Humana Insurance Company
Chart of Standardized Medicare Supplement Policies

Basic Benefits included in Medicare Supplement Policies

- **Inpatient Hospital Care:** Covers the Medicare Part A coinsurance
- **Medical Costs:** Covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved payment amount)
- **Blood:** Covers the first three pints of blood each year
- **Hospice:** Covers Part A coinsurance
- **Home Health Care and Medical Supplies:** Covers Medicare Part A or B cost sharing

Medigap Benefits	Basic Plan	Extended Basic Plan*	High Deductible Coverage Plan**
Basic Benefits	✓	✓	✓
Medicare Part A: Skilled Nursing Facility Coinsurance	✓	✓	✓
Medicare Part A Deductible		✓	✓
Medicare Part B Deductible		✓	
Medicare Part B Excess charges (100%)		✓	
Preventive Care (Non-Medicare covered)		✓	✓
Physical Therapy	20%	20%	20%
Outpatient Mental Health	40%	40%	40%
Foreign Travel Emergency	80%		100%
Coverage while in a Foreign Country		80%	
State-Mandated Benefits (Diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations)	✓	✓	✓

Optional Riders
You may add any of the following four riders to the Basic Plan. • Medicare Part A Deductible • Medicare Part B Deductible • Medicare Part B Excess charges (100%) • Preventive Care (Non-Medicare covered)

*100% after you spend $1,000 of out-of-pocket costs for a calendar year.

**Benefits from the High Deductible Coverage Plan will not begin until out-of-pocket expenses exceed $2,110. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A.

Note: The check marks in this chart mean the benefit is covered.

Humana Insurance Company
Overview of Medicare Supplement Policies with Different Cost-sharing

Benefits	Medicare Supplement Plan with 50 Percent Coverage	Medicare Supplement Plan with 75 Percent Coverage
Medicare Part A Coinsurance and Hospital Benefits	✓	✓
Medicare Part A Deductible	50%	75%
Medicare Part A Skilled Nursing Facility Coinsurance	50%	75%
Medicare Part B Coinsurance or Copayment	50%, except 100% coinsurance for Part B Preventive Services	75%, except 100% coinsurance for Part B Preventive Services
Blood	50%	75%
Hospice Care Coinsurance or Copayment	50%	75%
State-Mandated Benefits (Diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations)	✓	✓

Note: The check marks in this chart mean the benefit is covered.

The Medicare Supplement Plan with 50 Percent Coverage and the Medicare Supplement Plan with 75 Percent Coverage provide different cost-sharing for items and services than the Basic and the Extended Basic Plan. You will have to pay some out-of-pocket costs for some covered services until you meet the yearly limit (Currently, Medicare Supplement Plan with 50 Percent Coverage - $4,800; Medicare Supplement Plan with 75 Percent Coverage - $2,400. Once you meet the yearly limit, the Medicare Supplement policy pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. Charges from your doctor that exceed Medicare-approved amounts, called “excess charges,” aren’t covered and don’t count toward the out-of-pocket limit. You will have to pay these excess charges. The out-of-pocket yearly limit can increase each year because of inflation.

Humana Medicare Supplement Monthly Premiums for Area 1

Area 1 includes the following counties:
Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Sherburne, Washington, and Wright

Community Rates Effective Date 07-01-2013		
Plan	**Preferred**	**Standard**
Basic	$164.33	$192.88
Optional Benefits (Riders)*		
1. Medicare Part A Deductible ☐	$ 54.10	$64.63
2. Medicare Part B Deductible ☐	$12.24	$12.24
3. Medicare Part B Excess Charges ☐	$5.69	$6.82
4. Preventive Medical Care ☐	$10.24	$11.37
Determine Your Monthly Premium for Basic and Optional Benefits (if any):	$_____	$_____

*You purchased this benefit if the box is checked and you paid the premium.

Community Rates Effective Date 07-01-2013		
Plan	**Preferred**	**Standard**
Extended Basic	$332.23	$388.20
High Deductible Coverage Plan	$115.19	$134.43

Community Rates Effective Date 07-01-2013		
Plan	**Preferred**	**Standard**
50 Percent Coverage	$117.73	$137.28
75 Percent Coverage	$164.33	$191.38

Humana Medicare Supplement Monthly Premiums for Area 2

Area 2 includes the following counties:
Carlton, Olmsted, and St. Louis

Community Rates Effective Date 07-01-2013		
Plan	**Preferred**	**Standard**
Basic	$154.99	$181.90
Optional Benefits (Riders)*		
1. Medicare Part A Deductible ☐	$50.99	$60.91
2. Medicare Part B Deductible ☐	$12.24	$12.24
3. Medicare Part B Excess Charges ☐	$5.36	$6.43
4. Preventive Medical Care ☐	$9.65	$10.72
Determine Your Monthly Premium for Basic and Optional Benefits (if any):	$_____	$_____

*You purchased this benefit if the box is checked and you paid the premium.

