

# Benefit Chart of Medicare Supplement Plans Sold on or After January 1, 2020 Humana Insurance Company of Kentucky offers Humana Achieve Medicare Supplement Plans A, F, G, High Deductible G and N

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. 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 <sup>1</sup> | K                          | L                          | M   | N                           | C | F <sup>1</sup> |                                          |  |
| 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 <sup>3</sup> | ✓ | ✓              |                                          |  |
| Blood (first three pints)                                                                                            | ✓                                 | ✓ | ✓ | ✓              | 50%                        | 75%                        | ✓   | ✓                           | ✓ | ✓              |                                          |  |
| Part A Hospice Care Coinsurance or Copayment                                                                         | ✓                                 | ✓ | ✓ | ✓              | 50%                        | 75%                        | ✓   | ✓                           | ✓ | ✓              |                                          |  |
| Skilled Nursing Facility Coinsurance                                                                                 |                                   |   | ✓ | ✓              | 50%                        | 75%                        | ✓   | ✓                           | ✓ | ✓              |                                          |  |
| Medicare Part A Deductible                                                                                           |                                   | ✓ | ✓ | ✓              | 50%                        | 75%                        | 50% | ✓                           | ✓ | ✓              |                                          |  |
| Medicare Part B Deductible                                                                                           |                                   |   |   |                |                            |                            |     |                             | ✓ | ✓              |                                          |  |
| Medicare Part B Excess Charges                                                                                       |                                   |   |   | ✓              |                            |                            |     |                             |   | ✓              |                                          |  |
| Foreign Travel Emergency (up to plan limits)                                                                         |                                   |   | ✓ | ✓              |                            |                            | ✓   | ✓                           | ✓ | ✓              |                                          |  |
| Out of Pocket Limit in 2023 <sup>2</sup>                                                                             |                                   |   |   |                | <b>\$6,940<sup>2</sup></b> | <b>\$3,470<sup>2</sup></b> |     |                             |   |                |                                          |  |

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

<sup>2</sup> 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.

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

# Premium Rating Area Classification

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

## Area 1: (Premium rates begin on page 3)

Austin, Bailey, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Hardin, Harris, Jefferson, Liberty, Matagorda, Montgomery, Orange, San Jacinto, Walker, Waller, Washington, Wharton

## Area 2: (Premium rates begin on page 8)

Andrews, Aransas, Bee, Borden, Brooks, Calhoun, Camp, Clay, Collin, Comal, Cooke, Crane, Dallas, Delta, Denton, DeWitt, Duval, Ector, Ellis, Fannin, Franklin, Glasscock, Grayson, Guadalupe, Hopkins, Howard, Hunt, Jackson, Jeff Davis, Jim Hogg, Jim Wells, Karnes, Kaufman, Kenedy, Kleberg, Lamar, Lavaca, Loving, Martin, Midland, Montague, Navarro, Nueces, Pecos, Rains, Red River, Reeves, Refugio, Rockwall, San Patricio, Titus, Upton, Van Zandt, Victoria, Ward, Wilson, Winkler, Wood

## Area 3: (Premium rates begin on page 14)

Anderson, Angelina, Archer, Armstrong, Atascosa, Bandera, Bastrop, Baylor, Bell, Bexar, Blanco, Bosque, Bowie, Brazos, Brewster, Briscoe, Brown, Burleson, Burnet, Caldwell, Callahan, Cameron, Carson, Cass, Castro, Cherokee, Childress, Cochran, Coke, Coleman, Collingsworth, Comanche, Concho, Coryell, Cottle, Crockett, Crosby, Culberson, Dallam, Dawson, Deaf Smith, Dickens, Dimmit, Donley, Eastland, Edwards, El Paso, Erath, Falls, Fayette, Fisher, Floyd, Foard, Freestone, Frio, Gaines, Garza, Gillespie, Goliad, Gonzales, Gray, Gregg, Grimes, Hale, Hall, Hamilton, Hansford, Hardeman, Harrison, Hartley, Haskell, Hays, Hemphill, Henderson, Hidalgo, Hill, Hockley, Hood, Houston, Hudspeth, Hutchinson, Irion, Jack, Jasper, Johnson, Jones, Kendall, Kent, Kerr, Kimble, King, Kinney, Knox, La Salle, Lamb, Lampasas, Lee, Leon, Limestone, Lipscomb, Live Oak, Llano, Lubbock, Lynn, Madison, Marion, Mason, Maverick, McCulloch, McLennan, McMullen, Medina, Menard, Mills, Mitchell, Moore, Morris, Motley, Nacogdoches, Newton, Nolan, Ochiltree, Oldham, Palo Pinto, Panola, Parker, Parmer, Polk, Potter, Presidio, Randall, Reagan, Real, Roberts, Robertson, Runnels, Rusk, Sabine, San Augustine, San Saba, Schleicher, Scurry, Shackelford, Shelby, Sherman, Smith, Somervell, Starr, Stephens, Sterling, Stonewall, Sutton, Swisher, Tarrant, Taylor, Terrell, Terry, Throckmorton, Tom Green, Travis, Trinity, Tyler, Upshur, Uvalde, Val Verde, Webb, Wheeler, Wichita, Wilbarger, Willacy, Williamson, Wise, Yoakum, Young, Zapata, Zavala

# Humana Achieve Medicare Supplement Area 1 Monthly Premiums

Effective Date: 07-01-2023

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

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| <65*-Male             | Preferred    | N/A      | N/A      | N/A      | N/A                    | N/A      |
|                       | Standard     | \$977.81 | N/A      | N/A      | N/A                    | N/A      |
| <65*-Female           | Preferred    | N/A      | N/A      | N/A      | N/A                    | N/A      |
|                       | Standard     | \$865.55 | N/A      | N/A      | N/A                    | N/A      |
| 65-Male               | Preferred    | \$143.42 | \$174.47 | \$144.13 | \$65.69                | \$110.28 |
|                       | Standard     | \$164.63 | \$200.35 | \$165.45 | \$75.24                | \$126.51 |
| 65-Female             | Preferred    | \$127.15 | \$154.63 | \$127.78 | \$58.36                | \$97.82  |
|                       | Standard     | \$145.93 | \$177.52 | \$146.65 | \$66.82                | \$112.20 |
| 66-Male               | Preferred    | \$143.42 | \$174.47 | \$144.13 | \$65.69                | \$110.28 |
|                       | Standard     | \$164.63 | \$200.35 | \$165.45 | \$75.24                | \$126.51 |
| 66-Female             | Preferred    | \$127.15 | \$154.63 | \$127.78 | \$58.36                | \$97.82  |
|                       | Standard     | \$145.93 | \$177.52 | \$146.65 | \$66.82                | \$112.20 |
| 67-Male               | Preferred    | \$143.42 | \$174.47 | \$144.13 | \$65.69                | \$110.28 |
|                       | Standard     | \$164.63 | \$200.35 | \$165.45 | \$75.24                | \$126.51 |
| 67-Female             | Preferred    | \$127.15 | \$154.63 | \$127.78 | \$58.36                | \$97.82  |
|                       | Standard     | \$145.93 | \$177.52 | \$146.65 | \$66.82                | \$112.20 |
| 68-Male               | Preferred    | \$145.54 | \$177.06 | \$146.27 | \$66.65                | \$114.60 |
|                       | Standard     | \$167.07 | \$203.32 | \$167.91 | \$76.34                | \$131.50 |
| 68-Female             | Preferred    | \$129.03 | \$156.92 | \$129.67 | \$59.20                | \$101.65 |
|                       | Standard     | \$148.09 | \$180.16 | \$148.82 | \$67.79                | \$116.60 |
| 69-Male               | Preferred    | \$148.41 | \$180.56 | \$149.15 | \$67.94                | \$119.11 |
|                       | Standard     | \$170.38 | \$207.34 | \$171.22 | \$77.82                | \$136.68 |
| 69-Female             | Preferred    | \$131.57 | \$160.02 | \$132.22 | \$60.35                | \$105.64 |
|                       | Standard     | \$151.00 | \$183.73 | \$151.76 | \$69.10                | \$121.18 |
| 70-Male               | Preferred    | \$152.08 | \$185.03 | \$152.83 | \$69.59                | \$123.80 |
|                       | Standard     | \$174.58 | \$212.49 | \$175.46 | \$79.72                | \$142.06 |
| 70-Female             | Preferred    | \$134.81 | \$163.97 | \$135.48 | \$61.81                | \$109.79 |
|                       | Standard     | \$154.73 | \$188.27 | \$155.50 | \$70.78                | \$125.95 |

**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.

(Continued on next page)

