OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

Humana Healthy Living Medicare Supplement Plans

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

Insured by Humana Insurance Company

CO81077HLM20

Humana®

Humana Insurance Company offers Plans A, F, High Deductible F, K and N with innovative benefits for dental and vision coverage.

Benefit Chart of Medicare Supplement Plans Sold on or After January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

In Colorado, it is a requirement that all plans offered by Humana Insurance Company are available to under age 65 Medicare qualified individuals.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A Coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A Hospice Care Coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled Nursing Facility Coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A Deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B Deductible									✓	✓
Medicare Part B Excess Charges				✓						✓
Foreign Travel Emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out of Pocket Limit in 2023[2]					**$6,940[2]**	**$3,470[2]**				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2,700 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High Deductible Plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

Premium Rating Area Classification

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

Area 1: (Premium rates begin on page 3)
Adams, Arapahoe, Cheyenne, Delta, Denver, Mesa, Montrose, Rio Blanco

Area 2: (Premium rates begin on page 7)
Boulder, Broomfield, Clear Creek, Douglas, Eagle, El Paso, Huerfano, Jefferson, Kit Carson, Lake, Lincoln, Morgan, Phillips, Pitkin, Pueblo, Sedgwick

Area 3: (Premium rates begin on page 7)
Alamosa, Archuleta, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Dolores, Elbert, Fremont, Garfield, Gilpin, Grand, Gunnison, Hinsdale, Jackson, Kiowa, La Plata, Larimer, Las Animas, Logan, Mineral, Moffat, Montezuma, Otero, Ouray, Park, Prowers, Rio Grande, Routt, Saguache, San Juan, San Miguel, Summit, Teller, Washington, Weld, Yuma

Humana Healthy Living Medicare Supplement Area 1 Monthly Premiums

Effective Date: 09-01-2022

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

Attained Age & Gender	Premium Type	Plan A	Plan F	High Deductible Plan F	Plan K	Plan N
<65*-Male	Preferred	$632.41	$836.15	$240.76	$386.81	$578.15
	Standard	$937.90	$1,242.38	$352.48	$570.78	$856.79
<65*-Female	Preferred	$630.87	$834.06	$240.16	$385.84	$576.71
	Standard	$935.51	$1,239.21	$351.62	$569.37	$854.63
65-Male	Preferred	$191.31	$249.52	$79.41	$121.12	$175.80
	Standard	$278.57	$365.58	$111.33	$173.70	$255.40
65-Female	Preferred	$190.86	$248.93	$79.24	$120.85	$175.39
	Standard	$277.90	$364.67	$111.08	$173.30	$254.80
66-Male	Preferred	$198.36	$258.89	$81.98	$125.37	$182.23
	Standard	$289.10	$379.60	$115.19	$180.05	$265.01
66-Female	Preferred	$196.11	$255.92	$81.17	$124.04	$180.21
	Standard	$285.78	$375.17	$113.96	$178.03	$261.99
67-Male	Preferred	$205.70	$268.66	$84.67	$129.81	$188.93
	Standard	$300.07	$394.19	$119.20	$186.64	$275.02
67-Female	Preferred	$203.40	$265.59	$83.83	$128.42	$186.83
	Standard	$296.62	$389.61	$117.94	$184.57	$271.87
68-Male	Preferred	$213.31	$278.80	$87.47	$134.38	$195.88
	Standard	$311.48	$409.36	$123.37	$193.51	$285.42
68-Female	Preferred	$210.92	$275.61	$86.58	$132.94	$193.71
	Standard	$307.90	$404.57	$122.05	$191.35	$282.16
69-Male	Preferred	$221.24	$289.36	$90.37	$139.17	$203.12
	Standard	$323.33	$425.11	$127.71	$200.64	$296.23
69-Female	Preferred	$216.81	$283.43	$88.74	$136.49	$199.06
	Standard	$316.67	$416.27	$125.28	$196.64	$290.17
70-Male	Preferred	$229.51	$300.32	$93.39	$144.15	$210.66
	Standard	$335.68	$441.52	$132.23	$208.08	$307.50
70-Female	Preferred	$222.88	$291.52	$90.96	$140.16	$204.59
	Standard	$325.77	$428.34	$128.60	$202.10	$298.44

