

Sales Agent Field Guide

Humana Medicare Supplement Plans



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[Humana.com](https://www.humana.com)



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Humana – Who We Are

Humana – Who We Are

Humana, headquartered in Louisville, Kentucky, is one of the nation's largest publicly traded health benefits companies, with 14 million medical members and 7.0 million specialty members. The company, founded in 1961, is traded on the New York Stock Exchange (NYSE: HUM).

Humana offers coordinated health insurance coverage and related services to employer groups, government-sponsored plans and individuals through:

- Administrative services products
- Preferred provider organizations
- Consumer driven plans
- Health maintenance organizations
- Medicare Supplement plans
- Medicare Advantage plans
- Medicare Prescription Drug plans
- Plans for U.S. military dependents and retirees
- Individual major medical plans



Humana's Financial Strength

- Fortune 100 company with 2017 revenues of approximately \$53.76 billion.
- Total assets of approximately \$27.17 billion as of December 31, 2017.
- Net income for 2017 was \$2.44 billion.
- Approximately 14 million medical members including 8.1 million Medicare members of which 2.8 million are Medicare Advantage members and 5.3 million Prescription Drug Plan members.
- The company's strategy is on track creating innovative, consumer-directed products and services powered by leading edge information technology.

Agent Information

Agent Conduct

Humana is committed to providing quality products and services. In order to maintain this commitment and to comply with all state and federal laws, Humana has enacted a code of conduct for its agent representatives and independent contractors.

As representatives of Humana, agents should always act with professionalism and integrity. The best interest of the customer should always take the highest priority. A high level of customer service will be maintained by answering customer calls quickly and accurately, staying informed of coverage needs, and promoting an atmosphere of trust with the policyholder.

Agents will accurately promote the strengths of Humana and its products without disparaging competitors. Only Humana-approved materials will be used in presenting product information. Benefits, features, costs, exclusions, and limitations will be adequately disclosed to the applicant in compliance with Humana and regulatory guidelines.

Monitoring will ensure that all agents representing Humana are fully licensed and have accepted this code of conduct. Humana reserves the right to discontinue its relationship with anyone who is unwilling or unable to follow this code of conduct on an ongoing basis.

Licensing and Appointment for Humana's Agents

All agents who solicit insurance business on behalf of Humana (and all companies affiliated with Humana) as well as any agent or agency that will receive commissions from Humana are required to complete a Group Producing Agent or Agency contract.

All agents or agencies soliciting insurance business are required to hold an active agent or agency license in every state they solicit business. Along with licensing requirements for agents or agencies, states require agents or agencies to be appointed by Humana in each state in which business is solicited.

An agent or agency appointment with Humana cannot be processed without an active agent license. Both the writing agent and agent of record must be licensed, contracted, and appointed.

Please contact the Agent Support Line (contact information on page 28) for details regarding what you need to do to sell Humana's Medicare Supplement Plans.

Humana Medicare Supplement Plans

Coverage Features

Humana Medicare Supplement Plans and Humana Healthy Living Medicare Supplement Plans offer protection to customers from the gaps in Medicare Parts A and B. Plans include features such as:

Freedom to choose any doctor, hospital, or clinic that accepts Medicare.

Some plans provide coverage for services received by providers who do not accept Medicare.

Portable coverage that can be used anywhere in the United States and, with certain plans, even out of the country.

- Nationwide coverage is provided. Humana's Medicare Supplement Plans do not contain provider or hospital networks (exception, Plan F Select in **Louisiana**).
 - **Louisiana's** Plan F Select contains a hospital network only. Policyholders enrolled in this plan must use a participating hospital. Benefits will not be provided if hospitalized in an out-of-network hospital, unless the hospitalization is for emergency services as described in their policy.
- Policyholders enrolled in Plans C, F, High Deductible F, G, or N receive foreign travel emergency coverage as well.

Built-in Vision and Dental innovative benefits on Humana Healthy Living Medicare Supplement Plans.

- Network providers (where permitted) can be found on **Humana.com**.
 - Policyholders can find participating dental providers by selecting "Humana Dental Medicare Network," and vision providers by utilizing the EyeMed network.

Pricing

Premium Discounting

- *ACH Discount* – Policyholders save \$2 on their monthly premium by electing to make future payments electronically via automatic bank withdrawal or by credit card payment. If applicants wish to take advantage of this discount, be sure to elect an automatic payment option in the future payment section of the enrollment application. See page 10 for additional details.
- *Household Discount (where approved)* – Policyholders with effective dates of 6/1/2010 and later sharing a residence save 5% on their monthly premium. To enroll in the Household Discount program be sure applicants provide the name and Medicare ID of the **other** policyholder living at their residential address in the Discounting section of the enrollment application. (Household is defined as a condominium unit, single family home, or apartment within an apartment complex.)
Please Note: in **Washington** the discount is offered as a Spousal Discount.

Humana Medicare Supplement Plans

- *Early Enrollment Discount (Arizona and Massachusetts only)*
 - **Arizona** – Policyholders save on their monthly premium if enrolling between the ages of 65 and 73. They will continue to receive the discount, which diminishes by 3% annually at time of renewal, through age 77.

Age at time of Enrollment	Discount
65	39%
66	36%
67	33%
68	30%
69	27%
70	24%
71	21%
72	18%
73	15%

- **Massachusetts** – Applicants save 15% on their monthly premium by enrolling at age 65. The discount then diminishes by 5% annually at time of renewal through age 67.

Standard and Preferred rates

- Tobacco use and Medicare eligibility prior to age 65 are used as rate determining factors (where permitted).

Humana practices Attained-age rating (where permitted).

- *Attained-age rating*: Premium is based on Policyholders current age and will be adjusted annually as they get older. (Please note, in some attained-age states where plans are offered to those under the age of 65 qualifying for Medicare due to disability, policies are issued on an issue-age basis.) When quoting, the premium should be determined based on the applicant's age at the end of the proposed coverage effective month.
- *Community rating* (where required by the state): Generally the same monthly premium is charged to everyone regardless of age. In some states, premiums vary due to tobacco use and/or Medicare eligibility prior to age 65.
- *Issue-age rating* (where required by the state): Premium is based on age at time of policy issue. Policyholders will remain in that age group for the life of the policy. When quoting, the premium should be determined based on the applicant's age as of the proposed coverage effective date.

Area rating by county (where permitted).

- Although Medicare Supplement Plans are offered statewide, premiums can vary by county. Most states are divided in up to 3 rating areas depending upon medical cost variations.

Rate increases

- Rates will not increase more than once in a 12 month period. These increases take effect no sooner than the policyholder's anniversary date. Annual age increases for attained-age states, will take place at time of renewal. Age is determined as of the end of the month in which the policy is renewing.

Humana Medicare Supplement Plans

Other Features

Electronic claims coordination with Medicare.

Guaranteed renewable

- Coverage cannot be cancelled for reasons other than lack of premium payment or fraud.
- One time enrollment. No annual enrollment action required.

30-day free look period

- If the policyholder is not satisfied with his/her Medicare Supplement plan, the policy may be returned within 30 days of delivery and it will be considered void from their effective date of coverage. Humana will refund paid premium less any claims incurred during that 30 days.

Plan availability

- Humana Medicare Supplement Plans (standardized plan offering)
 - Humana commonly offers Plans A, B, C, F, High Deductible F, G, K, L, and N with some variance by state. See your state's Outline of Coverage for plan availability.
- Humana Healthy Living Medicare Supplement Plans include innovative Dental and Vision benefits.
 - Plans offered: A, F, High Deductible F, K, and N.
- Waiver State plan offerings
 - **Massachusetts, Minnesota, and Wisconsin** offer plans that do not conform to the nationally standardized menu; however, the benefit structures are similar.
 - **Massachusetts** offers a Core Plan (basic benefits, similar to a Plan A) and Supplement 1 (similar to a Plan C).
 - **Minnesota** offers a Basic Plan (similar to a Plan A) and optional riders that can be purchased in addition to the Basic Plan. Cost Share plans are available (similar to Plans High Deductible F, K, L and N).
 - **Wisconsin** also offers a Basic Plan (similar to Plan A) and optional riders as well as Cost Share plans (similar to Plans K, L and High Deductible F).