# Humana Achieve Medicare Supplement Area 1 Monthly Premiums

Effective Date: 07-01-2023

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 71-Male               | Preferred    | \$156.57 | \$190.52 | \$157.35 | \$71.61                | \$129.28 |
|                       | Standard     | \$179.76 | \$218.79 | \$180.65 | \$82.05                | \$148.37 |
| 71-Female             | Preferred    | \$138.80 | \$168.83 | \$139.48 | \$63.61                | \$114.64 |
|                       | Standard     | \$159.31 | \$193.85 | \$160.10 | \$72.84                | \$131.53 |
| 72-Male               | Preferred    | \$161.22 | \$196.18 | \$162.02 | \$73.70                | \$135.00 |
|                       | Standard     | \$185.09 | \$225.30 | \$186.02 | \$84.46                | \$154.96 |
| 72-Female             | Preferred    | \$142.90 | \$173.84 | \$143.60 | \$65.45                | \$119.70 |
|                       | Standard     | \$164.03 | \$199.61 | \$164.84 | \$74.96                | \$137.36 |
| 73-Male               | Preferred    | \$166.79 | \$202.97 | \$167.61 | \$76.21                | \$140.32 |
|                       | Standard     | \$191.50 | \$233.12 | \$192.46 | \$87.34                | \$161.07 |
| 73-Female             | Preferred    | \$147.83 | \$179.85 | \$148.56 | \$67.68                | \$124.41 |
|                       | Standard     | \$169.70 | \$206.53 | \$170.55 | \$77.52                | \$142.78 |
| 74-Male               | Preferred    | \$172.55 | \$210.00 | \$173.41 | \$78.81                | \$145.86 |
|                       | Standard     | \$198.13 | \$241.21 | \$199.12 | \$90.33                | \$167.44 |
| 74-Female             | Preferred    | \$152.93 | \$186.08 | \$153.69 | \$69.97                | \$129.31 |
|                       | Standard     | \$175.57 | \$213.68 | \$176.45 | \$80.16                | \$148.40 |
| 75-Male               | Preferred    | \$179.38 | \$218.33 | \$180.27 | \$81.88                | \$151.61 |
|                       | Standard     | \$205.99 | \$250.77 | \$207.00 | \$93.86                | \$174.05 |
| 75-Female             | Preferred    | \$158.97 | \$193.43 | \$159.76 | \$72.69                | \$134.40 |
|                       | Standard     | \$182.52 | \$222.16 | \$183.42 | \$83.29                | \$154.26 |
| 76-Male               | Preferred    | \$186.47 | \$226.97 | \$187.40 | \$85.08                | \$157.60 |
|                       | Standard     | \$214.15 | \$260.72 | \$215.21 | \$97.53                | \$180.94 |
| 76-Female             | Preferred    | \$165.25 | \$201.09 | \$166.06 | \$75.52                | \$139.70 |
|                       | Standard     | \$189.74 | \$230.96 | \$190.68 | \$86.55                | \$160.35 |
| 77-Male               | Preferred    | \$193.85 | \$235.98 | \$194.81 | \$88.40                | \$163.83 |
|                       | Standard     | \$222.63 | \$271.08 | \$223.74 | \$101.36               | \$188.10 |
| 77-Female             | Preferred    | \$171.78 | \$209.06 | \$172.63 | \$78.46                | \$145.20 |
|                       | Standard     | \$197.24 | \$240.11 | \$198.22 | \$89.93                | \$166.69 |
| 78-Male               | Preferred    | \$201.52 | \$245.33 | \$202.53 | \$91.86                | \$170.29 |
|                       | Standard     | \$231.46 | \$281.83 | \$232.61 | \$105.33               | \$195.54 |
| 78-Female             | Preferred    | \$178.57 | \$217.34 | \$179.46 | \$81.52                | \$150.93 |
|                       | Standard     | \$205.05 | \$249.64 | \$206.08 | \$93.44                | \$173.27 |

**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.

(Continued on next page)

# Humana Achieve Medicare Supplement Area 1 Monthly Premiums

Effective Date: 07-01-2023

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 79-Male               | Preferred    | \$209.50 | \$255.06 | \$210.55 | \$95.45                | \$177.03 |
|                       | Standard     | \$240.63 | \$293.03 | \$241.83 | \$109.46               | \$203.28 |
| 79-Female             | Preferred    | \$185.64 | \$225.95 | \$186.55 | \$84.69                | \$156.89 |
|                       | Standard     | \$213.17 | \$259.55 | \$214.24 | \$97.10                | \$180.12 |
| 80-Male               | Preferred    | \$217.81 | \$265.19 | \$218.89 | \$99.18                | \$182.28 |
|                       | Standard     | \$250.17 | \$304.67 | \$251.42 | \$113.76               | \$209.32 |
| 80-Female             | Preferred    | \$192.98 | \$234.92 | \$193.94 | \$88.00                | \$161.53 |
|                       | Standard     | \$221.63 | \$269.84 | \$222.72 | \$100.91               | \$185.47 |
| 81-Male               | Preferred    | \$226.44 | \$275.72 | \$227.57 | \$103.07               | \$187.68 |
|                       | Standard     | \$260.10 | \$316.77 | \$261.40 | \$118.23               | \$215.54 |
| 81-Female             | Preferred    | \$200.62 | \$244.23 | \$201.61 | \$91.44                | \$166.32 |
|                       | Standard     | \$230.41 | \$280.57 | \$231.56 | \$104.86               | \$190.97 |
| 82-Male               | Preferred    | \$233.18 | \$283.94 | \$234.33 | \$106.11               | \$193.25 |
|                       | Standard     | \$267.84 | \$326.22 | \$269.18 | \$121.72               | \$221.94 |
| 82-Female             | Preferred    | \$206.58 | \$251.49 | \$207.60 | \$94.13                | \$171.25 |
|                       | Standard     | \$237.27 | \$288.92 | \$238.44 | \$107.95               | \$196.64 |
| 83-Male               | Preferred    | \$240.10 | \$292.39 | \$241.30 | \$109.23               | \$198.99 |
|                       | Standard     | \$275.82 | \$335.95 | \$277.20 | \$125.31               | \$228.54 |
| 83-Female             | Preferred    | \$212.71 | \$258.98 | \$213.77 | \$96.89                | \$176.34 |
|                       | Standard     | \$244.32 | \$297.53 | \$245.54 | \$111.12               | \$202.48 |
| 84-Male               | Preferred    | \$247.24 | \$301.10 | \$248.48 | \$112.45               | \$204.90 |
|                       | Standard     | \$284.04 | \$345.96 | \$285.45 | \$129.01               | \$235.35 |
| 84-Female             | Preferred    | \$219.04 | \$266.69 | \$220.12 | \$99.73                | \$181.56 |
|                       | Standard     | \$251.59 | \$306.39 | \$252.85 | \$114.40               | \$208.50 |
| 85-Male               | Preferred    | \$254.61 | \$310.07 | \$255.88 | \$115.76               | \$210.99 |
|                       | Standard     | \$292.50 | \$356.29 | \$293.96 | \$132.82               | \$242.34 |
| 85-Female             | Preferred    | \$225.55 | \$274.64 | \$226.67 | \$102.67               | \$186.95 |
|                       | Standard     | \$259.08 | \$315.53 | \$260.37 | \$117.77               | \$214.69 |
| 86-Male               | Preferred    | \$262.18 | \$319.32 | \$263.49 | \$119.17               | \$217.27 |
|                       | Standard     | \$301.21 | \$366.91 | \$302.72 | \$136.74               | \$249.55 |
| 86-Female             | Preferred    | \$232.25 | \$282.81 | \$233.41 | \$105.69               | \$192.50 |
|                       | Standard     | \$266.79 | \$324.93 | \$268.12 | \$121.25               | \$221.07 |

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

(Continued on next page)

# Humana Achieve Medicare Supplement Area 1 Monthly Premiums

Effective Date: 07-01-2023

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 87-Male               | Preferred    | \$268.69 | \$327.25 | \$270.02 | \$122.10               | \$222.64 |
|                       | Standard     | \$308.69 | \$376.03 | \$310.23 | \$140.11               | \$255.74 |
| 87-Female             | Preferred    | \$238.01 | \$289.83 | \$239.20 | \$108.28               | \$197.26 |
|                       | Standard     | \$273.41 | \$333.00 | \$274.77 | \$124.22               | \$226.54 |
| 88-Male               | Preferred    | \$275.36 | \$335.38 | \$276.73 | \$125.10               | \$228.16 |
|                       | Standard     | \$316.35 | \$385.39 | \$317.94 | \$143.57               | \$262.08 |
| 88-Female             | Preferred    | \$243.91 | \$297.02 | \$245.12 | \$110.94               | \$202.15 |
|                       | Standard     | \$280.19 | \$341.28 | \$281.60 | \$127.28               | \$232.16 |
| 89-Male               | Preferred    | \$282.19 | \$343.71 | \$283.60 | \$128.18               | \$233.81 |
|                       | Standard     | \$324.22 | \$394.97 | \$325.84 | \$147.10               | \$268.59 |
| 89-Female             | Preferred    | \$249.96 | \$304.40 | \$251.20 | \$113.67               | \$207.14 |
|                       | Standard     | \$287.14 | \$349.76 | \$288.58 | \$130.41               | \$237.91 |
| 90-Male               | Preferred    | \$287.79 | \$350.55 | \$289.23 | \$130.71               | \$238.45 |
|                       | Standard     | \$330.66 | \$402.83 | \$332.31 | \$150.01               | \$273.91 |
| 90-Female             | Preferred    | \$254.92 | \$310.44 | \$256.18 | \$115.89               | \$211.24 |
|                       | Standard     | \$292.85 | \$356.72 | \$294.31 | \$132.98               | \$242.63 |
| 91-Male               | Preferred    | \$293.51 | \$357.52 | \$294.98 | \$133.27               | \$243.18 |
|                       | Standard     | \$337.24 | \$410.85 | \$338.92 | \$152.97               | \$279.36 |
| 91-Female             | Preferred    | \$259.97 | \$316.61 | \$261.27 | \$118.18               | \$215.43 |
|                       | Standard     | \$298.67 | \$363.81 | \$300.16 | \$135.60               | \$247.45 |
| 92-Male               | Preferred    | \$299.34 | \$364.63 | \$300.83 | \$135.91               | \$248.00 |
|                       | Standard     | \$343.94 | \$419.03 | \$345.66 | \$155.99               | \$284.91 |
| 92-Female             | Preferred    | \$265.13 | \$322.91 | \$266.45 | \$120.49               | \$219.71 |
|                       | Standard     | \$304.60 | \$371.05 | \$306.13 | \$138.27               | \$252.35 |
| 93-Male               | Preferred    | \$305.29 | \$371.88 | \$306.81 | \$138.58               | \$252.92 |
|                       | Standard     | \$350.77 | \$427.37 | \$352.54 | \$159.07               | \$290.56 |
| 93-Female             | Preferred    | \$270.40 | \$329.33 | \$271.74 | \$122.86               | \$224.06 |
|                       | Standard     | \$310.66 | \$378.43 | \$312.21 | \$141.00               | \$257.36 |
| 94-Male               | Preferred    | \$311.35 | \$379.28 | \$312.91 | \$141.31               | \$257.95 |
|                       | Standard     | \$357.76 | \$435.87 | \$359.54 | \$162.21               | \$296.33 |
| 94-Female             | Preferred    | \$275.77 | \$335.88 | \$277.14 | \$125.28               | \$228.50 |
|                       | Standard     | \$316.83 | \$385.95 | \$318.41 | \$143.78               | \$262.47 |