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

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Humana Healthy Living Medicare Supplement Area 1 Monthly Premiums

Effective Date: 09-01-2022

Attained Age & Gender	Premium Type	Plan A	Plan F	High Deductible Plan F	Plan K	Plan N
71-Male	Preferred	$238.10	$311.76	$96.53	$149.30	$218.48
	Standard	$348.51	$458.59	$136.91	$215.81	$319.20
71-Female	Preferred	$229.09	$299.80	$93.25	$143.89	$210.29
	Standard	$335.09	$440.73	$132.00	$207.71	$306.95
72-Male	Preferred	$247.01	$323.62	$99.80	$154.67	$226.62
	Standard	$361.87	$476.34	$141.79	$223.84	$331.39
72-Female	Preferred	$235.53	$308.35	$95.59	$147.78	$216.17
	Standard	$344.71	$453.51	$135.52	$213.51	$315.72
73-Male	Preferred	$256.32	$335.97	$103.18	$160.29	$235.11
	Standard	$375.74	$494.79	$146.88	$232.22	$344.05
73-Female	Preferred	$242.14	$317.15	$98.01	$151.76	$222.19
	Standard	$354.58	$466.65	$139.13	$219.46	$324.73
74-Male	Preferred	$265.97	$348.81	$106.71	$166.10	$243.92
	Standard	$390.17	$513.99	$152.15	$240.89	$357.22
74-Female	Preferred	$248.96	$326.22	$100.51	$155.85	$228.42
	Standard	$364.77	$480.23	$142.86	$225.61	$334.04
75-Male	Preferred	$276.03	$362.20	$110.41	$172.15	$253.09
	Standard	$405.20	$533.99	$157.64	$249.95	$370.92
75-Female	Preferred	$256.01	$335.56	$103.08	$160.10	$234.81
	Standard	$375.29	$494.21	$146.70	$231.94	$343.64
76-Male	Preferred	$286.47	$376.07	$114.22	$178.44	$262.60
	Standard	$420.79	$554.74	$163.35	$259.34	$385.14
76-Female	Preferred	$263.24	$345.18	$105.73	$164.46	$241.43
	Standard	$386.10	$508.56	$150.66	$238.47	$353.49
77-Male	Preferred	$297.33	$390.52	$118.19	$184.97	$272.50
	Standard	$437.04	$576.31	$169.30	$269.12	$399.94
77-Female	Preferred	$270.68	$355.08	$108.44	$168.92	$248.20
	Standard	$397.21	$523.36	$154.72	$245.13	$363.61

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

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Humana Healthy Living Medicare Supplement Area 1 Monthly Premiums

