Outline of Medicare Supplement Coverage

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

Humana Reader's Digest Healthy Living Medicare Supplement Plan

HUMANA
Reader's Digest
HEALTHY LIVING PLAN

LA81077RD

Humana Reader's Digest Healthy Living Medicare Supplement Insurance Plans
Humana Health Benefit Plan of Louisiana, Inc. offers Plans A, F, High Deductible F, K and N
Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Basic Benefits:

- **Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses:** Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood:** First three pints of blood each year.
- **Hospice:** Part A coinsurance

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
Innovative Benefits				Innovative Benefits			Innovative Benefits			Innovative Benefits
							Out-of-pocket limit $4,660; paid at 100% after limit reached	Out-of-pocket limit $2,330; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,070 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUM RATING AREA CLASSIFICATION

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

AREA 1: *(Premium rates begin on page 3)*
Area 1 includes all parishes in the state except Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. Tammany, and Washington

AREA 2: *(Premium rates begin on page 6)*
Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. Tammany, and Washington

HUMANA READER'S DIGEST HEALTHY LIVING MEDICARE SUPPLEMENT AREA 1 MONTHLY PREMIUMS

Effective Date: 03-01-2012

Attained Age & Gender		Plan A	Plan F	High Deductible Plan F	Plan K	Plan N
<65*-Male	Preferred	$350.11	$439.40	$185.53	$265.29	$351.30
	Standard	$517.28	$650.74	$271.29	$390.51	$519.06
<65*-Female	Preferred	$349.24	$438.31	$185.08	$264.64	$350.43
	Standard	$515.99	$649.11	$270.63	$389.54	$517.76
65-Male	Preferred	$147.32	$183.03	$81.49	$113.39	$147.79
	Standard	$214.18	$267.57	$115.79	$163.48	$214.90
65-Female	Preferred	$146.97	$182.60	$81.31	$113.13	$147.45
	Standard	$213.67	$266.91	$115.53	$163.09	$214.38
66-Male	Preferred	$152.72	$189.87	$84.26	$117.44	$153.22
	Standard	$222.26	$277.78	$119.94	$169.53	$223.00
66-Female	Preferred	$151.02	$187.71	$83.39	$116.16	$151.51
	Standard	$219.71	$274.56	$118.63	$167.62	$220.45
67-Male	Preferred	$158.34	$196.97	$87.14	$121.65	$158.86
	Standard	$230.66	$288.40	$124.25	$175.82	$231.43
67-Female	Preferred	$156.58	$194.74	$86.24	$120.33	$157.09
	Standard	$228.02	$285.06	$122.89	$173.84	$228.78
68-Male	Preferred	$164.19	$204.36	$90.14	$126.03	$164.72
	Standard	$239.40	$299.45	$128.73	$182.37	$240.20
68-Female	Preferred	$162.35	$202.04	$89.20	$124.65	$162.88
	Standard	$236.65	$295.97	$127.32	$180.30	$237.44
69-Male	Preferred	$170.27	$212.05	$93.26	$130.58	$170.82
	Standard	$248.49	$310.93	$133.39	$189.17	$249.32
69-Female	Preferred	$166.85	$207.73	$91.51	$128.02	$167.40
	Standard	$243.38	$304.48	$130.77	$185.35	$244.20
70-Male	Preferred	$176.59	$220.05	$96.51	$135.32	$177.17
	Standard	$257.94	$322.89	$138.24	$196.25	$258.81
70-Female	Preferred	$171.51	$213.62	$93.90	$131.51	$172.07
	Standard	$250.35	$313.29	$134.35	$190.56	$251.19

*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.

(*Continued on next page*)

