Sales Agent Field Guide

Humana Medicare Supplement Plans

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GH16094M10

Contents

Humana – Who We Are

Humana, headquartered in Louisville, Kentucky, is one of the nation's largest publicly traded health benefits companies, with 10.2 million medical members and 7.1 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 2011 revenues of approximately $36.83 billion.
- Total assets of approximately $17.7 billion as of December 31, 2011.
- Net income for 2011 was $36.83 billion.
- Approximately 10.2 million medical members including 4.5 million Medicare members of which 1.96 million are Medicare Advantage members and 2.5 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.
- "BBB" investment grade rating from Standard & Poor's

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 24) 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 Reader's Digest 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.

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

- Members are covered nationwide. 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. Members 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.
- Members enrolled in Plans C, F, High Deductible F, G, or N receive foreign travel emergency coverage as well.

Pricing

Premium Discounting

- *ACH Discount* – Members 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)* – Humana and Humana Reader's Digest Medicare Supplement 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.)

- *Early Enrollment Discount (AZ and MA only)*
  - AZ – Applicants save on their monthly premium if enrolling between the ages of 65 and 73. Members continue to receive the discount, which diminishes by 3% annually, 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%

  - MA – Applicants save 15% on their monthly premium by enrolling at age 65. The discount then diminishes by 5% annually 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 member's 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, those policies are issued on an issue-age basis.)
- *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 and they will remain in that age group for the life of the policy.

Area rating by county (where permitted).

Rates will not increase more than once in a 12 month period for inflationary or cost trend purposes. These increases take effect no sooner than the policyholder's anniversary date. Annual age increases for attained-age states, will occur within one month of the member's birthday (except in the states of Michigan and Nevada).

Humana Medicare Supplement Plans

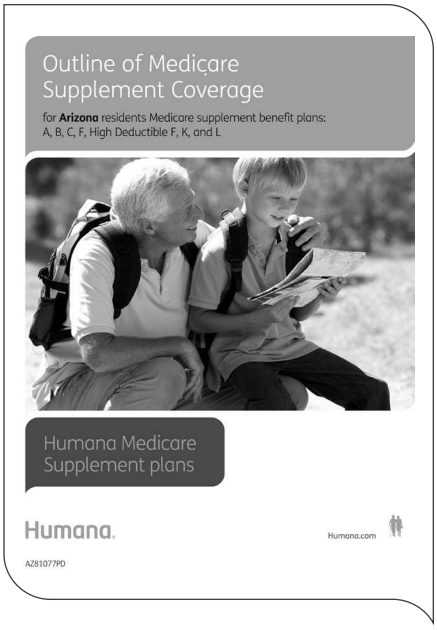
Other Features

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 member 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, K, L, and N with some variance by state. See your state's Outline of Coverage for plan availability.
- Humana Reader's Digest Healthy Living Medicare Supplement Plans (most states include Vision and Dental innovative 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 F).
  - 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 a Humana Medicare Supplement plan 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, New York, and Texas, but the services are offered post-enrollment. Extra services are NOT available in the state of Iowa. Extra services are not contractually offered, nor guaranteed under Humana's Medicare Supplement insurance policies and services may be added or discontinued annually.

Humana Medicare Supplement plans as well as Humana Reader's Digest Healthy Living Medicare Supplement plans provide the following extra services at no additional cost:

Rx Discount – The member 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. Members 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 member through EyeMed, which offers access to 40,000 national providers including optometrists, ophthalmologists, and opticians at 20,000 locations. Members 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 members. Whether the concern is immediate or long-term, members 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.

***My*Humana** – Log onto **Humana.com** and register for *My*Humana, 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, members are eligible for 10 nutritious, precooked frozen meals delivered to their door at no cost. To arrange for this service, members 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 Alaska or Hawaii.)

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

Additional Extra Services Available with Humana Medicare Supplement Plans

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. (Not available to policyholders living in Nevada or Pennsylvania.)

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

Additional Extra Services Available with Humana Reader's Digest Healthy Living Medicare Supplement Plans

Reader's Digest Discounts – Members receive discounts on products at www.readersdigeststore.com. They'll have a passcode giving them an exclusive, ongoing 20% discount for most items at the Reader's Digest store. This would include health-related books and magazines and subscriptions to Reader's Digest magazine.

3-book Reader's Digest Healthy Living Library – Members can purchase most of the popular Reader's Digest health book titles *(Food Cures, Long Life Prescription, What works What Doesn't)* for a substantial discount. Typical retail price for all three books: $98.88. Member price for all three books: $29.99 (plus S & H).