For plan details refer to an Outline of Coverage (sample pictured here). Outlines of Coverage for all states are available within the Agent Self-Service Center at [Humana.com](https://www.humana.com).

Humana Medicare Supplement Plans

Extra Services

Please note not all extra services are offered in all states; availability may vary. No promotional discussion is allowed pre-sale in the following states: Connecticut, Georgia, Illinois, Kansas, and New York, but the services are offered post-enrollment. Extra services are not contractually offered, nor guaranteed under Humana's Medicare Supplement insurance policies, and services may be added or discontinued annually. (Please note: In the state of **Montana**, applicants must authorize the release of personal information for those services administered by third parties - SilverSneakers. There is a form included in the **Montana** app packet for doing so.)

Humana Medicare Supplement Plans as well as Humana Healthy Living Medicare Supplement Plans provide the following extra services at no additional cost:

SilverSneakers® Fitness – Basic fitness center membership that entitles the member to use any equipment, attend group exercise classes, and work with trained advisors at participating SilverSneakers® fitness centers.

SilverSneakers® Steps – For members without easy access to a participating center, this pedometer based walking program is available.

Rx Discount – The policyholder can save an average of 20% or more on prescription drugs at participating pharmacies. The discount program can be used for weight loss, impotence, hair loss, smoking cessation, and many other prescriptions that are not covered by Medicare. Most major pharmacy chains participate. Policyholders can find out if an independent pharmacy participates by calling 1-800-866-0581. Agents can access information via the Pharmacy Locator within the Agent Self-Service Center at **Humana.com**.

Vision Discount – This program is available to the policyholder through EyeMed, which offers access to 40,000 national providers including optometrists, ophthalmologists, and opticians at 20,000 locations. Policyholders can locate a participating EyeMed provider by calling 1-866-392-6056.

HumanaFirst® – Nurse advice line offering 24-hour health information, guidance, and support for policyholders. Whether the concern is immediate or long-term, policyholders can call 1-800-622-9529 for expert advice to find out how Humana can help them lead a healthier life and get the most out of their health plan.

MyHumana – Members can log onto **Humana.com** and register for MyHumana, your password-protected, personal page, to review details of your claims, use health and pharmacy tools, and find health information and resources. You can also find Medicare information at **Humana.com/Medicare**.

Shared Decision Making – Humana provides members with resources to decide on, prepare for, and recover from surgery via **Humana.com/MyDecision**. Tools help members work with their doctors to understand treatment options and make decisions about surgery that weight benefits and risks, including their personal values and preferences. Surgery preparation resources cover topics such as what to expect before, during and after surgery and how to avoid complications to have a successful recovery.

Humana Medicare Supplement Plans

WellDine™ Meal Program – After an overnight stay in the hospital or nursing facility, policyholders are eligible for 10 nutritious, precooked frozen meals delivered to their door at no cost. To arrange for this service, policyholders call 1-866-96MEALS (1-866-966-3257) after discharge and provide their Humana policyholder ID number and other basic information. A Humana representative will assist in scheduling delivery. (Not available to policyholders living in **Montana and North Dakota**.)

Hearing Discount – Discounts on hearing aids and services are available through HearUSA, TruHearing, and Beltone.

Lifeline® Medical Alert Systems - Lifeline is committed to improving the quality of life for seniors and their families. The solutions give seniors and those with disabilities the always-on support they need to live independent lives. Lifeline offers the most widely adopted and proven fall detection in the United States today, with more than 200,000 falls detected automatically. Policyholders can choose from multiple service options at discounted prices. To order, policyholders can call Philips Lifeline at 1-800-594-8192 (TTY: 1-800-855-2881) and can learn more by visiting <http://www.offer.lifelinesys.com/humana/>.

Member Experience / Post-Sale Communications Only

These programs are available to Humana Medicare Supplement policyholders but are **not** allowed to be discussed or promoted during the sales process. Information is here for reference only should an agent receive a question from a policyholder.

USA Senior Care Network Premium Savings Program – An opportunity for policyholders to receive a \$100 credit off of a future premium payment if the policyholder goes to a participating hospital that is part of the USA Senior Care Network and has an inpatient stay that requires payment of a Part A deductible. The network arrangement is non-restrictive and has no impact on the policyholder's freedom to visit any provider who accepts Medicare. This program is purely a savings opportunity. Policyholders can find hospitals that are part of USA Senior Care Network by calling USA Senior Care at 1-800-872-3860. (Please note: this program is not available on Plan A, High Deductible F or Select F.)

Humana At Home® Private Pay Service (SeniorBridge) – A 10% discount on Humana At Home private pay services (SeniorBridge) available for policyholders or a family member. Services include hourly and daily accredited homecare and professional care management. Services are provided by Licensed Nurses, Social Workers, Certified Home Health Aides (CHHAs), Certified Nursing Assistants (CNAs) and specialty companions who offer professional oversight, planning, coordination and implementation of care plans. Policyholders can visit HumanaAtHome.com/privatepay to learn about available services in their area or, can get a free consultation by calling 1-800-694-8326.

Please refer Medicare Supplement policyholders to their Extra Services Brochure for more information.

Humana Medicare Supplement Plans

Eligibility Requirements

Applicants must be age 65 or older (may vary by state; review your state's Outline of Coverage for details) and enrolled in Medicare Parts A and B. Policies are issued based on the applicant's state of residence. Additionally, when and where required, applicants must be able to pass Medical Underwriting and will be required to complete a telephonic underwriting review.

Enrollment Application

The proper submission of an enrollment application is critical in our ability to provide the best possible service to you and our applicants. Carefully review these steps to ensure your business will be processed without delay.

The Sales Agent initiates the application process. After confirming with the applicant that a Humana Medicare Supplement Plan meets his or her needs, providing rates, and confirming eligibility, follow these steps to successfully submit the enrollment application.

The applicant completes the Medicare Supplement Enrollment Application. Responses to all questions necessary for the efficient processing of the enrollment will be required within the electronic application (FastApp and MAPA). The application cannot be submitted without required responses. If a paper application is being submitted information must be printed on the enrollment application in clear, legible, capital block letters in blue or black ink. Additionally, fill in all circles completely, where applicable, to ensure proper scanning. **Sales Agents are responsible for ensuring that the applicant answers all required questions on the application.** Please review the marking instructions on the paper enrollment application for additional guidance. If an error is made when completing the application, please be sure the applicant initials the correction.

Personal information

Be sure to complete all information in full.

An application may be submitted up to 90 days in advance of the proposed effective date. The electronic application will not allow users to submit applications for effective dates more than 90 days in advance. Applications received on or after the proposed effective date will be made effective the first day of the following month.

Enrollment Application



Follow these easy steps to become a Humana Medicare Supplement insurance policy.

