OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

Humana Connect Medicare Supplement Plans

for Wisconsin residents Medicare supplement benefit plans: Basic plan

Insured by Humana Benefit Plan of Illinois, Inc.

WI81077HCM20

Humana®

Medicare Supplement Insurance

The Wisconsin Insurance Commissioner has set standards for Medicare supplement insurance. This policy meets these standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see the "Wisconsin Guide to Health Insurance for People with Medicare" included in this package. Do not buy this policy if you did not get the guide.

Premium Information

We can only raise your premium if we raise the premium for all policies like yours in this state. No change in premium will be made because of the number of claims you file, nor because of a change in your health or your type of work.

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

If your policy was issued as an under age 65 policy, due to disability, when you turn 65 premiums will remain at the disabled rates. Also, if your residence changes such that you move into a new rating area, your rates may be adjusted.

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 Benefit Plan of Illinois, Inc.
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 directly to you.

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.

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.

Neither Humana Benefit Plan of Illinois, Inc. nor its agents are connected with Medicare.

Basic Benefits Included in Medicare Supplement Policies

Only applicants **first** eligible for Medicare before 2020 may purchase the Medicare Part B Deductible Optional Rider.

- **Inpatient Hospital Care:** Covers the Medicare Part A coinsurance.
- **Medical Costs:** Covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved payment amount.)*
- **Blood:** Covers the first three pints of blood each year.

Medigap Benefits	Basic Plan	Optional Riders
Basic Benefits	✓	Insurance companies are allowed to offer these five riders to a Medicare supplement policy. • Medicare Part A Deductible • Additional Home Health Care (365 visits including those paid by Medicare) • Medicare Part B Deductible • Medicare Part B Excess Charges • Foreign Travel Emergency
Medicare Part A: Skilled Nursing Facility Coinsurance	✓	
Inpatient Mental Health Coverage	175 days per lifetime in addition to Medicare	
Home Health Care	40 visits in addition to those paid by Medicare	
Medicare Part B: Coinsurance	✓	
Outpatient Mental Health	✓	

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 6)
Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha

Area 2: (Premium rates begin on page 8)
Brown, Dane, and Outagamie

Area 3: (Premium rates begin on page 10)
Adams, Ashland, Barron, Bayfield, Buffalo, Burnett, Calumet, Chippewa, Clark, Columbia, Crawford, Dodge, Door, Douglas, Dunn, Eau Claire, Florence, Fond Du Lac, Forest, Grant, Green, Green Lake, Iowa, Iron, Jackson, Jefferson, Juneau, Kewaunee, La Crosse, Lafayette, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Marquette, Menominee, Monroe, Oconto, Oneida, Pepin, Pierce, Polk, Portage, Price, Richland, Rock, Rusk, Sauk, Sawyer, Shawano, Sheboygan, St. Croix, Taylor, Trempealeau, Vernon, Vilas, Walworth, Washburn, Waupaca, Waushara, Winnebago, and Wood

