



OUTLINE OF MEDICARE SUPPLEMENT COVERAGE
Humana Medicare Supplement Plans

for Kansas residents Medicare supplement benefit plans: A, F, G, High
Deductible G and N

Insured by Humana Benefit Plan of Illinois, Inc.

KS81077N3M20

Humana[®]

Humana Benefit Plan of Illinois, Inc. offers Plans A, F, G, High Deductible G and N 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. 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 2025 ² | | | | | \$7,220² | \$3,610² | | | | |

¹ Plans F and G also have a high deductible option which require first paying a plan deductible of \$2,870 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.

Humana Medicare Supplement Statewide Monthly Premiums

Effective Date: 03-01-2025

| Attained Age & Gender | Premium Type | Plan A | Plan F | Plan G | High Deductible Plan G | Plan N |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| <65-Male | Preferred | \$203.97 | \$232.93 | \$204.18 | \$55.41 | \$150.04 |
| | Standard | \$234.28 | \$267.58 | \$234.51 | \$63.43 | \$172.25 |
| <65-Female | Preferred | \$179.60 | \$205.08 | \$179.78 | \$48.97 | \$132.18 |
| | Standard | \$206.24 | \$235.53 | \$206.44 | \$56.02 | \$151.71 |
| 65-Male | Preferred | \$203.97 | \$232.93 | \$204.18 | \$55.41 | \$150.04 |
| | Standard | \$234.28 | \$267.58 | \$234.51 | \$63.43 | \$172.25 |
| 65-Female | Preferred | \$179.60 | \$205.08 | \$179.78 | \$48.97 | \$132.18 |
| | Standard | \$206.24 | \$235.53 | \$206.44 | \$56.02 | \$151.71 |
| 66-Male | Preferred | \$203.97 | \$232.93 | \$204.18 | \$55.41 | \$150.04 |
| | Standard | \$234.28 | \$267.58 | \$234.51 | \$63.43 | \$172.25 |
| 66-Female | Preferred | \$179.60 | \$205.08 | \$179.78 | \$48.97 | \$132.18 |
| | Standard | \$206.24 | \$235.53 | \$206.44 | \$56.02 | \$151.71 |
| 67-Male | Preferred | \$203.97 | \$232.93 | \$204.18 | \$55.41 | \$150.04 |
| | Standard | \$234.28 | \$267.58 | \$234.51 | \$63.43 | \$172.25 |
| 67-Female | Preferred | \$179.60 | \$205.08 | \$179.78 | \$48.97 | \$132.18 |
| | Standard | \$206.24 | \$235.53 | \$206.44 | \$56.02 | \$151.71 |
| 68-Male | Preferred | \$208.01 | \$237.56 | \$208.22 | \$56.48 | \$153.00 |
| | Standard | \$238.92 | \$272.89 | \$239.15 | \$64.66 | \$175.65 |
| 68-Female | Preferred | \$183.15 | \$209.13 | \$183.34 | \$49.91 | \$134.79 |
| | Standard | \$210.33 | \$240.20 | \$210.53 | \$57.09 | \$154.70 |
| 69-Male | Preferred | \$212.13 | \$242.27 | \$212.34 | \$57.58 | \$156.02 |
| | Standard | \$243.66 | \$278.30 | \$243.89 | \$65.91 | \$179.13 |
| 69-Female | Preferred | \$186.78 | \$213.28 | \$186.96 | \$50.87 | \$137.44 |
| | Standard | \$214.49 | \$244.97 | \$214.70 | \$58.19 | \$157.76 |
| 70-Male | Preferred | \$218.44 | \$249.48 | \$218.66 | \$59.24 | \$160.64 |
| | Standard | \$250.90 | \$286.60 | \$251.15 | \$67.83 | \$184.44 |
| 70-Female | Preferred | \$192.33 | \$219.61 | \$192.51 | \$52.33 | \$141.50 |
| | Standard | \$220.87 | \$252.26 | \$221.08 | \$59.88 | \$162.43 |