Community Rates Effective Date 07-01-2013		
Plan	**Preferred**	**Standard**
Extended Basic	$313.24	$365.99
High Deductible Coverage Plan	$108.68	$126.82

Community Rates Effective Date 07-01-2013		
Plan	**Preferred**	**Standard**
50 Percent Coverage	$111.08	$129.50
75 Percent Coverage	$154.99	$180.49

Humana Medicare Supplement Monthly Premiums for Area 3

Area 3 includes the following counties:
Aitkin, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Cass, Chippewa, Chisago, Clay, Clearwater, Cook, Cottonwood, Crow Wing, Dodge, Douglas, Faribault, Fillmore, Freeborn, Goodhue, Grant, Houston, Hubbard, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac Qui Parle, Lake, Lake of Woods, Le Sueur, Lincoln, Lyon, McLeod, Mahnomen, Marshall, Martin, Meeker, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Otter Tail, Pennington, Pine, Pipestone, Polk, Pope, Red Lake, Redwood, Renville, Rice, Rock, Roseau, Sibley, Stearns, Steele, Stevens, Swift, Todd, Traverse, Wabasha, Wadena, Waseca, Watonwan, Wilkin, Winona, and Yellow Medicine

Community Rates Effective Date 07-01-2013		
Plan	**Preferred**	**Standard**
Basic	$144.00	$168.98
Optional Benefits (Riders)*		
1. Medicare Part A Deductible ☐	$47.33	$56.53
2. Medicare Part B Deductible ☐	$12.24	$12.24
3. Medicare Part B Excess Charges ☐	$4.98	$5.97
4. Preventive Medical Care ☐	$8.96	$9.95
Determine Your Monthly Premium for Basic and Optional Benefits (if any):	$_____	$_____

*You purchased this benefit if the box is checked and you paid the premium.

Community Rates Effective Date 07-01-2013		
Plan	**Preferred**	**Standard**
Extended Basic	$290.88	$339.84
High Deductible Coverage Plan	$101.02	$117.85

Community Rates Effective Date 07-01-2013		
Plan	**Preferred**	**Standard**
50 Percent Coverage	$103.24	$120.34
75 Percent Coverage	$144.00	$167.67

Premium Information

We, Humana Insurance Company, can only change the renewal premium for your policy if we also change the renewal premium for all policies that we issue like yours in this State. No change in premium will be made because of the number of claims you file, nor because of a change in your health or your type of work.

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.

This policy provides an anticipated loss ratio of 84%. This means that, on the average, policyholders may expect that $84.00 of every $100.00 in premium will be returned as benefits to policyholders over the life of the contract.

This policy does not cover all medical expenses beyond those covered by Medicare. This policy does not cover all skilled nursing home care expenses and does not cover custodial or residential nursing care. Read your policy carefully to determine which nursing home facilities and expenses are covered by your policy.

Right to return policy

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

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

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

Policy replacement

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

Notice

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

Neither Humana Insurance Company nor its agents are connected with Medicare.

This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the "Medicare & You" handbook for more details.

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.

Basic Medicare Supplement Plan

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

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

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$0 or ☐ $1,184 (Optional Part A deductible rider***)	$1,184 or $0
61st through 90th day	All but $296 a day	$296 a day	$0
91st through 150th day while using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
Beyond 150 days	$0	100% of Medicare eligible expenses**	$0
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $148 a day	Up to $148 a day	$0
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

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

Basic Medicare Supplement Plan

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

*Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$0 or ☐ $147 (Optional Part B deductible rider***)	$147 or $0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges**			
(above Medicare-approved amounts)	$0	$0 or ☐ 100% (Optional Part B Excess Charges Rider***)	All costs or $0
Blood			
First three pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$0 or ☐ $147 (Optional Part B deductible rider***)	$147 or $0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

**Except for ambulance services and medical supplies and equipment, all health care providers in Minnesota shall not charge any person with Medicare in Minnesota any amount in excess of the Medicare-approved amount for any Medicare-covered services provided.