Reader's Digest Health Bulletins – Members will receive four special reports in the mail throughout the year from Reader's Digest. Each report is devoted to a key health issue, such as heart health, nutrition, pain management, and brain health. Reports will highlight the latest research, new cures, ways to better your lifestyle, and prevention tips, all in an easy-to-read and colorful format.

Reader's Digest Mind Stretcher Series – Members will get a complimentary subscription to the massively popular brain-exercise series. A new volume comes quarterly and includes puzzles and games.

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.

Enrollment Application

The proper submission of new enrollment applications 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 the Humana Medicare Supplement plan meets his or her needs, providing rates, and confirming eligibility, follow these steps to successfully submit the enrollment application.


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.
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
9. Keep Member Copy For Your Records
   Return the original copy of your completed Enrollment Application, first month's premium and any additional required forms.

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The applicant completes the Medicare Supplement Enrollment Application. Information must be printed on the enrollment application in clear, legible, capital block letters in blue or black ink. **Sales Agents are responsible for ensuring that the applicant answers all required questions on the application.** Please review the marking instructions on the enrollment application for additional guidance. If an error is made when completing the application, please be sure the applicant initials the correction.

(Enrollment Application continued next page)

Personal information

Be sure to complete all information in full. Where applicable, fill in circles completely to ensure proper scanning.

An application may be submitted up to 90 days in advance of the proposed effective date. 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.)

Other coverage information

Be sure to complete all information in full. Fill in circles completely to ensure proper scanning. When replacing coverage remember to fill in all start dates and end dates if applicable, as well as the carrier/plan information for the coverage being replaced. Applicants must indicate that they intend to replace their current coverage with the Medicare Supplement plan they are electing to enroll when completing ALL "Intent to Replace" questions. If using an electronic application, you will not be able to submit the application if any of these questions contain a "NO" response.

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.*

A list of state-specific open enrollment and guaranteed issue periods is included on page 17 and 18 of this guide.

If completing an application electronically, you will not be able to submit the application if it has been indicated that the applicant qualifies for Guaranteed Issue but does not meet the criteria defined in the "Choosing a Medigap Guide" or the state specific criteria outlined on page 17 and 18.

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 regardless of the responses provided to the Medical Questions on the application unless the applicant indicates they have been prescribed one or more of the drugs listed on page 14 and 15 or the applicant's height and weight fall into the denial ranges provided on page 16. Only in these situations should an application not be submitted.

(Enrollment Application continued next page)

Humana Medicare Supplement Plans

Monthly premium determination

Use the answers to the questions in this section to provide the appropriate base premium quote in the next section.

Discount determination

If your client qualifies for the Household discount, provide the name and Medicare claim number of the other policyholder/enrollee in this section. 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 their enrollment application.

In AZ and MA 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. 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). If the application is not approved, the first month's premium payment will be refunded.

- 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, particularly if the applicant is also purchasing a PDP (Prescription Drug Plan), to help ensure it posts to the proper account. Electronic/automatic payment methods are always preferable and make the application easier to process.

(Enrollment Application continued next page)

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 as well as factor in any rate change due to aging (where applicable). 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." If 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.

(Enrollment Application continued next page)

Prompt submission of paper applications
Failure to submit applications promptly may affect the effective date of coverage. Be sure to retain a copy of the application for your records. A copy must also be left with the applicant.

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.

The following fax number can be used to expedite PENDED applications by faxing in missing enrollment forms directly to Enrollment: **1-502-508-9003**.

FastApp and MAPA
FastApp (used for telephonic enrollment) and MAPA (used by field agents) are "smart" applications. All questions required for enrollment must be answered before the application can be submitted. The application can also determine Open Enrollment as well as Guaranteed Issue periods. When an applicant is eligible for either, the application will disable the Medical Questions as well as the applicable rate determining questions as they are not required. If the applicant does not qualify for Open Enrollment or Guaranteed Issue, the questions will remain enabled and required. All additional enrollment forms required in a given state are built into the application as well. For example, when a Notice of Replacement is required, it will be presented prior to the submission of the application. You will not be able to submit the application without first completing the required form. If using MAPA, please be sure to upload regularly to ensure prompt submission of your applications.

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 can expect to receive a call from Humana's Medicare Supplement Underwriting Department within 2 business days after completing and submitting their application. Their application will not be accepted for enrollment until after the Underwriting process has been completed and it has been confirmed that they are eligible for a Humana Medicare Supplement plan.