- 1 Have Your Medicare Card Ready**
Please print legibly and complete the entire form. You will need to fill in the information exactly as it appears on your Medicare card. Each person must complete a separate application.
- 2 Read and Complete Other Coverage Information**
Be sure you read and understand the information before completing this section. If you intend to replace your current Medicare Supplement policy or Medicare Advantage plan with this policy, be sure to complete the enclosed form titled Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage.
- 3 Complete Guaranteed Acceptance**
Please fill out this section if you are eligible for guaranteed acceptance. If a Notice of Replacement Form is required to be submitted with your application, please provide the criteria qualifying you for guaranteed acceptance on the form. For example, if you qualify for guaranteed acceptance due to a Medicare Advantage plan exit, please check "Disenrollment from a Medicare Advantage plan" and indicate that your plan is exiting the market and no longer available.
- 4 Read and Complete Medical Questions**
- 5 Determine Your Premium**
- 6 Determine Your Discount**
- 7 Be Sure to Include Your Initial Premium Payment**
Your first month's premium payment must be included. This is necessary even if you choose our Automatic Bank Withdrawal or Auto Credit Card Charge options for future premium payments.
- 8 Sign and Date the Enrollment Application**

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Humana Medicare Supplement Plans

Other coverage information

Be sure to complete all information in full. When replacing coverage all start dates and carrier/plan information will be required within the electronic application. End dates are also needed if known but are only required if coverage is ending prior to the signature date of the application. Please remember to complete this information as applicable within the paper application as well. If required responses are left blank within the paper application, the processing of the application will be delayed. Applicants must also indicate that they intend to replace their current coverage with the Medicare Supplement plan they are electing. Please be aware that if an applicant qualifies for a Guaranteed Acceptance period (see below), the coverage they are losing/replacing must be identified within this section. If this information is not provided or if the applicant indicates a lapse in coverage greater than 63 days (or the state required time period), the application will be underwritten. If this section is not completed correctly, the electronic form will not allow the user to submit the application as guaranteed acceptance. Additionally, if a paper application is submitted the enrollment process will be delayed.

Guaranteed acceptance determination

Guaranteed Issue Guidelines can be found in the current CMS publication of *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* provided in the Humana Medicare Supplement Sales/Enrollment Kits.

A list of state-specific open enrollment and guaranteed issue periods is included on page 19 and 20 of this guide.

Medical questions, if applicable based on Guaranteed Acceptance and Open Enrollment (not applicable in Connecticut, Massachusetts, New York, or Vermont)

All health questions must be answered, including the question regarding prescription medications and reason for the prescription, unless an application is submitted during an open enrollment or guaranteed issue period. Sales agents are responsible for reviewing and explaining all medical questions to applicants during the application process. Sales agents are responsible for marking accurate answers to medical questions as given by applicants. Humana reserves the right to monitor Sales Agents' books of business for inaccurate health information.

ALL applications should be submitted unless the applicant indicates they have been prescribed one or more of the drugs listed on page 14 and 15, they suffer from one of the conditions listed on page 16 and 17, or the applicant's height and weight fall into the denial ranges provided on page 18. Only in these situations should an application not be submitted. If the applicant is deemed ineligible, electronic applications should be saved and if using MAPA, they should also be uploaded.

Premium determination

Use the answers to the questions in this section to provide the appropriate base premium quote in the next section. Please be aware, these questions will only be enabled within the electronic applications when they are required for premium determination. If it is determined that the applicant is enrolling during their Medicare Supplement Open Enrollment Period or they qualify for Guaranteed Acceptance, some or all of these questions are not used for rate determination and therefore, responses are not necessary.

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Humana Medicare Supplement Plans

Discount determination

If the applicant qualifies for the Household or Spousal discount, provide the name and Medicare claim number of the **other** policyholder/enrollee in this section. **This section should NOT be completed with the applicant's information.** Additional information can be found in the Outline of Coverage providing details around how to qualify for the discount as well as a page to calculate the applicant's monthly discounted premium. This is the amount required to be submitted with the enrollment application.

In **Arizona** and **Massachusetts** an Early Enrollment discount is also available. See the Outline of Coverage for more information. Applicants qualify for this discount due to age only. Nothing additional has to be included on the enrollment application.

Monthly premium, initial payment and recurring payment options

Be sure to quote current rates based on the answers in the previous 2 sections. If the Effective Date of the rates in the Outline of Coverage is nearing or over a year old, check for updated rates. The electronic applications will always quote the most current rate. Monitor Sales Compass notifications for news on annual rate changes.

A \$2 per month discount will apply if **automatic bank withdrawal or recurring credit card payment** is the chosen recurring payment method.

Humana requires the first month's premium to process the application (not applicable in Arizona).

- Approved methods for submitting initial premium payments include: Automatic checking/savings account withdrawal (ACH), personal check, money order, or credit card. If fields for entering ACH information are not available in the Initial Payment section include "ACH" in the check number field of the Initial Payment section along with all banking information. Applications submitted without the initial premium payment will **not** be processed until payment is received.
- Post-dating checks will not ensure the payment is held and this is not an acceptable practice to suggest. Payments will be processed upon receipt (regardless of effective date of coverage).
- If applicant is paying the initial payment by check, the payment is processed within 2-5 business days of receipt, regardless of approval or denial of the application. It is NOT held until the coverage effective date. If the application is not approved, the first month's premium payment will be refunded (refunds are typically processed within 5-10 business days of the date of denial). The applicant should indicate "Med Supp" in the check's note or memo section. If the applicant is also a PDP (Prescription Drug Plan) member that chooses to pay via coupon book for ongoing future payments, a separate check will need to be submitted for each plan. Again, "Med Supp" will need to be written in the memo section of the check for payments applicable to the Med Supp plan and "PDP" in the memo section for payments applicable to the Prescription Drug Plan. When a check is being submitted for the initial payment, the ACH fields should **not** be completed in the "initial payment" section. Entering ACH information in the "initial payment" section, as well as submitting a check, will result in two account withdrawals. Electronic/automatic payment methods are always preferable and make the application easier to process.

(Enrollment Application continued next page)

Humana Medicare Supplement Plans

- If applicant is paying the initial payment by automatic withdrawal or credit card, the payment will be processed when coverage becomes effective. Payments will not be drafted if the application is denied.

Recurring Payments

Automatic Bank Withdrawal: If the applicant would like to have future premiums automatically withdrawn from their checking or savings accounts, please ensure that they complete the bank information.

- The withdrawal will take place between the 2nd and 7th of each month. Humana will draft only the balance due for that month. The payment being drafted is for the current month, not the future month.

Recurring Credit Card Payment: If the applicant would like to have future premiums automatically charged to their credit card, please ensure that they complete the credit card information for the card they want to use.

Coupon Book: If the applicant elects coupon book to pay ongoing monthly premiums, the applicant is responsible for remitting the amount due by the first of the following month and the first of every month thereafter. Sales agents are not authorized to collect ongoing premiums.

Annual Payments: If an applicant makes an annual payment, they should monitor notices regarding premium changes. This will help avoid potential payment shortfalls in the future.

Sign and date the enrollment application

The applicant and agent must both sign the application. Under no circumstances should a Sales Agent sign an application in place of an applicant.

Applications must be dated the day the application is completed and signed by the applicant, not the date it is sent to Humana or the date the insurance is to become effective. Backdating of applications is strictly prohibited.

Agents must list all health insurance policies sold to the applicant which are still in force and all policies sold to the applicant within the past five years which are no longer in force. If none, please be sure to write "none" in both fields (Company and Type). If both fields are left blank, the application will pend.

Office use only

To receive proper commission credit, you must fully complete the agent/agency information in the "Office Use Only" portion of the application:

- Writing Agent - Fill in your name as contracted with Humana.
- Writing Agent ID - Fill in your writing agent ID (i.e. your SAN/SSN).
- Commission Level - This field can be ignored.
- MGA Code - This field can be ignored.
- Affinity Code - provide your Affinity Code if applicable.
- Agency - not applicable to Career Agents. Delegated agents not being directly paid commissions need to provide their agency's name.
- Agency ID - not applicable to Career Agents. Delegated agents need to provide the Federal Tax ID (FEIN) of the agency to receive commission payment if the Agency name was provided.

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Humana Medicare Supplement Plans

Prompt submission of paper applications

Failure to submit applications promptly may affect the effective date of coverage. A copy of the completed application will be provided to the applicant upon policy fulfillment.

Humana Career Agents

Submit applications to the Manager of Sales Administration (MSA) for your service area within 1 business day of the applicant/agent signature date.