Humana Connect Medicare Supplement Area 1 Monthly Premiums

Effective Date: 06-01-2024

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

Attained Age & Gender	Basic Plan	Part A Deductible Rider 1	Additional Home Health Rider 2	Part B Deductible Rider 3	Part B Excess Charges Rider 4	Foreign Travel Emergency Rider 5	Basic with all Optional Riders
<65*-Male	$458.65	$77.54	$19.02	$19.99	$20.48	$4.52	$600.20
<65*-Female	$457.50	$77.37	$18.99	$19.99	$20.44	$4.52	$598.81
65-Male	$184.67	$31.01	$7.61	$19.99	$8.22	$1.79	$253.29
65-Female	$184.20	$30.94	$7.59	$19.99	$8.15	$1.79	$252.66
66-Male	$191.96	$32.26	$7.91	$19.99	$8.50	$1.90	$262.52
66-Female	$189.66	$31.89	$7.82	$19.99	$8.44	$1.83	$259.63
67-Male	$199.55	$33.55	$8.23	$19.99	$8.86	$1.95	$272.13
67-Female	$197.17	$33.19	$8.10	$19.99	$8.73	$1.94	$269.12
68-Male	$207.47	$34.89	$8.55	$19.99	$9.22	$2.01	$282.13
68-Female	$204.96	$34.49	$8.46	$19.99	$9.13	$2.00	$279.03
69-Male	$215.68	$36.28	$8.88	$19.99	$9.58	$2.10	$292.51
69-Female	$211.06	$35.52	$8.68	$19.99	$9.39	$2.07	$286.71
70-Male	$224.22	$37.75	$9.23	$19.99	$10.00	$2.18	$303.37
70-Female	$217.36	$36.59	$8.99	$19.99	$9.67	$2.11	$294.71
71-Male	$233.10	$39.25	$9.61	$19.99	$10.37	$2.29	$314.61
71-Female	$223.80	$37.71	$9.22	$19.99	$9.99	$2.18	$302.89
72-Male	$242.34	$40.81	$10.01	$19.99	$10.80	$2.37	$326.32
72-Female	$230.47	$38.81	$9.52	$19.99	$10.26	$2.26	$311.31
73-Male	$251.98	$42.46	$10.38	$19.99	$11.23	$2.44	$338.48
73-Female	$237.30	$39.97	$9.80	$19.99	$10.57	$2.33	$319.96
74-Male	$261.97	$44.14	$10.85	$19.99	$11.67	$2.57	$351.19
74-Female	$244.35	$41.17	$10.09	$19.99	$10.88	$2.39	$328.87
75-Male	$272.36	$45.95	$11.24	$19.99	$12.16	$2.68	$364.38
75-Female	$251.66	$42.43	$10.38	$19.99	$11.21	$2.44	$338.11
76-Male	$283.18	$47.74	$11.74	$19.99	$12.63	$2.77	$378.05
76-Female	$259.15	$43.68	$10.69	$19.99	$11.55	$2.53	$347.59

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 Connect Medicare Supplement Area 1 Monthly Premiums

Effective Date: 06-01-2024

Attained Age & Gender	Basic Plan	Part A Deductible Rider 1	Additional Home Health Rider 2	Part B Deductible Rider 3	Part B Excess Charges Rider 4	Foreign Travel Emergency Rider 5	Basic with all Optional Riders
77-Male	$294.41	$49.70	$12.17	$19.99	$13.15	$2.89	$392.31
77-Female	$266.84	$44.99	$11.02	$19.99	$11.90	$2.63	$357.37
78-Male	$303.20	$51.16	$12.54	$19.99	$13.54	$2.97	$403.40
78-Female	$274.80	$46.33	$11.39	$19.99	$12.27	$2.70	$367.48
79-Male	$312.24	$52.68	$12.91	$19.99	$13.92	$3.05	$414.79
79-Female	$280.25	$47.27	$11.56	$19.99	$12.53	$2.76	$374.36
80-Male	$321.54	$54.27	$13.28	$19.99	$14.36	$3.17	$426.61
80-Female	$285.80	$48.20	$11.81	$19.99	$12.73	$2.78	$381.31
81-Male	$331.14	$55.91	$13.71	$19.99	$14.76	$3.25	$438.76
81-Female	$291.51	$49.17	$12.02	$19.99	$13.02	$2.83	$388.54
82-Male	$341.01	$57.59	$14.12	$19.99	$15.21	$3.33	$451.25
82-Female	$297.28	$50.16	$12.29	$19.99	$13.23	$2.93	$395.88
83-Male	$351.21	$59.30	$14.55	$19.99	$15.71	$3.45	$464.21
83-Female	$303.18	$51.17	$12.55	$19.99	$13.55	$2.97	$403.41
84-Male	$361.66	$61.06	$14.96	$19.99	$16.15	$3.54	$477.36
84-Female	$309.21	$52.21	$12.80	$19.99	$13.81	$3.03	$411.05
85+-Male	$372.46	$62.91	$15.44	$19.99	$16.61	$3.64	$491.05
85+-Female	$315.37	$53.20	$13.05	$19.99	$14.10	$3.09	$418.80

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.

