Humana

SALES AGENT FIELD GUIDE



Sales agent field guide

Humana Medicare Supplement Insurance Plans

Humana

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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 15 million medical members and 4.7 million specialty members as of December 31, 2025.

The company, founded in 1961, is traded on the New York Stock Exchange (NYSE: HUM).

With plans for diverse populations throughout the U.S. and certain U.S. territories—and benefits based on what members have said they need and want—Humana's health plans are designed to deliver more than what's expected of health plans. We call it human care: the way we listen to members, anticipate their needs, and strive to go above and beyond to support their goals.

Our plan options include:

- Medicare coverage for those eligible:
  - Medicare Advantage (MA) plans
  - Medicare Advantage prescription drug (MAPD) plans
  - Medicare Part D prescription drug plans (PDPs)
  - Medicare Supplement plans
  - Individual and family plans for dental and vision, as well as Humana Extend plans that combine dental, vision and hearing coverage
- Medicaid coverage for adults and children who qualify based on income

Humana strives to offer more than just healthcare to our members and community. Learn more about our environmental, social and governance impacts at **Humana.com/about/impact**.

Humana's financial strength

- 2025 annual revenue of approximately $122 billion
- Total assets of approximately $48 billion as of December 31, 2025
- 2025 net income was $1.1 billion
- As of December 31, 2025, approximately 15 million medical members including 8.3 million Medicare members of which 5.2 million are Medicare Advantage members, with the remaining 2.4 million prescription drug plan members; in addition, approximately 528,000 Medicare Supplement members
- AM Best Rating — A (Excellent) as of December 2025*

* https://news.ambest.com/PR/PressContent.aspx?altsrc=108&refnum=36887

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 Humana producer contract.

All agents or agencies soliciting insurance business are required to hold an active agent or agency license in every state in which 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 Unit (ASU) (contact information on page 31) for questions about contracting/appointments, product support, marketing materials or general questions regarding selling Humana Medicare Supplement Insurance Plans.

Humana Medicare Supplement Insurance Plans

Coverage features

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

- Freedom to choose any doctor, hospital or clinic that accepts Medicare patients
- Coverage—with some plans—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 provided—Humana Medicare Supplement Insurance Plans do not contain provider or hospital networks
  - Policyholders enrolled in Plans C, F, high-deductible F, G, high-deductible 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), including dental and vision, can be found on **Humana.com.** Please note: Effective May 1, 2023, the Humana Healthy Living Medicare Supplement Insurance Plans are no longer available, existing members will remain covered.
- Electronic claims coordination with Medicare

Guaranteed renewable

- Coverage cannot be canceled for reasons other than lack of premium payment or fraud.
- One-time enrollment means there is no annual enrollment action required.

30-day free-look period

- If the policyholder is not satisfied with their Medicare Supplement insurance 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 the paid premium less any claims incurred during that 30 days.

Plan availability

- Humana Medicare Supplement Insurance Plans
  - Humana commonly offers Plans A, B, C, F, high-deductible F, G, high-deductible G, K, L and N with some variance by state and product. See your product and state's Outline of Coverage for plan availability.*
  - **Wisconsin** offers plans that do not conform to the nationally standardized menu; however, the benefit structures are similar with some variance by product.
  - **Wisconsin** offers a Basic Plan (similar to Plan A) and optional riders as well as Cost-sharing Plans (similar to Plans K, L and high-deductible F).

* Plans C, F and high-deductible Plan F are not available to newly eligible applicants effective Jan. 1, 2020. Please refer to page 8 for more information.

For plan details, refer to an Outline of Coverage. Outlines of Coverage for all states are available within the agent self-service center—Vantage—on **Humana.com**. You may also view and print Outlines of Coverage via **Humana.com**.

1. Go to **Humana.com** and sign in.
2. Select Vantage.
3. Scroll down to Medicare Supplement and select "Med Supp OOC's and App Packets." All Medicare Supplement order information and a link to view and print the Outlines of Coverage are listed.

Please note: Effective May 1, 2023, the Humana Healthy Living Medicare Supplement Insurance Plans are no longer available, existing members will remain covered.

Pricing

Premium discounting

Recurring automatic checking/savings account withdrawal (ACH) or credit card payment discount Humana Med Supp policyholders save $2 on their monthly premium by electing to make future payments electronically via automatic bank withdrawal or by credit card payment. If applicants wish to take advantage of this discount, be sure to elect an automatic payment option in the future payment section of the enrollment application. See page 17 for additional details.

Please note: Effective March 1, 2022, policyholders in Idaho are not eligible for ACH discount.

Household discount* Humana Med Supp policyholders with effective dates of June 1, 2010, and later who share a residence save on their monthly premium. To enroll in the household discount program, be sure applicants provide the name and Medicare ID of the other Humana Med Supp 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: North Dakota requires policyholders to be of family relation.

Enhanced household discount* Humana Med Supp policyholders are eligible for the enhanced household discount when they reside with a spouse (including civil union/domestic partner) or have continuously resided with at least one, but no more than three adults in the past 12 months. For the purpose of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid and recognized in your state of residence. We may request additional documentation to determine eligibility.

*** Where approved. Varies by product and state. Please check the Outline of Coverage for specific discount.**

Please note: Enhanced household discount is only available in certain states. Please check the Outline of Coverage for availability.

Early enrollment discount (Arizona)

Arizona

Policyholders save on their monthly premium when first enrolling in Medicare Part B. They will receive a discount based on your Medicare Part B effective date as indicated in the following table. They may receive the discount for up to a total of 10 years depending on your Medicare Part B effective date. The discount decreases by 3% each year. The table below does not apply to the Humana Achieve product. Please refer to the Arizona Humana Achieve Outline of Coverage for early enrollment discount details.

Years from Medicare Part B effective date	Discount
<1	39%
>=1 year <2 years	36%
>=2 years <3 years	33%
>=3 years <4 years	30%
>=4 years <5 years	27%
>=5 years <6 years	24%
>=6 years <7 years	21%
>=7 years <8 years	18%
>=8 years <9 years	15%
>=9 years <10 years	12%
>=10 years	0%

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 policyholder'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, 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 insurance plans are offered statewide, premiums can vary by county. Most states are divided in up to three 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.

Extra services

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

Humana Medicare Supplement Insurance Plans provide the following extra services at no additional cost. Availability may vary by product:

SilverSneakers*: Get a 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.

Drug discount program: A policyholder may get discounts on prescriptions that are not covered by insurance at certain drug stores. They may find out if a pharmacy will provide a discount by calling Humana Customer Care at the number located on their ID card.

Vision discount: This program is available to the policyholder through EyeMed. Policyholders can locate a participating EyeMed provider by calling **866-392-6056**.

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

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

Humana Well Dine® meal program: After an overnight stay in the hospital or nursing facility, policyholders are eligible for 14 nutritious meals delivered to their door at no additional cost. To arrange for this service, policyholders can call **877-402-1030** after discharge and provide their Humana policyholder ID number and other basic information. A Humana representative will assist in scheduling delivery. (Not available to policyholders living in Montana and North Dakota.)

* Currently available to all policyholders with a Medicare Supplement insurance plan offered by Humana subsidiaries, **except** for policyholders with a Humana Achieve Medicare Supplement Insurance Plan.

Hearing discount: Discounts on hearing aids and services are available through HearUSA and TruHearing®.

Lifeline medical alert systems: Lifeline® is committed to improving the quality of life for seniors and their families. These systems provide seniors and those with disabilities the always-on support they need to live independent lives. Policyholders can choose from multiple service options at discounted prices.