**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.

(Continued on next page)

# Humana Achieve Medicare Supplement Area 1 Monthly Premiums

Effective Date: 07-01-2023

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 95-Male               | Preferred    | \$317.54 | \$386.82 | \$319.12 | \$144.10               | \$263.06 |
|                       | Standard     | \$364.87 | \$444.55 | \$366.70 | \$165.41               | \$302.22 |
| 95-Female             | Preferred    | \$281.23 | \$342.55 | \$282.65 | \$127.75               | \$233.03 |
|                       | Standard     | \$323.12 | \$393.64 | \$324.74 | \$146.62               | \$267.67 |
| 96-Male               | Preferred    | \$323.85 | \$394.52 | \$325.46 | \$146.95               | \$268.28 |
|                       | Standard     | \$372.13 | \$453.40 | \$373.98 | \$168.68               | \$308.22 |
| 96-Female             | Preferred    | \$286.83 | \$349.36 | \$288.25 | \$130.27               | \$237.65 |
|                       | Standard     | \$329.54 | \$401.47 | \$331.19 | \$149.51               | \$273.00 |
| 97-Male               | Preferred    | \$330.29 | \$402.37 | \$331.94 | \$149.84               | \$273.61 |
|                       | Standard     | \$379.53 | \$462.43 | \$381.43 | \$172.02               | \$314.34 |
| 97-Female             | Preferred    | \$292.52 | \$356.31 | \$293.98 | \$132.83               | \$242.36 |
|                       | Standard     | \$336.10 | \$409.46 | \$337.78 | \$152.46               | \$278.41 |
| 98-Male               | Preferred    | \$336.85 | \$410.38 | \$338.54 | \$152.80               | \$279.04 |
|                       | Standard     | \$387.08 | \$471.64 | \$389.01 | \$175.41               | \$320.59 |
| 98-Female             | Preferred    | \$298.33 | \$363.40 | \$299.82 | \$135.44               | \$247.16 |
|                       | Standard     | \$342.77 | \$417.60 | \$344.49 | \$155.47               | \$283.95 |
| 99+-Male              | Preferred    | \$343.55 | \$418.55 | \$345.27 | \$155.82               | \$284.58 |
|                       | Standard     | \$394.79 | \$481.03 | \$396.75 | \$178.88               | \$326.97 |
| 99+-Female            | Preferred    | \$304.25 | \$370.63 | \$305.78 | \$138.12               | \$252.07 |
|                       | Standard     | \$349.60 | \$425.92 | \$351.34 | \$158.54               | \$289.59 |

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

# Humana Achieve Medicare Supplement Area 2 Monthly Premiums

Effective Date: 07-01-2023

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

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| <65*-Male             | Preferred    | N/A      | N/A      | N/A      | N/A                    | N/A      |
|                       | Standard     | \$848.28 | N/A      | N/A      | N/A                    | N/A      |
| <65*-Female           | Preferred    | N/A      | N/A      | N/A      | N/A                    | N/A      |
|                       | Standard     | \$750.92 | N/A      | N/A      | N/A                    | N/A      |
| 65-Male               | Preferred    | \$124.65 | \$151.58 | \$125.26 | \$57.23                | \$95.90  |
|                       | Standard     | \$143.04 | \$174.02 | \$143.76 | \$65.51                | \$109.99 |
| 65-Female             | Preferred    | \$110.54 | \$134.37 | \$111.08 | \$50.88                | \$85.10  |
|                       | Standard     | \$126.82 | \$154.22 | \$127.45 | \$58.21                | \$97.57  |
| 66-Male               | Preferred    | \$124.65 | \$151.58 | \$125.26 | \$57.23                | \$95.90  |
|                       | Standard     | \$143.04 | \$174.02 | \$143.76 | \$65.51                | \$109.99 |
| 66-Female             | Preferred    | \$110.54 | \$134.37 | \$111.08 | \$50.88                | \$85.10  |
|                       | Standard     | \$126.82 | \$154.22 | \$127.45 | \$58.21                | \$97.57  |
| 67-Male               | Preferred    | \$124.65 | \$151.58 | \$125.26 | \$57.23                | \$95.90  |
|                       | Standard     | \$143.04 | \$174.02 | \$143.76 | \$65.51                | \$109.99 |
| 67-Female             | Preferred    | \$110.54 | \$134.37 | \$111.08 | \$50.88                | \$85.10  |
|                       | Standard     | \$126.82 | \$154.22 | \$127.45 | \$58.21                | \$97.57  |
| 68-Male               | Preferred    | \$126.49 | \$153.82 | \$127.12 | \$58.07                | \$99.66  |
|                       | Standard     | \$145.16 | \$176.60 | \$145.88 | \$66.47                | \$114.31 |
| 68-Female             | Preferred    | \$112.17 | \$136.36 | \$112.72 | \$51.61                | \$88.43  |
|                       | Standard     | \$128.69 | \$156.51 | \$129.33 | \$59.06                | \$101.39 |
| 69-Male               | Preferred    | \$128.98 | \$156.86 | \$129.62 | \$59.18                | \$103.57 |
|                       | Standard     | \$148.03 | \$180.09 | \$148.76 | \$67.76                | \$118.81 |
| 69-Female             | Preferred    | \$114.37 | \$139.04 | \$114.94 | \$52.61                | \$91.89  |
|                       | Standard     | \$131.22 | \$159.60 | \$131.88 | \$60.19                | \$105.36 |
| 70-Male               | Preferred    | \$132.15 | \$160.73 | \$132.81 | \$60.61                | \$107.63 |
|                       | Standard     | \$151.68 | \$184.54 | \$152.43 | \$69.40                | \$123.47 |
| 70-Female             | Preferred    | \$117.18 | \$142.47 | \$117.76 | \$53.87                | \$95.48  |
|                       | Standard     | \$134.46 | \$163.54 | \$135.12 | \$61.65                | \$109.50 |

**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.

(Continued on next page)

# Humana Achieve Medicare Supplement Area 2 Monthly Premiums

Effective Date: 07-01-2023

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 71-Male               | Preferred    | \$136.05 | \$165.49 | \$136.73 | \$62.37                | \$112.39 |
|                       | Standard     | \$156.16 | \$190.01 | \$156.94 | \$71.42                | \$128.94 |
| 71-Female             | Preferred    | \$120.64 | \$146.69 | \$121.23 | \$55.43                | \$99.69  |
|                       | Standard     | \$138.43 | \$168.38 | \$139.11 | \$63.44                | \$114.34 |
| 72-Male               | Preferred    | \$140.08 | \$170.40 | \$140.78 | \$64.18                | \$117.35 |
|                       | Standard     | \$160.79 | \$195.66 | \$161.59 | \$73.51                | \$134.65 |
| 72-Female             | Preferred    | \$124.20 | \$151.03 | \$124.80 | \$57.03                | \$104.08 |
|                       | Standard     | \$142.52 | \$173.38 | \$143.23 | \$65.28                | \$119.39 |
| 73-Male               | Preferred    | \$144.91 | \$176.29 | \$145.63 | \$66.36                | \$121.96 |
|                       | Standard     | \$166.35 | \$202.44 | \$167.18 | \$76.01                | \$139.95 |
| 73-Female             | Preferred    | \$128.47 | \$156.24 | \$129.11 | \$58.96                | \$108.16 |
|                       | Standard     | \$147.44 | \$179.38 | \$148.18 | \$67.49                | \$124.09 |
| 74-Male               | Preferred    | \$149.91 | \$182.39 | \$150.66 | \$68.61                | \$126.76 |
|                       | Standard     | \$172.10 | \$209.46 | \$172.95 | \$78.61                | \$145.48 |
| 74-Female             | Preferred    | \$132.90 | \$161.64 | \$133.56 | \$60.95                | \$112.41 |
|                       | Standard     | \$152.53 | \$185.58 | \$153.29 | \$69.79                | \$128.97 |
| 75-Male               | Preferred    | \$155.83 | \$189.61 | \$156.60 | \$71.28                | \$131.75 |
|                       | Standard     | \$178.91 | \$217.75 | \$179.79 | \$81.66                | \$151.21 |
| 75-Female             | Preferred    | \$138.13 | \$168.02 | \$138.82 | \$63.31                | \$116.83 |
|                       | Standard     | \$158.56 | \$192.93 | \$159.34 | \$72.50                | \$134.05 |
| 76-Male               | Preferred    | \$161.99 | \$197.11 | \$162.79 | \$74.05                | \$136.95 |
|                       | Standard     | \$185.99 | \$226.38 | \$186.91 | \$84.85                | \$157.18 |
| 76-Female             | Preferred    | \$143.58 | \$174.67 | \$144.29 | \$65.76                | \$121.42 |
|                       | Standard     | \$164.82 | \$200.57 | \$165.63 | \$75.32                | \$139.33 |
| 77-Male               | Preferred    | \$168.38 | \$204.92 | \$169.22 | \$76.93                | \$142.35 |
|                       | Standard     | \$193.35 | \$235.36 | \$194.31 | \$88.17                | \$163.40 |
| 77-Female             | Preferred    | \$149.25 | \$181.58 | \$149.98 | \$68.31                | \$126.20 |
|                       | Standard     | \$171.32 | \$208.51 | \$172.18 | \$78.25                | \$144.83 |