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

Basic Medicare Supplement Plan

*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.

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $147 of Medicare-approved amounts*	$0	$0 or ☐ $147 (Optional Part B deductible rider***)	$147 or $0
Remainder of Medicare-approved amounts	80%	20%	$0

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

Basic Medicare Supplement Plan

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during travel outside the USA (includes hospital, medical expenses, and supplies)	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
Preventive Medical Care Benefit – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.			
Routine annual medical exam, including diagnostic X-rays and laboratory services	$0	$0 or ☐ up to $120 (Optional Preventive Medical Care rider***)	All costs or Balance
Immunizations not otherwise covered under Part D of the Medicare program and routine screening procedures for cancer, including mammograms, Pap smears, surveillance tests for ovarian cancer, prostate cancer screening (including antigen blood test and digital rectal examination), and colorectal cancer screening test.	$0	100%	$0

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

Extended Basic Medicare Supplement Plan

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

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

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A deductible)	$0
61st through 90th day	All but $296 a day	$296 a day	$0
91st through 150th day while using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
Beyond 150 days	$0	100% of Medicare eligible expenses**	$0
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $148 a day	Up to $148 a day	$0
101st through 120th day	$0	80%	20%
121st day and after	$0	$0	All costs
Blood			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

Extended Basic Medicare Supplement Plan

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

*Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges**			
(above Medicare-approved amounts)	$0	100%	$0
Blood			
First three pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Medicare Parts A & B

Home Health Care MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

**Except for ambulance services and medical supplies and equipment, all health care providers in Minnesota shall not charge any person with Medicare in Minnesota any amount in excess of the Medicare-approved amount for any Medicare-covered services provided.

Extended Basic Medicare Supplement Plan

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during travel outside the USA (includes hospital, medical expenses, and supplies)	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
Preventive Medical Care Benefit – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.			
Up to $120 each calendar year for routine annual medical exam, including diagnostic X-rays and laboratory services	$0	$120	Balance
Immunizations not otherwise covered under Part D of the Medicare program and routine screening procedures for cancer, including mammograms, Pap smears, surveillance tests for ovarian cancer, prostate cancer screening (including antigen blood test and digital rectal examination), and colorectal cancer screening test.	$0	100%	$0

High Deductible Coverage Plan

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.

**Benefits from the High Deductible Coverage Plan will not begin until out-of-pocket expenses exceed $2,110. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A.

Services	Medicare Pays	After You Pay $2,110 Deductible,** Plan Pays	In Addition To $2,110 Deductible,** You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A deductible)	$0
61st through 90th day	All but $296 a day	$296 a day	$0
91st through 150th day while using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
Beyond 150 days	$0	100% of Medicare eligible expenses***	$0
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $148 a day	Up to $148 a day	$0
101st through 120th day	$0	80%	20%
121st 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 as provided in the policy's "Core Benefits."

High Deductible Coverage Plan

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

**Benefits from the High Deductible Coverage Plan will not begin until out-of-pocket expenses exceed $2,110. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A.

Services	Medicare Pays	After You Pay $2,110 Deductible,** Plan Pays	In Addition To $2,110 Deductible,** You Pay
Blood			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

High Deductible Coverage Plan

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

*Once you have been billed $147 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.

**Benefits from the High Deductible Coverage Plan will not begin until out-of-pocket expenses exceed $2,110. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A.

Services	Medicare Pays	After You Pay $2,110 Deductible,** Plan Pays	In Addition To $2,110 Deductible,** You Pay
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges**			
(above Medicare-approved amounts)	$0	$0	All costs
Blood			
First three pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

**Except for ambulance services and medical supplies and equipment, all health care providers in Minnesota shall not charge any person with Medicare in Minnesota any amount in excess of the Medicare-approved amount for any Medicare-covered services provided.

High Deductible Coverage Plan

Medicare Parts A & B

*Once you have been billed $147 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.

**Benefits from the High Deductible Coverage Plan will not begin until out-of-pocket expenses exceed $2,110. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A.