To order, policyholders can call Lifeline at **800-543-3546 (TTY: 711)** and can learn more by visiting www.offer.lifelinesys.com/humana/.

All product names, logos, brands and trademarks are property of their respective owners, and any use does not imply endorsement.

Post-sale communications only

The program below is available to Humana Medicare Supplement Insurance Plan policyholders but is 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

This program is 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 nonrestrictive 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 **800-872-3860**. (Please note: Premium credit is available only on plans that cover the Part A deductible.)

Please refer Medicare Supplement policyholders to the extra services flyer they'll receive in their welcome packet 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 and will be required to complete a telephonic underwriting review.

MACRA and Humana Medicare Supplement Insurance Plans

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) prohibits the sale of Medigap policies that cover Part B deductibles to "newly eligible" Medicare beneficiaries. "Newly eligible" beneficiaries are defined as those individuals who: (a) have attained age 65 on or after Jan. 1, 2020; or (b) first become eligible for Medicare due to age, disability or end-stage renal disease on or after Jan. 1, 2020.

As a result, current Medicare Supplement insurance plans C, F and high-deductible F are not available to the "newly eligible" as of Jan. 1, 2020, because they cover the Part B deductible. Humana offers Plan G and high-deductible G in all states as a replacement for Plan F and high-deductible F. Current enrollees (those eligible for Medicare prior to Jan. 1, 2020) are not affected. Current enrollees can continue with their Plan C or Plan F, including F high-deductible plan, and may continue to buy Plans C or F beyond Jan. 1, 2020.

The three states that obtained waivers from implementing the standardized Medicare Supplement plans (MA, MN and WI) also must comply with eliminating coverage for the Part B deductible.

Preexisting conditions

To help control rising costs, Humana policies include a preexisting 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 preexisting condition limitation will be reduced by the number of months that coverage was in force. If this policy replaces another Medicare Supplement policy, the preexisting condition limitation will be reduced by the number of months that coverage was in force. The preexisting condition limitation is waived when application is made during guaranteed issue situations. Preexisting condition requirements vary by state.

Open Enrollment guidelines

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

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

Please note: Open Enrollment applications may be submitted up to 90 days in advance of the proposed effective date with the possible exception in some state-specific guaranteed issue rights. Please refer to the state-specific Open Enrollment and guaranteed issue guidelines section.

State-specific Open Enrollment and guaranteed issue guidelines

In addition to the guaranteed issue scenarios described in the **Guide to choosing a Medigap Policy**, the following states have additional guaranteed issue periods that you should know about. This is not a complete list. Plans G, G(HD) and N are restricted in some guarantee issue scenarios in most states. Plans G, G(HD) and N are not restricted during the initial Medicare Supplement Open Enrollment Period. Please note that Plans G and G(HD) are only restricted to applicants eligible for Medicare prior to Jan. 1, 2020. Please review your state regulations for additional scenarios which may qualify an applicant for guaranteed issue into a Medicare Supplement insurance plan. Proof of prior coverage is required for guaranteed issue applications. Applicants are not required to complete medical underwriting if qualifying for a guaranteed issue right.

Please note: Applicants in CA, ME, OK** and OR can apply for any plan available in the state. MACRA rules would still apply and Plans C, F and high deductible F can not be purchased by an individual new to Medicare on or after 1/1/2020.

** OK- Plan N is restricted from GI rights. All other plans available.

Annual Guaranteed Issue Period: “Birthday Rule GI”

For states that allow for an annual guaranteed issue period due to the applicant having a birthday, proper submission of an enrollment application is critical in our ability to provide the best service to you and our applicants. Prior to submission, please also review the state-specific guidelines below for the state you are submitting to ensure accuracy. If the applicant qualifies for Birthday Rule GI, complete the application following these steps.

1. Answer **“Yes”** to **“Do you have another Medicare Supplement policy in force?”**

Complete the question by also providing the existing company and the plan currently covering the applicant. A Notice of Replacement form is required to be completed due to the applicant replacing their current policy.

2. Answer **“No”** to **“Are you applying for coverage during your Medicare Supplement Open Enrollment Period?”**

This question is for individuals who are in their initial Open Enrollment Period.

3. Answer **“Yes”** to **“Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed issue?”**

When completing the Notice of Replacement form, select “other (please specify)” and enter “Birthday Rule GI.”

The initial Medicare Supplement Open Enrollment period lasts for 6 months and begins on the first day of the month the beneficiary is both age 65 or older and enrolled in Medicare Part B. This definition also extends to states that have an initial Medicare Supplement Open Enrollment Period for individuals under age 65 who qualify for Medicare because of disability or end-stage renal disease

(ESRD). Applications received outside of this specified period of initial open enrollment shall be categorized either as guaranteed issue (GI), as required by law, or subject to a Medical Underwriting (UW) assessment.

California, Colorado, Kansas, Maine, Montana, Ohio, Oregon, Tennessee, Texas, Utah, West Virginia and Wisconsin

Individuals are guaranteed issue into a Medicare Supplement insurance plan when losing Medicaid.

California

An individual is entitled to an annual enrollment period lasting 60 days commencing with the individual's birthday. Current Medicare Supplement policyholders (with any carrier) are guaranteed issue into a like or lesser Medicare Supplement insurance plan (see plan comparison table on page 15) during this annual enrollment period. 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 healthcare services, moving away from the base or losing access to healthcare services at the military base. Applicants must apply no more than six 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 insurance plans, they are guaranteed issue into any carrier's Medicare Supplement insurance 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 six 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 six months.

Delaware

Effective January 1, 2026, Medicare Supplement policyholders are entitled to an annual enrollment period which starts 30 days prior to the applicant's birthday and lasts 30 days after. They may replace their current plan with an equal or lesser plan offered by any issuer.

In addition, individuals enrolled in a Medicare Advantage plan who are canceling their Medicare Advantage plan to return to Original Medicare during Medicare open enrollment periods may purchase any Medicare Supplement plan as guaranteed issue. This guaranteed issue right would apply during the annual enrollment period (10/15 to 12/7) and the Medicare Advantage Open Enrollment Period (1/1 to 3/31).

Paper applications are required for both the birthday rule and Medicare Advantage replacements. A notice of replacement is required for both guaranteed issue scenarios. For qualifying Medicare Advantage replacements, on the Notice of Replacement form select "Other" and indicate "annual enrollment period."

Idaho
A Medicare Supplement policyholder is entitled to an annual 63-day guaranteed issue period starting with the policyholder's birthday. They may replace their current plan with an equal or lesser plan offered by any issuer.

Illinois
An individual is entitled to an annual enrollment period which starts on the applicant's birthday and lasts for 45 days. To qualify, the applicant must be at least age 65 but no more than age 75 and have a current Medicare Supplement policy issued by a Humana subsidiary. They may replace their current policy with an equal or lesser plan issued by the same issuer of their current policy. Applications may be submitted up to 30 days prior to the start of the annual enrollment period with coverage beginning no sooner than the applicant's birthday month.

When completing an application for the Illinois annual enrollment period, please write "Humana" as the offering company in response to questions regarding "Do you have another Medicare Supplement policy in force?".

Indiana
Effective March 15, 2026 applicants have an annual 30 days before and 30 days after the applicant's birthday to enroll into a Medicare Supplement Plan without underwriting. During this annual guaranteed issue period the applicant can replace their current plan with the same type of lettered plan offered by any issuer. Coverage effective date must be the first day of the month following application signature date.