Humana Connect Medicare Supplement Area 2 Monthly Premiums

Effective Date: 06-01-2024

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

Attained Age & Gender	Basic Plan	Part A Deductible Rider 1	Additional Home Health Rider 2	Part B Deductible Rider 3	Part B Excess Charges Rider 4	Foreign Travel Emergency Rider 5	Basic with all Optional Riders
<65*-Male	$388.08	$65.56	$16.08	$19.99	$17.32	$3.82	$510.85
<65*-Female	$387.10	$65.42	$16.05	$19.99	$17.28	$3.82	$509.66
65-Male	$156.44	$26.22	$6.44	$19.99	$6.95	$1.52	$217.56
65-Female	$156.05	$26.16	$6.42	$19.99	$6.89	$1.52	$217.03
66-Male	$162.60	$27.28	$6.69	$19.99	$7.19	$1.61	$225.36
66-Female	$160.66	$26.96	$6.61	$19.99	$7.13	$1.54	$222.89
67-Male	$169.02	$28.37	$6.96	$19.99	$7.49	$1.65	$233.48
67-Female	$167.01	$28.06	$6.84	$19.99	$7.38	$1.64	$230.92
68-Male	$175.71	$29.50	$7.23	$19.99	$7.79	$1.70	$241.92
68-Female	$173.59	$29.16	$7.15	$19.99	$7.72	$1.69	$239.30
69-Male	$182.65	$30.67	$7.51	$19.99	$8.10	$1.78	$250.70
69-Female	$178.75	$30.03	$7.34	$19.99	$7.94	$1.75	$245.80
70-Male	$189.88	$31.92	$7.80	$19.99	$8.45	$1.84	$259.88
70-Female	$184.08	$30.93	$7.60	$19.99	$8.17	$1.79	$252.56
71-Male	$197.38	$33.18	$8.13	$19.99	$8.77	$1.93	$269.38
71-Female	$189.53	$31.88	$7.79	$19.99	$8.44	$1.84	$259.47
72-Male	$205.20	$34.50	$8.46	$19.99	$9.13	$2.00	$279.28
72-Female	$195.16	$32.81	$8.04	$19.99	$8.68	$1.91	$266.59
73-Male	$213.34	$35.90	$8.78	$19.99	$9.50	$2.06	$289.57
73-Female	$200.94	$33.80	$8.29	$19.99	$8.94	$1.97	$273.93
74-Male	$221.80	$37.32	$9.17	$19.99	$9.87	$2.18	$300.33
74-Female	$206.90	$34.81	$8.53	$19.99	$9.20	$2.02	$281.45
75-Male	$230.58	$38.85	$9.50	$19.99	$10.28	$2.27	$311.47
75-Female	$213.07	$35.87	$8.78	$19.99	$9.48	$2.06	$289.25
76-Male	$239.73	$40.36	$9.92	$19.99	$10.68	$2.34	$323.02
76-Female	$219.41	$36.93	$9.04	$19.99	$9.77	$2.14	$297.28

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 Connect Medicare Supplement Area 2 Monthly Premiums