**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.

(Continued on next page)

# Humana Achieve Medicare Supplement Area 2 Monthly Premiums

Effective Date: 07-01-2023

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 78-Male               | Preferred    | \$175.04 | \$213.03 | \$175.91 | \$79.93                | \$147.95 |
|                       | Standard     | \$201.00 | \$244.69 | \$202.00 | \$91.61                | \$169.84 |
| 78-Female             | Preferred    | \$155.13 | \$188.76 | \$155.90 | \$70.96                | \$131.16 |
|                       | Standard     | \$178.10 | \$216.77 | \$178.99 | \$81.30                | \$150.54 |
| 79-Male               | Preferred    | \$181.96 | \$221.47 | \$182.87 | \$83.05                | \$153.79 |
|                       | Standard     | \$208.96 | \$254.40 | \$210.00 | \$95.20                | \$176.56 |
| 79-Female             | Preferred    | \$161.26 | \$196.23 | \$162.05 | \$73.72                | \$136.33 |
|                       | Standard     | \$185.14 | \$225.36 | \$186.06 | \$84.48                | \$156.48 |
| 80-Male               | Preferred    | \$189.16 | \$230.25 | \$190.10 | \$86.28                | \$158.35 |
|                       | Standard     | \$217.23 | \$264.49 | \$218.32 | \$98.92                | \$181.80 |
| 80-Female             | Preferred    | \$167.63 | \$204.00 | \$168.46 | \$76.59                | \$140.36 |
|                       | Standard     | \$192.47 | \$234.29 | \$193.42 | \$87.78                | \$161.11 |
| 81-Male               | Preferred    | \$196.65 | \$239.39 | \$197.63 | \$89.65                | \$163.03 |
|                       | Standard     | \$225.84 | \$274.99 | \$226.97 | \$102.80               | \$187.19 |
| 81-Female             | Preferred    | \$174.25 | \$212.07 | \$175.12 | \$79.57                | \$144.51 |
|                       | Standard     | \$200.09 | \$243.59 | \$201.09 | \$91.21                | \$165.89 |
| 82-Male               | Preferred    | \$202.49 | \$246.51 | \$203.49 | \$92.29                | \$167.87 |
|                       | Standard     | \$232.55 | \$283.18 | \$233.71 | \$105.83               | \$192.75 |
| 82-Female             | Preferred    | \$179.42 | \$218.37 | \$180.31 | \$81.90                | \$148.78 |
|                       | Standard     | \$206.04 | \$250.83 | \$207.06 | \$93.88                | \$170.81 |
| 83-Male               | Preferred    | \$208.50 | \$253.84 | \$209.53 | \$94.99                | \$172.84 |
|                       | Standard     | \$239.47 | \$291.62 | \$240.67 | \$108.94               | \$198.47 |
| 83-Female             | Preferred    | \$184.74 | \$224.87 | \$185.66 | \$84.29                | \$153.19 |
|                       | Standard     | \$212.15 | \$258.30 | \$213.21 | \$96.64                | \$175.87 |
| 84-Male               | Preferred    | \$214.69 | \$261.40 | \$215.76 | \$97.79                | \$177.97 |
|                       | Standard     | \$246.60 | \$300.30 | \$247.82 | \$112.15               | \$204.37 |
| 84-Female             | Preferred    | \$190.23 | \$231.56 | \$191.17 | \$86.76                | \$157.72 |
|                       | Standard     | \$218.46 | \$265.98 | \$219.55 | \$99.48                | \$181.09 |

**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.

(Continued on next page)

# Humana Achieve Medicare Supplement Area 2 Monthly Premiums

Effective Date: 07-01-2023

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 85-Male               | Preferred    | \$221.08 | \$269.18 | \$222.18 | \$100.66               | \$183.25 |
|                       | Standard     | \$253.94 | \$309.26 | \$255.20 | \$115.45               | \$210.44 |
| 85-Female             | Preferred    | \$195.87 | \$238.44 | \$196.84 | \$89.31                | \$162.40 |
|                       | Standard     | \$224.95 | \$273.91 | \$226.08 | \$102.40               | \$186.46 |
| 86-Male               | Preferred    | \$227.65 | \$277.19 | \$228.78 | \$103.62               | \$188.69 |
|                       | Standard     | \$261.49 | \$318.47 | \$262.80 | \$118.86               | \$216.69 |
| 86-Female             | Preferred    | \$201.68 | \$245.53 | \$202.69 | \$91.92                | \$167.21 |
|                       | Standard     | \$231.64 | \$282.06 | \$232.79 | \$105.42               | \$191.99 |
| 87-Male               | Preferred    | \$233.29 | \$284.07 | \$234.45 | \$106.15               | \$193.35 |
|                       | Standard     | \$267.98 | \$326.38 | \$269.31 | \$121.78               | \$222.06 |
| 87-Female             | Preferred    | \$206.68 | \$251.63 | \$207.71 | \$94.17                | \$171.34 |
|                       | Standard     | \$237.39 | \$289.06 | \$238.56 | \$108.00               | \$196.74 |
| 88-Male               | Preferred    | \$239.07 | \$291.13 | \$240.26 | \$108.76               | \$198.14 |
|                       | Standard     | \$274.63 | \$334.49 | \$276.00 | \$124.77               | \$227.56 |
| 88-Female             | Preferred    | \$211.80 | \$257.86 | \$212.85 | \$96.48                | \$175.58 |
|                       | Standard     | \$243.27 | \$296.25 | \$244.48 | \$110.65               | \$201.61 |
| 89-Male               | Preferred    | \$245.00 | \$298.35 | \$246.22 | \$111.43               | \$203.04 |
|                       | Standard     | \$281.45 | \$342.80 | \$282.85 | \$127.84               | \$233.20 |
| 89-Female             | Preferred    | \$217.04 | \$264.26 | \$218.12 | \$98.84                | \$179.91 |
|                       | Standard     | \$249.29 | \$303.60 | \$250.54 | \$113.37               | \$206.59 |
| 90-Male               | Preferred    | \$249.85 | \$304.28 | \$251.11 | \$113.62               | \$207.07 |
|                       | Standard     | \$287.03 | \$349.63 | \$288.46 | \$130.36               | \$237.82 |
| 90-Female             | Preferred    | \$221.34 | \$269.50 | \$222.44 | \$100.77               | \$183.47 |
|                       | Standard     | \$254.24 | \$309.63 | \$255.51 | \$115.59               | \$210.69 |
| 91-Male               | Preferred    | \$254.81 | \$310.33 | \$256.08 | \$115.85               | \$211.16 |
|                       | Standard     | \$292.74 | \$356.57 | \$294.20 | \$132.93               | \$242.54 |
| 91-Female             | Preferred    | \$225.72 | \$274.85 | \$226.85 | \$102.75               | \$187.10 |
|                       | Standard     | \$259.29 | \$315.79 | \$260.58 | \$117.87               | \$214.87 |

**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.

(Continued on next page)

# Humana Achieve Medicare Supplement Area 2 Monthly Premiums

Effective Date: 07-01-2023

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 92-Male               | Preferred    | \$259.87 | \$316.49 | \$261.16 | \$118.13               | \$215.35 |
|                       | Standard     | \$298.55 | \$363.67 | \$300.04 | \$135.54               | \$247.35 |
| 92-Female             | Preferred    | \$230.20 | \$280.31 | \$231.35 | \$104.76               | \$190.81 |
|                       | Standard     | \$264.43 | \$322.06 | \$265.76 | \$120.18               | \$219.12 |
| 93-Male               | Preferred    | \$265.03 | \$322.78 | \$266.35 | \$120.45               | \$219.61 |
|                       | Standard     | \$304.48 | \$370.90 | \$306.01 | \$138.22               | \$252.25 |
| 93-Female             | Preferred    | \$234.77 | \$285.88 | \$235.94 | \$106.82               | \$194.58 |
|                       | Standard     | \$269.69 | \$328.46 | \$271.03 | \$122.55               | \$223.46 |
| 94-Male               | Preferred    | \$270.28 | \$329.20 | \$271.64 | \$122.81               | \$223.97 |
|                       | Standard     | \$310.53 | \$378.28 | \$312.08 | \$140.94               | \$257.26 |
| 94-Female             | Preferred    | \$239.42 | \$291.56 | \$240.62 | \$108.92               | \$198.43 |
|                       | Standard     | \$275.04 | \$334.98 | \$276.41 | \$124.96               | \$227.89 |
| 95-Male               | Preferred    | \$275.66 | \$335.74 | \$277.03 | \$125.24               | \$228.41 |
|                       | Standard     | \$316.70 | \$385.81 | \$318.29 | \$143.72               | \$262.37 |
| 95-Female             | Preferred    | \$244.17 | \$297.34 | \$245.39 | \$111.05               | \$202.36 |
|                       | Standard     | \$280.50 | \$341.65 | \$281.90 | \$127.42               | \$232.41 |
| 96-Male               | Preferred    | \$281.12 | \$342.41 | \$282.53 | \$127.70               | \$232.94 |
|                       | Standard     | \$323.00 | \$393.48 | \$324.61 | \$146.55               | \$267.57 |
| 96-Female             | Preferred    | \$249.02 | \$303.25 | \$250.25 | \$113.24               | \$206.37 |
|                       | Standard     | \$286.06 | \$348.44 | \$287.49 | \$129.93               | \$237.02 |
| 97-Male               | Preferred    | \$286.71 | \$349.22 | \$288.14 | \$130.21               | \$237.55 |
|                       | Standard     | \$329.42 | \$401.31 | \$331.06 | \$149.45               | \$272.88 |
| 97-Female             | Preferred    | \$253.96 | \$309.28 | \$255.22 | \$115.46               | \$210.46 |
|                       | Standard     | \$291.75 | \$355.37 | \$293.21 | \$132.49               | \$241.72 |
| 98-Male               | Preferred    | \$292.40 | \$356.17 | \$293.86 | \$132.78               | \$242.27 |
|                       | Standard     | \$335.96 | \$409.30 | \$337.64 | \$152.39               | \$278.30 |
| 98-Female             | Preferred    | \$259.00 | \$315.42 | \$260.29 | \$117.73               | \$214.62 |
|                       | Standard     | \$297.54 | \$362.43 | \$299.03 | \$135.09               | \$246.52 |