Kentucky
Kentucky applicants have a 60-day annual enrollment period starting with the applicant's birthday to switch insurers and replace the same plan they currently have.

Louisiana
An individual is entitled to an annual enrollment period which starts on the applicant's birthday and lasts 63 days. During this period, they are eligible to replace their current Medicare Supplement insurance plan with any plan offered by the same issuer or any affiliate company of their current policy. If replacing their current Medicare Supplement insurance plan with a policy that will be issued by a new company, they are only eligible for a plan of equal or lesser value. When completing an application for the Louisiana annual enrollment period, please write "Humana" as the offering company in response to questions regarding "Do you have another Medicare Supplement policy in force?".

Maine
An annual enrollment period is available to applicants enrolling in Plan A during the month of July. All applicants are guaranteed issue when losing medical benefits through the Medicaid program.

If an applicant enrolled in coverage that supplements Medicare less than 36 months prior to their proposed coverage effective date with no gap in coverage greater than 90 days, they qualify for guaranteed issue into a plan of equal or lesser value (see plan comparison table on page 14).
If the applicant has been covered under a Medicare Advantage plan since first becoming eligible for Medicare but no more than 36 months prior to their proposed coverage effective date with no gap in coverage greater than 90 days, they qualify for guaranteed issue into any plan.

Additionally, if an applicant is enrolled in and has maintained a Medicare Supplement policy (with any carrier) since first becoming eligible for Medicare Part B, they qualify for guaranteed issue into an equal or lesser plan (see plan comparison table on page 15). If replacing Plans E, H, I or J, the applicant qualifies for guaranteed issue into all the plans except for Plans E and H, which excludes

Plans C, F and G and Plans F and G, respectively. The applicant must apply no more than 90 days from the date their coverage ends.

Maryland

The state of Maryland has amended their Medicare Supplement regulations to include a new guaranteed issue right ensuring that eligible individuals who miss their initial Medicare Supplement Open Enrollment Period during a declared public health emergency will have a 63-day period to enroll in a Medicare supplement policy without underwriting. The 63-day period starts on the later of the date of termination from the Maryland Medical Assistance Program (Program) or the date they are notified of termination. This guaranteed issue right will only apply if a public heath emergency has been in place and once ended.

A Medicare Supplement policyholder in Maryland is entitled to an annual 30-day guaranteed issue period starting with the policyholder's birthday. They may replace their current plan with an equal or lesser plan offered by any issuer.

Michigan

All applicants are guaranteed issue when enrolling in Medicare Supplement insurance plans A, C or D issued by Humana Insurance Company as required by a major medical insurer in Michigan. (This does not apply to Medicare Supplement plans offered by other Humana subsidiaries.)

Missouri

Missouri Medicare Supplement policyholders are guaranteed issue into a plan of equal value (see plan comparison table on page 15) offered by any company if enrolling within 30 days (before or after) of their current policy's anniversary date. For example, replacing a Plan F for a Plan F or Plan G for a Plan G.

If replacing plans E, H, I or J which are no longer available, the applicant qualifies for guaranteed issue into any plan available.

Nevada

Medicare Supplement policyholders (with any carrier) are entitled to a 60-day annual enrollment period beginning with the first day of the applicant's birthday month. During this period, an individual may purchase a Medicare Supplement insurance plan that has equal or lesser benefits. Applications may be submitted up to 60 days prior to the start of the annual enrollment period with coverage beginning no sooner than the applicant's birthday month.

Oklahoma

A Medicare Supplement policyholder in Oklahoma has a sixty (60) day enrollment period that starts annually on a Medicare Supplement policyholder's birthday. A qualifying applicant may replace their current policy with a policy of like or lesser benefits.

Oregon

Current Medicare Supplement policyholders (with any carrier) are guaranteed issue into a like or lesser Medicare Supplement insurance plan (see plan comparison table on page 15) 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.

The applicant has a guaranteed issue period if the individual joined a Medicare Advantage plan or a Program of All-Inclusive Care for the Elderly (PACE) within six months after becoming enrolled

in Medicare Part B and disenrolls no later than 12 months after joining such plan or program. This change extends the standard federal guaranteed issue period.

The applicant has a guaranteed issue period when the applicant lost or is losing TRICARE as described in Title XVII of the Social Security Act. The GI period begins on the later of (1) the date the individual receives notice of termination (if notice is not received a notice that a claim has been denied due to termination) or (2) the date the coverage terms or ceases; and ends 63 days thereafter. The Medicare Supplement insurance plan options available to individuals who do qualify for a guaranteed issue policy will be the same as the options available to individuals who lose employer group coverage.

The applicant has an Open Enrollment Period if they were eligible for Medicare prior to age 65 due to disability and moved to Oregon from a state that does not require Medicare Supplement insurance plans to be offered to those under age 65. They must enroll within 63 days of establishing Oregon residency.

Rhode Island

Effective July 2025, applicants in Rhode Island are guarantee issue (GI) annually if applying during Medicare Annual Enrollment Period (AEP) to replace their current Medicare Advantage plan or Medicare Supplement plan with a new Medicare Supplement plan for coverage effective January 1 following AEP. During this annual period which runs October 15 until December 7, applicants will be GI into any Humana Medicare Supplement Plan offered. Those under the age of 65 are only GI into Plan A. Paper applications are required along with a Notice of Replacement. On the Notice of Replacement form select “Other” and indicate “Annual Enrollment Period.”

Tennessee

Individuals under the age of 65 receive a six-month guaranteed issue period for the standard scenarios found in the **Guide to Choosing a Medigap Policy**.

Utah

Effective May 7, 2025, Utah applicants are entitled to a 60-day annual enrollment period starting on the applicant’s birthday to replace their current Medicare Supplement policy with a new Medicare Supplement policy of equal or lesser benefits from Humana. Paper applications are required.
When completing an application for the Utah annual enrollment period, please write “Humana” as the offering company in response to questions regarding “Do you have another Medicare Supplement policy in force?”.

Virginia

Effective July 1, 2025, Virginia applicants are entitled to a 60-day annual enrollment period starting on the applicant’s birthday to replace their current Medicare Supplement policy with a new Medicare Supplement policy of equal benefits. Paper applications are required.

Washington

Current Medicare Supplement policyholders (with any carrier) qualify for guaranteed issue when replacing their current plan with another Medicare Supplement insurance plan. They may replace their current plan with any plan option available by an issuer. Plan A policyholders are only guaranteed acceptance into Plan A.

West Virginia

Effective June 11, 2026, West Virginia applicants are entitled to a 60-day annual enrollment period starting on the first day of the month of the individual’s birthday to replace their current Medicare Supplement policy with a new Medicare Supplement policy of lesser or equal benefits offered by the

same issuer or any affiliated company of their current policy. To qualify for this annual enrollment period the applicant must be enrolled in their current policy for at least 24 months prior to switching policies. As electronic channels are being updated paper applications are required and proof of prior coverage may be requested.

Please note: If neither the issuing insurer nor any affiliated insurer of the individual's existing policy has accepted applications for a Medicare Supplement policy providing the same or lesser standardized benefits for a period of at least 12 months, the individual may purchase a Medicare Supplement policy providing the same or lesser standardized benefits from any insurer authorized to issue Medicare Supplement policies in this state.

Wyoming

Effective June 4, 2025, Wyoming applicants are entitled to a 63-day annual enrollment period starting with the applicant's birthday to replace their current Medicare Supplement policy with a new Medicare Supplement policy of equal or lesser benefits. Paper applications are required.