Effective Date: 06-01-2024

Attained Age & Gender	Basic Plan	Part A Deductible Rider 1	Additional Home Health Rider 2	Part B Deductible Rider 3	Part B Excess Charges Rider 4	Foreign Travel Emergency Rider 5	Basic with all Optional Riders
77-Male	$249.22	$42.02	$10.29	$19.99	$11.11	$2.45	$335.08
77-Female	$225.91	$38.04	$9.32	$19.99	$10.06	$2.22	$305.54
78-Male	$256.65	$43.25	$10.60	$19.99	$11.45	$2.51	$344.45
78-Female	$232.64	$39.17	$9.63	$19.99	$10.37	$2.28	$314.08
79-Male	$264.30	$44.54	$10.92	$19.99	$11.76	$2.58	$354.09
79-Female	$237.24	$39.96	$9.77	$19.99	$10.59	$2.33	$319.88
80-Male	$272.16	$45.89	$11.23	$19.99	$12.14	$2.68	$364.09
80-Female	$241.94	$40.75	$9.99	$19.99	$10.76	$2.35	$325.78
81-Male	$280.27	$47.27	$11.59	$19.99	$12.48	$2.74	$374.34
81-Female	$246.77	$41.57	$10.16	$19.99	$11.01	$2.39	$331.89
82-Male	$288.62	$48.69	$11.94	$19.99	$12.86	$2.82	$384.92
82-Female	$251.65	$42.41	$10.39	$19.99	$11.19	$2.47	$338.10
83-Male	$297.24	$50.14	$12.30	$19.99	$13.28	$2.92	$395.87
83-Female	$256.63	$43.26	$10.61	$19.99	$11.46	$2.51	$344.46
84-Male	$306.07	$51.62	$12.65	$19.99	$13.65	$2.99	$406.97
84-Female	$261.73	$44.14	$10.83	$19.99	$11.67	$2.56	$350.92
85+-Male	$315.21	$53.19	$13.06	$19.99	$14.04	$3.08	$418.57
85+-Female	$266.94	$44.97	$11.03	$19.99	$11.92	$2.61	$357.46

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 Connect Medicare Supplement Area 3 Monthly Premiums

Effective Date: 06-01-2024

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

Attained Age & Gender	Basic Plan	Part A Deductible Rider 1	Additional Home Health Rider 2	Part B Deductible Rider 3	Part B Excess Charges Rider 4	Foreign Travel Emergency Rider 5	Basic with all Optional Riders
<65*-Male	$408.84	$69.08	$16.94	$19.99	$18.25	$4.03	$537.13
<65*-Female	$407.81	$68.93	$16.91	$19.99	$18.21	$4.03	$535.88
65-Male	$164.74	$27.63	$6.78	$19.99	$7.32	$1.60	$228.06
65-Female	$164.33	$27.57	$6.76	$19.99	$7.26	$1.60	$227.51
66-Male	$171.24	$28.74	$7.05	$19.99	$7.58	$1.70	$236.30
66-Female	$169.19	$28.41	$6.97	$19.99	$7.52	$1.63	$233.71
67-Male	$178.00	$29.89	$7.33	$19.99	$7.89	$1.73	$244.83
67-Female	$175.88	$29.57	$7.21	$19.99	$7.78	$1.72	$242.15
68-Male	$185.05	$31.09	$7.61	$19.99	$8.21	$1.79	$253.74
68-Female	$182.82	$30.72	$7.54	$19.99	$8.13	$1.78	$250.98
69-Male	$192.37	$32.32	$7.91	$19.99	$8.54	$1.87	$263.00
69-Female	$188.25	$31.64	$7.73	$19.99	$8.37	$1.84	$257.82
70-Male	$199.98	$33.63	$8.22	$19.99	$8.91	$1.94	$272.67
70-Female	$193.86	$32.59	$8.01	$19.99	$8.61	$1.88	$264.94
71-Male	$207.89	$34.97	$8.57	$19.99	$9.24	$2.04	$282.70
71-Female	$199.61	$33.59	$8.21	$19.99	$8.90	$1.94	$272.24
72-Male	$216.12	$36.36	$8.92	$19.99	$9.62	$2.11	$293.12
72-Female	$205.55	$34.57	$8.48	$19.99	$9.14	$2.01	$279.74
73-Male	$224.71	$37.83	$9.25	$19.99	$10.01	$2.18	$303.97
73-Female	$211.63	$35.61	$8.73	$19.99	$9.42	$2.08	$287.46
74-Male	$233.61	$39.33	$9.66	$19.99	$10.40	$2.29	$315.28
74-Female	$217.91	$36.68	$8.99	$19.99	$9.69	$2.13	$295.39
75-Male	$242.86	$40.93	$10.02	$19.99	$10.83	$2.39	$327.02
75-Female	$224.42	$37.80	$9.25	$19.99	$9.99	$2.18	$303.63
76-Male	$252.51	$42.53	$10.46	$19.99	$11.25	$2.47	$339.21
76-Female	$231.09	$38.92	$9.53	$19.99	$10.29	$2.25	$312.07