Effective Date: 09-01-2022

Attained Age & Gender	Premium Type	Plan A	Plan F	High Deductible Plan F	Plan K	Plan N
78-Male	Preferred	$305.80	$401.79	$121.29	$190.09	$280.22
	Standard	$449.72	$593.18	$173.94	$276.76	$411.53
78-Female	Preferred	$278.36	$365.28	$111.25	$173.54	$255.19
	Standard	$408.68	$538.61	$158.93	$252.06	$374.09
79-Male	Preferred	$314.53	$413.42	$124.49	$195.35	$288.21
	Standard	$462.78	$610.56	$178.70	$284.64	$423.43
79-Female	Preferred	$283.63	$372.31	$113.19	$176.72	$260.01
	Standard	$416.59	$549.11	$161.81	$256.81	$381.28
80-Male	Preferred	$323.52	$425.35	$127.77	$200.76	$296.42
	Standard	$476.20	$628.39	$183.61	$292.70	$435.67
80-Female	Preferred	$288.99	$379.43	$115.14	$179.94	$264.90
	Standard	$424.59	$559.75	$164.74	$261.62	$388.59
81-Male	Preferred	$332.77	$437.66	$131.16	$206.34	$304.86
	Standard	$490.03	$646.80	$188.67	$301.04	$448.28
81-Female	Preferred	$294.49	$386.74	$117.16	$183.29	$269.93
	Standard	$432.81	$570.69	$167.74	$266.59	$396.11
82-Male	Preferred	$342.30	$450.33	$134.65	$212.09	$313.55
	Standard	$504.28	$665.74	$193.88	$309.64	$461.30
82-Female	Preferred	$300.07	$394.19	$119.20	$186.64	$275.02
	Standard	$441.16	$581.79	$170.80	$271.60	$403.69
83-Male	Preferred	$352.15	$463.41	$138.24	$218.00	$322.53
	Standard	$518.99	$685.30	$199.26	$318.47	$474.69
83-Female	Preferred	$305.77	$401.77	$121.28	$190.08	$280.21
	Standard	$449.69	$593.13	$173.93	$276.75	$411.47
84-Male	Preferred	$362.27	$476.87	$141.95	$224.10	$331.75
	Standard	$534.09	$705.39	$204.80	$327.58	$488.48
84-Female	Preferred	$311.63	$409.51	$123.42	$193.60	$285.54
	Standard	$458.40	$604.72	$177.11	$281.99	$419.43

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

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Humana Healthy Living Medicare Supplement Area 1 Monthly Premiums

Effective Date: 09-01-2022

Attained Age & Gender	Premium Type	Plan A	Plan F	High Deductible Plan F	Plan K	Plan N
85+-Male	Preferred	$372.69	$490.74	$145.76	$230.36	$341.26
	Standard	$549.68	$726.14	$210.49	$336.97	$502.71
85+-Female	Preferred	$317.53	$417.41	$125.58	$197.16	$290.96
	Standard	$467.27	$616.52	$180.34	$287.33	$427.51

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

Humana Healthy Living Medicare Supplement Area 2 & 3 Monthly Premiums

Effective Date: 09-01-2022

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

Attained Age & Gender	Premium Type	Plan A	Plan F	High Deductible Plan F	Plan K	Plan N
<65*-Male	Preferred	$564.28	$745.55	$215.84	$345.78	$516.01
	Standard	$836.07	$1,106.96	$315.24	$509.45	$763.91
<65*-Female	Preferred	$562.91	$743.69	$215.31	$344.92	$514.73
	Standard	$833.95	$1,104.14	$314.47	$508.20	$761.99
65-Male	Preferred	$171.85	$223.63	$72.29	$109.40	$158.05
	Standard	$249.48	$326.89	$100.69	$156.18	$228.87
65-Female	Preferred	$171.45	$223.11	$72.14	$109.16	$157.68
	Standard	$248.88	$326.08	$100.47	$155.82	$228.33
66-Male	Preferred	$178.12	$231.97	$74.58	$113.18	$163.77
	Standard	$258.85	$339.36	$104.12	$161.83	$237.42
66-Female	Preferred	$176.12	$229.33	$73.86	$112.00	$161.97
	Standard	$255.89	$335.42	$103.03	$160.03	$234.73
67-Male	Preferred	$184.65	$240.66	$76.97	$117.13	$169.73
	Standard	$268.61	$352.34	$107.69	$167.69	$246.32
67-Female	Preferred	$182.60	$237.93	$76.22	$115.89	$167.86
	Standard	$265.54	$348.27	$106.57	$165.85	$243.52
68-Male	Preferred	$191.42	$249.68	$79.46	$121.20	$175.91
	Standard	$278.76	$365.84	$111.40	$173.80	$255.57
68-Female	Preferred	$189.29	$246.85	$78.67	$119.92	$173.98
	Standard	$275.57	$361.58	$110.23	$171.88	$252.67
69-Male	Preferred	$198.47	$259.08	$82.04	$125.46	$182.35
	Standard	$289.30	$379.85	$115.26	$180.15	$265.19
69-Female	Preferred	$194.53	$253.80	$80.59	$123.07	$178.74
	Standard	$283.38	$371.99	$113.10	$176.59	$259.80