Plan-to-plan changes

Please note: Current Humana Medicare Supplement Insurance Plan policyholders switching to a plan of equal value (e.g., an Indiana Plan F to a Kentucky Plan F) qualify for guaranteed issue when moving to a new state; however, a new application must be completed. Switching to the same plan, upgrades or downgrades (e.g., Indiana Plan F to Indiana Plan F, switching from Indiana Plan F to Indiana Plan G, or Indiana Plan N to Indiana Plan G) does not qualify for guaranteed issue, and members will be subject to medical underwriting.

Switching from a Humana Medicare Supplement Insurance Plan or Humana Healthy Living product to a Humana Value or Humana Achieve Medicare Supplement product is not considered guaranteed issue and the application is subject to underwriting. If a member is moving states and the current product is not available in their new state, they qualify for guaranteed issue into a plan of equal value (such as Indiana Value Plan F to Kentucky Plan F, since Humana Value plans are not offered in Kentucky). If the plan they are replacing is not available, they may elect a plan of lesser value and qualify for guaranteed issue.

Members who enrolled in a Humana Medicare Supplement Insurance Plan prior to June 1, 2010, will be underwritten for all plan changes (with the exception of **Oregon and Washington**). Current policyholders wishing to reduce their monthly premium due to the discontinued use of tobacco products (must be tobacco-free for at least 12 months) do not qualify for guaranteed issue and will be underwritten regardless of the plan into which they are re-enrolling.

We encourage agents to remain involved in member moves/plan changes to ensure the desired outcome for their client.

Plan comparison chart

Current plan (includes select offerings)	Equal to	Lesser
A	A	High-Deductible Plans F & G
B	B	A, High-Deductible Plans F & G
C	C	A, B, D, High-Deductible Plans F & G, K, L, M, N
D	D	A, B, High-Deductible Plans F & G, K, L, M, N
E	E (no longer offered)	A, B, D, High-Deductible Plans F & G, K, L, M, N
F	F	A, B, C, D, High-Deductible Plans F & G, G, K, L, M, N
High-deductible F	High-deductible F	High-Deductible Plan G
G	G	A, B, D, High-Deductible Plans F & G, K, L, M, N
High-deductible G	High-deductible G	None
H	H (no longer offered)	A, B, D, High-Deductible Plans F & G, K, L, M, N
I	I (no longer offered)	A, B, D, High-Deductible Plans F & G, K, L, M, N
J	J (no longer offered)	All Plans
K	K	A, B, High-Deductible Plans F & G
L	L	A, B, High-Deductible Plans F & G, K
M	M	A, B, High-Deductible Plans F & G, K, L
N	N	A, B, High-Deductible Plans F & G, K, L, M

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

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 Insurance Plan meets their 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 (Humana Enrollment Platform (HEP)). 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.

Methods of enrollment

Electronic submission (most preferred):

- Humana Enrollment Platform (HEP)

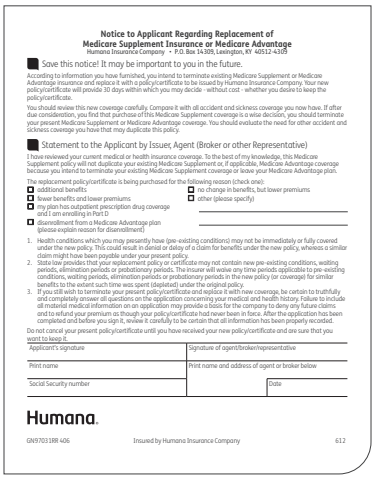
Paper submissions

- Envelopes should **always** be addressed to “Humana Medicare Enrollment.”
- Please note that a prepaid return envelope is included with a Medicare Supplement sales kit when ordering via Order Entry System (OES).
- Mail (check, ACH or credit/debit payments accepted):
  Applications submitted via regular mail:
  Humana Medicare Enrollment
  P.O. Box 14309
  Lexington, KY 40512-9801

  Applications submitted via expedited services (FedEx, UPS, Priority Mail, etc.):
  Humana Medicare Enrollment
  2432 Fortune Drive
  Lexington, KY 40509
- Fax: **877-889-9936** (ACH or credit/debit card payments only)
- Upload on Vantage Agent Portal (ACH or credit/debit card payments only)

Required forms

Notice of replacement



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
☐ lower benefits and lower premiums
☐ my plan has outpatient prescription drug coverage and I am enrolling in Part D
☐ disenrollment from a Medicare Advantage plan (please 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

Humana.

GN97031IR 406 Insured by Humana Insurance Company 612

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

- Have you had coverage 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.

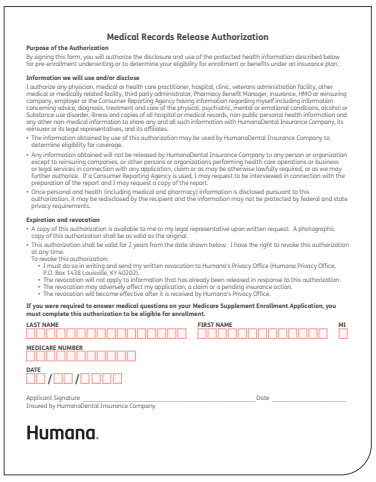
A NOR form is required for ALL replacements of Medicare Advantage or Medicare Supplement coverage, even if applicant qualifies for guaranteed acceptance due to the replacement. If the applicant qualifies for a guaranteed issue period, the qualifying event must be listed on the NOR. If it is not, the application will be underwritten.

For example, if an applicant qualifies for guaranteed acceptance due to Medicare Advantage plan exit, please check "Disenrollment from a Medicare Advantage plan" and indicate that the plan is exiting the market and is no longer available. Similarly, if the applicant qualifies due to a trial right (see the Choosing a Medigap Policy Guide), the applicable trial right should be clearly written on the form.

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

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 New York). Failure to do so will result in the application pending. Forms vary by state. The form will be required after completing the enrollment application as part of the electronic process if the applicant is enrolling outside of an Open Enrollment or guaranteed issue period.



Medical Records Release Authorization

Purpose of the Authorization

By signing this form, you will authorize the disclosure and use of the 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, alcohol or Substance use disorder, illness and copies of all hospital or medical records, non-public personal health information and any other non-medical information to share any and all such information with HumanaDental Insurance Company, its reinsurer or its legal representatives, and its affiliates.

- The information obtained by use of this authorization may be used by HumanaDental Insurance Company to determine eligibility for coverage.
- Any information obtained will not be released by HumanaDental 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 NUMBER

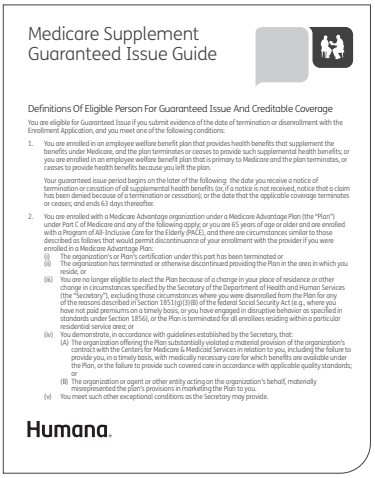
DATE

Applicant Signature _____ Date _____
Insured by HumanaDental Insurance Company

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Medicare Supplement Guaranteed Issue 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, freestanding form. Failure to submit the form will result in the application pending. In **Florida and Pennsylvania**, the form must be presented to the applicant prior to completing the enrollment application. Receipt of this information is then acknowledged within the enrollment application. Forms may vary by state. In both states, the form will be required prior to beginning the enrollment application in the electronic applications.