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 Connect Medicare Supplement Area 3 Monthly Premiums

Effective Date: 06-01-2024

Attained Age & Gender	Basic Plan	Part A Deductible Rider 1	Additional Home Health Rider 2	Part B Deductible Rider 3	Part B Excess Charges Rider 4	Foreign Travel Emergency Rider 5	Basic with all Optional Riders
77-Male	$262.51	$44.28	$10.84	$19.99	$11.71	$2.58	$351.91
77-Female	$237.94	$40.08	$9.82	$19.99	$10.60	$2.34	$320.77
78-Male	$270.34	$45.58	$11.17	$19.99	$12.06	$2.65	$361.79
78-Female	$245.04	$41.28	$10.14	$19.99	$10.93	$2.40	$329.78
79-Male	$278.40	$46.93	$11.51	$19.99	$12.40	$2.71	$371.94
79-Female	$249.89	$42.11	$10.30	$19.99	$11.16	$2.46	$335.91
80-Male	$286.68	$48.35	$11.83	$19.99	$12.79	$2.82	$382.46
80-Female	$254.84	$42.94	$10.53	$19.99	$11.34	$2.48	$342.12
81-Male	$295.24	$49.81	$12.21	$19.99	$13.15	$2.89	$393.29
81-Female	$259.93	$43.81	$10.71	$19.99	$11.60	$2.52	$348.56
82-Male	$304.03	$51.30	$12.58	$19.99	$13.55	$2.97	$404.42
82-Female	$265.07	$44.69	$10.95	$19.99	$11.79	$2.61	$355.10
83-Male	$313.11	$52.83	$12.97	$19.99	$13.99	$3.08	$415.97
83-Female	$270.32	$45.59	$11.18	$19.99	$12.07	$2.65	$361.80
84-Male	$322.42	$54.40	$13.33	$19.99	$14.39	$3.16	$427.69
84-Female	$275.69	$46.51	$11.41	$19.99	$12.30	$2.70	$368.60
85+-Male	$332.04	$56.05	$13.76	$19.99	$14.80	$3.24	$439.88
85+-Female	$281.18	$47.39	$11.62	$19.99	$12.56	$2.75	$375.49

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.

Calculating Your Monthly Premium

$_____Basic Medicare Supplement Insurance

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT
Each of these riders may be purchased separately.

$_____**1. Medicare Part A Deductible**
100% of Medicare Part A Deductible

$_____**2. Additional Home Health Care**
An aggregate of 365 visits per year including those covered by Medicare

$_____**3. Medicare Part B Deductible**
100% of Medicare Part B Deductible

$_____**4. Medicare Part B Excess Charges**
Difference between the Medicare eligible charge and the amount charged by the provider which shall be no greater than the actual charge or the limited charge allowed by Medicare, whichever is less.

$_____**5. Foreign Travel Emergency**
After a deductible not greater than $250, covers at least 80% of expenses associated with emergency medical care received outside the United States, beginning the first 60 days of a trip with a lifetime maximum of at least $50,000.

$_____MONTHLY TOTAL FOR BASIC POLICY AND SELECTED OPTIONAL BENEFITS

IN ADDITION TO THIS OUTLINE OF COVERAGE, HUMANA WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

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 4 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 3 of your enrollment application.

Calculate Your Premium

Base monthly premium (please refer to pages 6-11): _____

ACH Discount (applied to base premium): _____

Household Discount (applied to base premium): _____

Premium Quote (base premium minus discounts): _____

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

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

Outline of Basic Medicare Supplement Insurance Plan

This chart shows the benefits included in this Medicare supplement plan.