**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.

(Continued on next page)

# Humana Achieve Medicare Supplement Area 2 Monthly Premiums

Effective Date: 07-01-2023

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 99+-Male              | Preferred    | \$298.21 | \$363.26 | \$299.70 | \$135.40               | \$247.07 |
|                       | Standard     | \$342.65 | \$417.44 | \$344.35 | \$155.40               | \$283.83 |
| 99+-Female            | Preferred    | \$264.13 | \$321.70 | \$265.45 | \$120.05               | \$218.87 |
|                       | Standard     | \$303.46 | \$369.65 | \$304.97 | \$137.76               | \$251.41 |

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

# Humana Achieve Medicare Supplement Area 3 Monthly Premiums

Effective Date: 07-01-2023

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

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| <65*-Male             | Preferred    | N/A      | N/A      | N/A      | N/A                    | N/A      |
|                       | Standard     | \$813.74 | N/A      | N/A      | N/A                    | N/A      |
| <65*-Female           | Preferred    | N/A      | N/A      | N/A      | N/A                    | N/A      |
|                       | Standard     | \$720.35 | N/A      | N/A      | N/A                    | N/A      |
| 65-Male               | Preferred    | \$119.64 | \$145.47 | \$120.23 | \$54.98                | \$92.07  |
|                       | Standard     | \$137.28 | \$167.00 | \$137.97 | \$62.92                | \$105.58 |
| 65-Female             | Preferred    | \$106.11 | \$128.97 | \$106.63 | \$48.89                | \$81.71  |
|                       | Standard     | \$121.73 | \$148.01 | \$122.33 | \$55.92                | \$93.67  |
| 66-Male               | Preferred    | \$119.64 | \$145.47 | \$120.23 | \$54.98                | \$92.07  |
|                       | Standard     | \$137.28 | \$167.00 | \$137.97 | \$62.92                | \$105.58 |
| 66-Female             | Preferred    | \$106.11 | \$128.97 | \$106.63 | \$48.89                | \$81.71  |
|                       | Standard     | \$121.73 | \$148.01 | \$122.33 | \$55.92                | \$93.67  |
| 67-Male               | Preferred    | \$119.64 | \$145.47 | \$120.23 | \$54.98                | \$92.07  |
|                       | Standard     | \$137.28 | \$167.00 | \$137.97 | \$62.92                | \$105.58 |
| 67-Female             | Preferred    | \$106.11 | \$128.97 | \$106.63 | \$48.89                | \$81.71  |
|                       | Standard     | \$121.73 | \$148.01 | \$122.33 | \$55.92                | \$93.67  |
| 68-Male               | Preferred    | \$121.41 | \$147.62 | \$122.01 | \$55.78                | \$95.67  |
|                       | Standard     | \$139.32 | \$169.47 | \$140.01 | \$63.84                | \$109.72 |
| 68-Female             | Preferred    | \$107.67 | \$130.87 | \$108.20 | \$49.58                | \$84.90  |
|                       | Standard     | \$123.52 | \$150.20 | \$124.13 | \$56.73                | \$97.33  |
| 69-Male               | Preferred    | \$123.80 | \$150.54 | \$124.41 | \$56.85                | \$99.42  |
|                       | Standard     | \$142.07 | \$172.82 | \$142.77 | \$65.07                | \$114.04 |
| 69-Female             | Preferred    | \$109.78 | \$133.45 | \$110.33 | \$50.54                | \$88.22  |
|                       | Standard     | \$125.95 | \$153.17 | \$126.58 | \$57.82                | \$101.14 |
| 70-Male               | Preferred    | \$126.84 | \$154.25 | \$127.47 | \$58.22                | \$103.32 |
|                       | Standard     | \$145.57 | \$177.09 | \$146.29 | \$66.65                | \$118.51 |
| 70-Female             | Preferred    | \$112.48 | \$136.74 | \$113.03 | \$51.75                | \$91.67  |
|                       | Standard     | \$129.05 | \$156.95 | \$129.69 | \$59.22                | \$105.11 |

**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.

(Continued on next page)

# Humana Achieve Medicare Supplement Area 3 Monthly Premiums

Effective Date: 07-01-2023

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 71-Male               | Preferred    | \$130.58 | \$158.82 | \$131.23 | \$59.90                | \$107.88 |
|                       | Standard     | \$149.87 | \$182.34 | \$150.61 | \$68.59                | \$123.76 |
| 71-Female             | Preferred    | \$115.80 | \$140.78 | \$116.36 | \$53.25                | \$95.70  |
|                       | Standard     | \$132.86 | \$161.59 | \$133.52 | \$60.93                | \$109.75 |
| 72-Male               | Preferred    | \$134.45 | \$163.53 | \$135.11 | \$61.64                | \$112.64 |
|                       | Standard     | \$154.31 | \$187.75 | \$155.08 | \$70.59                | \$129.24 |
| 72-Female             | Preferred    | \$119.21 | \$144.95 | \$119.79 | \$54.78                | \$99.91  |
|                       | Standard     | \$136.79 | \$166.39 | \$137.46 | \$62.70                | \$114.60 |
| 73-Male               | Preferred    | \$139.08 | \$169.18 | \$139.77 | \$63.73                | \$117.07 |
|                       | Standard     | \$159.64 | \$194.26 | \$160.44 | \$72.99                | \$134.32 |
| 73-Female             | Preferred    | \$123.31 | \$149.95 | \$123.92 | \$56.63                | \$103.83 |
|                       | Standard     | \$141.51 | \$172.14 | \$142.21 | \$64.82                | \$119.11 |
| 74-Male               | Preferred    | \$143.87 | \$175.03 | \$144.59 | \$65.89                | \$121.67 |
|                       | Standard     | \$165.16 | \$200.99 | \$165.97 | \$75.48                | \$139.63 |
| 74-Female             | Preferred    | \$127.56 | \$155.13 | \$128.19 | \$58.54                | \$107.90 |
|                       | Standard     | \$146.38 | \$178.09 | \$147.12 | \$67.02                | \$123.79 |
| 75-Male               | Preferred    | \$149.55 | \$181.95 | \$150.29 | \$68.45                | \$126.46 |
|                       | Standard     | \$171.69 | \$208.94 | \$172.53 | \$78.41                | \$145.12 |
| 75-Female             | Preferred    | \$132.58 | \$161.25 | \$133.23 | \$60.81                | \$112.14 |
|                       | Standard     | \$152.17 | \$185.14 | \$152.92 | \$69.62                | \$128.66 |
| 76-Male               | Preferred    | \$155.46 | \$189.14 | \$156.23 | \$71.11                | \$131.44 |
|                       | Standard     | \$178.48 | \$217.22 | \$179.36 | \$81.47                | \$150.85 |
| 76-Female             | Preferred    | \$137.80 | \$167.62 | \$138.48 | \$63.16                | \$116.55 |
|                       | Standard     | \$158.17 | \$192.46 | \$158.95 | \$72.33                | \$133.72 |
| 77-Male               | Preferred    | \$161.59 | \$196.64 | \$162.39 | \$73.87                | \$136.62 |
|                       | Standard     | \$185.54 | \$225.83 | \$186.46 | \$84.65                | \$156.81 |
| 77-Female             | Preferred    | \$143.24 | \$174.25 | \$143.94 | \$65.60                | \$121.13 |
|                       | Standard     | \$164.41 | \$200.08 | \$165.23 | \$75.14                | \$139.00 |

**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.

(Continued on next page)

# Humana Achieve Medicare Supplement Area 3 Monthly Premiums

Effective Date: 07-01-2023

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 78-Male               | Preferred    | \$167.98 | \$204.42 | \$168.81 | \$76.75                | \$141.99 |
|                       | Standard     | \$192.88 | \$234.78 | \$193.84 | \$87.95                | \$162.99 |
| 78-Female             | Preferred    | \$148.88 | \$181.14 | \$149.62 | \$68.15                | \$125.89 |
|                       | Standard     | \$170.91 | \$208.00 | \$171.76 | \$78.06                | \$144.48 |
| 79-Male               | Preferred    | \$174.61 | \$212.51 | \$175.49 | \$79.74                | \$147.60 |
|                       | Standard     | \$200.51 | \$244.10 | \$201.51 | \$91.39                | \$169.43 |
| 79-Female             | Preferred    | \$154.76 | \$188.30 | \$155.52 | \$70.79                | \$130.85 |
|                       | Standard     | \$177.67 | \$216.24 | \$178.55 | \$81.11                | \$150.17 |
| 80-Male               | Preferred    | \$181.52 | \$220.94 | \$182.42 | \$82.84                | \$151.97 |
|                       | Standard     | \$208.44 | \$253.78 | \$209.49 | \$94.97                | \$174.46 |
| 80-Female             | Preferred    | \$160.87 | \$195.75 | \$161.67 | \$73.54                | \$134.71 |
|                       | Standard     | \$184.70 | \$224.81 | \$185.61 | \$84.28                | \$154.62 |
| 81-Male               | Preferred    | \$188.70 | \$229.70 | \$189.64 | \$86.07                | \$156.46 |
|                       | Standard     | \$216.71 | \$263.85 | \$217.79 | \$98.69                | \$179.63 |
| 81-Female             | Preferred    | \$167.22 | \$203.50 | \$168.05 | \$76.40                | \$138.69 |
|                       | Standard     | \$192.00 | \$233.73 | \$192.96 | \$87.57                | \$159.20 |
| 82-Male               | Preferred    | \$194.31 | \$236.53 | \$195.26 | \$88.60                | \$161.10 |
|                       | Standard     | \$223.14 | \$271.70 | \$224.25 | \$101.59               | \$184.96 |
| 82-Female             | Preferred    | \$172.18 | \$209.54 | \$173.03 | \$78.64                | \$142.79 |
|                       | Standard     | \$197.71 | \$240.68 | \$198.69 | \$90.13                | \$163.92 |
| 83-Male               | Preferred    | \$200.07 | \$243.56 | \$201.06 | \$91.20                | \$165.87 |
|                       | Standard     | \$229.78 | \$279.80 | \$230.93 | \$104.57               | \$190.45 |
| 83-Female             | Preferred    | \$177.28 | \$215.77 | \$178.17 | \$80.93                | \$147.02 |
|                       | Standard     | \$203.57 | \$247.84 | \$204.59 | \$92.78                | \$168.77 |
| 84-Male               | Preferred    | \$206.01 | \$250.81 | \$207.03 | \$93.88                | \$170.79 |
|                       | Standard     | \$236.61 | \$288.13 | \$237.79 | \$107.66               | \$196.11 |
| 84-Female             | Preferred    | \$182.55 | \$222.19 | \$183.45 | \$83.30                | \$151.37 |
|                       | Standard     | \$209.63 | \$255.21 | \$210.67 | \$95.50                | \$173.78 |