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 prescription drugs found on page 14 and 15 or their Body Mass Index (BMI) falls into one of the deniable ranges found in the following BMI table (see page 16).

You will receive notification emails providing you with the status of your enrollments 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 client's 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 your client. It is requested that you assist with contacting the client and instructing them to call the Underwriting department. A letter is also sent to the client.

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

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

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.

Medications Related to Uninsurable Conditions

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

B
Baclofen
Baraclude
Benztropine Mesylate
Betapace
Betaseron
Bicalutamide
Bromocriptine Mesylate

C
Campral
Carbidopa/Levodopa
Carvedilol
Casodex
Ceenu
Cellcept
Cerefolin
Chlorpromazine Hcl
Cilostazol
Clozapine
Clozaril
Combivir
Comtan
Copaxone
Cordarone
Coreg
Coreg Cr
Crixivan
Cyclophosphamide
Cyclosporine

D
Demadex
Didanosine
Didronel
Digoxin
Droxia
DuoNeb

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

F
Fanapt
Fareston
Felbatol
Femara
Fentanyl
Fluorouracil
Fluphenazine Decanoate
Fluphenazine Hcl
Flutamide
Fosrenol

H
Haloperidol
Haloperidol Decanoate
Hepsera
Humira Pen
Hydrea
Hydromorphone Hcl
Hydroxyurea

I
Ilaris
Imuran
Intelence
Intron-A
Invega
Invirase
Iressa
Isentress

K
Kaletra
Kineret
Kogenate Fs

L
Lanoxin
Letairis
Letrozole
Leukeran
Leukine
Lexiva
Lithium
Lodosyn
Loxapine
Loxapine Succinate
Loxitane
Lysodren

M
Matulane
Megace
Megestrol Acetate
Mercaptopurine

Medications Related to Uninsurable Conditions *(continued)*

Mitomycin
Moban
Multaq
Mustargen
Mycophenolate Mofetil
Myfortic
Myleran

N
Naltrexone Hcl
Namenda
Nardil
Navane
Nebupent
Neoral
Neulasta
Neupogen
Neupro
Nexavar
Nilandron
Norvir

O
Olanzapine
Orencia

P
Parlodel
Pegasys
Peg-Intron Redipen
Pergolide Mesylate
Phoslo
Plavix
Pletal
Pradaxa
Prezista
Procrit
Prograf
propafenone
Purinethol

R
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
Seroquel
Simponi
Sinemet
Sps
Stalevo
Stalevo 100
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
Vivitro

W
Warfarin Sodium

X
Xeloda
Xenazine
Xyrem

Z
Zelapar
Zerit
Ziagen
Zidovudine
Zoladex
Zyprexa

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	Deniable BMI of 41 or more
	Weight (lbs.)	Weight (lbs.)
4’	46 or less	134 or more
4’1”	48 or less	140 or more
4’2”	50 or less	146 or more
4’3”	52 or less	152 or more
4’4”	54 or less	158 or more
4’5”	56 or less	164 or more
4’6”	58 or less	170 or more
4’7”	60 or less	176 or more
4’8”	62 or less	183 or more
4’9”	65 or less	189 or more
4’10”	67 or less	196 or more
4’11”	69 or less	203 or more
5’	72 or less	210 or more
5’1”	74 or less	217 or more
5’2”	77 or less	224 or more
5’3”	79 or less	231 or more
5’4”	82 or less	239 or more
5’5”	84 or less	246 or more
5’6”	87 or less	254 or more
5’7”	89 or less	262 or more
5’8”	92 or less	270 or more
5’9”	95 or less	278 or more
5’10”	98 or less	286 or more
5’11”	100 or less	294 or more

Height (ft/in)	Deniable BMI of 14 or less	Deniable BMI of 41 or more
	Weight (lbs.)	Weight (lbs.)
6’	103 or less	302 or more
6’1”	106 or less	311 or more
6’2”	109 or less	319 or more
6’3”	112 or less	328 or more
6’4”	115 or less	337 or more
6’5”	118 or less	346 or more
6’6”	121 or less	355 or more
6’7”	124 or less	364 or more
6’8”	127 or less	373 or more
6’9”	131 or less	383 or more
6’10”	134 or less	392 or more
6’11”	137 or less	402 or more
7’	141 or less	412 or more
7’1”	144 or less	421 or more
7’2”	147 or less	431 or more
7’3”	151 or less	441 or more
7’4”	154 or less	452 or more
7’5”	158 or less	462 or more
7’6”	161 or less	472 or more
7’7”	165 or less	483 or more
7’8”	169 or less	494 or more
7’9”	172 or less	504 or more
7’10”	176 or less	515 or more
7’11”	180 or less	526 or more
8’	184 or less	537 or more

Humana Medicare Supplement Plans

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.

