	1.092
2	1.047
3	0.964
Out of State	1.200

County	Geographic Area	County	Geographic Area
Arkansas	2	Lee	3
Ashley	3	Lincoln	3
Baxter	3	Little River	3
Benton	3	Logan	3
Boone	3	Lonoke	2
Bradley	3	Madison	3
Calhoun	3	Marion	3
Carroll	3	Miller	3
Chicot	3	Mississippi	3
Clark	2	Monroe	2
Clay	3	Montgomery	2
Cleburne	3	Nevada	3
Cleveland	3	Newton	3
Columbia	3	Ouachita	3
Conway	2	Perry	2
Craighead	3	Phillips	3
Crawford	3	Pike	2
Crittenden	3	Poinsett	3
Cross	3	Polk	2
Dallas	3	Pope	3
Desha	3	Prairie	2
Drew	3	Pulaski	1
Faulkner	2	Randolph	3
Franklin	3	St. Francis	3
Fulton	3	Saline	2
Garland	2	Scott	3
Grant	2	Searcy	3
Greene	3	Sebastian	3
Hempstead	3	Sevier	3
Hot Spring	2	Sharp	3
Howard	3	Stone	3
Independence	3	Union	3
Izard	3	Van Buren	2
Jackson	2	Washington	3
Jefferson	3	White	2
Johnson	3	Woodruff	2
Lafayette	3	Yell	3
Lawrence	3		

Note 1: If the insured moves to a new state, the out of state factor will apply.

Note 2: The area classification for a county may change, or a different method of classification (e.g., by zip code) may be used upon state review and approval.

SERFF Tracking #:

HUMA-128624065

State Tracking #:**Company Tracking #:**

AR-16-2012

State:

Arkansas

Filing Company:

Humana Insurance Company

TOI/Sub-TOI:

MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010

Product Name:

2010 Individual Medicare Supplement Plans

Project Name/Number:

2012 HH Discount Forms w Supporting Rates/AR-16-2012

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	08/16/2012
Comments:			
Attachment(s):			
Flesch Cert.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	08/16/2012
Comments:	Please refer to the Form Schedule Tab.		

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	08/16/2012
Comments:			
Attachment(s):			
AR81077PDN.pdf			

Certification of Flesch Reading Ease Test

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 Numbers:
ARGHHH40IHH1
Flesch Score: 45.7

A handwritten signature in cursive script, appearing to read "Turner".

Tiffany Turner
Compliance Analyst

Date: June 18, 2012

Outline of Medicare Supplement Coverage

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



Humana Medicare Supplement plans

AR81077PDN

HUMANA[®]

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.

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						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit [\$4,660]; paid at 100% after limit reached	Out-of-pocket limit [\$2,330]; 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 [\$2,070] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2,070]. 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: [11-01-2011]

Area 1 includes the following county: [Pulaski]

Plan	Preferred	Standard
Plan A	[\$100.00]	[\$100.00]
Plan B	[\$100.00]	[\$100.00]
Plan C	[\$100.00]	[\$100.00]
Plan F	[\$100.00]	[\$100.00]
High Deductible Plan F	[\$100.00]	[\$100.00]
Plan K	[\$100.00]	[\$100.00]
Plan L	[\$100.00]	[\$100.00]
Plan N	[\$100.00]	[\$100.00]

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

Effective Date: [11-01-2011]

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	[\$100.00]	[\$100.00]
Plan B	[\$100.00]	[\$100.00]
Plan C	[\$100.00]	[\$100.00]
Plan F	[\$100.00]	[\$100.00]
High Deductible Plan F	[\$100.00]	[\$100.00]
Plan K	[\$100.00]	[\$100.00]
Plan L	[\$100.00]	[\$100.00]
Plan N	[\$100.00]	[\$100.00]

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

Effective Date: [11-01-2011]

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	[\$100.00]	[\$100.00]
Plan B	[\$100.00]	[\$100.00]
Plan C	[\$100.00]	[\$100.00]
Plan F	[\$100.00]	[\$100.00]
High Deductible Plan F	[\$100.00]	[\$100.00]
Plan K	[\$100.00]	[\$100.00]
Plan L	[\$100.00]	[\$100.00]
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.

Premium discounts may be applied or discontinued based on eligibility.

Disclosure

Use this outline to compare benefits and premiums among policies.

Read your policy very carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right to return policy

If you find that you are not satisfied with your policy, you may return it to:

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

If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments less any claims paid.

Policy replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

This policy may not fully cover all of your medical costs.