**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.

(Continued on next page)

# Humana Achieve Medicare Supplement Area 3 Monthly Premiums

Effective Date: 07-01-2023

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 85-Male               | Preferred    | \$212.14 | \$258.27 | \$213.19 | \$96.63                | \$175.85 |
|                       | Standard     | \$243.66 | \$296.72 | \$244.87 | \$110.82               | \$201.93 |
| 85-Female             | Preferred    | \$187.96 | \$228.79 | \$188.89 | \$85.74                | \$155.85 |
|                       | Standard     | \$215.85 | \$262.81 | \$216.93 | \$98.30                | \$178.93 |
| 86-Male               | Preferred    | \$218.44 | \$265.96 | \$219.53 | \$99.47                | \$181.07 |
|                       | Standard     | \$250.90 | \$305.55 | \$252.15 | \$114.09               | \$207.93 |
| 86-Female             | Preferred    | \$193.53 | \$235.59 | \$194.50 | \$88.25                | \$160.47 |
|                       | Standard     | \$222.27 | \$270.63 | \$223.37 | \$101.20               | \$184.24 |
| 87-Male               | Preferred    | \$223.85 | \$272.56 | \$224.96 | \$101.90               | \$185.54 |
|                       | Standard     | \$257.13 | \$313.14 | \$258.40 | \$116.89               | \$213.08 |
| 87-Female             | Preferred    | \$198.33 | \$241.44 | \$199.32 | \$90.41                | \$164.43 |
|                       | Standard     | \$227.78 | \$277.34 | \$228.91 | \$103.67               | \$188.79 |
| 88-Male               | Preferred    | \$229.40 | \$279.33 | \$230.53 | \$104.40               | \$190.13 |
|                       | Standard     | \$263.50 | \$320.92 | \$264.81 | \$119.76               | \$218.35 |
| 88-Female             | Preferred    | \$203.24 | \$247.42 | \$204.24 | \$92.63                | \$168.49 |
|                       | Standard     | \$233.42 | \$284.24 | \$234.58 | \$106.22               | \$193.46 |
| 89-Male               | Preferred    | \$235.08 | \$286.26 | \$236.25 | \$106.96               | \$194.83 |
|                       | Standard     | \$270.04 | \$328.89 | \$271.39 | \$122.71               | \$223.76 |
| 89-Female             | Preferred    | \$208.26 | \$253.55 | \$209.30 | \$94.89                | \$172.65 |
|                       | Standard     | \$239.20 | \$291.29 | \$240.39 | \$108.82               | \$198.24 |
| 90-Male               | Preferred    | \$239.74 | \$291.94 | \$240.94 | \$109.07               | \$198.70 |
|                       | Standard     | \$275.40 | \$335.44 | \$276.77 | \$125.12               | \$228.19 |
| 90-Female             | Preferred    | \$212.39 | \$258.58 | \$213.44 | \$96.74                | \$176.06 |
|                       | Standard     | \$243.95 | \$297.08 | \$245.16 | \$110.96               | \$202.17 |
| 91-Male               | Preferred    | \$244.49 | \$297.74 | \$245.71 | \$111.20               | \$202.62 |
|                       | Standard     | \$280.87 | \$342.10 | \$282.27 | \$127.58               | \$232.72 |
| 91-Female             | Preferred    | \$216.59 | \$263.71 | \$217.67 | \$98.64                | \$179.55 |
|                       | Standard     | \$248.79 | \$302.98 | \$250.03 | \$113.14               | \$206.18 |

**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.

(Continued on next page)

# Humana Achieve Medicare Supplement Area 3 Monthly Premiums

Effective Date: 07-01-2023

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 92-Male               | Preferred    | \$249.34 | \$303.66 | \$250.58 | \$113.39               | \$206.64 |
|                       | Standard     | \$286.44 | \$348.91 | \$287.87 | \$130.09               | \$237.34 |
| 92-Female             | Preferred    | \$220.89 | \$268.95 | \$221.99 | \$100.57               | \$183.10 |
|                       | Standard     | \$253.72 | \$308.99 | \$254.99 | \$115.35               | \$210.26 |
| 93-Male               | Preferred    | \$254.30 | \$309.69 | \$255.56 | \$115.62               | \$210.73 |
|                       | Standard     | \$292.13 | \$355.84 | \$293.60 | \$132.66               | \$242.04 |
| 93-Female             | Preferred    | \$225.27 | \$274.29 | \$226.39 | \$102.54               | \$186.72 |
|                       | Standard     | \$258.76 | \$315.13 | \$260.05 | \$117.63               | \$214.42 |
| 94-Male               | Preferred    | \$259.33 | \$315.85 | \$260.63 | \$117.88               | \$214.91 |
|                       | Standard     | \$297.94 | \$362.92 | \$299.43 | \$135.27               | \$246.84 |
| 94-Female             | Preferred    | \$229.73 | \$279.74 | \$230.88 | \$104.55               | \$190.41 |
|                       | Standard     | \$263.89 | \$321.39 | \$265.21 | \$119.94               | \$218.67 |
| 95-Male               | Preferred    | \$264.49 | \$322.12 | \$265.80 | \$120.21               | \$219.17 |
|                       | Standard     | \$303.85 | \$370.14 | \$305.38 | \$137.93               | \$251.74 |
| 95-Female             | Preferred    | \$234.28 | \$285.29 | \$235.46 | \$106.60               | \$194.18 |
|                       | Standard     | \$269.13 | \$327.79 | \$270.47 | \$122.30               | \$223.00 |
| 96-Male               | Preferred    | \$269.73 | \$328.52 | \$271.08 | \$122.57               | \$223.51 |
|                       | Standard     | \$309.90 | \$377.50 | \$311.44 | \$140.65               | \$256.73 |
| 96-Female             | Preferred    | \$238.94 | \$290.96 | \$240.12 | \$108.70               | \$198.03 |
|                       | Standard     | \$274.47 | \$334.30 | \$275.84 | \$124.71               | \$227.43 |
| 97-Male               | Preferred    | \$275.09 | \$335.05 | \$276.46 | \$124.98               | \$227.94 |
|                       | Standard     | \$316.05 | \$385.01 | \$317.63 | \$143.43               | \$261.83 |
| 97-Female             | Preferred    | \$243.67 | \$296.74 | \$244.89 | \$110.83               | \$201.95 |
|                       | Standard     | \$279.92 | \$340.95 | \$281.32 | \$127.16               | \$231.93 |
| 98-Male               | Preferred    | \$280.55 | \$341.72 | \$281.95 | \$127.44               | \$232.46 |
|                       | Standard     | \$322.33 | \$392.67 | \$323.94 | \$146.25               | \$267.02 |
| 98-Female             | Preferred    | \$248.51 | \$302.63 | \$249.75 | \$113.00               | \$205.94 |
|                       | Standard     | \$285.48 | \$347.72 | \$286.90 | \$129.66               | \$236.54 |

**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.

(Continued on next page)

# Humana Achieve Medicare Supplement Area 3 Monthly Premiums

Effective Date: 07-01-2023

| Attained Age & Gender | Premium Type | Plan A   | Plan F   | Plan G   | High Deductible Plan G | Plan N   |
|-----------------------|--------------|----------|----------|----------|------------------------|----------|
| 99+-Male              | Preferred    | \$286.12 | \$348.51 | \$287.55 | \$129.95               | \$237.07 |
|                       | Standard     | \$328.74 | \$400.48 | \$330.38 | \$149.14               | \$272.33 |
| 99+-Female            | Preferred    | \$253.43 | \$308.65 | \$254.70 | \$115.23               | \$210.02 |
|                       | Standard     | \$291.15 | \$354.64 | \$292.60 | \$132.22               | \$241.23 |

**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.

## Premium Information

We, Humana Insurance Company of Kentucky, 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.

We will not change the premium for your policy until such change has been filed with and approved by the Texas Department of Insurance.

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

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

Premium discounts may be applied or discontinued based on eligibility.

**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.\*

**Save 12% on your monthly premium** when you reside with your spouse (including civil union/domestic partner) or you have continuously resided with at least one, but no more than three adults in the past 12 months. For the purpose of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid and recognized in your state of residence.\*\* We may request additional documentation to determine eligibility.\*\*

## Calculate Your Premium

Base monthly premium (please refer to pages 3-19):

ACH Discount (applied to base premium):

Enhanced 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 enhanced household premium discount will be removed if the spouse (civil union/domestic partner) or other adult(s) no longer resides with you (other than in the case of his/her death). 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.