Alaska - Extends guaranteed issue to individuals who voluntarily leave an Employer Welfare Benefit Plan whether the plan pays primary or secondary to Medicare. The applicant must apply no more than 63 days from the date their coverage ends.

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 18) beginning on their birthday and lasting for 30 days each year. 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, members 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%. Members 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. Additionally, if a member 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 18). 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 Reader's Digest 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 18) 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.

Nebraska – Extends guaranteed issue to individuals who lose eligibility under an Employer Welfare Benefit Plan that pays secondary to Medicare. The applicant must apply no more than 63 days from the date their coverage ends.

Humana Medicare Supplement Plans

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.

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

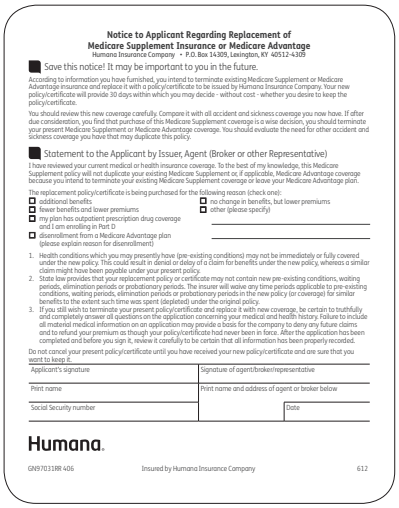
Please note: Current Humana and Humana Reader's Digest Medicare Supplement policyholders switching to a plan of equal value (i.e. an Indiana Plan F to a Kentucky Plan F, an Indiana Humana Plan F to an Indiana Reader's Digest Plan F) qualify for guaranteed issue; however, a new application must be completed. 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.

Additional Required Forms

Notice of Replacement: Any Sales Agent replacing health insurance must accurately complete a Notice of Replacement (NOR) form and attach it to the new enrollment application. 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 14309, Lexington, KY 40512-4309

Save 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 may 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
- ☐ fewer 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 explain 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 insurer 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 as though your policy/certificate had 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.

Do 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
Social Security number	Date

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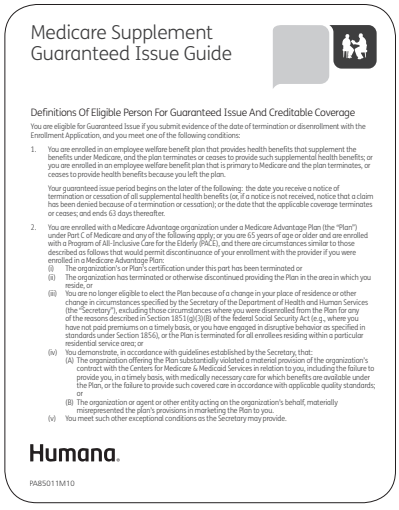
In the state of New York, the following question is considered in addition to the two above:

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.

Failure to complete and return the NOR will result in the applicant's enrollment being pended until Humana receives the completed NOR. Forms may vary by state and are included as part of the application packet rather than a separate, free-standing form.

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 applicant's enrollment being pended. 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.



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:

1. You are enrolled in an employee 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 employee welfare benefit plan that is primary to Medicare and 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 all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or the date that the applicable coverage terminates or ceases; and ends 63 days thereafter.

2. 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 65 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 as follows that would permit discontinuance of your enrollment with the provider if you were enrolled in a Medicare Advantage Plan;
   (i) The organization's or Plan's certification under this part has been terminated or
   (ii) The organization has terminated or otherwise discontinued providing the Plan in the area in which you reside, or
   (iii) 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"), excluding those circumstances where you were disenrolled from the Plan for any of the reasons described in Section 1851(g)(3)(B) of the federal Social Security Act (e.g., where you have not paid premiums on a timely basis, or you have engaged in disruptive behavior as specified in standards under Section 1856), or the Plan is terminated for all enrollees residing within a particular residential service area; or
   (iv) You demonstrate, in accordance with guidelines established by the Secretary, that:
      (A) 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
      (B) The organization or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the Plan to you.
   (v) You meet such other exceptional conditions as the Secretary may provide.

