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Humana – Who We Are

Humana, headquartered in Louisville, Kentucky, is one of the nation’s largest publicly traded health benefits companies, with 12.1 million medical members and 8.1 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 2012 revenues of approximately $39.13 billion.
- Total assets of approximately $20.0 billion as of December 31, 2012.
- Net income for 2012 was $1.2 billion.
- Approximately 12.1 million medical members including 5.4 million Medicare members of which 1.93 million are Medicare Advantage members and 3.0 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.
- “A-” investment grade rating from AM Best. (Rating is applicable to Humana Insurance Company.)
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 27) 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 assignment. 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 Medical 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 payments electronically. If applicants wish to take advantage of this discount, be sure to elect an automatic payment option in the payment section of the enrollment application.

- **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.
• **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.

<table>
<thead>
<tr>
<th>Age at time of Enrollment</th>
<th>Discount</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>39%</td>
</tr>
<tr>
<td>66</td>
<td>36%</td>
</tr>
<tr>
<td>67</td>
<td>33%</td>
</tr>
<tr>
<td>68</td>
<td>30%</td>
</tr>
<tr>
<td>69</td>
<td>27%</td>
</tr>
<tr>
<td>70</td>
<td>24%</td>
</tr>
<tr>
<td>71</td>
<td>21%</td>
</tr>
<tr>
<td>72</td>
<td>18%</td>
</tr>
<tr>
<td>73</td>
<td>15%</td>
</tr>
</tbody>
</table>

- **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 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 also available (similar to Plans K, L, and High Deductible F).
  – Wisconsin also offers a Basic Plan (similar to Plan A) and optional riders as well as Cost Share plans (similar to Plans K and L).

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.
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, Idaho, Illinois, Kansas, Maine, 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 and QuitNet. 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.

- **HumanaVitality®** – A comprehensive wellness program designed to help policyholders adopt a healthier lifestyle in simple, manageable steps. Only available in Alabama, Arizona, California, Colorado, Florida, Kentucky, Massachusetts, Nevada, New Mexico, North Carolina, Ohio, Pennsylvania, Utah and Virginia.

- **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.

- **Humana Active Outlook℠** – Life-enrichment program designed exclusively for Humana Medicare members. Through Humana Active Outlook mailings, online content, seminars, and classes members receive information about healthy living, Medicare news, and valuable discounts and coupons from major brands.

- **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.
QuitNet® Comprehensive – Included in the Humana Active Outlook program, QuitNet is an evidence-based smoking cessation program that offers expert advice, personalized support, unlimited social support from fellow quitters, practical quit tips, and celebration of milestones reached, all designed to help tobacco users quit – and stay tobacco-free.

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-Medicare.com.

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.)

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

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.)

SeniorBridge® Homecare & Care Management – A 10% discount on SeniorBridge accredited homecare and professional care management services. SeniorBridge has Licensed Nurses, Social Workers, Certified Home Health Aides (CHHAs), Certified Nursing Assistants (CNAs) and specialty companions to provide professional oversight, planning, coordination and implementation of care plans. This program is available to the policyholder and a family member. Policyholders can visit SeniorBridge.com to check available services in their area or, can get a free consultation by calling 1-800-694-8326 or emailing contactus@SeniorBridge.com.

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

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. (In West Virginia, applications may be submitted no more than 30 days in advance of the proposed effective date.)

(Enrollment Application continued next page)
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, 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.

(Enrollment Application continued next page)
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). The initial 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).

- 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 by check, please indicate “Med Supp” in the check’s note or memo section. If the applicant is also purchasing a PDP (Prescription Drug Plan), a separate check will need to be submitted. Electronic/automatic payment methods are always preferable and make the application easier to process.
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 - provide your commission level.
- MGA Code - provide your MGA code.
- 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.
- Ignore bubbles for Attachments and bubble labeled MAN as well as fields for GR and BN.