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

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Humana Healthy Living Medicare Supplement Area 2 & 3 Monthly Premiums

Effective Date: 09-01-2022

Attained Age & Gender	Premium Type	Plan A	Plan F	High Deductible Plan F	Plan K	Plan N
70-Male	Preferred	$205.83	$268.83	$84.73	$129.89	$189.06
	Standard	$300.29	$394.45	$119.28	$186.77	$275.22
70-Female	Preferred	$199.93	$261.00	$82.57	$126.34	$183.66
	Standard	$291.47	$382.73	$116.05	$181.45	$267.16
71-Male	Preferred	$213.47	$279.01	$87.52	$134.47	$196.02
	Standard	$311.70	$409.64	$123.45	$193.64	$285.63
71-Female	Preferred	$205.46	$268.37	$84.60	$129.66	$188.73
	Standard	$299.76	$393.75	$119.08	$186.44	$274.73
72-Male	Preferred	$221.40	$289.56	$90.43	$139.25	$203.26
	Standard	$323.59	$425.43	$127.79	$200.79	$296.47
72-Female	Preferred	$211.19	$275.97	$86.69	$133.12	$193.96
	Standard	$308.32	$405.12	$122.21	$191.60	$282.53
73-Male	Preferred	$229.68	$300.55	$93.44	$144.25	$210.81
	Standard	$335.93	$441.85	$132.32	$208.24	$307.74
73-Female	Preferred	$217.07	$283.80	$88.84	$136.66	$199.32
	Standard	$317.10	$416.81	$125.42	$196.89	$290.55
74-Male	Preferred	$238.27	$311.97	$96.58	$149.42	$218.65
	Standard	$348.77	$458.93	$137.01	$215.96	$319.45
74-Female	Preferred	$223.14	$291.87	$91.06	$140.30	$204.86
	Standard	$326.17	$428.89	$128.74	$202.36	$298.83
75-Male	Preferred	$247.22	$323.88	$99.87	$154.80	$226.81
	Standard	$362.14	$476.72	$141.89	$224.02	$331.64
75-Female	Preferred	$229.41	$300.18	$93.35	$144.08	$210.55
	Standard	$335.53	$441.33	$132.16	$207.99	$307.37
76-Male	Preferred	$256.51	$336.22	$103.26	$160.40	$235.27
	Standard	$376.01	$495.18	$146.97	$232.37	$344.29
76-Female	Preferred	$235.84	$308.74	$95.71	$147.96	$216.44
	Standard	$345.15	$454.10	$135.68	$213.80	$316.13

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

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Humana Healthy Living Medicare Supplement Area 2 & 3 Monthly Premiums