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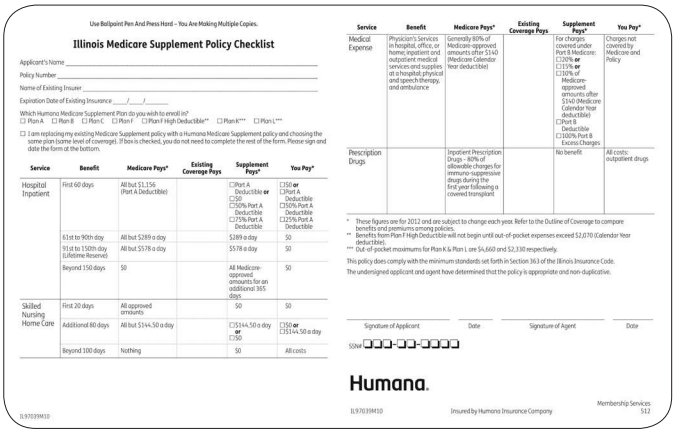
(Other Required Forms continued next page)

Humana Medicare Supplement Plans

Medicare Supplement Comparison Statement/Policy Checklist: In Kentucky and Illinois, applicants must complete and return this form when replacing coverage. Failure to do so will result in the applicant's enrollment being pended until Humana receives the completed forms. ALL sections must be completed including the demographic section at the top of the form. Forms vary by state and are included as part of the application packet rather than a separate, free-standing form.



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

Illinois Medicare Supplement Policy Checklist

Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance ____/____/____

Which Humana Medicare Supplement Plan do you wish to enroll in?
☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan F ☐ Plan F High Deductible** ☐ Plan K*** ☐ Plan L***

☐ I am replacing my existing Medicare Supplement policy with a Humana Medicare Supplement policy and choosing the same plan (same level of coverage). If box is checked, you do not need to complete the rest of the form. Please sign and date the form at the bottom.

Service	Benefit	Medicare Pays*	Existing Coverage Pays	Supplement Pays*	You Pay*
Hospital Inpatient	First 60 days	All but $1,156 (Part A Deductible)		☐Part A Deductible **or** ☐$0 ☐50% Part A Deductible ☐75% Part A Deductible	☐$0 **or** ☐Part A Deductible ☐50% Part A Deductible ☐25% Part A Deductible
	61st to 90th day	All but $289 a day		$289 a day	$0
	91st to 150th day (Lifetime Reserve)	All but $578 a day		$578 a day	$0
	Beyond 150 days	$0		All Medicare-approved amounts for an additional 365 days	$0
Skilled Nursing Home Care	First 20 days	All approved amounts		$0	$0
	Additional 80 days	All but $144.50 a day		☐$144.50 a day **or** ☐$0	☐$0 **or** ☐$144.50 a day
	Beyond 100 days	Nothing		$0	All costs
Medical Expense	Physician's Services in hospital, office, or home; inpatient and outpatient medical services and supplies at a hospital; physical and speech therapy, and ambulance	Generally 80% of Medicare-approved amounts after $140 (Medicare Calendar Year deductible)		For charges covered under Part B Medicare: ☐20% **or** ☐15% **or** ☐10% of Medicare-approved amounts after $140 (Medicare Calendar Year deductible) ☐Part B Deductible ☐100% Part B Excess Charges	Charges not covered by Medicare and Policy
Prescription Drugs		Inpatient Prescription Drugs – 80% of allowable charges for immuno-suppressive drugs during the first year following a covered transplant		No benefit	All costs: outpatient drugs

* These figures are for 2012 and are subject to change each year. Refer to the Outline of Coverage to compare benefits and premiums among policies.
** Benefits from Plan F High Deductible will not begin until out-of-pocket expenses exceed $2,070 (Calendar Year deductible).
*** Out-of-pocket maximums for Plan K & Plan L are $4,660 and $2,330 respectively.

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-duplicative.

Signature of Applicant | Date | Signature of Agent | Date

SSN# ☐☐☐-☐☐-☐☐☐☐

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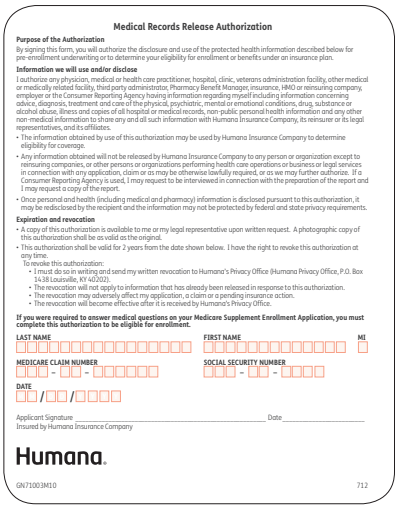
IL97039M10 | Insured by Humana Insurance Company | Membership Services 512

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 with the enrollment application. Failure to do so will result in the applicant's enrollment being pended. Forms vary by state.