Medicare Supplement
Guaranteed Issue Guide

Definitions Of Eligible Person For Guaranteed Issue And Creditable Coverage

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

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.

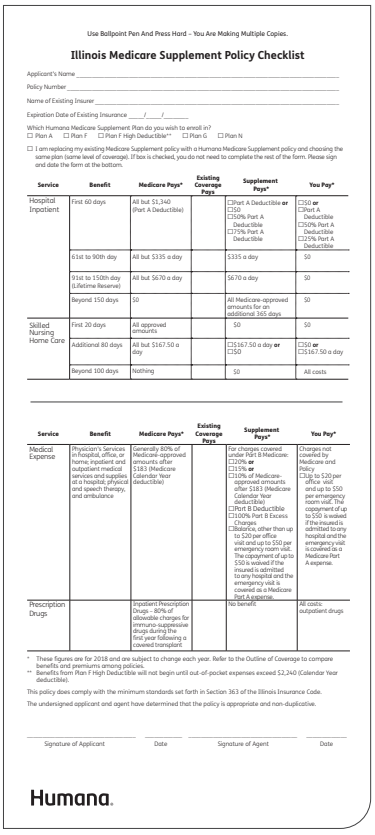
   Your guaranteed issue period begins on the later of the following: the date you receive a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or the date that the applicable 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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Medicare Supplement 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 insurance plan or group/employer coverage. In **Kentucky**, the form is required when replacing a Medicare Advantage plan or another Medicare Supplement insurance 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, freestanding form. In both states, the form will be required (when applicable) prior to beginning the enrollment application in the electronic applications.



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

Illinois Medicare Supplement Policy Checklist

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 F ☐ Plan F High Deductible** ☐ Plan G ☐ Plan N

☐ 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 $1,340 (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 $335 a day		$335 a day	$0
	91st to 150th day (Lifetime Reserve)	All but $670 a day		$670 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 $167.50 a day		☐$167.50 a day **or** ☐$0	☐$0 **or** ☐$167.50 a day
	Beyond 100 days	Nothing		$0	All costs

Service	Benefit	Medicare Pays*	Existing Coverage Pays	Supplement Pays*	You Pay*
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 $183 (Medicare Calendar Year deductible)		For charges covered under Part B Medicare: ☐20% **or** ☐0% **or** ☐10% of Medicare-approved amounts after $183 (Medicare Calendar Year deductible) ☐Part B Deductible ☐100% Part B Excess Charges ☐Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Charges not covered by Medicare and Medicare ☐Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
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 2018 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 $2,240 (Calendar Year deductible).

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 _____

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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

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 Insurance 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.

Tips for completing applications

Personal information

Be sure to complete all information in full. All applications (Open Enrollment/Guaranteed Issue/ Underwritten) may be submitted up to 90 days in advance of the proposed effective date, with the possible exception in some state specific guaranteed issue rights. Please refer to the state-specific Open Enrollment and guaranteed issue guidelines section. Applications received on or after the proposed effective date will be made effective the first day of the following month.

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 issue 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. Please note that proof of coverage to determine guaranteed issue is required.

Submitting proof of Guaranteed Issue (GI) for paper applications

Proof of GI should be included with the application at the time of initial submission. If you have proof of loss of coverage to provide when the initial application is submitted, use Vantage Service Inquiry to submit that documentation. If requested by Humana after an application is submitted, please send that documentation to the enrollment mailbox at MedSuppCorrespondence@humana.com and include the applicant's name in the subject line. If you are unable to email the requested documentation, please use the fax number: 502-508-9003. Fax must include a cover sheet with the applicant's name and Proof of GI.

Guaranteed acceptance determination

Guaranteed issue guidelines can be found in the current Centers for Medicare & Medicaid Services publication of **Guide to Choosing a Medigap Policy** provided in the Humana Medicare Supplement Insurance Plan sales/enrollment kits.

A list of state-specific Open Enrollment and guaranteed issue periods is included on pages 9–12 of this Agent Field Guide.

Medical questions, if applicable based on guaranteed acceptance and Open Enrollment

(not applicable in New York)

All health questions must be answered, including the question regarding prescription medications and reason for the prescription, unless an application is submitted during an Open Enrollment or guaranteed issue period. Sales agents are responsible for reviewing and explaining all medical questions to applicants

during the application process. Sales agents are responsible for marking accurate answers to medical questions as given by applicants. Humana reserves the right to monitor sales agents' books of business for inaccurate health information.

ALL applications should be submitted unless the applicant indicates they have been prescribed one or more of the drugs listed on page 33 and 34, they suffer from one of the conditions listed on page 35 and 36, or the applicant's height and weight fall into the denial ranges provided on page 36. Only in these situations should an application not be submitted. If the applicant is deemed ineligible, electronic applications should be saved.

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.

Discount determination

If the household discount is offered, provide the name and Medicare number of the other policyholder/enrollee in the appropriate section of the application. If the enhanced household discount is offered, please provide the name of the individual living with the applicant in this section. **This section should NOT be completed with the applicant's information.**

Check a product's state Outline of Coverage for discount availability. Additional information can be found in the Outline of Coverage providing details about 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, an early enrollment discount is also available. See the Outline of Coverage for more information. Applicants qualify for this discount due to Part B effective date 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 two 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 AgentAdvantage University email notifications for news on annual rate changes.

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

Please note: Effective March 1, 2022, policyholders in Idaho are not eligible for ACH discount.

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

- Approved methods for submitting initial premium payments include: ACH, personal check, money order or credit card. If selecting ACH for Initial Payment, include "ACH" in the check number field of the Initial Payment section along with all banking information. Applications submitted without the initial premium payment will **not** be processed until payment is received.
- Post-dating checks will not ensure the payment is held, and this is not an acceptable practice to suggest. Payments will be processed upon receipt regardless of effective date of coverage.

- If applicant is paying the Initial Payment by check, the payment is processed within two to five business days of receipt, regardless of approval or denial of the application. It is NOT held until the coverage effective date. Attach the check with a paperclip or gently staple it to the application to keep the pieces together.

  If the application is not approved, the first month's premium payment will be refunded (refunds are typically processed within five to 10 business days of the date of denial). The applicant should indicate "Med Supp" in the check's note or memo section. If the applicant is also a PDP (prescription drug plan) member that chooses to pay via coupon book for ongoing future payments, a separate check will need to be submitted for each plan. Again, "Med Supp" will need to be written in the memo section of the check for payments applicable to the Med Supp plan and "PDP" in the memo section for payments applicable to the prescription drug plan. When a check is being submitted for the Initial Payment, the ACH fields should not be completed in the "Initial Payment" section. Entering ACH information in the "Initial Payment" section, as well as submitting a check, will result in two account withdrawals. Electronic/automatic payment methods are always preferable and make the application easier to process.
- If applicant is paying the Initial Payment by automatic withdrawal or credit card, the applicant will have two options when the their initial premium will be drafted. The applicant can chose for initial premium to be drafted at time of application approval or drafted when coverage becomes effective. Payments will not be drafted if the application is denied.

Future payment methods

Recurring 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 first and seventh 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 to use the 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.

Please note: If member wants to make three, six, nine or twelve month payments, please multiply monthly premium amount by however many months the applicant wants to pay. Please make sure applicant is aware of premium changes or address changes that could potentially change their monthly premium amount.