Basic Medicare Supplement Coverage

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 $1,676	$0 or ☐ $1,676 (Optional Part A Deductible Rider**)	$1,676 or $0
61st to 90th day	All but $419 a day	$419 a day	$0
91st day and after:	All but $838 a day	$838 a day	$0
while using 60 lifetime reserve days once lifetime reserve days are used:			
• additional 365 days	$0	100% of Medicare eligible expenses***	$0
• beyond the additional 365 days	$0	$0	$0
Beyond 150 days	$0	100% of Medicare eligible expenses***	$0
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 $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs

** This is an optional rider. You purchased this benefit if the box is checked and you paid the premium.

*** 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 as provided in the policy's "Core Benefits."

Basic Medicare Supplement Coverage

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

*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
Inpatient Psychiatric Care			
Inpatient psychiatric care in a participating psychiatric hospital	190 days per lifetime	175 days per lifetime after Medicare days are exhausted	All costs over lifetime maximum
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

Basic Medicare Supplement Coverage

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

* Once you have been billed $257 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 $257 of Medicare-approved amounts*	$0	$0 or ☐ $257 (Optional Part B deductible rider**)	$257 or $0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20% ☐ (Optional Medicare Part B Excess Charges Rider**)	Charges exceeding eligible charges or $0
Blood			
First three pints	$0	All costs	$0
Next $257 of Medicare-approved amounts*	$0	$0 or $257 (Optional Part B deductible rider**)	$257 or $0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Home Health Care MEDICARE-APPROVED SERVICES			
	100% of charges for visits considered medically necessary by Medicare	Up to 40 visits per calendar year or ☐ Optional Home Health Care Rider**	All expenses beyond 40 visits per year or All expenses beyond 365 visits per year

** This is an optional rider. You purchased this benefit if the box is checked and you paid the premium.

Basic Medicare Supplement Coverage

Other Benefits - Not Covered by Medicare

Services	Medicare Pays	Plan Pays	You Pay
Preventive Medical Care Benefit – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.			
Up to $300 each calendar year for routine annual medical exam, including diagnostic X-rays and laboratory services	$0	$300	Balance
Up to $25 each calendar year for immunizations and injections	$0	$25	Balance
Foreign Travel ☐ Optional Foreign Travel Rider**			
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

** This is an optional rider. You purchased this benefit if the box is checked and you paid the premium.

Limitations and Exclusions

Unless specifically stated otherwise, this Policy does not cover any service or portion of a service that is not a Medicare Eligible Expense, including but not limited to:

1. Services that are provided before Your coverage begins or after it ends.
2. Services or supplies for any Injury or Sickness that is covered by Worker's Compensation or a similar law.
3. Custodial care and non-medical transportation.
4. Routine physical exams, check-ups, and immunizations not covered by Medicare, except as provided for under the Basic Plan.
5. Treatment of alcoholism and drug dependence, except to the extent covered by Medicare or as required by Wisconsin law.
6. Services or supplies for cosmetic surgery, unless
   a. You receive an Injury which results in bodily damage requiring the surgery; or
   b. It qualifies as reconstructive surgery performed following surgery, and both the surgery and the reconstructive surgery are Medically Necessary and covered by Medicare.
7. Charges made by a Hospital owned or run by the United States Government or a state government unless You are legally required to pay for such charges.
8. Charges in connection with education or training or medical services provided by a member of your family.
9. Charges for which You are paid or entitled to payment by or through a public program, other than Medicaid.
10. Charges for eyeglasses, hearing aids, contact lenses or the examination or fitting of such aids, not covered by Medicare.
11. Dental care or treatment, except as related to surgery of the jaw or related structures or setting fractures of the jaw or facial bones; dentures and dental appliances.
12. Charges for which benefits are payable for those expenses under the mandatory part of any auto insurance policy written to comply with
    a. a "no fault" insurance law" or
    b. an uninsured motorist insurance law.
13. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet not covered by Medicare or as required by Wisconsin law.
14. Chiropractic care in connection with detection and correction of structural imbalance, distortion, misalignment or subluxation of the vertebrae to remove nerve interference and its effects unless covered by Medicare or required by Wisconsin law.
15. Home health care, or private duty nursing, including full-time nursing at home, in excess of 40* visits per calendar year, including what Medicare pays. (*365 visits if optional rider Rider 2 is purchased.)
16. Outpatient prescription drugs.
17. Treatment of any Injury or Sickness caused by war or any act of war, whether declared or undeclared.
18. Charges paid for by Medicare or charges that would have been paid for by Medicare if You were enrolled in Parts A and B of Medicare.
19. The Medicare Part A and Part B Deductibles, unless appropriate optional riders (Rider 1 and Rider 3, respectively) are purchased.
20. Physician charges in excess of Medicare Eligible Expenses, unless the optional rider (Rider 4) is purchased.
21. Most care received outside the United States.
22. Charges which You are not legally required to pay or which would not have been made in the absence of insurance.
23. Skilled nursing facility care beyond what is covered by Medicare and the additional 30 days of skilled nursing facility care mandated by Wisconsin.