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 Medicare Supplement Statewide Monthly Premiums

Effective Date: 03-01-2025

| Attained Age & Gender | Premium Type | Plan A | Plan F | Plan G | High Deductible Plan G | Plan N |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 71-Male | Preferred | \$224.94 | \$256.90 | \$225.15 | \$60.96 | \$165.41 |
| | Standard | \$258.38 | \$295.13 | \$258.63 | \$69.80 | \$189.92 |
| 71-Female | Preferred | \$198.03 | \$226.14 | \$198.23 | \$53.84 | \$145.69 |
| | Standard | \$227.43 | \$259.77 | \$227.66 | \$61.61 | \$167.24 |
| 72-Male | Preferred | \$232.07 | \$265.05 | \$232.30 | \$62.84 | \$170.63 |
| | Standard | \$266.58 | \$304.51 | \$266.84 | \$71.97 | \$195.92 |
| 72-Female | Preferred | \$204.30 | \$233.31 | \$204.51 | \$55.50 | \$150.29 |
| | Standard | \$234.64 | \$268.02 | \$234.88 | \$63.52 | \$172.53 |
| 73-Male | Preferred | \$241.26 | \$275.58 | \$241.50 | \$65.27 | \$177.38 |
| | Standard | \$277.17 | \$316.61 | \$277.44 | \$74.77 | \$203.69 |
| 73-Female | Preferred | \$212.40 | \$242.56 | \$212.61 | \$57.64 | \$156.21 |
| | Standard | \$243.95 | \$278.65 | \$244.20 | \$65.98 | \$179.35 |
| 74-Male | Preferred | \$250.83 | \$286.52 | \$251.08 | \$67.80 | \$184.39 |
| | Standard | \$288.17 | \$329.20 | \$288.45 | \$77.67 | \$211.75 |
| 74-Female | Preferred | \$220.81 | \$252.19 | \$221.03 | \$59.87 | \$162.39 |
| | Standard | \$253.63 | \$289.72 | \$253.89 | \$68.55 | \$186.44 |
| 75-Male | Preferred | \$260.79 | \$297.90 | \$261.05 | \$70.43 | \$191.69 |
| | Standard | \$299.61 | \$342.29 | \$299.91 | \$80.71 | \$220.15 |
| 75-Female | Preferred | \$229.56 | \$262.19 | \$229.79 | \$62.18 | \$168.79 |
| | Standard | \$263.70 | \$301.23 | \$263.96 | \$71.21 | \$193.82 |
| 76-Male | Preferred | \$271.14 | \$309.74 | \$271.41 | \$73.18 | \$199.28 |
| | Standard | \$311.52 | \$355.90 | \$311.83 | \$83.85 | \$228.87 |
| 76-Female | Preferred | \$238.66 | \$272.61 | \$238.90 | \$64.58 | \$175.47 |
| | Standard | \$274.16 | \$313.19 | \$274.44 | \$73.97 | \$201.49 |
| 77-Male | Preferred | \$281.91 | \$322.05 | \$282.19 | \$76.02 | \$207.16 |
| | Standard | \$323.90 | \$370.06 | \$324.22 | \$87.13 | \$237.94 |
| 77-Female | Preferred | \$248.13 | \$283.43 | \$248.38 | \$67.09 | \$182.42 |
| | Standard | \$285.05 | \$325.65 | \$285.33 | \$76.86 | \$209.47 |

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 Medicare Supplement Statewide Monthly Premiums