HUMANA READER'S DIGEST HEALTHY LIVING MEDICARE SUPPLEMENT AREA 1 MONTHLY PREMIUMS

Effective Date: 03-01-2012

Attained Age & Gender		Plan A	Plan F	High Deductible Plan F	Plan K	Plan N
71-Male	Preferred	$183.17	$228.36	$99.88	$140.25	$183.77
	Standard	$267.77	$335.31	$143.28	$203.62	$268.67
71-Female	Preferred	$176.29	$219.66	$96.35	$135.09	$176.87
	Standard	$257.48	$322.31	$138.01	$195.91	$258.35
72-Male	Preferred	$190.01	$237.01	$103.39	$145.37	$190.64
	Standard	$278.00	$348.24	$148.53	$211.28	$278.94
72-Female	Preferred	$181.21	$225.89	$98.88	$138.78	$181.81
	Standard	$264.85	$331.62	$141.78	$201.43	$265.74
73-Male	Preferred	$197.13	$246.00	$107.04	$150.70	$197.78
	Standard	$288.63	$361.68	$153.99	$219.24	$289.61
73-Female	Preferred	$186.28	$232.29	$101.47	$142.57	$186.89
	Standard	$272.41	$341.18	$145.67	$207.09	$273.33
74-Male	Preferred	$204.53	$255.36	$110.84	$156.24	$205.21
	Standard	$299.69	$375.67	$159.66	$227.53	$300.71
74-Female	Preferred	$191.51	$238.90	$104.16	$146.49	$192.14
	Standard	$280.24	$351.07	$149.68	$212.95	$281.18
75-Male	Preferred	$212.24	$265.10	$114.79	$162.02	$212.94
	Standard	$311.21	$390.23	$165.57	$236.16	$312.27
75-Female	Preferred	$196.90	$245.71	$106.92	$150.53	$197.55
	Standard	$288.29	$361.25	$153.81	$218.98	$289.26
76-Male	Preferred	$220.23	$275.21	$118.89	$168.01	$220.96
	Standard	$323.16	$405.34	$171.70	$245.11	$324.26
76-Female	Preferred	$202.44	$252.72	$109.77	$154.68	$203.11
	Standard	$296.57	$371.72	$158.06	$225.19	$297.57
77-Male	Preferred	$228.55	$285.73	$123.16	$174.24	$229.31
	Standard	$335.60	$421.06	$178.08	$254.42	$336.74
77-Female	Preferred	$208.13	$259.92	$112.69	$158.94	$208.82
	Standard	$305.08	$382.48	$162.43	$231.56	$306.11
78-Male	Preferred	$235.05	$293.95	$126.50	$179.11	$235.84
	Standard	$345.31	$433.34	$183.07	$261.70	$346.49
78-Female	Preferred	$214.02	$267.36	$115.71	$163.35	$214.73
	Standard	$313.88	$393.60	$166.94	$238.15	$314.94

(*Continued on next page*)

HUMANA READER'S DIGEST HEALTHY LIVING MEDICARE SUPPLEMENT AREA 1 MONTHLY PREMIUMS

Effective Date: 03-01-2012

Attained Age & Gender		Plan A	Plan F	High Deductible Plan F	Plan K	Plan N
79-Male	Preferred	$241.74	$302.41	$129.93	$184.12	$242.55
	Standard	$355.31	$445.98	$188.20	$269.19	$356.52
79-Female	Preferred	$218.06	$272.47	$117.78	$166.38	$218.79
	Standard	$319.92	$401.24	$170.04	$242.68	$321.01
80-Male	Preferred	$248.63	$311.11	$133.46	$189.27	$249.46
	Standard	$365.60	$458.99	$193.48	$276.89	$366.85
80-Female	Preferred	$222.17	$277.66	$119.89	$169.46	$222.91
	Standard	$326.06	$409.00	$173.19	$247.27	$327.16
81-Male	Preferred	$255.72	$320.08	$137.10	$194.59	$256.58
	Standard	$376.20	$472.39	$198.92	$284.84	$377.49
81-Female	Preferred	$226.39	$282.99	$122.05	$172.62	$227.14
	Standard	$332.36	$416.97	$176.42	$252.00	$333.49
82-Male	Preferred	$263.02	$329.31	$140.85	$200.06	$263.91
	Standard	$387.12	$486.20	$204.52	$293.01	$388.44
82-Female	Preferred	$230.66	$288.40	$124.25	$175.82	$231.43
	Standard	$338.75	$425.05	$179.70	$256.78	$339.90
83-Male	Preferred	$270.56	$338.84	$144.72	$205.70	$271.47
	Standard	$398.38	$500.43	$210.29	$301.45	$399.74
83-Female	Preferred	$235.03	$293.92	$126.49	$179.09	$235.82
	Standard	$345.28	$433.31	$183.05	$261.68	$346.46
84-Male	Preferred	$278.31	$348.63	$148.69	$211.51	$279.24
	Standard	$409.96	$515.07	$216.23	$310.12	$411.36
84-Female	Preferred	$239.50	$299.57	$128.78	$182.44	$240.30
	Standard	$351.96	$441.75	$186.48	$266.68	$353.16
85+-Male	Preferred	$286.30	$358.74	$152.79	$217.49	$287.27
	Standard	$421.91	$530.18	$222.36	$319.07	$423.35
85+-Female	Preferred	$244.04	$305.32	$131.11	$185.84	$244.86
	Standard	$358.75	$450.33	$189.96	$271.76	$359.97