Online billing payments

1. Visit **humana.com/member/pay-your-premium** and click "Sign in to MyHumana"; once signed in, the user can click on any Billing links to enter the Billing portal. If they are not on auto pay, they'll see a "Sign up for autopay" link in the top right.

2. If the member doesn't have a MyHumana account, they can still make one-time payments digitally through **Express Pay**, also accessed via Humana.com/pay-your-premium. They can enter either UMID or Billing ID, and ZIP code to see their account balance and make a one-time payment.

3. Sign in to the **MyHumana mobile app** and select the "Manage my billing account" link in the "Pay My Premium" section.

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. Please note that applications must be submitted within 10 days of signature date. Applications submitted after 10 days from signature date will not be processed and the application will be declined.

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) or use the bubble on the application indicating NONE or Not Applicable. If both fields are left blank, the application will pend.

Agent use only

To receive proper commission credit, you must fully complete the agent/agency information on all parts of the application, including the Agent Use Only Section on the bottom of the paper. Complete only the fields shown below:

- **Writing agent name**: Fill in your name as contracted with Humana.
- **Writing agent ID (SAN)**: Fill in your writing agent ID (i.e., your SAN/SSN).
- **Agency**: not applicable to career agents. Delegated agents not being directly paid commissions need to provide their agency's name.
- **Agency ID (SAN):** not applicable to career agents. Delegated agents need to provide the SAN of the agency to receive commission payment if the Agency name was provided.

There are four (4) options for completing an electronic app in Humana Enrollment Platform (HEP):

1. **Electronic Signature** — An email will be sent to the consumer with a link that can be accessed to sign the application electronically.

2. Digital Signature (available for Career and External Agents only) — Captures a Digital Signature using your touch screen, mouse pen, or approved signature pad.

3. Telephonic Signature — A verbal signature that is taken through an agent-assisted voice recording with the client.

4. SMS/Text Signature — Select SMS text Signature on application.

- The beneficiary must have a valid mobile phone number
- The beneficiary must be able to access their text messages
- The mobile phone number must belong to the beneficiary

The agent will receive a personal code that will be displayed below the "phone number" field on the application. The applicant will receive and access a link provided in the text message and enter the personal code along with their date of birth. The applicant will also be prompted to enter their first and last names in a signature field and click the submit to finalize the signature process.

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. Please note that applications must be submitted within 10 days of signature date. Applications submitted after 10 days from signature date will not be processed and the application will be declined.

Humana career agents

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

Noncareer or partner agents

Submit applications within two business days of applicant/agent signature date:

Envelopes should **always** be addressed to "Humana Medicare Enrollment."

Please note that a prepaid return envelope is included with a Medicare Supplement Sales Kit when ordering via OES.

Applications submitted via regular mail:

Humana Medicare Enrollment
P.O. Box 14309
Lexington, KY 40512-9801

Applications submitted via expedited services (FedEx, UPS, Priority Mail, etc.):

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 **877-889-9936.** Applications CANNOT be faxed if initial premium is being paid by check. Please do not both fax and mail in applications.

In the event an application is pended, you will receive an email alert notifying you of the missing information that needs to be submitted. If you must submit the missing information via paper, the following fax number can be used to expedite PENDED applications by faxing in missing enrollment forms directly to Enrollment: **502-508-9003**. This fax number should not be used to submit new business.

Application submission method from Vantage

Paper applications may also be sent in through the Vantage Portal.

- Confirm your email address in your Vantage profile.
- Register that same email address with Humana Secure Mail.
  - Instructions are within the Job Aid attached.
  - Registration only needs to be completed once.
- Scan your application into a PDF, TIF or TIFF format.
  - Applications should be written with black ink so characters are dark and stand out.
  - Resolution should be medium to high to ensure the scan has a distinct image on each page.
  - Save the file with the client's name so you can easily find it if necessary.
- Open the "Upload Paper Applications" form on the quote and enroll card in Vantage.
  - Review the guidance on the top of the form for how to successfully email paper application documents via Vantage.
  - Complete the form fields, including adding your attachment, and select "Submit."

Benefits

- Timely submission: Email is often easier to access than a fax machine, and submitting applications quickly typically means quicker turnaround times for processing.
- Extra tracking: You receive two communications per submission:
  1. A copy of the submission with date/timestamp that will arrive almost immediately
  2. A notification confirming if the submission was accepted or denied into the process
  - No longer wonder if all pages are transmitted: You confirm the scanned file wasn't corrupt or locked, all pages were present, and everything showed clear and legible leading to seamless receipt and potentially reducing opened applications.

Enrollment Doc Transmitter mobile app

- You can download the Enrollment Doc Transmitter app from Google Play™ or App Store® by searching Humana Enrollment Doc Transmitter.
- Once you've downloaded and accepted the terms of the app, you simply point, shoot and send.

Benefits for using the Enrollment Doc Transmitter app:

- You don't have to wait until you get back to the office to submit your enrollment docs; transmit them while in the field.
- You'll have clearer and more consistent image quality.
- Automatic successful or failed transmission notifications are sent to you via email.

Tracking your applications

Reporting tool for partner agents

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

1. Log in to Vantage on **Humana.com** using your user ID and password.
2. Select Vantage.
3. Under MyHumana Business, select "Enrollment Reporting."
4. Choose report type from the drop-down menu and enter applicable search dates.
5. Choose the product in question.
6. At the bottom of the screen, select "Request Report" to generate the report.

Vantage application status indicators‡

Application milestones average cycletime**

Application received (day one to two)††

- Acknowledgement that application is in house and being worked
- For electronic submissions, visible within 24 hours of online application process
- Paper within two to three days of receipt

Validation in progress (day two to four)‡‡

- Missing information being obtained/internal pends being cleared
- Will remain in this status until information received from the agent

Underwriting in progress (day three to five)††

- Outreach by underwriting to member within 48 hours of underwriting receipt
- Agent will receive communication after failed attempts to reach the member

Processing application (day five to seven)‡‡

- Application has been cleared of all pends, missing info and underwriting request; should be issued within 24 hours

Policy issued (GI/OEP applications average day two to three; underwriting applications average day five to seven)‡‡

- Policy number issued to member

‡ Vantage is not updated in real time. Status adjustments occur within 12–24 hours.

** Note during AEP peak season, end-to-end processing may be 10–12 days for electronic submission; 15+ days for paper.

†† These are not all statuses that may show in Vantage but are key indicators of application flow.

‡‡ Note that agent communication is also ongoing during process via email for receipt, missing information, attempted UW contact, and policy issuance/statuses shown also represent off-peak expectations.

Underwriting guidelines

(not applicable in New York)

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. An application will complete underwriting within two business days once received. If additional information is needed to complete underwriting, they will receive a call from Humana's Underwriting Department. The applicant must be able to complete the telephonic underwriting review. If the applicant is unable to complete the telephonic underwriting review for any reason, the application will be denied.

Note: We no longer require telephone health interviews for all of our applications. We may require a clarifying telephone interview on underwritten applications if an underwriter needs additional information.

The medical records release authorization form, included in the sales kit and incorporated into the Humana Enrollment Platform (HEP) 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 the Underwriting Department 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 33 and 34, they suffer from one of the conditions listed on page 35 and 36, or the applicant's height and weight fall into the denial ranges provided on page 36.

Humana Real-Time Underwriting

All Humana Medicare Supplement Insurance Plan applications submitted via Humana Enrollment Platform (HEP) that require underwriting will go through Real-Time Underwriting.