Effective Date: 03-01-2025

| Attained Age & Gender | Premium Type | Plan A | Plan F | Plan G | High Deductible Plan G | Plan N |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 78-Male | Preferred | \$293.11 | \$334.85 | \$293.40 | \$78.99 | \$215.37 |
| | Standard | \$336.78 | \$384.78 | \$337.11 | \$90.53 | \$247.38 |
| 78-Female | Preferred | \$257.98 | \$294.69 | \$258.24 | \$69.69 | \$189.63 |
| | Standard | \$296.36 | \$338.59 | \$296.67 | \$79.85 | \$217.78 |
| 79-Male | Preferred | \$304.75 | \$348.16 | \$305.06 | \$82.06 | \$223.90 |
| | Standard | \$350.17 | \$400.09 | \$350.51 | \$94.07 | \$257.20 |
| 79-Female | Preferred | \$268.22 | \$306.39 | \$268.48 | \$72.41 | \$197.13 |
| | Standard | \$308.15 | \$352.06 | \$308.45 | \$82.96 | \$226.40 |
| 80-Male | Preferred | \$316.86 | \$362.02 | \$317.17 | \$85.26 | \$232.78 |
| | Standard | \$364.09 | \$416.01 | \$364.45 | \$97.76 | \$267.41 |
| 80-Female | Preferred | \$278.86 | \$318.57 | \$279.15 | \$75.21 | \$204.94 |
| | Standard | \$320.39 | \$366.05 | \$320.71 | \$86.21 | \$235.38 |
| 81-Male | Preferred | \$329.45 | \$376.41 | \$329.78 | \$88.59 | \$242.02 |
| | Standard | \$378.57 | \$432.58 | \$378.95 | \$101.59 | \$278.02 |
| 81-Female | Preferred | \$289.94 | \$331.23 | \$290.23 | \$78.15 | \$213.06 |
| | Standard | \$333.12 | \$380.62 | \$333.46 | \$89.57 | \$244.72 |
| 82-Male | Preferred | \$342.56 | \$391.39 | \$342.90 | \$92.06 | \$251.62 |
| | Standard | \$393.65 | \$449.80 | \$394.02 | \$105.57 | \$289.06 |
| 82-Female | Preferred | \$301.46 | \$344.40 | \$301.75 | \$81.19 | \$221.50 |
| | Standard | \$346.37 | \$395.77 | \$346.73 | \$93.08 | \$254.42 |
| 83-Male | Preferred | \$356.17 | \$406.97 | \$356.52 | \$95.66 | \$261.60 |
| | Standard | \$409.30 | \$467.71 | \$409.71 | \$109.72 | \$300.54 |
| 83-Female | Preferred | \$313.43 | \$358.10 | \$313.75 | \$84.36 | \$230.28 |
| | Standard | \$360.15 | \$411.51 | \$360.51 | \$96.71 | \$264.52 |
| 84-Male | Preferred | \$370.33 | \$423.17 | \$370.71 | \$99.41 | \$271.99 |
| | Standard | \$425.59 | \$486.34 | \$426.02 | \$114.02 | \$312.48 |
| 84-Female | Preferred | \$325.90 | \$372.34 | \$326.22 | \$87.66 | \$239.40 |
| | Standard | \$374.47 | \$427.90 | \$374.85 | \$100.51 | \$275.02 |

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 Medicare Supplement Statewide Monthly Premiums