Non-Career or External Agents

Submit applications within 2 business days of applicant/agent signature date to:
Humana Medicare Enrollment
2432 Fortune Drive
Lexington, KY 40509

If initial premium is being paid by credit card or ACH, enrollment applications can be faxed to **1-877-889-9936**. Enrollments can NOT be faxed if initial premium is being paid by check. Please do not both fax and mail in enrollments.

In the event an application is pended, you will receive an email alert notifying you of the missing information that needs to be submitted. If you must submit the missing information via paper, the following fax number can be used to expedite PENDED applications by faxing in missing enrollment forms directly to Enrollment: **1-502-508-9003**.

Tracking your applications

MAPA Reporting

Medicare Supplement MAPA reporting allows Career agents to track their personal activity on submitted applications. Please follow these steps to access this tool:

1. Log in to **www.humana.com** using your user ID & password
2. Click on Medicare Agent Workbench
3. Under Products & Enrollment click on MAPA tools
4. Under MAPA tasks to the right of the screen click on Application Status
5. Select filter criteria as required and hit submit
6. Run results

Delegated Reporting Tool

Delegated agents can track their Medicare Supplement business for the past 18 months. Agents are able to access the Delegated Reporting Tool to view submitted applications, active and terminated enrollments as well as commission statements. Please follow these steps to access this tool:

1. Log in **www.humana.com** using your user ID & password
2. Click on Medicare Agent Workbench
3. Under Track Applications and Enrollments click on Enter Search Tool
4. Choose report type from the drop down menu and enter applicable search dates
5. Choose the product in question
6. At the bottom of the screen click Request Report to generate the report

Humana Medicare Supplement Plans

Underwriting Guidelines (not applicable in Connecticut, Massachusetts, New York, or Vermont)

At Humana, we believe that an adequate level of underwriting leads to better premium rates for our customers. For this reason:

Unless the applicant qualifies for Guaranteed Issue or Open Enrollment, all applicants will be underwritten. Please inform your clients that they are not approved until the application has been reviewed by Humana's Medicare Supplement Underwriting Department. Their application will be reviewed within 2 business days after completing and submitting the application. If additional information is needed to complete underwriting, they will receive a call from Humana's Underwriting Department. The applicant must be able to complete the telephonic underwriting review. If the applicant is unable to complete the telephonic underwriting review for any reason, the application will be denied.

The Medical Release Form, included in the Sales Kit and incorporated into the FastApp and MAPA application processes, is required to be submitted with all applications completed outside of an Open Enrollment Period or Guaranteed Issue scenario. Applications will not be sent to Underwriting until the form is received delaying the enrollment process.

ALL applications must be submitted regardless of the responses provided in the Medical Questions section of the application unless the applicant indicates they have been prescribed one or more of the drugs listed on page 14 and 15, they suffer from one of the conditions listed on page 16 and 17, or the applicant's height and weight fall into the denial ranges provided on page 18.

You will receive notification emails providing you with the status of your submitted applications during the Underwriting process. Please ensure the email address you have on file with Humana remains current. Notifications you can expect to receive are as follows:

Underwriting Review - email is sent upon receipt of the applicants application by the Underwriting department. This lets you know that the review will be completed within the next 24-48 hours (if the Underwriting consultant is able to reach your client telephonically).

Please Call - email is sent in the event the Underwriting consultant cannot reach the applicant. It is requested that you assist with contacting the applicant and instructing them to call the Underwriting department. A letter is also sent to the applicant.

Cancel - email is sent notifying you that either the applicant has asked that their application be withdrawn or the Underwriting review was not completed due to a lack of response from the applicant. This will occur after 45 days. A letter is also sent to the applicant.

Decline - email is sent alerting you that the applicant was not able to pass the Medical Underwriting portion of the enrollment process. A letter is also sent to the applicant.

Standard - email is sent upon completion of the Underwriting process. This only means that the applicant has passed Medical Underwriting. The application must then be reviewed by the Enrollment team to ensure accuracy and eligibility for coverage. Please DO NOT forward this email on to applicants.

The applicant should know that coverage is not effective at time of application and current coverage should not be cancelled until their application has been processed and their Humana Medicare Supplement policy is issued. If an applicant has current coverage (including Medicare Advantage), auto disenrollment is not triggered by purchasing a Medicare Supplement Plan. The applicant must contact their insurance carrier to terminate their existing plan.

Humana Medicare Supplement Plans

Medications Related to Uninsurable Conditions

Below is a partial listing of medications that will result in denial. If the applicant has taken one or more of the following within the past 12 months, do not submit the application. This list is not all-inclusive. Please remember to keep in mind the brand or generic version associated with the medications listed below.

A	C	Emtriva	Ipratropium Bromide HFA
Abilify	Campral	Enbrel	Iressa
Actiq	Carbidopa/Levodopa	Epivir	Isentress
Afinitor	Casodex	Equetro	J
Aggrenox	Ceenu	Ergoloid Mesylates	Jantoven
Akineton	Cellcept	Etoposide	K
Alkeran	Cerefolin	Exelon	Kaletra
Amiodarone	Chlorpromazine HCL	Exemestane	Kineret
Ampyra	Cilostazol	F	Kogenate FS
Anagrelide Hydrochloride	Clopidogrel	Fanapt	L
Anastrozole	Clozapine	Fareston	Lanoxin
Antabuse	Clozaril	Felbatol	Letairis
Aptivus	Combivent	Femara	Letrozole
Aranesp	Combivir	Fentanyl	Leukeran
Aranesp Albumin Free	Comtan	Fluphenazine Decanoate	Leukine
Arava	Copaxone	Fluphenazine Hcl	Lexiva
Aricept	Cordarone	Flutamide	Lithium
Arimidex	Coumadin	Fosrenol	Lodosyn
Aromasin	Crixivan	H	Loxapine
Atripla	Cyclophosphamide	Haloperidol	Loxapine Succinate
Atrovent HFA	Cyclosporine	Haloperidol Decanoate	Loxitane
Aubagio	D	Hepsera	Lysodren
Avinza	Demadex	Humira Pen	M
Avonex	Diazoxide	Hydrea	Matulane
Azathioprine	Didanosine	Hydromorphone HCL	Megace
Azilect	Didronel	Hydroxycloquine	Megestrol Acetate
B	Digoxin	Hydroxyurea	Mercaptopurine
Baclofen	Dipyridamole-aspirin	I	Methotrexate
Baraclude	Donepezil	Ilaris	Mitomycin
Benzotropine Mesylate	Droxia	Imuran	Moban
Betapace	DuoNeb	Intelence	Multaq
Betaseron	E	Intron-A	Mustargen
Bicalutamide	Effient	Invega	Mycophenolate
Bosulif	Eldepryl	Invirase	Mofetil
Brilinta	Elquis		Myfortic
Bromocriptine Mesylate	Embeda		Myleran
Butrans	Emcyt		

Humana Medicare Supplement Plans

Medications Related to Uninsurable Conditions

Below is a partial listing of medications that will result in denial. If the applicant has taken one or more of the following within the past 12 months, do not submit the application. This list is not all-inclusive. Please remember to keep in mind the brand or generic version associated with the medications listed below.