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

For services not covered by Medicare, we determine the usual, customary, and reasonable reimbursement amounts taking into account the area where You live and the circumstances of the care rendered. The determination includes fees charged by the provider for the service to the majority of his or her patients, the normative fee billed by the majority of providers for the same procedure or service, and fee appropriateness given the service (taking into account the level of care and type of treatment rendered).

Grievance Procedures

Your policy provides complete details on these procedures.

Situations might arise when you have a question or concern about your benefits or our claim payment decisions. Most benefit and claim questions or concerns can be resolved by contacting our Customer Service department.

Our toll-free telephone number is: **1-800-866-0581**.

If your question or concern can't be resolved by our Customer Service department, you or an authorized representative can file a written grievance. You can designate a representative to act for you by sending us a signed letter of authorization with your written grievance. Grievance means any dissatisfaction with our provision of services or claims practices, expressed in writing to us, by you or on your behalf. To file a grievance:

1) Write down your claim or benefit concern, including the reason you disagree with our payment or coverage decision.

2) Mail, deliver, or fax your written grievance, along with copies of any related materials (such as letters or other supporting documents), to us at the following address:

   Humana Benefit Plan of Illinois, Inc.
   Attn: Grievance and Appeals Department
   P.O. Box 14546
   Lexington, KY 40512-4546

If your life, health, or ability to regain maximum function is in serious jeopardy, or your pain can't be managed without the care or treatment being grieved, call us at one of the following telephone numbers and we can expedite the grievance process for you:

Toll Free **1-800-867-6601**; Fax **1-800-949-2961**

We'll provide a prompt, complete, and unbiased review of your request and our decision. If you designate a representative, we'll send the results of our review to him or her instead of to you. The results will include our claim or benefit decision, the reason for our decision, and identify the policy provisions on which we based our decision.

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

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.

In addition to this Outline of Coverage, Humana will send an annual notice to you 30 days prior to the Effective Date of Medicare changes which will describe these changes and the charges in your Medicare supplement coverage.

1) See address and phone number on the back of your ID card if you have questions on this notice.

2) Unless your plan or any applicable state law allows you additional time.

Notes

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

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

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**.

California members or residents:

You may also call the California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.

GCHMEMAEN

Auxiliary aids and services, free of charge, are available to you.
877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m., Eastern time.

Humana Inc. and its subsidiaries provide free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 **(Korean)** 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Tagalog (Tagalog – Filipino) Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

French Creole (Haitian Creole): Kreyòl Ayisyen (French Creole) Rele nimewo ki e dike anwo a pou resevwa sèvis éd gratis nan lang.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Polski (Polish) Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima para receber serviços gratuitos de assistência no idioma.

Italiano (Italian) Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

日本語 (Japanese): 無料の言語支援サービスを受けるには、上記の番号までお電話ください。

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

فارسی (Farsi): برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

हिंदी (Hindi): भाषा सहायता सेवाएं मुफ्त में प्राप्त करने के लिए ऊपर के नंबर पर कॉल करें।

հայերեն (Armenian): Զանգահարեք վերը նշված հեռախոսահամարով՝ անվճար լեզվական օգնության ծառայություններ ստանալու համար:

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.

Hmoob (Hmong) Hu rau tus xov tooj saum toj sauv kom tau txais kev pab txhais lus dawb.

This notice is available at **www.humana.com/legal/multi-language-support**.

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Insured by Humana Benefit Plan of Illinois, Inc.