Effective Date: 03-01-2025

| Attained Age & Gender | Premium Type | Plan A | Plan F | Plan G | High Deductible Plan G | Plan N |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 85-Male | Preferred | \$385.08 | \$440.01 | \$385.45 | \$103.30 | \$282.78 |
| | Standard | \$442.54 | \$505.71 | \$442.98 | \$118.50 | \$324.91 |
| 85-Female | Preferred | \$338.85 | \$387.15 | \$339.18 | \$91.08 | \$248.91 |
| | Standard | \$389.37 | \$444.93 | \$389.76 | \$104.44 | \$285.94 |
| 86-Male | Preferred | \$400.39 | \$457.53 | \$400.80 | \$107.35 | \$294.02 |
| | Standard | \$460.16 | \$525.86 | \$460.62 | \$123.16 | \$337.83 |
| 86-Female | Preferred | \$352.32 | \$402.56 | \$352.67 | \$94.64 | \$258.78 |
| | Standard | \$404.87 | \$462.65 | \$405.28 | \$108.54 | \$297.30 |
| 87-Male | Preferred | \$416.33 | \$475.75 | \$416.75 | \$111.57 | \$305.70 |
| | Standard | \$478.49 | \$546.82 | \$478.96 | \$128.01 | \$351.26 |
| 87-Female | Preferred | \$366.33 | \$418.59 | \$366.70 | \$98.35 | \$269.05 |
| | Standard | \$420.98 | \$481.07 | \$421.40 | \$112.80 | \$309.11 |
| 88-Male | Preferred | \$432.91 | \$494.70 | \$433.34 | \$115.95 | \$317.84 |
| | Standard | \$497.55 | \$568.60 | \$498.04 | \$133.05 | \$365.22 |
| 88-Female | Preferred | \$380.91 | \$435.25 | \$381.29 | \$102.20 | \$279.73 |
| | Standard | \$437.74 | \$500.24 | \$438.19 | \$117.23 | \$321.40 |
| 89-Male | Preferred | \$445.83 | \$509.48 | \$446.27 | \$119.37 | \$327.32 |
| | Standard | \$512.42 | \$585.60 | \$512.92 | \$136.98 | \$376.12 |
| 89-Female | Preferred | \$392.28 | \$448.25 | \$392.67 | \$105.21 | \$288.06 |
| | Standard | \$450.81 | \$515.19 | \$451.27 | \$120.69 | \$330.97 |
| 90-Male | Preferred | \$459.15 | \$524.71 | \$459.61 | \$122.89 | \$337.08 |
| | Standard | \$527.73 | \$603.11 | \$528.24 | \$141.03 | \$387.34 |
| 90-Female | Preferred | \$403.99 | \$461.63 | \$404.39 | \$108.31 | \$296.65 |
| | Standard | \$464.28 | \$530.58 | \$464.74 | \$124.25 | \$340.84 |
| 91-Male | Preferred | \$472.86 | \$540.39 | \$473.34 | \$126.52 | \$347.13 |
| | Standard | \$543.50 | \$621.15 | \$544.04 | \$145.20 | \$398.91 |
| 91-Female | Preferred | \$416.05 | \$475.42 | \$416.46 | \$111.50 | \$305.48 |
| | Standard | \$478.14 | \$546.44 | \$478.63 | \$127.92 | \$351.01 |

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 Medicare Supplement Statewide Monthly Premiums