How it works

- If the application passes Real-Time Underwriting it will be passed to our Enrollment team for processing.
- If it is determined that the application requires further review, it will go to the Enrollment team for validation and then to the Humana Underwriting team for evaluation.
- If the application is denied for any reason, written notification of the denial is sent to the applicant. The applicant's medical history will not be discussed with the Agent. If an applicant questions the reason(s) for the decline, they can reach out to the **Humana Underwriting team at 1-800-825-7858, option 4**.

Agent and applicant communications

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:

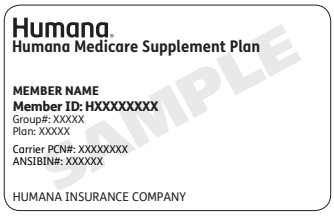
- **Underwriting review:** An email is sent upon receipt of the applicant's application by the Underwriting Department. This lets you know that the review will be completed within the next 24–48 hours unless submitted via Humana Enrollment Platform (HEP), please refer to real-time underwriting section (if the underwriting consultant is able to reach your client telephonically).

- **Please call:** An 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:** An 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:** An 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:** An 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 the 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 insurance plan. The applicant must contact their insurance carrier to terminate their existing plan.**

Additional enrollment processing information

Policy delivery



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

Humana Medicare Supplement Insurance Plan/PDP



Many applicants seeking to enroll in a Humana Medicare Supplement Insurance 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 insurance 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 Unit (contact information on page 31).

Changes to in-force business

Address change

Policyholders should contact Humana directly for address changes either in writing or over the phone. We encourage agents to remain involved in member moves to ensure the desired outcome for their client.

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 Insurance Plan 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 plan they are replacing is not available, they may elect a plan of lesser value and qualify for guaranteed issue. In all other cases, the application will be subject to medical underwriting. Information on premium changes or plan availability due to a move is available through Customer Care (contact information on page 31). See Plan Comparison chart on page 15 for lesser and equal plans.

Cancellation of coverage

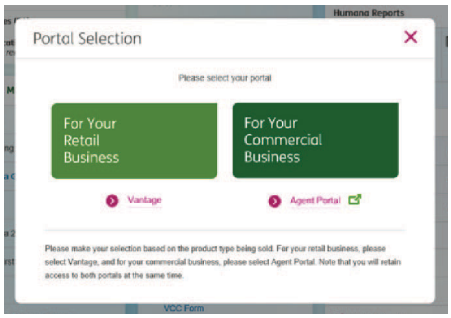
A cancellation request can be made in writing or over the phone by the policyholder or their legal representative. The cancellation will be effective the last day of the month in which Humana receives notification. Some states do require a prorated termination date based on the cancellation date requested.

Rescission of coverage

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

Agent support

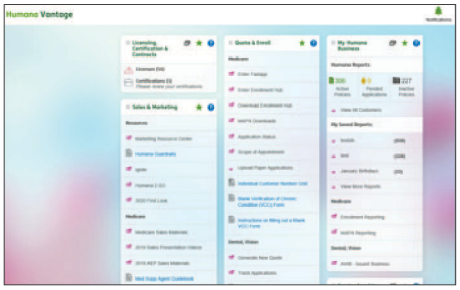
Vantage—Humana's agent portal



The Vantage Agent Portal offers you:

- Enhanced transparency, robust filtering and customized reports
- Visibility to where your Humana clients are in the enrollment process
- 24/7 access to your Humana Medicare book of business, ability to view application and member status—making it easier to keep track of your book of business
- Accessibility on your tablet or mobile device

Sign in to **Humana.com** and select Vantage (see image to the right).



Commissions

Humana annualizes commissions for all new policies written for the first year; renewals are on an earned monthly basis. For information about commissions for career agents, submit an inquiry through the HIP Portal.

For noncareer or partner agents, commission checks are paid weekly. Dates are adjusted for weekends and holidays.

Commissions are calculated using commissionable premium only. Commissionable premium is referred to as the base rate less any applicable discounts (household, early enrollment), less premium attributed to the Part B deductible benefit. For questions regarding commission payments, call the Agent Support Unit (contact information on page 31).

Marketing materials

Agents can order Medicare Supplement Enrollment kits, including all required forms, on Vantage, the Humana agent portal, through their Humana broker relationship manager or executive, or by contacting the Agent Support Unit (contact information on page 31). To place an order, you'll need to provide:

- Your seven-digit agent ID
- Shipping address
- State(s) for which you need kits
- Quantity of kits

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

To order printed Med Supp Enrollment kits on Vantage, click on Medicare Sales Materials under the Medicare heading. From there, click on Medicare Supplement Only Request and follow the instructions.

To view and/or print Outlines of Coverage or App packets, click on the Med Supp OOC's & App Packets link under the Medicare Supplement heading.

Agent Marketing Hub

Accessible through Vantage, the Agent Marketing Hub (AMH) contains Medicare Supplement sales presentations, you can use to market to prospects and your book of business.

- Simply log on to Vantage from **Humana.com** and click on the Agent Marketing Hub (AMH) link under the Sales and Marketing section.

Humana contact information

Important customer phone numbers

Member Customer Care: **800-866-0581**
Billing/enrollment: **800-866-0581**
Claims/benefits: **800-866-0581**
TDD (for hearing impaired): **711**

Important agent contact information

Agent Support Unit (8 a.m. – 9 p.m., Eastern time)
For questions such as contracting/appointments, product support, marketing materials, and general questions:
Phone: **800-309-3163, Option 2**
Email: agentsupport@humana.com
Fax: **502-508-0062**

PLEASE NOTE: Agent Support Unit does not receive service inquiries. Please check your Vantage dashboard for service inquiry updates.

Check Enrollment Status

If you are interested in checking the status of an application, visit your MyHumana Business page on Vantage to check enrollment status.
If you have questions related to prescription drugs, please use the Rx Calculator tool on Vantage under the "Drug Cost Lookup" tab.

- **For Medicare Beneficiary Identifier (MBI) lookups and to view/print member cards, use Marx Access or medicare.gov.**
- **For Post enrollment inquiries please call800-309-3163, Option 1**

Underwriting

Customer Care: **800-825-7858**
Agents: Press 2
Agent underwriting prescreen questions: Press 4
For all other inquires: Press 2

Access to care

Access to care and critical, time-sensitive issues that need immediate attention should be called in to Customer Care for guidance and solutions. This will allow for escalation with a supervisor and/or manager.
Phone: **800-866-0581**

Enrollment, billing and claims inquiries

Service inquiry tool

Service inquiries offers a way for agents to provide post-enrollment customer service to their members. The service inquiry requests are processed by the Agent Retail Sales Operations Support (ARSOS) team. ARSOS will work with the agent to provide information about the resolution of the inquiry.

To submit an inquiry, go to the “Service Inquiries” tab on Vantage.

To find the Service Inquiry job aids:

1. Log in to Vantage.
2. Go to AgentAdvantage University.
3. Enter “Service Inquiry” in the search bar to find the job aids.

Order Member ID cards

Agents can order member ID cards via My Business Center for assigned members.