Effective Date: 09-01-2022

Attained Age & Gender	Premium Type	Plan A	Plan F	High Deductible Plan F	Plan K	Plan N
77-Male	Preferred	$266.17	$349.08	$106.79	$166.21	$244.08
	Standard	$390.47	$514.37	$152.26	$241.07	$357.46
77-Female	Preferred	$242.46	$317.55	$98.12	$151.93	$222.46
	Standard	$355.03	$467.26	$139.29	$219.73	$325.14
78-Male	Preferred	$273.71	$359.11	$109.55	$170.76	$250.95
	Standard	$401.75	$529.38	$156.39	$247.87	$367.77
78-Female	Preferred	$249.29	$326.62	$100.62	$156.04	$228.68
	Standard	$365.24	$480.83	$143.04	$225.89	$334.46
79-Male	Preferred	$281.47	$369.45	$112.40	$175.44	$258.06
	Standard	$413.37	$544.84	$160.63	$254.88	$378.36
79-Female	Preferred	$253.98	$332.88	$102.34	$158.87	$232.97
	Standard	$372.27	$490.17	$145.60	$230.12	$340.86
80-Male	Preferred	$289.47	$380.07	$115.32	$180.25	$265.36
	Standard	$425.31	$560.71	$165.00	$262.05	$389.25
80-Female	Preferred	$258.75	$339.21	$104.08	$161.73	$237.32
	Standard	$379.39	$499.64	$148.21	$234.40	$347.36
81-Male	Preferred	$297.70	$391.02	$118.33	$185.22	$272.87
	Standard	$437.61	$577.09	$169.50	$269.47	$400.47
81-Female	Preferred	$263.64	$345.72	$105.88	$164.71	$241.79
	Standard	$386.70	$509.37	$150.88	$238.82	$354.05
82-Male	Preferred	$306.18	$402.29	$121.44	$190.33	$280.60
	Standard	$450.29	$593.94	$174.13	$277.12	$412.05
82-Female	Preferred	$268.61	$352.34	$107.69	$167.69	$246.32
	Standard	$394.13	$519.25	$153.60	$243.28	$360.80
83-Male	Preferred	$314.94	$413.93	$124.63	$195.59	$288.59
	Standard	$463.38	$611.34	$178.92	$284.98	$423.96
83-Female	Preferred	$273.68	$359.09	$109.54	$170.75	$250.94
	Standard	$401.72	$529.34	$156.38	$247.86	$367.72

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

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Humana Healthy Living Medicare Supplement Area 2 & 3 Monthly Premiums

Effective Date: 09-01-2022

Attained Age & Gender	Premium Type	Plan A	Plan F	High Deductible Plan F	Plan K	Plan N
84-Male	Preferred	$323.95	$425.90	$127.93	$201.02	$296.79
	Standard	$476.81	$629.21	$183.85	$293.08	$436.23
84-Female	Preferred	$278.89	$365.97	$111.45	$173.88	$255.68
	Standard	$409.47	$539.65	$159.21	$252.52	$374.80
85+-Male	Preferred	$333.22	$438.24	$131.32	$206.59	$305.25
	Standard	$490.68	$647.67	$188.91	$301.44	$448.89
85+-Female	Preferred	$284.14	$373.00	$113.37	$177.05	$260.50
	Standard	$417.36	$550.15	$162.09	$257.27	$381.99

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

Medicare Supplement Discounts*

ACH Discount

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

Household Discount**

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

Calculate Your Premium

Base monthly premium (please refer to pages 3-10): _____

ACH Discount (applied to base premium): _____

Household Discount (applied to base premium): _____

Premium Quote (base premium minus discounts): _____

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

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

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.

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

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

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.

The plans described in this Outline of Coverage include innovative benefits for dental and vision coverage. In addition, Humana offers Medicare Supplement Insurance plans that do not contain innovative benefits. For more information, please contact Humana at 1-888-310-8482.

Complete answers are very important

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

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

Plan A

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

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

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$0	$1,600 (Part A deductible)
61st through 90th day	All but $400 a day	$400 a day	$0
91st day and after:			
while using 60 lifetime reserve days once lifetime reserve days are used:	All but $800 a day	$800 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0**
• beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $200 a day	$0	Up to $200 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 $226 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 $226 of Medicare-approved amounts*	$0	$0	$226 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
(above Medicare-approved amounts)	$0	$0	All costs
Blood			
First three pints	$0	All costs	$0
Next $226 of Medicare-approved amounts*	$0	$0	$226 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Medicare (Parts A and B)

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $226 of Medicare-approved amounts*	$0	$0	$226 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Plan A