Medical Records Release Authorization

Purpose of the Authorization
By signing this form, you will authorize the disclosure and use of the protected 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 and/or disclose
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 reinsuring company, employer or the Consumer Reporting Agency having information regarding myself including information concerning advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness and copies of all hospital or medical records, non-public personal health information and any other non-medical information to share any and all such information with Humana Insurance Company, its reinsurer or its legal representatives, and its affiliates.

- The information obtained by use of this authorization may be used by Humana Insurance Company to determine eligibility for coverage.
- Any information obtained will not be released by Humana Insurance Company to any person or organization except to reinsuring companies, or other persons or organizations performing health care operations or business or legal services in connection with any application, claim or as may be otherwise lawfully 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 I 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 redisclosed 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 photographic copy of this authorization shall be as valid 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:
- I must do so in writing and send my written revocation to Humana's Privacy Office (Humana Privacy Office, P.O. Box 1438 Louisville, KY 40202).
- The revocation will not apply to information that has already been released in response to this authorization.
- The revocation may adversely affect my application, a claim or a pending insurance action.
- The revocation will become effective after it is received by Humana's Privacy Office.

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 CLAIM NUMBER ☐☐☐-☐☐-☐☐☐☐☐☐ SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

DATE ☐☐/☐☐/☐☐☐☐

Applicant Signature _____ Date _____
Insured by Humana Insurance Company

Humana.

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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

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

CoverColorado Form - to be presented to those applicants under the age of 65 who do not qualify for a Humana Medicare Supplement plan due to prescription drugs and/or BMI.
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 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

How to Check Enrollment Status Online

For members or sales agents, please follow the following steps:

1. Navigate to **Humana.com.**
2. Click on Tools and Resources.
3. Click View ID Card, the first link under Quick Links (lower right hand corner of screen) to go to the Humana ID Card Viewer.
4. Enter the client's SSN, DOB, and ZIP to display a printable Letter of Coverage. The Letter of Coverage confirms enrollment and can be used until an ID card is received.

If you encounter any issues when attempting to view enrollment status online, please contact the Agent Support Line (contact information on page 24).

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 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 the Medicare Supplement Open Enrollment Period or guaranteed issue situations.

Pre-existing condition requirements vary by state.

(Additional Enrollment Processing Information continued next page)

Additional Enrollment Processing Information

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 a client records "Payment for Med Supp" or "Med Supp" on the memo line, we can more easily identify and post the funds to the correct plan. For more information, contact the Agent Support Line (contact information on page 24).

Changes to In-force Business

Address Change: Members 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 from the member's account with the next billing cycle.

In-State Move: 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 members move from the state where they initially enrolled, they may choose to continue coverage under their current plan with a premium adjustment or enroll as guaranteed issue into a plan of equal value available in their new state of residence. A new enrollment application must be submitted.

Information on premium changes or plan availability due to a move is available through Customer Service (contact information on page 24).

Cancellation of Coverage: A cancellation request can be made in writing or over the phone by the member 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 24). 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 on page 24).

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 "Plans & Products," select "Insurance Products," and then "Medicare Supplement Plans" under "Individual 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 24).

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 24).

(Agent Support continued next page)

Agent Support

Humana Contact Information

Important MEMBER 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

For policyholders with effective dates prior to June 1, 2010,
Important Louisiana MEMBER Phone Numbers

Member Customer Service:	1-877-866-4077
Billing/Enrollment:	1-877-866-4077
TDD (For Hearing Impaired):	1-800-846-5277

Important AGENT Contact Information
Agency Management

Commissions:	1-800-558-4444 (ext. 8919) or AgencyMgmt@humana.com

Agent Support Line (8 a.m. – 9 p.m. EST)
For questions such as contracting/appointments, product support, marketing materials, or general questions:

Career Agents:	1-866-921-6245
Non-Career Agents:	1-800-309-3163
Email:	AgentSupport@humana.com
Fax:	1-502-508-0062

Enrollment Issues

Email:	medsuppcorrespondence@humana.com

Service Issues

Email:	msopsupport@humana.com

Underwriting

Customer Service:	1-800-825-7858

Notes