Appendix

Medications related to uninsurable conditions

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

A

Abilify
Actiq
Afinitor
Aggrenox
Akineton
Alkeran
Amiodarone
Ampyra
Anagrelide Hydrocholride
Anastrozole
Anoro Ellipta
Antabuse
Aptivus
Aranesp
Aranesp Albumin Free
Arava
Aricept
Arimidex
Aripiprazole
Aromasin
Atripla
Atrovent HFA
Aubagio
Avinza
Avonex
Azathioprine
Azilect

B

Baclofen
Baraclude
Benztropine Mesylate
Betapace
Betaseron
Bicalutamide
Bosulif
Breo Ellipta
Brilinta
Bromocriptine Mesylate
Butrans

C

Campral
Carbidopa/Levodopa
Casodex
Ceenu
Cellcept
Cerefolin
Chlorpromazine HCL
Cilostazol
Clopidogrel
Clozapine
Clozaril
Combivent
Combivir
Comtan
Copaxone
Cordarone
Coumadin
Crixivan
Cyclophosphamide
Cyclosporine

D

Diazoxide
Didanosine
Didronel
Digoxin
Dipyridamole-aspirin
Dofetilide
Donepezil
Droxia
DuoNeb
Dupixent

E

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

F

Fanapt
Fareston
Felbatol
Femara
Fentanyl
Flecainide
Fluphenazine Decanoate
Fluphenazine HCL
Flutamide
Fosrenol
Furosemide >60 mg

H

Haloperidol
Haloperidol Decanoate
Hepsera
Humira Pen
Hydrea
Hydromorphone HCL
Hydroxycloroquine
Hydroxyurea

I

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

J

Jantoven

K

Kaletra
Kineret
Kogenate FS

L

Lanoxin
Leflunomide
Letairis
Letrozole
Leukeran
Leukine
Lexiva
Lithium
Lodosyn

Medications related to uninsurable conditions (continued)

Loxapine
Loxapine Succinate
Loxitane
Lysodren

M

Matulane
Megace
Megestrol Acetate
Memantine
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
Nitroglycerin Patch
Norvir

O

Olanzapine
Orencia
Oxycodone Hydrochloride

P

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

R

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

S

Saphris
Selegiline Hcl
Selzentry
Simponi
Sinemet
Skyrizi
Sotalol
SPS
Stalevo
Stalevo 100
Stribild
Sustiva
Sutent
Symbyax

T

Tabloid
Tacrolimus
Tambocor
Tamoxifen Citrate
Tarceva
Targretin
Tasmar
Taxotere
Temodar
Thalomid
Thioridazine Hcl
Thiothixene
Tice Bcg
Tikosyn
Tracleer
Trelegy Ellipta
Trental
Trexall
Trifluoperazine Hcl
Trihexyphenidyl Hcl
Trizivir
Tysabri

V

Valcyte
Videx
Viracept
Viramune
Viread
Vivitrol

W

Warfarin Sodium

X

Xarelto
Xtandi
Xeloda
Xenazine
Xyrem

Z

Zaltrap
Zelapar
Zerit
Ziagen
Zidovudine
Zoladex
Zyprexa

Medicare Supplement ineligible conditions

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

A

AIDS, ARC or HIV
Addison's disease
Adrenal insufficiency
Alcohol abuse/alcoholism
Alzheimer's disease
Ankylosing spondylitis
Aortic aneurysm
Arterial embolism
Artificial opening for feeding or elimination (within the last 12 months)
Atherosclerosis/arteriosclerosis
Atrial fibrillation
Autoimmune hepatitis

B

Bed sore (decubitus ulcer)
Bedridden
Biliary cirrhosis
Bipolar disorder
Brain tumor
Bronchiectasis
Burns: extensive, third degree

C

Cancer: internal
Carotid artery disease
Cerebral hemorrhage
Cerebral palsy
Chest pain (angina pectoris)
Chronic kidney disease
Chronic obstructive pulmonary disease (COPD)
Cirrhosis of the liver
Confined to a wheelchair
Coma, brain compression/anoxic damage or severe head injury
Congestive heart failure
Coronary heart disease (blockage)
Crippling arthritis
Crohn's disease
Cushing's syndrome
Cystic fibrosis

D

Delusions/hallucinations
Dementia
Diabetic neuropathy
Drug abuse

E

Emphysema
End stage renal disease (ESRD)
Enlarged heart (cardiomyopathy)

H

Hardening of the arteries
Heart attack (myocardial infarction)
Heart disease
Heart enlargement
Heart failure
Hemophilia
Hepatitis B
Hepatitis C
Huntington's disease

I

Internal cancer

K

Kidney disease requiring dialysis
Kidney failure

L

Left bundle branch block
Leukemia
Lou Gehrig's disease
Lupus (systemic lupus erythematosus)
Lymphoma

M

Malnutrition
Marfan syndrome
Melanoma
Multiple or lateral sclerosis
Multiple myeloma
Multiple personality disorder
Muscular dystrophy
Myasthenia gravis

N

NASH (Nonalcoholic Steatohepatitis)
Neuralgic or poor circulation that has caused an ulcer on the skin
Neuropathy/diabetic neuropathy

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
Polymyalgia rheumatica
Polymyositis
Psoriatic arthritis
Pulmonary embolism
Pulmonary fibrosis
Pulmonary hypertension

R

Respiratory dependence
Rheumatoid arthritis

S

Sarcoidosis

Medicare Supplement ineligible conditions (continued)

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

Thoracic aneurysm
Transient ischemic attack (TIA)

U

Ulcerative colitis
Uncontrolled diabetes
Uncontrolled high blood pressure (hypertension)
Uncontrolled high cholesterol

V

Ventricular arrhythmias
Ventricular fibrillation or flutter

W

Wet macular degeneration

Body mass index

If applicant's height and weight fall into one of these ranges, they are not eligible for coverage. Do not submit the enrollment application.

Height (ft./in.)	Deniable BMI of 14 or less Weight (lbs.)	Deniable BMI of 40.5 or more Weight (lbs.)
4'	46 or less	133 or more
4'1"	48 or less	138 or more
4'2"	50 or less	144 or more
4'3"	52 or less	150 or more
4'4"	54 or less	156 or more
4'5"	56 or less	162 or more
4'6"	58 or less	168 or more
4'7"	60 or less	174 or more
4'8"	62 or less	181 or more
4'9"	65 or less	187 or more
4'10"	67 or less	194 or more
4'11"	69 or less	201 or more
5'	72 or less	207 or more
5'1"	74 or less	214 or more
5'2"	77 or less	221 or more
5'3"	79 or less	229 or more
5'4"	82 or less	236 or more
5'5"	84 or less	243 or more
5'6"	87 or less	251 or more
5'7"	89 or less	259 or more
5'8"	92 or less	266 or more
5'9"	95 or less	274 or more
5'10"	98 or less	282 or more
5'11"	100 or less	290 or more

Height (ft./in.)	Deniable BMI of 14 or less Weight (lbs.)	Deniable BMI of 40.5 or more Weight (lbs.)
6'	103 or less	299 or more
6'1"	106 or less	307 or more
6'2"	109 or less	315 or more
6'3"	112 or less	324 or more
6'4"	115 or less	333 or more
6'5"	118 or less	342 or more
6'6"	121 or less	351 or more
6'7"	124 or less	360 or more
6'8"	127 or less	369 or more
6'9"	131 or less	378 or more
6'10"	134 or less	387 or more
6'11"	137 or less	397 or more
7'	141 or less	406 or more
7'1"	144 or less	416 or more
7'2"	147 or less	426 or more
7'3"	151 or less	436 or more
7'4"	154 or less	446 or more
7'5"	158 or less	456 or more
7'6"	161 or less	467 or more
7'7"	165 or less	477 or more
7'8"	169 or less	488 or more
7'9"	172 or less	498 or more
7'10"	176 or less	509 or more
7'11"	180 or less	520 or more
8'	184 or less	531 or more

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