(Enrollment Application continued next page)
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 you have a pended application, you will receive an email alert notifying you of the missing information that needs to be submitted. You will need to call your prospect and access the application via the link included in the notice to submit the missing information. 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
Medicare Supplement MAPA reporting allows 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
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 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.
Medications Related to Uninsurable Conditions
Below is a partial listing of medications that will result in denial. If the applicant takes one or more of the following, do not submit the application. This list is not all-inclusive.

A
Abilify
Actiq
Afinitor
Akineton
Alkeran
Ampyra
Anagrelide Hydrochloride
Antabuse
Aptivus
Aranesp
Aranesp Albumin Free
Arava
Aricept
Arimidex
Aromasin
Atripla
Atrovent HFA
Aubagio
Avinza
Avonex
Azathioprine
Azilect

Chlorpromazine HCL
Clofazimine
Clozapine
Clobazam
Combivir
Comtan
Copaxone
Cordarone
Crixivan
Cyclophosphamide
Cyclosporine

D
Demadex
Diazoxide
Didanosine
Didronel
Digoxin
Dipyridamole-aspirin
Droxia
DuoNeb

E
Eldepryl
Embeda
Emcyc
Emtriva
Enbrel
Epivir
Equetro
Ergoloid Mesylates
Etoposide
Exelon
Exemestane

F
Fanapt
Fareston
Felbatol
Femara
Fentanyl
Fluorouracil
Fluphenazine Decanoate

Fluphenazine HCL
Flutamide
Flusumide

H
Haloperidol
Haloperidol Decanoate
Hepsera
Humira Pen
Hydrea
Hydromorphone HCL
Hydroxyurea

I
Ilaris
Imuran
Intelence
Intron-A
Invega
Invirase
Ipratropium Bromide HFA
Iressa
Isentress

K
Kaletra
Kineret
Kogenate FS

L
Lanoxin
Letairis
Letrozole
Leukeran
Leukine
Lexiva
Lithium
Lodosyn
Loroxine
Loxapine
Looxapine Succinate
Loritane
Lysodren
Medications Related to Uninsurable Conditions

Below is a partial listing of medications that will result in denial. If the applicant takes one or more of the following, do not submit the application. This list is not all-inclusive.

**M**
- Matulane
- Megace
- Megestrol Acetate
- Mercaptopurine
- Methotrexate
- Mitomycin
- Moban
- Multaq
- Mustargen
- Mycophenolate Mofetil
- Myfortic
- Myleran

**N**
- Nalbuphine HCL
- Naltrexone HCL
- Namenda
- Nardil
- Navane
- Nebupent
- Neoral
- Neulasta
- Neupogen
- Neupro
- Nexavar
- Nilandron
- Norvir

**O**
- Olanzapine
- Oremia

**P**
- Parlodel
- Pegasys
- Peg-IFN Redipen
- Pergolide Mesylate
- Phoslo
- Plavix
- Pletal
- Pradaxa
- Prezista
- Procrit
- Prograf
- Propafenone

**R**
- Purinethol
- Rapamune
- Razadyne
- Razadyne ER
- Rebetol
- Remicade
- Renagel
- Renuela
- Requip
- Rescriptor
- Revatio
- Revlimid
- Reyataz
- Ribasphere
- Ridaura
- Rilutek
- Risperdal
- Risperdal Consta
- Risperidone
- Roferon-A

**S**
- Saphris
- Selegiline HCL
- Selegiline HCL
- Seroquel
- Simponi
- Sinemet
- Sps
- Stalevo
- Stalevo 100
- Stribild
- Sustiva
- Sutent
- Symbyax

**T**
- Tabloid
- Tacrolimus
- Tambocor
- Tamoxifen Citrate
- Tarceva
- Targetin
- Tasmear
- Taxotere
- Temodar
- Thalomid
- Thioridazine HCL
- Thiothixene
- Tice Bcg
- Tikosyn
- Torsemide
- Tracleer
- Trental
- Trexall
- Trigliuphenazine HCL
- Trigluphenidyl HCL
- Trizivir
- Truvada
- Tysabri