Services	Medicare Pays	After You Pay $2,110 Deductible,** Plan Pays	In Addition To $2,110 Deductible,** You Pay
Home Health Care MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	After You Pay $2,110 Deductible,** Plan Pays	In Addition To $2,110 Deductible,** You Pay
Foreign Travel NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during travel outside the USA (includes hospital, medical expenses, and supplies)	$0	100% of covered expenses	Expenses not paid by Medicare or the policy
Preventive Medical Care Benefit – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.			
Up to $120 each calendar year for routine annual medical exam, including diagnostic X-rays and laboratory services	$0	$120	Balance

High Deductible Coverage Plan

Other Benefits - Not Covered By Medicare *(continued)*

Services	Medicare Pays	After You Pay $2,110 Deductible,** Plan Pays	In Addition To $2,110 Deductible,** You Pay
Immunizations not otherwise covered under Part D of the Medicare program and routine screening procedures for cancer, including mammograms, Pap smears, surveillance tests for ovarian cancer, prostate cancer screening (including antigen blood test and digital rectal examination), and colorectal cancer screening test.	$0	100%	$0

Medicare Supplement Plan with 50 Percent Coverage

*You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $4,800 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$592 (50% of Part A deductible)	$592 (50% of Part A deductible)♦
61st through 90th day	All but $296 a day	$296 a day	$0
91st day and after: while using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
once lifetime reserve days are used:			
• additional 365 days	$0	100% of Medicare eligible expenses***	$0
• beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care** You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $148 a day	Up to $74 a day	Up to $74 a day♦
101st day and after	$0	$0	All costs

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

Medicare Supplement Plan with 50 Percent Coverage

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

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

Medicare Supplement Plan with 50 Percent Coverage

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

****Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147 of Medicare-approved amounts****	$0	$0	$147 (Part B deductible)****♦
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	Generally 10%♦
Part B Excess Charges			
(above Medicare-approved amounts)**	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $4,800)*
Blood			
First three pints	$0	50%	50% ♦
Next $147 of Medicare-approved amounts****	$0	$0	$147 (Part B deductible)****♦
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%♦
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $4,800 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**Except for ambulance services and medical supplies and equipment, all health care providers in Minnesota shall not charge any person with Medicare in Minnesota any amount in excess of the Medicare-approved amount for any Medicare-covered services provided.

Medicare Supplement Plan with 50 Percent Coverage

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $147 of Medicare-approved amounts	$0	$0	$147 (Part B deductible)♦
Remainder of Medicare-approved amounts	80%	20%	10%♦

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
Preventive Medical Care Benefit – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.			
Routine annual medical exam, including diagnostic X-rays and laboratory services	$0	$0	All cost
Immunizations not otherwise covered under Part D of the Medicare program and routine screening procedures for cancer, including mammograms, Pap smears, surveillance tests for ovarian cancer, prostate cancer screening (including antigen blood test and digital rectal examination), and colorectal cancer screening test.	$0	100%	$0

Medicare Supplement Plan with 75 Percent Coverage

*You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,400 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

Services	Medicare Pays	Plan Pays	You Pay*
Hospitalization** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$888 (75% of Part A deductible)	$296 (25% of Part A deductible)♦
61st through 90th day	All but $296 a day	$296 a day	$0
91st day and after: while using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
once lifetime reserve days are used:			
• additional 365 days	$0	100% of Medicare eligible expenses	$0***
• beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care** You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $148 a day	Up to $111 a day	Up to $37 a day♦
101st day and after	$0	$0	All costs

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

Medicare Supplement Plan with 75 Percent Coverage

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

Services	Medicare Pays	Plan Pays	You Pay*
Blood			
First three pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments ♦

Medicare Supplement Plan with 75 Percent Coverage

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

****Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147 of Medicare-approved amounts****	$0	$0	$147 (Part B deductible)****♦
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges			
(above Medicare-approved amounts)**	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $2,400)*
Blood			
First three pints	$0	75%	25% ♦
Next $147 of Medicare-approved amounts****	$0	$0	$147 (Part B deductible)****♦
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $4,800 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**Except for ambulance services and medical supplies and equipment, all health care providers in Minnesota shall not charge any person with Medicare in Minnesota any amount in excess of the Medicare-approved amount for any Medicare-covered services provided.

Medicare Supplement Plan with 75 Percent Coverage

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $147 of Medicare-approved amounts	$0	$0	$147 (Part B deductible)♦
Remainder of Medicare-approved amounts	80%	15%	5%♦

Other Benefits - Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
Preventive Medical Care Benefit – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.			
Routine annual medical exam, including diagnostic X-rays and laboratory services	$0	$0	All cost
Immunizations not otherwise covered under Part D of the Medicare program and routine screening procedures for cancer, including mammograms, Pap smears, surveillance tests for ovarian cancer, prostate cancer screening (including antigen blood test and digital rectal examination), and colorectal cancer screening test.	$0	100%	$0