## Disclosure

Use this outline to compare benefits and premiums among policies.

## Read your policy very carefully

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

## **Right to return policy**

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

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

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

## **Policy replacement**

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

## **Notice**

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

Neither Humana Insurance Company of Kentucky 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.

## **Limitations and Exclusions**

The policy may not cover expenses due to a pre-existing condition for which medical advice was given or treatment was recommended by or received from a physician within six months prior to the effective date of the policy, unless the expenses are incurred 90 days or more after the effective date.

Unless Medicare Supplements standards require us to do so, we do not provide benefits under this policy for the following:

1. Services and supplies not eligible under Medicare.
2. Services and supplies which are not determined by Medicare to be Medically Necessary.
3. Payment of services and supplies which duplicate those covered by Medicare

## **Refund of premiums**

We will refund the appropriate portion of any unearned premium to You upon cancellation or termination of the policy before the end of its term. Any unearned premium due to death shall be paid to your estate.

## **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                        |
|-------------------------------------------------------------------------------------|---------------------|---------------------------------------|--------------------------------|
| <b>Hospitalization*</b>                                                             |                     |                                       |                                |
| Semiprivate room and board, general nursing and miscellaneous services and supplies |                     |                                       |                                |
| First 60 days                                                                       | All but \$1,600     | \$0                                   | \$1,600<br>(Part A deductible) |
| 61st through 90th day                                                               | All but \$400 a day | \$400 a day                           | \$0                            |
| 91st day and after:                                                                 |                     |                                       |                                |
| while using 60 lifetime reserve days<br>once lifetime reserve days are used:        | All but \$800 a day | \$800 a day                           | \$0                            |
| • additional 365 days                                                               | \$0                 | 100% of Medicare<br>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<br>amounts | \$0 | \$0                  |
| 21st through 100th day | All but \$200<br>a day  | \$0 | Up to \$200<br>a day |
| 101st day and after    | \$0                     | \$0 | All costs            |

## Blood

|                    |      |             |     |
|--------------------|------|-------------|-----|
| First three pints  | \$0  | Three pints | \$0 |
| Additional amounts | 100% | \$0         | \$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 A) – Hospital Services – Per Benefit Period (Continued)

| Services                                                                                       | Medicare Pays                                                                              | Plan Pays                      | You Pay |
|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------|---------|
| <b>Hospice Care</b>                                                                            |                                                                                            |                                |         |
| 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     |

## Medicare (Part B) – Medical Services – Per Calendar Year

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

| Services                                                                                                                                                                                                                                 | Medicare Pays | Plan Pays     | You Pay                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------|------------------------------|
| <b>Medical Expenses</b>                                                                                                                                                                                                                  |               |               |                              |
| IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |               |                              |
| First \$226 of Medicare-approved amounts*                                                                                                                                                                                                | \$0           | \$0           | \$226<br>(Part B deductible) |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                   | Generally 80% | Generally 20% | \$0                          |
| <b>Part B Excess Charges</b>                                                                                                                                                                                                             |               |               |                              |
| (above Medicare-approved amounts)                                                                                                                                                                                                        | \$0           | \$0           | All costs                    |
| <b>Blood</b>                                                                                                                                                                                                                             |               |               |                              |
| First three pints                                                                                                                                                                                                                        | \$0           | All costs     | \$0                          |
| Next \$226 of Medicare-approved amounts*                                                                                                                                                                                                 | \$0           | \$0           | \$226<br>(Part B deductible) |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                   | 80%           | 20%           | \$0                          |

Plan A

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

| Services                      | Medicare Pays | Plan Pays | You Pay |
|-------------------------------|---------------|-----------|---------|
| 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<br>MEDICARE-APPROVED SERVICES                         |               |           |                              |
| Medically necessary skilled care services and medical supplies         | 100%          | \$0       | \$0                          |
| Durable medical equipment<br>First \$226 of Medicare-approved amounts* | \$0           | \$0       | \$226<br>(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   |
|-------------------------------------------------------------------------------------|---------------------|---------------------------------------|-----------|
| <b>Hospitalization*</b>                                                             |                     |                                       |           |
| Semiprivate room and board, general nursing and miscellaneous services and supplies |                     |                                       |           |
| First 60 days                                                                       | All but \$1,600     | \$1,600<br>(Part A deductible)        | \$0       |
| 61st through 90th day                                                               | All but \$400 a day | \$400 a day                           | \$0       |
| 91st day and after:                                                                 |                     |                                       |           |
| while using 60 lifetime reserve days<br>once lifetime reserve days are used:        | All but \$800 a day | \$800 a day                           | \$0       |
| • additional 365 days                                                               | \$0                 | 100% of Medicare<br>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<br>amounts | \$0                  | \$0       |
| 21st through 100th day | All but \$200<br>a day  | Up to \$200<br>a day | \$0       |
| 101st day and after    | \$0                     | \$0                  | All costs |

## Blood

|                    |      |             |     |
|--------------------|------|-------------|-----|
| First three pints  | \$0  | Three pints | \$0 |
| Additional amounts | 100% | \$0         | \$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 A) – Hospital Services – Per Benefit Period (Continued)

| Services                                                                                       | Medicare Pays                                                                              | Plan Pays                      | You Pay |
|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------|---------|
| <b>Hospice Care</b>                                                                            |                                                                                            |                                |         |
| 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     |

## Medicare (Part B) – Medical Services – Per Calendar Year

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

| Services                                                                                                                                                                                                                                                            | Medicare Pays | Plan Pays                 | You Pay |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------|---------|
| <b>Medical Expenses</b><br>IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |                           |         |
| First \$226 of Medicare-approved amounts*                                                                                                                                                                                                                           | \$0           | \$226 (Part B deductible) | \$0     |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                                              | Generally 80% | Generally 20%             | \$0     |
| <b>Part B Excess Charges</b><br>(above Medicare-approved amounts)                                                                                                                                                                                                   |               |                           |         |
| <b>Blood</b>                                                                                                                                                                                                                                                        |               |                           |         |
| First three pints                                                                                                                                                                                                                                                   | \$0           | All costs                 | \$0     |
| Next \$226 of Medicare-approved amounts*                                                                                                                                                                                                                            | \$0           | \$226 (Part B deductible) | \$0     |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                                              | 80%           | 20%                       | \$0     |

# Plan F

## Medicare (Part B) – Medical Services – Per Calendar Year (Continued)

| Services                            | Medicare Pays | Plan Pays | You Pay |
|-------------------------------------|---------------|-----------|---------|
| <b>Clinical Laboratory Services</b> |               |           |         |
| TESTS FOR DIAGNOSTIC SERVICES       | 100%          | \$0       | \$0     |

## Medicare (Parts A and B)

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

## Other Benefits – Not Covered By Medicare

| Services                                                                                                                                                                  | Medicare Pays | Plan Pays                                     | You Pay                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------|----------------------------------------------------|
| <b>Foreign Travel</b><br><b>Not covered by Medicare</b><br>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   |
|-------------------------------------------------------------------------------------|---------------------|---------------------------------------|-----------|
| <b>Hospitalization*</b>                                                             |                     |                                       |           |
| Semiprivate room and board, general nursing and miscellaneous services and supplies |                     |                                       |           |
| First 60 days                                                                       | All but \$1,600     | \$1,600<br>(Part A deductible)        | \$0       |
| 61st through 90th day                                                               | All but \$400 a day | \$400 a day                           | \$0       |
| 91st day and after:                                                                 |                     |                                       |           |
| while using 60 lifetime reserve days<br>once lifetime reserve days are used:        | All but \$800 a day | \$800 a day                           | \$0       |
| • additional 365 days                                                               | \$0                 | 100% of Medicare<br>eligible expenses | \$0**     |
| • beyond the additional 365 days                                                    | \$0                 | \$0                                   | All costs |

|                                                                                                                                                                                       |                        |                      |           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------|-----------|
| <b>Skilled Nursing Facility Care*</b>                                                                                                                                                 |                        |                      |           |
| You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital |                        |                      |           |
| First 20 days                                                                                                                                                                         | All approved amounts   | \$0                  | \$0       |
| 21st through 100th day                                                                                                                                                                | All but \$200<br>a day | Up to \$200<br>a day | \$0       |
| 101st day and after                                                                                                                                                                   | \$0                    | \$0                  | All costs |
| <b>Blood</b>                                                                                                                                                                          |                        |                      |           |
| First three pints                                                                                                                                                                     | \$0                    | Three pints          | \$0       |
| Additional amounts                                                                                                                                                                    | 100%                   | \$0                  | \$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 A) – Hospital Services – Per Benefit Period (Continued)

| Services                                                                                       | Medicare Pays                                                                              | Plan Pays                      | You Pay |
|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------|---------|
| <b>Hospice Care</b>                                                                            |                                                                                            |                                |         |
| 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     |

## Medicare (Part B) – Medical Services – Per Calendar Year

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

| Services                                                                                                                                                                                                                                                            | Medicare Pays | Plan Pays     | You Pay                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------|--------------------------------------------------|
| <b>Medical Expenses</b><br>IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |               |                                                  |
| First \$226 of Medicare-approved amounts*                                                                                                                                                                                                                           | \$0           | \$0           | \$226<br>(Unless Part B deductible has been met) |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                                              | Generally 80% | Generally 20% | \$0                                              |
| <b>Part B Excess Charges</b><br>(above Medicare-approved amounts)                                                                                                                                                                                                   |               |               |                                                  |
|                                                                                                                                                                                                                                                                     | \$0           | 100%          | \$0                                              |
| <b>Blood</b>                                                                                                                                                                                                                                                        |               |               |                                                  |
| First three pints                                                                                                                                                                                                                                                   | \$0           | All costs     | \$0                                              |
| Next \$226 of Medicare-approved amounts*                                                                                                                                                                                                                            | \$0           | \$0           | \$226<br>(Unless Part B deductible has been met) |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                                              | 80%           | 20%           | \$0                                              |