Innovative Benefits

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

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

Plan F

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

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

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A deductible)	$0
61st through 90th day	All but $400 a day	$400 a day	$0
91st day and after:			
while using 60 lifetime reserve days once lifetime reserve days are used:	All but $800 a day	$800 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0**
• beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $200 a day	Up to $200 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 $226 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 $226 of Medicare-approved amounts*	$0	$226 (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 $226 of Medicare-approved amounts*	$0	$226 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Medicare (Parts A and B)

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $226 of Medicare-approved amounts*	$0	$226 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

Plan F

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel **Not covered by Medicare** Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan F

Innovative Benefits

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

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

High Deductible Plan F

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

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

** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2,700 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,700. 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 $2,700 Deductible,** Plan Pays	In Addition To $2,700 Deductible,** You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A deductible)	$0
61st through 90th day	All but $400 a day	$400 a day	$0
91st day and after:			
while using 60 lifetime reserve days once lifetime reserve days are used:	All but $800 a day	$800 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0***
• beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $200 a day	Up to $200 a day	$0
101st day and after	$0	$0	All costs

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

High Deductible Plan F

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

** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2,700 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,700. 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 $2,700 Deductible,** Plan Pays	In Addition To $2,700 Deductible,** You Pay
Blood			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

High Deductible Plan F

Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $226 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2,700 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,700. 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 $2,700 Deductible,** Plan Pays	In Addition To $2,700 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 $226 of Medicare-approved amounts*	$0	$226 (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 $226 of Medicare-approved amounts*	$0	$226 (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 $226 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2,700 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,700. 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 $2,700 Deductible,** Plan Pays	In Addition To $2,700 Deductible,** You Pay
Home Health Care MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $226 of Medicare-approved amounts*	$0	$226 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	After You Pay $2,700 Deductible,** Plan Pays	In Addition To $2,700 Deductible,** You Pay
Foreign Travel **Not covered by Medicare** Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

High Deductible Plan F

Innovative Benefits

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

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

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

Plan K

* You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $6,940 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 $1,600	$800 (50% of Part A deductible)	$800 (50% of Part A deductible)◆
61st through 90th day	All but $400 a day	$400 a day	$0
91st day and after:			
while using 60 lifetime reserve days once lifetime reserve days are used:	All but $800 a day	$800 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0***
• beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care** You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $200 a day	Up to $100 a day	Up to $100 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 $226 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 $226 of Medicare-approved amounts****	$0	$0	$226 (Part B deductible)****◆
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
Part B Excess Charges			
(above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $6,940)*
Blood			
First three pints	$0	50%	50%◆
Next $226 of Medicare-approved amounts****	$0	$0	$226 (Part B deductible)****◆
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $6,940 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

Plan K

Medicare (Parts A and B)

Services	Medicare Pays	Plan Pays	You Pay*
Home Health Care MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $226 of Medicare-approved amounts*****	$0	$0	$226 (Part B deductible)◆
Remainder of Medicare-approved amounts	80%	10%	10%◆

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

Plan K

Innovative Benefits

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

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

Plan N

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

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

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A deductible)	$0
61st through 90th day	All but $400 a day	$400 a day	$0
91st day and after:			
while using 60 lifetime reserve days once lifetime reserve days are used:	All but $800 a day	$800 a day	$0
• additional 365 days	$0	100% of Medicare eligible expenses	$0**
• beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $200 a day	Up to $200 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 $226 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 $226 of Medicare-approved amounts*	$0	$0	$226 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges			
(above Medicare-approved amounts)	$0	$0	All costs
Blood			
First three pints	$0	All costs	$0
Next $226 of Medicare-approved amounts*	$0	$0	$226 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Plan N

Medicare (Parts A and B)

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $226 of Medicare-approved amounts*	$0	$0	$226 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel **Not covered by Medicare** Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan N

Innovative Benefits

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

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

Notes

Notes

Important

At Humana, it is important you are treated fairly.

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

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

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

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

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

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

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

Insured by Humana Insurance Company