Effective Date: 03-01-2025

| Attained Age & Gender | Premium Type | Plan A | Plan F | Plan G | High Deductible Plan G | Plan N |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 92-Male | Preferred | \$486.99 | \$556.53 | \$487.48 | \$130.26 | \$357.49 |
| | Standard | \$559.75 | \$639.72 | \$560.29 | \$149.50 | \$410.81 |
| 92-Female | Preferred | \$428.47 | \$489.63 | \$428.90 | \$114.78 | \$314.59 |
| | Standard | \$492.42 | \$562.77 | \$492.93 | \$131.70 | \$361.48 |
| 93-Male | Preferred | \$496.68 | \$567.63 | \$497.18 | \$132.83 | \$364.60 |
| | Standard | \$570.90 | \$652.47 | \$571.46 | \$152.45 | \$418.99 |
| 93-Female | Preferred | \$437.00 | \$499.37 | \$437.43 | \$117.04 | \$320.84 |
| | Standard | \$502.23 | \$573.98 | \$502.74 | \$134.29 | \$368.67 |
| 94-Male | Preferred | \$506.58 | \$578.95 | \$507.08 | \$135.44 | \$371.84 |
| | Standard | \$582.27 | \$665.48 | \$582.85 | \$155.46 | \$427.32 |
| 94-Female | Preferred | \$445.69 | \$509.32 | \$446.14 | \$119.34 | \$327.22 |
| | Standard | \$512.23 | \$585.42 | \$512.76 | \$136.94 | \$376.00 |
| 95-Male | Preferred | \$516.67 | \$590.48 | \$517.19 | \$138.10 | \$379.25 |
| | Standard | \$593.88 | \$678.76 | \$594.47 | \$158.52 | \$435.83 |
| 95-Female | Preferred | \$454.57 | \$519.47 | \$455.03 | \$121.68 | \$333.72 |
| | Standard | \$522.44 | \$597.09 | \$522.98 | \$139.64 | \$383.49 |
| 96-Male | Preferred | \$521.82 | \$596.37 | \$522.34 | \$139.47 | \$383.02 |
| | Standard | \$599.80 | \$685.53 | \$600.39 | \$160.09 | \$440.17 |
| 96-Female | Preferred | \$459.09 | \$524.64 | \$459.55 | \$122.88 | \$337.04 |
| | Standard | \$527.65 | \$603.04 | \$528.19 | \$141.01 | \$387.30 |
| 97-Male | Preferred | \$527.01 | \$602.30 | \$527.55 | \$140.84 | \$386.83 |
| | Standard | \$605.78 | \$692.35 | \$606.37 | \$161.67 | \$444.56 |
| 97-Female | Preferred | \$463.67 | \$529.87 | \$464.13 | \$124.09 | \$340.40 |
| | Standard | \$532.90 | \$609.05 | \$533.45 | \$142.41 | \$391.15 |
| 98-Male | Preferred | \$532.27 | \$608.31 | \$532.80 | \$142.23 | \$390.68 |
| | Standard | \$611.82 | \$699.26 | \$612.42 | \$163.27 | \$448.98 |
| 98-Female | Preferred | \$468.29 | \$535.15 | \$468.76 | \$125.31 | \$343.77 |
| | Standard | \$538.21 | \$615.12 | \$538.76 | \$143.81 | \$395.04 |

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 Medicare Supplement Statewide Monthly Premiums

Effective Date: 03-01-2025

| Attained Age & Gender | Premium Type | Plan A | Plan F | Plan G | High Deductible Plan G | Plan N |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 99+-Male | Preferred | \$537.57 | \$614.37 | \$538.11 | \$143.64 | \$394.57 |
| | Standard | \$617.91 | \$706.23 | \$618.53 | \$164.88 | \$453.45 |
| 99+-Female | Preferred | \$472.95 | \$540.48 | \$473.42 | \$126.54 | \$347.20 |
| | Standard | \$543.58 | \$621.25 | \$544.13 | \$145.23 | \$398.97 |

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 12% 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 4-9): _____

ACH Discount (applied to base premium): _____

Household Discount (applied to base premium): _____

Premium Quote (base premium minus discounts): _____

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

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

Premium Information

We, Humana Benefit Plan of Illinois, Inc., 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.

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 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.

Renewability of policy

This policy is Guaranteed Renewable.

Cancellation

You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon receipt of such notice or on such later date as may be specified in such notice. In the event of cancellation or Your death, We will promptly return the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Notice

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

Neither Humana Benefit Plan of Illinois, Inc. 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 \$1,676 | \$0 | \$1,676 (Part A deductible) |
| 61st through 90th day | All but \$419 a day | \$419 a day | \$0 |
| 91st day and after: | | | |
| while using 60 lifetime reserve days | All but \$838 a day | \$838 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 \$209.50 a day | \$0 | Up to \$209.50 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 \$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 | \$257 (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 \$257 of Medicare-approved amounts* | \$0 | \$0 | \$257 (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 \$257 of Medicare-approved amounts* | \$0 | \$0 | \$257 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |

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 \$1,676 | \$1,676 (Part A deductible) | \$0 |
| 61st through 90th day | All but \$419 a day | \$419 a day | \$0 |
| 91st day and after: | | | |
| while using 60 lifetime reserve days | All but \$838 a day | \$838 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 \$209.50 a day | Up to \$209.50 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 \$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 | \$257 (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 \$257 of Medicare-approved amounts* | \$0 | \$257 (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 \$257 of Medicare-approved amounts* | \$0 | \$257 (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 G

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 | \$1,676 (Part A deductible) | \$0 |
| 61st through 90th day | All but \$419 a day | \$419 a day | \$0 |
| 91st day and after: | | | |
| while using 60 lifetime reserve days | All but \$838 a day | \$838 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 \$209.50 a day | Up to \$209.50 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 G

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 | \$257 (Part B deductible) |
| 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 \$257 of Medicare-approved amounts* | \$0 | \$0 | \$257 (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 \$257 of Medicare-approved amounts* | \$0 | \$0 | \$257 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |

Plan G

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 G

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 G after you have paid a calendar year \$2,870 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are \$2,870. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

| Services | Medicare Pays | After You Pay \$2,870 Deductible,** Plan Pays | In Addition To \$2,870 Deductible,** You Pay |
|---|------------------------|---|--|
| Hospitalization* | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but \$1,676 | \$1,676 (Part A deductible) | \$0 |
| 61st through 90th day | All but \$419 a day | \$419 a day | \$0 |
| 91st day and after: | | | |
| while using 60 lifetime reserve days once lifetime reserve days are used: | All but \$838 a day | \$838 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 \$209.50 a day | Up to \$209.50 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 G

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

** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,870 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are \$2,870. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

| Services | Medicare Pays | After You Pay \$2,870 Deductible,** Plan Pays | In Addition To \$2,870 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 G

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.

** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,870 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are \$2,870. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

| Services | Medicare Pays | After You Pay \$2,870 Deductible,** Plan Pays | In Addition To \$2,870 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 \$257 of Medicare-approved amounts* | \$0 | \$0 | \$257 (Unless Part B deductible has been met) |
| 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 \$257 of Medicare-approved amounts* | \$0 | \$0 | \$257 (Unless Part B deductible has been met) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |
| Clinical Laboratory Services | | | |
| TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

High Deductible Plan G

Medicare (Parts A and 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.

** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,870 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are \$2,870. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

| Services | Medicare Pays | After You Pay \$2,870 Deductible,** Plan Pays | In Addition To \$2,870 Deductible,** You Pay |
|--|---------------|---|--|
| Home Health Care | | | |
| MEDICARE-APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | \$0 | \$0 |
| Durable medical equipment | | | |
| First \$257 of Medicare-approved amounts* | \$0 | \$0 | \$257 (Unless Part B deductible has been met) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |

Other Benefits - Not Covered By Medicare

| Services | Medicare Pays | After You Pay \$2,870 Deductible,** Plan Pays | In Addition To \$2,870 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 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 \$1,676 | \$1,676 (Part A deductible) | \$0 |
| 61st through 90th day | All but \$419 a day | \$419 a day | \$0 |
| 91st day and after: | | | |
| while using 60 lifetime reserve days | All but \$838 a day | \$838 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 \$209.50 a day | Up to \$209.50 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 \$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 | \$257 (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 (subject to any applicable State or Federal restrictions on such charges) |
| Blood | | | |
| First three pints | \$0 | All costs | \$0 |
| Next \$257 of Medicare-approved amounts* | \$0 | \$0 | \$257 (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 \$257 of Medicare-approved amounts* | \$0 | \$0 | \$257 (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 |

AGENT REPRESENTING THIS PLAN

NAME: _____

PHONE NUMBER: _____

STREET ADDRESS: _____

**You have purchased Plan _____ and your
premium will be \$_____ on a monthly basis.**

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**.

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 libheng 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।

հայերէն (Armenian): Չանգահարեք վերը նշված հեռախոսահամարով՝ անվճար լեզվական օգնություն ծառայություններ ստանալու համար:

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કોલ 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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