# Plan G

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

| Services                            | Medicare Pays | Plan Pays | You Pay |
|-------------------------------------|---------------|-----------|---------|
| <b>Clinical Laboratory Services</b> |               |           |         |
| TESTS FOR DIAGNOSTIC SERVICES       | 100%          | \$0       | \$0     |

## Medicare (Parts A and B)

| Services                                                               | Medicare Pays | Plan Pays | You Pay                                          |
|------------------------------------------------------------------------|---------------|-----------|--------------------------------------------------|
| <b>Home Health Care</b><br>MEDICARE-APPROVED SERVICES                  |               |           |                                                  |
| Medically necessary skilled care services and medical supplies         | 100%          | \$0       | \$0                                              |
| Durable medical equipment<br>First \$226 of Medicare-approved amounts* | \$0           | \$0       | \$226<br>(Unless Part B deductible has been met) |
| Remainder of Medicare-approved amounts                                 | 80%           | 20%       | \$0                                              |

## Other Benefits - Not Covered By Medicare

| Services                                                                                                                                                                  | Medicare Pays | Plan Pays                                     | You Pay                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------|----------------------------------------------------|
| <b>Foreign Travel</b><br><b>Not covered by Medicare</b><br>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 \$2,700 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are \$2,700. 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 \$2,700 Deductible,** Plan Pays | In Addition To \$2,700 Deductible,** You Pay |
|-------------------------------------------------------------------------------------|---------------------|-----------------------------------------------|----------------------------------------------|
| <b>Hospitalization*</b>                                                             |                     |                                               |                                              |
| Semiprivate room and board, general nursing and miscellaneous services and supplies |                     |                                               |                                              |
| First 60 days                                                                       | All but \$1,600     | \$1,600<br>(Part A deductible)                | \$0                                          |
| 61st through 90th day                                                               | All but \$400 a day | \$400 a day                                   | \$0                                          |
| 91st day and after:                                                                 |                     |                                               |                                              |
| while using 60 lifetime reserve days once lifetime reserve days are used:           | All but \$800 a day | \$800 a day                                   | \$0                                          |
| • additional 365 days                                                               | \$0                 | 100% of Medicare eligible expenses            | \$0***                                       |
| • beyond the additional 365 days                                                    | \$0                 | \$0                                           | All costs                                    |

## Skilled Nursing Facility Care\*

You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital

|                        |                      |                   |           |
|------------------------|----------------------|-------------------|-----------|
| First 20 days          | All approved amounts | \$0               | \$0       |
| 21st through 100th day | All but \$200 a day  | Up to \$200 a day | \$0       |
| 101st day and after    | \$0                  | \$0               | All costs |

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

# High Deductible Plan 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 \$2,700 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are \$2,700. 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<br>Pay \$2,700<br>Deductible,**<br>Plan Pays | In Addition<br>To \$2,700<br>Deductible,**<br>You Pay |
|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------|
| <b>Blood</b>                                                                                   |                                                                                            |                                                        |                                                       |
| First three pints                                                                              | \$0                                                                                        | Three pints                                            | \$0                                                   |
| Additional amounts                                                                             | 100%                                                                                       | \$0                                                    | \$0                                                   |
| <b>Hospice Care</b>                                                                            |                                                                                            |                                                        |                                                       |
| 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 \$226 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\* This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,700 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are \$2,700. 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 \$2,700 Deductible,** | In Addition To \$2,700 Deductible,** You Pay     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------|--------------------------------------------------|
| <b>Medical Expenses</b>                                                                                                                                                                                                                  |               |                                     |                                                  |
| IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |                                     |                                                  |
| First \$226 of Medicare-approved amounts*                                                                                                                                                                                                | \$0           | \$0                                 | \$226<br>(Unless Part B deductible has been met) |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                   | Generally 80% | Generally 20%                       | \$0                                              |
| <b>Part B Excess Charges</b>                                                                                                                                                                                                             |               |                                     |                                                  |
| (above Medicare-approved amounts)                                                                                                                                                                                                        |               |                                     |                                                  |
| <b>Blood</b>                                                                                                                                                                                                                             |               |                                     |                                                  |
| First three pints                                                                                                                                                                                                                        | \$0           | All costs                           | \$0                                              |
| Next \$226 of Medicare-approved amounts*                                                                                                                                                                                                 | \$0           | \$0                                 | \$226<br>(Unless Part B deductible has been met) |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                   | 80%           | 20%                                 | \$0                                              |
| <b>Clinical Laboratory Services</b>                                                                                                                                                                                                      |               |                                     |                                                  |
| 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 \$226 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\* This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,700 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are \$2,700. 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 \$2,700 Deductible,** Plan Pays | In Addition To \$2,700 Deductible,** You Pay     |
|------------------------------------------------------------------------|---------------|-----------------------------------------------|--------------------------------------------------|
| <b>Home Health Care</b><br>MEDICARE-APPROVED SERVICES                  |               |                                               |                                                  |
| Medically necessary skilled care services and medical supplies         | 100%          | \$0                                           | \$0                                              |
| Durable medical equipment<br>First \$226 of Medicare-approved amounts* | \$0           | \$0                                           | \$226<br>(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 \$2,700 Deductible,** Plan Pays | In Addition To \$2,700 Deductible,** You Pay       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------|----------------------------------------------------|
| <b>Foreign Travel</b><br><b>Not covered by Medicare</b><br>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   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|------------------------------------|-----------|
| <b>Hospitalization*</b>                                                                                                                                                               |  |                      |                                    |           |
| Semiprivate room and board, general nursing and miscellaneous services and supplies                                                                                                   |  |                      |                                    |           |
| First 60 days                                                                                                                                                                         |  |                      |                                    |           |
|                                                                                                                                                                                       |  | All but \$1,600      | \$1,600<br>(Part A deductible)     | \$0       |
| 61st through 90th day                                                                                                                                                                 |  |                      |                                    |           |
|                                                                                                                                                                                       |  | All but \$400 a day  | \$400 a day                        | \$0       |
| 91st day and after:                                                                                                                                                                   |  |                      |                                    |           |
| while using 60 lifetime reserve days once lifetime reserve days are used:                                                                                                             |  | All but \$800 a day  | \$800 a day                        | \$0       |
| • additional 365 days                                                                                                                                                                 |  | \$0                  | 100% of Medicare eligible expenses | \$0**     |
| • beyond the additional 365 days                                                                                                                                                      |  | \$0                  | \$0                                | All costs |
| <b>Skilled Nursing Facility Care*</b>                                                                                                                                                 |  |                      |                                    |           |
| You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital |  |                      |                                    |           |
| First 20 days                                                                                                                                                                         |  |                      |                                    |           |
|                                                                                                                                                                                       |  | All approved amounts | \$0                                | \$0       |
| 21st through 100th day                                                                                                                                                                |  |                      |                                    |           |
|                                                                                                                                                                                       |  | All but \$200 a day  | Up to \$200 a day                  | \$0       |
| 101st day and after                                                                                                                                                                   |  |                      |                                    |           |
|                                                                                                                                                                                       |  | \$0                  | \$0                                | All costs |
| <b>Blood</b>                                                                                                                                                                          |  |                      |                                    |           |
| First three pints                                                                                                                                                                     |  |                      |                                    |           |
|                                                                                                                                                                                       |  | \$0                  | Three pints                        | \$0       |
| Additional amounts                                                                                                                                                                    |  |                      |                                    |           |
|                                                                                                                                                                                       |  | 100%                 | \$0                                | \$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 A) – Hospital Services – Per Benefit Period (Continued)

| Services                                                                                       | Medicare Pays                                                                              | Plan Pays                      | You Pay |
|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------|---------|
| <b>Hospice Care</b>                                                                            |                                                                                            |                                |         |
| 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     |

## Medicare (Part B) – Medical Services – Per Calendar Year

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

| Services                                                                                                                                                                                                                                                            | Medicare Pays | Plan Pays | You Pay                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------|------------------------------|
| <b>Medical Expenses</b><br>IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |           |                              |
| First \$226 of Medicare-approved amounts*                                                                                                                                                                                                                           | \$0           | \$0       | \$226<br>(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 |
|-----------------------------------|-----|-----|-----------|

# Plan N

## Medicare (Part B) – Medical Services – Per Calendar Year (Continued)

| Services                                 | Medicare Pays | Plan Pays | You Pay                      |
|------------------------------------------|---------------|-----------|------------------------------|
| <b>Blood</b>                             |               |           |                              |
| First three pints                        | \$0           | All costs | \$0                          |
| Next \$226 of Medicare-approved amounts* | \$0           | \$0       | \$226<br>(Part B deductible) |
| Remainder of Medicare-approved amounts   | 80%           | 20%       | \$0                          |
| <b>Clinical Laboratory Services</b>      |               |           |                              |
| TESTS FOR DIAGNOSTIC SERVICES            | 100%          | \$0       | \$0                          |

## Medicare (Parts A and B)

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

## Other Benefits – Not Covered By Medicare

| Services                                                                                                                                                                  | Medicare Pays | Plan Pays                                     | You Pay                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------|----------------------------------------------------|
| <b>Foreign Travel</b><br><b>Not covered by Medicare</b><br>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 |

## Important

---

### At Humana, it is important you are treated fairly.

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

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

### Auxiliary aids and services, free of charge, are available to you.

**877-320-1235 (TTY: 711)**

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

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

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

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



# Humana®

Insured by Humana Insurance Company of Kentucky

TXAI281077