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

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

Complete answers are very important

When you fill out the application for the new policy, be sure to truthfully and completely answer all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	\$0	[\$1,156] (Part A deductible)
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	\$0	Up to [\$144.50] a day
101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

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

*Once you have been billed [\$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	[\$140] (Part B deductible) \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First three pints Next [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$140] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$140] (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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	[\$1,156] (Part A deductible)	\$0
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	\$0	Up to [\$144.50] a day
101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

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

*Once you have been billed [\$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	[\$140] (Part B deductible) \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First three pints Next [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$140] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$140] (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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	[\$1,156] (Part A deductible)	\$0
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	Up to [\$144.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

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

*Once you have been billed [\$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	[\$140] (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First three pints Next [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs [\$140] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 [\$140] (Part B deductible) 20%	\$0 \$0 \$0

PLAN C

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN F

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	[\$1,156] (Part A deductible)	\$0
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	Up to [\$144.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

*Once you have been billed [\$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	[\$140] (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	100%	\$0
BLOOD First three pints Next [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs [\$140] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First [\$140] of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 [\$140] (Part B deductible) 20%	\$0 \$0 \$0

PLAN F

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN F

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,070] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,070]. 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 [\$2,070] Deductible,** Plan Pays	In Addition To [\$2,070] Deductible,** You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	[\$1,156] (Part A deductible)	\$0
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	Up to [\$144.50] 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 [\$2,070] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,070]. 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 [\$2,070] Deductible,** Plan Pays	In Addition To [\$2,070] Deductible,** You Pay
BLOOD First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed [\$140] 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 [\$2,070] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,070]. 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 [\$2,070] Deductible,** Plan Pays	In Addition To [\$2,070] Deductible,** You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [\$140] of Medicare-approved amounts*	\$0	[\$140] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	100%	\$0
BLOOD			
First three pints	\$0	All costs	\$0
Next [\$140] of Medicare-approved amounts*	\$0	[\$140] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

HIGH DEDUCTIBLE PLAN F

MEDICARE (PARTS A AND B)

*Once you have been billed [\$140] 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 [\$2,070] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,070]. 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 [\$2,070] Deductible,** Plan Pays	In Addition To [\$2,070] Deductible,** You Pay
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$140] of Medicare-approved amounts*	\$0	[\$140] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	After You Pay [\$2,070] Deductible,** Plan Pays	In Addition To [\$2,070] Deductible,** You Pay
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN K

*You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [\$4,660] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	[\$578] (50% of Part A deductible)	[\$578] (50% of Part A deductible)◆
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare’s requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	Up to [\$72.25] a day	Up to [\$72.25] a day◆
101st day and after	\$0	\$0	All costs

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD *(Continued)*

Services	Medicare Pays	Plan Pays	You Pay*
BLOOD First three pints	\$0	50%	50% ♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments ♦

PLAN K

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

****Once you have been billed [\$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay*
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$140] of Medicare-approved amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare-approved amounts	\$0 Generally 80% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 10%	[\$140] (Part B deductible)****◆ All costs above Medicare approved amounts Generally 10%◆
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4,660])*
BLOOD First three pints Next [\$140] of Medicare-approved amounts**** Remainder of Medicare-approved amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50%◆ [\$140] (Part B deductible)****◆ Generally 10%◆
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [\$4,660] 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*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$140] of Medicare-approved amounts*****	\$0	\$0	[\$140] (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 [\$2,330] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	[\$867] (75% of Part A deductible)	[\$289] (25% of Part A deductible)♦
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	Up to [\$108.38] a day	Up to [\$36.12] a day♦
101st day and after	\$0	\$0	All costs

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD *(Continued)*

Services	Medicare Pays	Plan Pays	You Pay*
BLOOD First three pints	\$0	75%	25% ♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments ♦

PLAN L

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

****Once you have been billed [\$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay*
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$140] of Medicare-approved amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare-approved amounts	\$0 Generally 80% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 15%	[\$140] (Part B deductible)****◆ All costs above Medicare approved amounts Generally 5%◆
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2,330])*
BLOOD First three pints Next [\$140] of Medicare-approved amounts**** Remainder of Medicare-approved amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25%◆ [\$140] (Part B deductible)****◆ Generally 5%◆
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [\$2,330] 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*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$140] of Medicare-approved amounts*****	\$0	\$0	[\$140] (Part B deductible)◆
Remainder of Medicare-approved amounts	80%	15%	5%◆

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

PLAN N

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,156]	[\$1,156] (Part A deductible)	\$0
61st through 90th day	All but [\$289] a day	[\$289] a day	\$0
91st day and after:			
while using 60 lifetime reserve days	All but [\$578] a day	[\$578] a day	\$0
once lifetime reserve days are used:			
- additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but [\$144.50] a day	Up to [\$144.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

*Once you have been billed [\$140] 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>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment</p> <p>First [\$140] 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>[\$140] (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>PART B EXCESS CHARGES (above Medicare-approved amounts)</p>	\$0	\$0	All costs
<p>BLOOD</p> <p>First three pints</p> <p>Next [\$140] 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>[\$140] (Part B deductible)</p> <p>\$0</p>
<p>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</p>	100%	\$0	\$0

PLAN N

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First [\$140] of Medicare-approved amounts*	\$0	\$0	[\$140] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

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