HUMANA READER'S DIGEST HEALTHY LIVING MEDICARE SUPPLEMENT AREA 2 MONTHLY PREMIUMS

Effective Date: 03-01-2012

Attained Age & Gender		Plan A	Plan F	High Deductible Plan F	Plan K	Plan N
<65*-Male	Preferred	$402.49	$505.63	$212.40	$304.53	$403.87
	Standard	$595.58	$749.72	$311.46	$449.15	$597.63
<65*-Female	Preferred	$401.50	$504.37	$211.89	$303.78	$402.87
	Standard	$594.09	$747.84	$310.70	$448.04	$596.14
65-Male	Preferred	$168.27	$209.52	$92.24	$129.09	$168.82
	Standard	$245.50	$307.16	$131.86	$186.94	$246.32
65-Female	Preferred	$167.87	$209.02	$92.03	$128.79	$168.42
	Standard	$244.91	$306.41	$131.55	$186.49	$245.73
66-Male	Preferred	$174.52	$217.42	$95.44	$133.76	$175.09
	Standard	$254.84	$318.96	$136.65	$193.93	$255.69
66-Female	Preferred	$172.55	$214.93	$94.43	$132.29	$173.11
	Standard	$251.89	$315.24	$135.14	$191.72	$252.73
67-Male	Preferred	$181.00	$225.62	$98.77	$138.62	$181.60
	Standard	$264.53	$331.22	$141.62	$201.19	$265.42
67-Female	Preferred	$178.97	$223.05	$97.72	$137.10	$179.55
	Standard	$261.49	$327.37	$140.06	$198.91	$262.37
68-Male	Preferred	$187.76	$234.16	$102.23	$143.68	$188.38
	Standard	$274.63	$343.98	$146.80	$208.75	$275.55
68-Female	Preferred	$185.63	$231.47	$101.14	$142.09	$186.24
	Standard	$271.45	$339.96	$145.17	$206.37	$272.36
69-Male	Preferred	$194.78	$243.03	$105.84	$148.94	$195.42
	Standard	$285.12	$357.24	$152.19	$216.61	$286.08
69-Female	Preferred	$190.84	$238.05	$103.81	$145.99	$191.47
	Standard	$279.23	$349.80	$149.16	$212.20	$280.17
70-Male	Preferred	$202.09	$252.27	$109.59	$154.41	$202.75
	Standard	$296.04	$371.05	$157.79	$224.79	$297.04
70-Female	Preferred	$196.22	$244.85	$106.57	$150.02	$196.87
	Standard	$287.27	$359.96	$153.29	$218.22	$288.24

*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.

(*Continued on next page*)

HUMANA READER'S DIGEST HEALTHY LIVING MEDICARE SUPPLEMENT AREA 2 MONTHLY PREMIUMS

Effective Date: 03-01-2012

Attained Age & Gender		Plan A	Plan F	High Deductible Plan F	Plan K	Plan N
71-Male	Preferred	$209.68	$261.87	$113.48	$160.10	$210.38
	Standard	$307.39	$385.40	$163.61	$233.30	$308.43
71-Female	Preferred	$201.73	$251.82	$109.40	$154.15	$202.40
	Standard	$295.51	$370.38	$157.52	$224.40	$296.51
72-Male	Preferred	$217.59	$271.87	$117.54	$166.03	$218.31
	Standard	$319.21	$400.34	$169.68	$242.15	$320.29
72-Female	Preferred	$207.42	$259.02	$112.32	$158.41	$208.11
	Standard	$304.02	$381.14	$161.88	$230.77	$305.05
73-Male	Preferred	$225.80	$282.26	$121.75	$172.18	$226.56
	Standard	$331.49	$415.87	$175.98	$251.34	$332.61
73-Female	Preferred	$213.27	$266.41	$115.32	$162.79	$213.98
	Standard	$312.76	$392.18	$166.36	$237.31	$313.82
74-Male	Preferred	$234.35	$293.06	$126.14	$178.58	$235.13
	Standard	$344.27	$432.02	$182.53	$260.91	$345.44
74-Female	Preferred	$219.31	$274.05	$118.42	$167.32	$220.04
	Standard	$321.79	$403.61	$171.00	$244.08	$322.88
75-Male	Preferred	$243.25	$304.32	$130.71	$185.25	$244.07
	Standard	$357.57	$448.84	$189.36	$270.88	$358.79
75-Female	Preferred	$225.54	$281.92	$121.62	$171.98	$226.29
	Standard	$331.09	$415.36	$175.77	$251.05	$332.22
76-Male	Preferred	$252.49	$315.99	$135.44	$192.17	$253.33
	Standard	$371.37	$466.29	$196.44	$281.22	$372.64
76-Female	Preferred	$231.94	$290.01	$124.90	$176.77	$232.71
	Standard	$340.66	$427.46	$180.68	$258.21	$341.81
77-Male	Preferred	$262.10	$328.14	$140.37	$199.37	$262.98
	Standard	$385.74	$484.44	$203.81	$291.98	$387.05
77-Female	Preferred	$238.51	$298.32	$128.27	$181.70	$239.31
	Standard	$350.49	$439.88	$185.72	$265.57	$351.68
78-Male	Preferred	$269.60	$337.63	$144.23	$204.99	$270.51
	Standard	$396.96	$498.63	$209.56	$300.38	$398.31
78-Female	Preferred	$245.31	$306.92	$131.76	$186.79	$246.13
	Standard	$360.65	$452.73	$190.93	$273.18	$361.88