N

Nalbuphine HCL
Naltrexone HCL
Namenda
Nardil
Navane
Nebupent
Neoral
Neulasta
Neupogen
Neupro
Nexavar
Nilandron
Nitroglycerin Patch
Norvir

O

Olanzapine
Orencia

P

Parlodel
Pegasys
Peg-Intron Redipen
Pentoxil
Pergolide Mesylate
Persantine
Phoslo
Plavix
Pletal
Pradaxa
Prezista
Procrit
Prograf
Propafenone
Purinethol

R

Ranexa
Rapamune
Razadyne
Razadyne ER
Rebetol
Remicade
Renagel
Renvela
Requip
Rescriptor
Revatio
Revlimid
Reyataz
Ribasphere
Ridaura
Rilutek
Risperdal
Risperdal Consta
Risperidone
Roferon-A

S

Saphris
Selegiline HCL
Selzentry
Simponi
Sinemet
Sotalol
Sps
Stalevo
Stalevo 100
Stribild
Sustiva
Sutent
Symbyax

T

Tabloid
Tacrolimus
Tambocor
Tamoxifen Citrate
Tarceva
Targretin
Tasmar
Taxotere
Temodar
Thalomid
Thioridazine HCL
Thiothixene
Tice Bcg
Tikosyn
Torsemide
Tracleer
Trental
Trexall
Trifluoperazine HCL
Trihexyphenidyl HCL
Trizivir
Truvada
Tysabri

V

Valcyte
Videx
Viracept
Viramune
Viread
Vivitrol

W

Warfarin Sodium

X

Xarelto
Xtandi
Xeloda
Xenazine
Xyrem

Z

Zaltrap
Zelapar
Zerit
Ziagen
Zidovudine
Zoladex
Zyprexa

Humana Medicare Supplement Plans

Medicare Supplement Ineligible Conditions

Below is a partial listing of conditions that will result in denial. If the applicant has suffered from one or more of the following in the last 2 years (3 years in CA), do not submit the application. This list is not all-inclusive.

A

AIDS, ARC or HIV
Addison's
Adrenal insufficiency
Alcohol Abuse / Alcoholism
Alzheimer's Disease
Ankylosing Spondylitis
Arterial embolism
Artificial opening for feeding or elimination (within the last 12 months)
Atherosclerosis/
arteriosclerosis
Atrial Fibrillation

B

Bed Sore (Decubitus ulcer)
Bedridden
Bipolar Disorder
Brain tumor
Burns – extensive third degree

C

Cancer - Internal
Carotid artery disease
Cerebral Hemorrhage
Cerebral Palsy
Chest Pain (Angina Pectoris)
Chronic Kidney Disease
Chronic Obstructive Pulmonary Disease (COPD)
Cirrhosis of the liver
Confined to a wheelchair

Coma, brain compression/
anoxic damage or severe
head injury
Congestive heart failure
Coronary heart disease
(blockage)
Crippling arthritis
Crohn's Disease
Cushing's Syndrome
Cystic Fibrosis

D

Delusions/Hallucinations
Dementia
Drug Abuse

E

Emphysema
End Stage Renal Disease
(ERSD)
Enlarged heart
(Cardiomyopathy)

H

Hardening of the arteries
Heart Attack
(myocardial infarction)
Heart disease
Heart Enlargement
Heart Failure
Hemophilia
Hepatitis B

Hepatitis C
Huntington's disease

I

Internal Cancer

K

Kidney disease requiring
dialysis
Kidney Failure

L

Leukemia
Lou Gehrig's Disease
Lupus (systemic lupus
erythematosus)

M

Malnutrition
Marfan Syndrome
Melanoma
Multiple or lateral sclerosis
Multiple personality disorder
Muscular dystrophy
Myasthenia Gravis

N

Neuralgic or poor circulation
that has caused an ulcer on
the skin
Neuropathy/Diabetic
Neuropathy

Humana Medicare Supplement Plans

Medicare Supplement Ineligible Conditions

Below is a partial listing of conditions that will result in denial. If the applicant has suffered from one or more of the following in the last 2 years (3 years in CA), do not submit the application.

This list is not all-inclusive.

O

Organ transplant (other than corneal)
Organic brain disorders
Osteopetrosis

P

Pacemaker
Paget's Disease
Pancreatitis
Paranoia
Paralysis
Paralytic condition
Parkinson's disease
Peripheral vascular disease
Polymyositis
Pulmonary embolism

R

Respiratory dependence
Rheumatoid arthritis

S

Sarcoidosis
Schizophrenia
Seizures within the past 12 months
Senile Dementia
Senility disorder
Sick sinus syndrome/brady-tachycardia syndrome/sinus node disease
Sickle Cell Anemia
Spina Bifida

Spinal cord disorders/injuries
Stroke
Suicide attempt
Systemic Lupus

T

Transient Ischemic Attack (TIA)

U

Ulcerative Colitis
Uncontrolled Diabetes
Uncontrolled high blood pressure (hypertension)
Uncontrolled high cholesterol

V

Ventricular arrhythmias
Ventricular fibrillation or flutter

Humana Medicare Supplement Plans

BODY MASS INDEX If applicants height and weight fall into one of these ranges they are not eligible for coverage. Do not submit the enrollment application.					
Height (ft/in)	Deniable BMI of 14 or less Weight (lbs.)	Deniable BMI of 40.5 or more Weight (lbs.)	Height (ft/in)	Deniable BMI of 14 or less Weight (lbs.)	Deniable BMI of 40.5 or more Weight (lbs.)
4'	46 or less	133 or more	6'	103 or less	299 or more
4'1"	48 or less	138 or more	6'1"	106 or less	307 or more
4'2"	50 or less	144 or more	6'2"	109 or less	315 or more
4'3"	52 or less	150 or more	6'3"	112 or less	324 or more
4'4"	54 or less	156 or more	6'4"	115 or less	333 or more
4'5"	56 or less	162 or more	6'5"	118 or less	342 or more
4'6"	58 or less	168 or more	6'6"	121 or less	351 or more
4'7"	60 or less	174 or more	6'7"	124 or less	360 or more
4'8"	62 or less	181 or more	6'8"	127 or less	369 or more
4'9"	65 or less	187 or more	6'9"	131 or less	378 or more
4'10"	67 or less	194 or more	6'10"	134 or less	387 or more
4'11"	69 or less	201 or more	6'11"	137 or less	397 or more
5'	72 or less	207 or more	7'	141 or less	406 or more
5'1"	74 or less	214 or more	7'1"	144 or less	416 or more
5'2"	77 or less	221 or more	7'2"	147 or less	426 or more
5'3"	79 or less	229 or more	7'3"	151 or less	436 or more
5'4"	82 or less	236 or more	7'4"	154 or less	446 or more
5'5"	84 or less	243 or more	7'5"	158 or less	456 or more
5'6"	87 or less	251 or more	7'6"	161 or less	467 or more
5'7"	89 or less	259 or more	7'7"	165 or less	477 or more
5'8"	92 or less	266 or more	7'8"	169 or less	488 or more
5'9"	95 or less	274 or more	7'9"	172 or less	498 or more
5'10"	98 or less	282 or more	7'10"	176 or less	509 or more
5'11"	100 or less	290 or more	7'11"	180 or less	520 or more
			8'	184 or less	531 or more

Humana Medicare Supplement Plans

Open Enrollment Guidelines

The Medicare Supplement Open Enrollment Period starts in the first month the applicant is covered under Medicare Part B and is age 65 or older. It will last for six months. If the applicant qualified for Medicare prior to age 65, they are still entitled to rights granted during the Medicare Supplement Open Enrollment Period at age 65.

Some states do require a Medicare Supplement Open Enrollment period to be granted to individuals under the age of 65 when they first become covered under Medicare Part B. Coverage for under 65 varies by state, please check the state's Outline of Coverage for plan availability.

State-Specific Open Enrollment and Guaranteed Issue Guidelines

In addition to the guaranteed issue scenarios described in the *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, the following states have additional open enrollment and guaranteed issue periods that you should know about. This is not a complete list. Please review your state regulations for additional scenarios which may qualify an applicant for guaranteed issue into a Medicare Supplement plan.

California, Kansas, Maine, Montana, Oregon, Tennessee, Texas, Utah, and Wisconsin – Individuals are guaranteed issue into a Medicare Supplement plan when losing Medicaid.