**V**
- Valcyte
- Videx
- Viracept
- Viramune
- Viread
- Vivitrol

**W**
- Warfarin Sodium

**X**
- Xtandi
- Xeloda
- Xenazine
- Xyrem

**Z**
- Zaltrap
- Zelapar
- Zerit
- Zigen
- Zidovudine
- Zolade
- Zymprexa
Medicare Supplement Ineligible Conditions

Below is a partial listing of conditions that will result in denial. If the applicant suffers from one or more of the following, 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)
Atrial Fibrillation
Coma, brain compression/anoxic damage or severe head injury
Congestive heart failure
Coronary heart disease
Crippling arthritis
Crohn’s Disease
Cushing’s Syndrome
Cystic Fibrosis

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

D
Delusions/Hallucinations
Dementia
Drug Abuse

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

H
Hardening of the arteries
Heart Attack
Heart disease
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 erythematosis)

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
Medicare Supplement Ineligible Conditions
Below is a partial listing of conditions that will result in denial. If the applicant suffers from one or more of the following, 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**
- 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
If applicants' height and weight fall into one of these ranges, they are not eligible for coverage. Do not submit the enrollment application.

<table>
<thead>
<tr>
<th>Height (ft/in)</th>
<th>Deniable BMI of 14 or less</th>
<th>Deniable BMI of 41 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Weight (lbs.)</td>
<td>Weight (lbs.)</td>
</tr>
<tr>
<td>4’</td>
<td>46 or less</td>
<td>134 or more</td>
</tr>
<tr>
<td>4’1”</td>
<td>48 or less</td>
<td>140 or more</td>
</tr>
<tr>
<td>4’2”</td>
<td>50 or less</td>
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<tr>
<td>4’3”</td>
<td>52 or less</td>
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<tr>
<td>4’10”</td>
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<tr>
<td>4’11”</td>
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<tr>
<td>8’</td>
<td>184 or less</td>
<td>537 or more</td>
</tr>
</tbody>
</table>
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, 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 20) 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.

**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.) 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 20). 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 20) 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 20) 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.

<table>
<thead>
<tr>
<th>Plan Comparison Chart</th>
<th>Current Plan (includes Select offerings)</th>
<th>Equal To</th>
<th>Lesser</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>A</td>
<td>High Deductible F, K, L, N</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>B</td>
<td>A, High Deductible F, K, L, N</td>
<td></td>
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<tr>
<td>C</td>
<td>C</td>
<td>A, B, High Deductible F, K, L, N</td>
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</tr>
<tr>
<td>D</td>
<td>D</td>
<td>A, B, C, High Deductible F, K, L, N</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>F</td>
<td>A, B, C, High Deductible F, K, L, N</td>
<td></td>
</tr>
<tr>
<td>High Deductible F</td>
<td>High Deductible F</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>G</td>
<td>A, B, C, F, High Deductible F, K, L, N</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>K</td>
<td>High Deductible F</td>
<td></td>
</tr>
<tr>
<td>L</td>
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<td></td>
</tr>
<tr>
<td>N</td>
<td>N</td>
<td>High Deductible F, K, L</td>
<td></td>
</tr>
</tbody>
</table>

**Non Standard Plans**
- Core (MA) | See standard Plan A
- Supplement 1 (MA) | See standard Plan C
- Basic (MN and WI) | See standard Plan A
- 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) | 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

**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 Washington).
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.

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, “plan exit” should be indicated on the Notice of Replacement. 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.

Guaranteed Acceptance Guide: This form defines categories for guaranteed acceptance and creditable coverage eligibility. In Texas, a copy of the form must be presented 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 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 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.
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.
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 27).

(Additional Enrollment Processing Information continued next page)
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 27).

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).
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 27). 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 27).

Humana Agent Portal
You may also view and print Outlines of Coverage via the Humana Agent Portal. Go to Humana.com, click on “for Agents & Brokers,” select “Medicare” from the dropdown, then scroll down and click on “Medicare Supplement Plans”. All Medicare Supplement Outlines of Coverage can be found here.

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.

For questions regarding commission payments call Agency Management (contact information on page 27).

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 27).