(*Continued on next page*)

HUMANA READER'S DIGEST HEALTHY LIVING MEDICARE SUPPLEMENT AREA 2 MONTHLY PREMIUMS

Effective Date: 03-01-2012

Attained Age & Gender		Plan A	Plan F	High Deductible Plan F	Plan K	Plan N
79-Male	Preferred	$277.33	$347.40	$148.19	$210.78	$278.27
	Standard	$408.51	$513.23	$215.49	$309.03	$409.90
79-Female	Preferred	$249.98	$312.83	$134.16	$190.29	$250.82
	Standard	$367.63	$461.56	$194.52	$278.42	$368.88
80-Male	Preferred	$285.28	$357.45	$152.27	$216.73	$286.24
	Standard	$420.39	$528.25	$221.58	$317.93	$421.83
80-Female	Preferred	$254.72	$318.82	$136.59	$193.84	$255.58
	Standard	$374.72	$470.51	$198.15	$283.72	$375.99
81-Male	Preferred	$293.48	$367.81	$156.47	$222.87	$294.47
	Standard	$432.64	$543.73	$227.87	$327.11	$434.12
81-Female	Preferred	$259.60	$324.98	$139.09	$197.49	$260.47
	Standard	$382.00	$479.72	$201.89	$289.18	$383.30
82-Male	Preferred	$301.91	$378.47	$160.80	$229.19	$302.93
	Standard	$445.25	$559.68	$234.34	$336.55	$446.77
82-Female	Preferred	$264.53	$331.22	$141.62	$201.19	$265.42
	Standard	$389.38	$489.05	$205.67	$294.70	$390.71
83-Male	Preferred	$310.62	$389.48	$165.27	$235.71	$311.67
	Standard	$458.25	$576.12	$241.01	$346.29	$459.82
83-Female	Preferred	$269.58	$337.60	$144.21	$204.97	$270.49
	Standard	$396.92	$498.59	$209.55	$300.36	$398.28
84-Male	Preferred	$319.56	$400.79	$169.86	$242.41	$320.64
	Standard	$471.63	$593.02	$247.87	$356.31	$473.24
84-Female	Preferred	$274.74	$344.12	$146.86	$208.84	$275.67
	Standard	$404.64	$508.34	$213.50	$306.13	$406.02
85+-Male	Preferred	$328.80	$412.46	$174.59	$249.33	$329.91
	Standard	$485.43	$610.47	$254.95	$366.65	$487.09
85+-Female	Preferred	$279.99	$350.76	$149.55	$212.77	$280.93
	Standard	$412.48	$518.25	$217.53	$312.01	$413.89

Premium Information

We, Humana Health Benefit Plan of Louisiana, 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.

Your premiums will also be adjusted annually following your 66th birthday.

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

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 Health Benefit Plan of Louisiana, 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.

Notice

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

Neither Humana Health Benefit Plan of Louisiana, 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.