California – Current Medicare Supplement policyholders (with any carrier) are guaranteed issue into a like or lesser Medicare Supplement plan (see plan comparison table on page 21) beginning 30 days prior to their birthday and ending 30 days after their birthday each year. Application signature dates will be accepted no more than 30 days prior to birthday. Coverage effective date must follow birthday.

Guaranteed issue is also available to individuals losing military health coverage due to the closing of a military base, the base no longer offering health care services, moving away from the base, or losing access to health care services at the military base. Applicants must apply no more than 6 months from the date their coverage ends.

Additionally, applicants are eligible for guaranteed issue if their current Medicare Advantage plan is reducing benefits, increasing cost sharing, terminating a provider contract, or increasing premiums by at least 15%. Applicants can enroll as guaranteed issue into a Medicare Supplement policy offered by their current carrier. If their carrier does not offer Medicare Supplement plans they are guaranteed issue into any carrier's Medicare Supplement plans.

Finally, individuals qualify for guaranteed issue due to termination of an employer retirement plan paying either primary or secondary to Medicare. Applicants must apply no more than 6 months from the date their coverage ends.

Colorado – Extends a guaranteed issue period of 63 days beginning with the date coverage ends to individuals voluntarily losing Employer Welfare Benefit coverage. For those involuntarily losing coverage the guaranteed issue period is extended to 6 months.

Humana Medicare Supplement Plans

Maine – An annual open enrollment period is available to applicants enrolling in Plan A during the month of July. (This does not apply to Humana Healthy Living Plan A.)

All applicants are guaranteed issue when losing medical benefits through the Medicaid program.

If an applicant enrolled in coverage that supplements Medicare less than 36 months prior to their proposed coverage effective date with no gap in coverage greater than 90 days, they qualify for guaranteed issue into a plan of equal or lesser value (see plan comparison table on page 21). If the applicant has been covered under a Medicare Advantage Plan since first becoming eligible for Medicare but no more than 36 months prior to their proposed coverage effective date with no gap in coverage greater than 90 days, they qualify for guaranteed issue into any plan.

Additionally, if an applicant is enrolled in and has maintained a Medicare Supplement policy (with any carrier) since first becoming eligible for Medicare Part B, they qualify for guaranteed issue into an equal or lesser plan (see plan comparison table on page 21). If replacing plans E, H, I, or J, the applicant qualifies for guaranteed issue into plans A, B, C, F, F(HD), K, L, or N. The applicant must apply no more than 90 days from the date their coverage ends.

Michigan – All applicants are guaranteed issue when enrolling in Humana Medicare Supplement Plans A or C. (This does not apply to Humana Healthy Living Plan A.)

Missouri – Current Medicare Supplement policyholders (with any carrier) are guaranteed issue into a Medicare Supplement plan of equal value (see plan comparison table on page 21) if enrolling within 30 days (before or after) their current policy's anniversary date. If replacing plans E, H, I, or J, the applicant qualifies for guaranteed issue into plans A, B, C, F, F(HD), K, L, or N.

Oregon – Current Medicare Supplement policyholders (with any carrier) are guaranteed issue into a like or lesser Medicare Supplement Plan (see plan comparison table on page 21) beginning 30 days prior to their birthday and ending 30 days after their birthday each year. Application signature dates will be accepted no more than 30 days prior to birthday. Coverage effective date must follow birthday.

Tennessee – Individuals under the age of 65 receive a 6 month guaranteed issue period for the standard scenarios found in the *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*.

Washington – Current Medicare Supplement policyholders (with any carrier) qualify for guaranteed issue when replacing their current plan with another Medicare Supplement plan. Plan A policyholders are only guaranteed acceptance into Plan A.

Humana Medicare Supplement Plans

PLAN COMPARISON CHART		
Current Plan (includes Select offerings)	Equal To	Lesser
A	A	High Deductible F
B	B	A, High Deductible F
C	C	A, B, High Deductible F, G, K, L, N
D	D	A, B, High Deductible F, K, L, N
F	F	A, B, C, High Deductible F, G, K, L, N
High Deductible F	High Deductible F	None
G	G	A, B, D, High Deductible F, K, L, N
K	K	A, B, High Deductible F
L	L	A, B, High Deductible F, K
M	M	A, B, High Deductible F, K, L
N	N	A, B, High Deductible F, K, L

Non Standard Plans	
Core (MA)	See standard Plan A
Supplement 1 (MA)	See standard Plan C
Basic (MN and WI)	See standard Plan B
Basic + Riders (MN and WI)	See standard Plan F
Extended Basic (MN)	See standard Plan F
50% Coverage (MN)	See standard Plan K
75% Coverage (MN)	See standard Plan L
High Deductible Coverage (MN and WI)	See standard Plan High Deductible Plan F
50% Cost Share +/- Rider (WI)	See standard Plan K
25% Cost Share +/- Rider (WI)	See standard Plan L
\$20/\$50 Copay Plan (MN)	See Standard Plan N

Please note: Current Humana and Humana Healthy Living Medicare Supplement policyholders switching to a plan of equal value (i.e. an Indiana Plan F to a Kentucky Plan F, an Indiana Humana Plan F to an Indiana Humana Healthy Living Plan F) qualify for guaranteed issue; however, a new application must be completed. Current policyholders wishing to reduce or increase their benefits (i.e. switch from a Plan F to a Plan K or a Plan A to a Plan C) will be subject to medical underwriting. Members who enrolled in a Humana Medicare Supplement Plan prior to June 1, 2010 will be underwritten for all plan changes (with the exception of **Oregon and Washington**). Current policyholders wishing to reduce their monthly premium due to the discontinued use of tobacco products (must be tobacco-free for at least 12 months) do not qualify for guaranteed issue and will be underwritten regardless of the plan they are re-enrolling.

Humana Medicare Supplement Plans

Additional Required Forms

Notice of Replacement: Any Sales Agent replacing health insurance must accurately complete a Notice of Replacement (NOR) form. If the applicant indicates they're replacing/losing coverage in either of the following questions the NOR must be completed and submitted (language may vary by state):

- If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. - If a start date is provided, the NOR should be submitted.
- Do you have another Medicare supplement policy in force? - If the applicant responds YES, the NOR should be submitted.

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage
Humana Insurance Company • P.O. Box 1430, Lexington, KY 40512-4309

Give this notice: It may be important to you in the future.

According to information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy/certificate to be issued by Humana Insurance Company. Your new policy/certificate will provide 30 days within which you decide, without cost, whether you desire to keep the policy/certificate.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to the Applicant by Issuer, Agent (Broker or other Representative)

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan.

The replacement policy/certificate is being purchased for the following reason (check one):

Additional benefits
 Lower benefits and lower premiums
 My plan has outpatient prescription drug coverage and I am enrolling in Part D
 Disenrollment from a Medicare Advantage plan (please specify reason for disenrollment) _____

No change in benefits, but lower premiums
 Other (please specify) _____

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage for similar benefits) to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy/certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium on (though your policy/certificate has never been in force). After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

To not cancel your present policy/certificate until you have received your new policy/certificate and are sure that you want to keep it.

Applicant's signature	Signature of agent/broker/representative
Print name	Print name and address of agent or broker below
	Date

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In the state of **New York**, the following question is considered in addition to the two above:

- Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) - If the applicant responds YES, the NOR should be submitted.

A NOR form is required for ALL replacements of Medicare Advantage or Medicare Supplement coverage, even if applicant qualifies for Guaranteed Acceptance due to the replacement. **If the applicant qualifies for a guaranteed acceptance period, the qualifying event must be listed on the NOR. If it is not, the application will be underwritten.** For example, if an applicant qualifies for guaranteed acceptance due to Medicare Advantage plan exit, please check "Disenrollment from a Medicare Advantage plan" and indicate that the plan is exiting the market and is no longer available. Similarly, if the applicant qualifies due to a Trial Right (see the Choosing a Medigap Policy Guide), the applicable Trial Right should be clearly written on the form.