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

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

PLAN A

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

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

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $140 of Medicare-approved amounts*	$0	$0	$140 (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 $140 of Medicare-approved amounts*	$0	$0	$140 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Medicare Parts A & B

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

PLAN A

Innovative Benefits

Services	Medicare Pays	Plan Pays	You Pay
DENTAL			
In-Network			
Preventive Services: - Cleaning, up to 2 per calendar year - Oral Exams, up to 2 per calendar year - 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%
Out-of-Network			
Preventive Services: - Cleaning, up to 2 per calendar year - Oral Exams, up to 2 per calendar year - 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%
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 $1,156	$1,156 (Part A deductible)	$0
61st through 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
while using 60 lifetime reserve days	All but $578 a day	$578 a day	$0
once lifetime reserve days are used:			
- additional 365 days	$0	100% of Medicare eligible expenses	$0**
- beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

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

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

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

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $140 of Medicare-approved amounts*	$0	$140 (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

Innovative Benefits

Services	Medicare Pays	Plan Pays	You Pay
DENTAL			
In-Network			
Preventive Services: - Cleaning, up to 2 per calendar year - Oral Exams, up to 2 per calendar year - 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%
Out-of-Network			
Preventive Services: - Cleaning, up to 2 per calendar year - Oral Exams, up to 2 per calendar year - 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%

PLAN F

Innovative Benefits *(continued)*

Services	Medicare Pays	Plan Pays	You Pay
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 one has paid a calendar year $2,070 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay $2,070 Deductible,** Plan Pays	In Addition To $2,070 Deductible,** You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,156	$1,156 (Part A deductible)	$0
61st through 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
while using 60 lifetime reserve days	All but $578 a day	$578 a day	$0
once lifetime reserve days are used:			
- additional 365 days	$0	100% of Medicare eligible expenses	$0***
- beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs

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

HIGH DEDUCTIBLE PLAN F

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

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,070 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay $2,070 Deductible,** Plan Pays	In Addition To $2,070 Deductible,** You Pay
BLOOD			
First three pints	$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 $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,070 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay $2,070 Deductible,** Plan Pays	In Addition To $2,070 Deductible,** You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $140 of Medicare-approved amounts*	$0	$140 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	100%	$0
BLOOD First three pints	$0	All costs	$0
Next $140 of Medicare-approved amounts*	$0	$140 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

MEDICARE (PARTS A AND B)

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

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,070 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay $2,070 Deductible,** Plan Pays	In Addition To $2,070 Deductible,** You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $140 of Medicare-approved amounts*	$0	$140 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits - Not Covered By Medicare

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

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 - Oral Exams, up to 2 per calendar year - 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%
Out-of-Network			
Preventive Services: - Cleaning, up to 2 per calendar year - Oral Exams, up to 2 per calendar year - 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%
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 $4,660 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

Services	Medicare Pays	Plan Pays	You Pay*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,156	$578 (50% of Part A deductible)	$578 (50% of Part A deductible)◆
61st through 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
while using 60 lifetime reserve days	All but $578 a day	$578 a day	$0
once lifetime reserve days are used:			
- additional 365 days	$0	100% of Medicare eligible expenses	$0***
- beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $144.50 a day	Up to $70.75 a day	Up to $70.75 a day◆
101st day and after	$0	$0	All costs

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

PLAN K

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

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

PLAN K

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

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

Services	Medicare Pays	Plan Pays	You Pay*
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $140 of Medicare-approved amounts****	$0	$0	$140 (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 $4,660)*
BLOOD			
First three pints	$0	50%	50%◆
Next $140 of Medicare-approved amounts****	$0	$0	$140 (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 $4,660 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN K

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $140 of Medicare-approved amounts*****	$0	$0	$140 (Part B deductible)◆
Remainder of Medicare-approved amounts	80%	10%	10%◆

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

Innovative Benefits

Services	Medicare Pays	Plan Pays	You Pay
DENTAL			
In-Network			
Preventive Services: - Cleaning, up to 2 per calendar year - Oral Exams, up to 2 per calendar year - 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%
Out-of-Network			
Preventive Services: - Cleaning, up to 2 per calendar year - Oral Exams, up to 2 per calendar year - 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%

PLAN K

Innovative Benefits *(continued)*

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

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

PLAN N

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

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

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $140 of Medicare-approved amounts*	$0	$0	$140 (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 $140 of Medicare-approved amounts*	$0	$0	$140 (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 & B

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

Other Benefits - Not Covered By Medicare

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

Innovative Benefits

Services	Medicare Pays	Plan Pays	You Pay
DENTAL			
In-Network			
Preventive Services: - Cleaning, up to 2 per calendar year - Oral Exams, up to 2 per calendar year - 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%

PLAN N

Innovative Benefits *(continued)*

Services	Medicare Pays	Plan Pays	You Pay
Out-of-Network			
Preventive Services: - Cleaning, up to 2 per calendar year - Oral Exams, up to 2 per calendar year - 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%
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

Humana-Medicare.com