Failure to complete and return the NOR will result in the applicant's enrollment pending until Humana receives the completed NOR. Forms may vary by state and will be required at the end of the enrollment process as part of the electronic application. For paper enrollments, the form is included as part of the application packet rather than a separate, free-standing form.

(Other Required Forms continued next page)

Humana Medicare Supplement Plans

Medical Release Form: For all applications submitted outside of an Open Enrollment or Guaranteed Issue period a Medical Release form must be completed and submitted (not required in **Connecticut, Massachusetts, New York or Vermont**). Failure to do so will result in the application pending. Forms vary by state. The form will be required after completing the enrollment application as part of the electronic process if the applicant is enrolling outside of an Open Enrollment or Guaranteed Issue period.

Medical Records Release Authorization

Purpose of the Authorization
By signing this form, you will authorize the disclosure and use of the predicted health information described below for pre-enrollment underwriting or to determine your eligibility for enrollment or benefits under an insurance plan.

Information we will use under disclosure
I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsurance company, employer or the Connecticut Health Agency having information regarding myself including identification information concerning public, diagnosis, treatment and all other pertinent information, mental or emotional condition, alcohol or substance use disorder, illness and copies of all hospital or medical records, non-public personal health information and any other non-medical information that you may have in all such information with Humana Medical Insurance Company, its insurer or its legal representatives, and its affiliates.

The information obtained by use of this authorization may be used by Humana Medical Insurance Company to determine eligibility for coverage.

Any information obtained will not be released by Humana Medical Insurance Company to any person or organization except to reinsurance companies, or other persons or organizations performing health care operations or business or health services in connection with any application, claim or any other authorized benefit required, or as we may further authorize. If a Consumer Reporting Agency is used, I may request to be interviewed in connection with the preparation of the report and may request a copy of the report.

Once personal and health (including medical and pharmacy) information is disclosed pursuant to this authorization, it may be retained by the recipient and the information may not be protected by federal and state privacy requirements.

Expiration and revocation
A copy of this authorization is available to me or my legal representative upon written request. A photostatic copy of this authorization shall be valid as well as the original.
This authorization shall be valid for 2 years from the date shown below. I have the right to revoke this authorization at any time.
To revoke this authorization:
1. I must file a written revocation and send my written revocation to Humana's Privacy Office (Humana Privacy Office, P.O. Box 1438 Louisville, KY 40202).
2. The revocation will not apply to information that has already been released in response to this authorization.
3. The revocation may adversely affect my application, a claim or a pending insurance action.
4. The revocation will become effective after it is received by Humana or its insurer or agent.

If you were required to answer medical questions on your Medicare Supplement Enrollment Application, you must complete this authorization to be eligible for enrollment.

LAST NAME: [] FIRST NAME: [] MI: []
 MEDICARE NUMBER: []
 DATE: []/[]/[]


Applicant Signature: _____ Date: _____
 Issued by Humana Medical Insurance Company

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Guaranteed Acceptance Guide: This form defines categories for guaranteed acceptance and creditable coverage eligibility. In **Texas**, a copy of the form must be submitted to and signed by the applicant to be submitted with the enrollment application. The form is included as part of the application packet rather than a separate, free-standing form. Failure to submit the form will result in the application pending. In **Florida and Pennsylvania**, the form must be presented to the applicant prior to completing the enrollment application. Receipt of this information is then acknowledged within the enrollment application. Forms may vary by state. In both states the form will be required prior to beginning the enrollment application in the electronic applications.

Medicare Supplement Guaranteed Issue Guide



Definitions of Eligible Person for Guaranteed Issue And Creditable Coverage

You are eligible for Guaranteed Issue if you submit evidence of the date of termination or disenrollment with the Enrollment Application, and you meet one of the following conditions:

- You are enrolled in an employer welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates or ceases to provide such supplemental health benefits, or you are enrolled in an employer welfare benefit plan that is primarily to Medicare as the plan terminates, or ceases to provide health benefits because you left the plan.
Your guaranteed issue period begins on the later of the following: the date you receive a notice of termination or cessation of supplemental health benefits (i.e. a notice not received, notice that action has been denied because of a termination or cessation), or the date that the applicable coverage terminates or ceases, and ends 63 days thereafter.
- You are enrolled with a Medicare Advantage organization under a Medicare Advantage Plan (the "Plan") under Part C of Medicare and any of the following apply: or you are 63 years of age or older and are enrolled with a Program of All-Inclusive Care for the Elderly (PACE), and there are circumstances similar to those described or follow that would permit discontinuance of your enrollment with the provider if you were enrolled in a Medicare Advantage Plan.
 - The organization or Plan's certification under that plan has been terminated or
 - The organization has terminated or otherwise discontinued providing the Plan in the area in which you reside, or
 - You are no longer eligible to elect the Plan because of a change in your place of residence or other change in circumstances specified by the Secretary of the Department of Health and Human Services (the "Secretary"), including those circumstances where you were disenrolled from the Plan for any of the reasons described in Section 1812(j)(1)(B) of the Federal Social Security Act (i.e. where you have not paid premiums on a timely basis, or you have engaged in disruptive behavior as specified in standards under Section 1816), or the Plan is terminated for all enrollees residing within a particular residential service area, or
 - You demonstrate, in accordance with guidelines established by the Secretary, that:
 - The organization offering the Plan substantially violated a material provision of the organization's contract with the Centers for Medicare & Medicaid Services in relation to you, including the failure to provide you, in a timely basis, with medically necessary care for which benefits are available under the Plan, or the failure to provide such covered care in accordance with applicable quality standards; or
 - The organization or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions or marketing the Plan to you.

You meet such other exceptional conditions as the Secretary may provide.

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Medicare Supplement Comparison Statement/ Policy Checklist: In **Kentucky** and **Illinois**, applicants must complete and return this form when replacing coverage. In **Illinois**, the form is required when replacing a Medicare Advantage Plan, another Medicare Supplement Plan, or group/ employer coverage. In **Kentucky**, the form is required when replacing a Medicare Advantage plan or another Medicare Supplement plan. Failure to do so will result in the application pending until Humana receives the completed forms. ALL sections must be completed including the demographic section at the top of the form. The form will pend if any field is left blank. All fields must at least contain "N/A." Forms vary by state and are included as part of the application packet rather than a separate, free-standing form. In both states the form will be required (when applicable) prior to beginning the enrollment application in the electronic applications.

Use Ballpoint Pen And Press Hard - You Are Making Multiple Copies.

Illinois Medicare Supplement Policy Checklist

Service	Benefits	Medicare Part A*	Existing Coverage	Supplement Plan**	You Pay*
Hospital Indemnity	First 60 days: All but \$1,100 (Part A Deductible) 61st to 90th day: All but \$375 a day 91st to 120th day: All but \$240 a day Beyond 120 days: 0	All but \$1,100 (Part A Deductible)	Other A Deductible or Copay Other Part A Deductible Other Part A Deductible Other Part A Deductible	0 0 0 0	0 0 0 0
Self-Care, Nursing, Home Care	First 20 days: All approved amounts Additional 60 days: All but \$167.50 a day Beyond 120 days: Nothing	All approved amounts All but \$167.50 a day Nothing	All Medicare approved amounts for or additional \$15 a day	0 0 0	0 0 All costs

* These figures are for 2018 and are subject to change each year. Refer to the Outline of Coverage to compare benefits for previous pricing cycles.
** Benefits from Part High Deductible will not begin until out-of-pocket expenses exceed \$1,200 (calendar Year applicable).
This policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.
The undersigned applicant and agent have determined that the policy is appropriate and non-abusive.

Signature of Applicant: _____ Date: _____ Signature of Agent: _____ Date: _____

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Humana Medicare Supplement Plans

Other required State-Specific Forms Include (these forms must be signed and submitted with the enrollment application):

- Florida Agent Certification Form
- Louisiana Select Disclosure Statement Acknowledgment (when enrolling in Plan F Select)
- Minnesota Notice of Insolvency Rights
- Minnesota Statement of Suitability

All of the forms listed above will be included, when required, as part of the electronic application.

The following forms must be presented to the applicant at time of application but are not required to be submitted with the enrollment form:

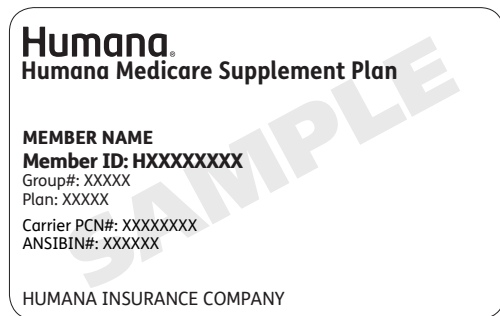
- New York Conditional Receipt
- Washington Notice of Rejection - to be presented to those applicants who do not qualify for a Humana Medicare Supplement Plan due to prescription drugs, deniable conditions, and/or BMI.
- Washington Notice of Restriction

Note: This is not an exhaustive list. Please fill out and return all applicable forms from your sales kits to ensure appropriate and complete processing.

Additional Enrollment Processing Information

Policy Delivery

After the application has been processed and accepted, the ID card will be mailed directly to the policyholder from Humana within five (5) business days, and the policy accompanied by a copy of the completed application will be mailed within ten (10) business days. A notice of application approval will be sent to the writing agent.



Pre-Existing Conditions

To help control rising costs, Humana policies include a pre-existing condition clause for newly issued Medicare Supplement policies.

Expenses resulting from a condition existing six months prior to policy effective date are not covered unless they are incurred three months after the policy effective date. If the policy replaces other creditable individual or group insurance coverage, this pre-existing condition limitation will be reduced by the number of months that coverage was in force. If this policy replaces another Medicare Supplement policy, the pre-existing condition limitation will be reduced by the number of months that coverage was in force. The pre-existing condition limitation is waived when application is made during guaranteed issue situations. Pre-existing condition requirements vary by state.

Humana Medicare Supplement and Prescription Drug Plan (PDP)

Many applicants seeking to enroll in a Humana Medicare Supplement Plan may have or purchase a Humana PDP. Since these are two separate plans, it is important to submit a separate check for the Medicare Supplement premium when submitting a paper application. To reduce the risk of posting Medicare Supplement premiums incorrectly, be sure applicants note in the memo section of their checks that the payment is applicable to their Medicare Supplement plan. When an applicant records "Payment for Med Supp" or "Med Supp" on the memo line, it is more easily identifiable and ensures accurate processing of funds. For more information, contact the Agent Support Line (contact information on page 28).

(Additional Enrollment Processing Information continued next page)

Additional Enrollment Processing Information

Changes to In-force Business

Address Change: Policyholders should contact Humana directly for address changes either in writing or over the phone. **Note:** An address change may result in a change in the premium rate. The change will be effective immediately and a new coupon book will automatically be issued or the new premium will be drafted with the next billing cycle.

In-State Move: In most states, premiums have been developed for up to three rating areas per state depending on the state. These rating areas are defined by county of residence. Please check rate charts in the Outline of Coverage for proper rate classification.

Out-of-State Move: When Humana Medicare Supplement policyholders move from the state their policy was initially issued, they may choose to continue coverage under their current plan with a premium adjustment or apply as guaranteed issue into a plan of **equal value** available in their new state of residence. A new enrollment application is required if applying in the new state of residence. If the policyholder chooses to enroll in a plan of greater or lesser value, they will be subject to medical underwriting.

Information on premium changes or plan availability due to a move is available through Customer Service (contact information on page 28).

Cancellation of Coverage: A cancellation request can be made in writing or over the phone by the policyholder or their legal representative. The cancellation will be effective the last day of the month in which Humana receives notification. Some states do require a prorated termination date based on the cancellation date requested.

Rescission of Coverage: If any information on any form is misstated or omitted, coverage may be rescinded. Rescission voids coverage from the effective date, and any premiums paid will be refunded, less any claims already paid. No payments will be made for any claims submitted, whether or not the treatment was related to the condition that was misstated (varies by state).

Agent Support

Marketing Materials

Non-Career Agents can order Medicare Supplement Enrollment kits, including all required forms, by contacting the Agent Support Line (contact information on page 28). In order to place your order, Agent Support will require:

- Your 7-digit Agent ID
- Shipping Address
- State(s) for which you need kits
- Quantity of kits

This information can be provided to Agent Support by phone, fax, or email (contact information on page 28).

Humana Agent Portal

You may also view and print Outlines of Coverage via the Humana Agent Portal. Go to **Humana.com**, click on “Agents & Brokers,” select “Medicare” from the dropdown, then scroll down and click on “See details about Medicare Supplement Plans, and lastly click on “View products in your state”. All Medicare Supplement Outlines of Coverage can be found here (You must first select the applicable state).

Commissions

For information about commissions for Career Agents, contact your Manager of Sales Administration (MSA).

For Non-Career or External Agents, commission checks are calculated twice each month, on the 10th and the 25th. Payments are made on the 15th and the last day of the month. Dates are adjusted for weekends and holidays.

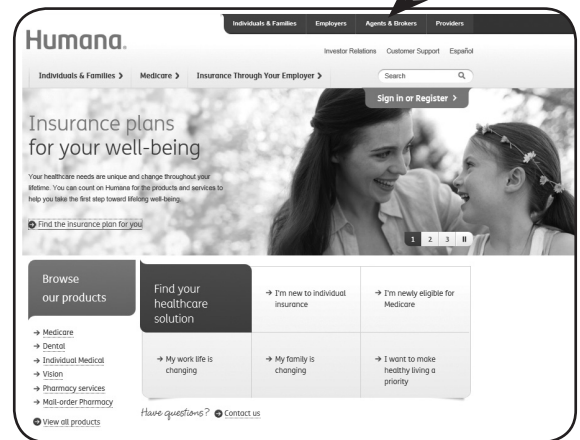
Commissions are calculated using commissionable premium only. Commissionable Premium is referred to as the base rate less any applicable discounts (Household, Early Enrollment), less premium attributed to the Part B deductible benefit.

For questions regarding commission payments call Agency Management (contact information on page 28).

Get Commissions Faster

Still waiting for paper commission checks? Get your money faster and with fewer hassles by signing up for direct deposit. We will continue to mail your commission statement after each deposit. To receive the form for direct deposit contact the Agent Support Line (contact information on page 28).

AGENT PORTAL
ENTRANCE



(Agent Support continued next page)

Agent Support

Humana Contact Information

Important CUSTOMER Phone Numbers

Member Customer Service: 1-800-866-0581
Billing/Enrollment: 1-800-866-0581
Claims/Benefits: 1-800-866-0581
TDD (For Hearing Impaired): 711

Important AGENT Contact Information

Agency Management

Commissions: 1-855-330-8128 or AgencyMGT@humana.com

Agent Support Line (8 a.m. – 9 p.m. EST)

For questions such as contracting/appointments, product support, marketing materials, or PRE-ENROLLMENT issues and general questions:

Agents: 1-800-309-3163
Email: AgentSupport@humana.com
Fax: 1-502-508-0062

Enrollment, Billing and Claims Inquiries

Please allow at least three business days for submissions to be reviewed. Due to complexity, research and possible approvals, certain issues may take up to five business days. Agents will receive a follow-up email every five business days with an updated status on open issues. Remember to limit each email to one member's issue(s).

Email: AgentRSOS@humana.com

Underwriting

Customer Service: 1-800-825-7858

Access to Care

Access to care and critical, time sensitive issues that need **immediate attention** should be called in to customer service for guidance and solutions. This will allow for escalation with a supervisor and/or manager.

Phone: 1-800-866-0581

