

SERFF Tracking Number: HUMA-126932436 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 47441
 Company Tracking Number: AR-21-2010
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
 Standard Plans 2010
 Product Name: 2010 Individual Medicare Supplement Plans
 Project Name/Number: EDU/Wizard/AR-21-2010

Filing at a Glance

Company: Humana Insurance Company
 Product Name: 2010 Individual Medicare Supplement Plans
 SERFF Tr Num: HUMA-126932436 State: Arkansas
 TOI: MS08I Individual Medicare Supplement - Standard Plans 2010
 SERFF Status: Closed-Filed-Closed
 State Tr Num: 47441
 Sub-TOI: MS08I.001 Plan A 2010
 Co Tr Num: AR-21-2010
 State Status: Filed-Closed
 Filing Type: Advertisement
 Reviewer(s): Stephanie Fowler
 Disposition Date: 12/16/2010
 Authors: Michele Zabel, Paula Williamson, Bettina Ponds, Tammy House, Tiffany Turner, Seth Johnson
 Date Submitted: 12/03/2010
 Disposition Status: Filed-Closed
 Implementation Date Requested: On Approval
 Implementation Date:
 State Filing Description:

General Information

Project Name: EDU/Wizard
 Project Number: AR-21-2010
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 12/16/2010
 Status of Filing in Domicile: Pending
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Individual
 Group Market Size:
 Group Market Type:
 Explanation for Other Group Market Type:
 State Status Changed: 12/16/2010
 Created By: Bettina Ponds
 Corresponding Filing Tracking Number:
 Deemer Date:
 Submitted By: Bettina Ponds
 Filing Description:
 RE: Humana Insurance Company/NAIC # 119, 73288
 Medicare Supplement Electronic Enrollment - Application Screens

Please find enclosed for your review and approval the following documents:

SERFF Tracking Number: HUMA-126932436 State: Arkansas
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1. GHA0A3BHH - text that will appear on Humana’s website providing general guidance and information on behalf of Humana Medicare Supplement insurance plans.

2. GHA09OHH – Wizard is a program that allows comparisons of plans in order for an applicant to make an informed choice.

Policy forms issued by Humana Insurance Company: ARMESM10A, ARMESM10B, ARMESM10C, ARMESM10F, ARMESM10F(HD), ARMESM10K, and ARMESM10L.

If you have any questions or require additional information, I can be reached in addition to SERFF at (502) 580-0964 or by email at bponds@humana.com.

Company and Contact

Filing Contact Information

Bettina Ponds, Medicare Supplement Product bponds@humana.com
 Compliance Analyst
 500 W. Main St. 502-580-0964 [Phone]
 Louisville, KY 40202

Filing Company Information

Humana Insurance Company	CoCode: 73288	State of Domicile: Wisconsin
1100 Employers Boulevard	Group Code: 119	Company Type: Life & Health
Green Bay, WI 54344	Group Name:	State ID Number:
(800) 558-4444 ext. [Phone]	FEIN Number: 39-1263473	

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: 2 forms @ \$50.00 each = \$100.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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SERFF Tracking Number: HUMA-126932436 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 47441
Company Tracking Number: AR-21-2010
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
Standard Plans 2010
Product Name: 2010 Individual Medicare Supplement Plans
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Humana Insurance Company \$100.00 12/03/2010 42608694

SERFF Tracking Number: HUMA-126932436 *State:* Arkansas
Filing Company: Humana Insurance Company *State Tracking Number:* 47441
Company Tracking Number: AR-21-2010
TOI: MS08I Individual Medicare Supplement - *Sub-TOI:* MS08I.001 Plan A 2010
Standard Plans 2010
Product Name: 2010 Individual Medicare Supplement Plans
Project Name/Number: EDU/Wizard/AR-21-2010

Disposition

Disposition Date: 12/16/2010

Implementation Date:

Status: Filed-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: HUMA-126932436 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 47441
 Company Tracking Number: AR-21-2010
 TOI: MS081 Individual Medicare Supplement - Sub-TOI: MS081.001 Plan A 2010
 Standard Plans 2010
 Product Name: 2010 Individual Medicare Supplement Plans
 Project Name/Number: EDU/Wizard/AR-21-2010

Amendment Letter

Submitted Date: 12/03/2010

Comments:

To whom it may concern,

I have revised the form number for the wizard screens to match the attachment.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
GHA09OHH H	Advertising	Wizard Screens	Initial					GHA09OHHH (Non Smoking-Non Disabled) .pdf

SERFF Tracking Number: HUMA-126932436 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 47441
 Company Tracking Number: AR-21-2010
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
 Standard Plans 2010
 Product Name: 2010 Individual Medicare Supplement Plans
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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Filed 12/16/2010	GHA0A3B	Advertising	Web Text	Initial			GHA0A3BHH (V1) - Web Text.pdf
Filed 12/16/2010	GHA09OH	Advertising	Wizard Screens	Initial			GHA09OHHH (Non Smoking-Non Disabled) .pdf

Button Options: 1) home, 2) contact us, 3) sign up for reminders, 4) search

Logo Humana | Medicare
Guidance when you need it most

Button Options: 1) Adjust Text Size, 2) E-mail This Page, 3) Print Page, 4) Español

Button Options: 1) Humana Medicare Plans, 2) About Medicare, 3) About Enrollment, 4) The Humana Difference, 5) Other Humana Products

Standard Footer to appear On All Pages

Telephone Hours
Toll-free: [Insert toll-free number] [8 a.m. to 8 p.m., 7 days a week]
TTY users: [Insert toll-free number]

Y0040_GH18029N CMS Approved MMDDYYYY
Last updated [MM-DD-YYYY]
GHA0A3BHH

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GHA0A3BHH

Homepage Announcement Copy

One of the following buttons may be added to each banner below to help instruct the user what to do next.

1. Compare [2011] Plans
2. Learn More
3. Compare and Enroll
4. Enroll or
5. Preview [2011] Plans

View Humana's Medicare Plans Online

Humana's Medicare Plans are flexible and affordable to meet your needs. [Review plans today!](#)

Display options:

1. Find your plan today
2. View Humana's Plans
3. View Humana's Medicare Plans

Link options:

- 1. Find out what you need to know**
- 2. General Information**
- 3. Learn More About Medicare**
- 4. New to Medicare?**

- Find out more about your Medicare options and Humana's Medicare plans.
 - If you're new to Medicare, you [may] [probably] have [many] questions about how Medicare works. Humana has a lot of information to help you learn more about Medicare.
 - If you're new to Medicare, you may have many questions about how Medicare works. Humana has the information you need to learn more about Medicare benefits.
 - If you're not ready to enroll yet or just want general guidance, Humana has the information you need [to learn more about Medicare].
-
- Understand Medicare basics
 - Discover the Humana difference
 - Learn about enrollment

Button Options: 1) Start Here, 2) Learn More, 3) Learn About Medicare, 4) Research, 5) Investigate, 6) Get Information, 7) Read More

Link Options:

- 1. Find a Plan or Find the Right [Humana] Plan For You**
- 2. Get Started or Start Here**
- 3. I'm ready to enroll or Ready to Enroll?**
- 4. Compare Plans or Enter Your ZIP Code to Get Started**

It's easy!

Optional lead sentences:

- Enter your ZIP code to view plans available in your area. You can compare benefits, estimate costs and enroll online.
Enter your ZIP code to get started
- Enter your Zip code to compare plans
- Enter your Zip code to review benefits
- Enter your Zip code to view plans
- Enter your Zip code to view plans and enroll
- Enter your ZIP Code to view plan benefits and premiums. You can compare plans side-by-side and [even] enroll online [instantly] [at your convenience].

Visit **Humana.com** to check enrollment status, view member information, access member tools, resources and more.

Home > Humana Medicare Plans

Medicare insurance guidance when you need it most

At Humana, we're ready to help you sort through your choices so you can make decisions with confidence. Explore the following plan options to understand your Medicare insurance options.

Medicare Advantage Plans

Humana's [Medicare Advantage plans](#) can help you get more from your healthcare dollar. Explore how you can save with drug and medical coverage all in one plan.

Medicare Prescription Drug Plans

Everyone wants to save money on prescription drugs. Humana's [prescription drug plans](#) may help you do just that. With Humana, you get more than a prescription plan that works for you, you receive support and guidance.

Medicare Supplement Plans

Humana's [Medicare Supplement insurance plans](#) help cover some of the costs not covered by Medicare Parts A and B, so you have more predictable costs.

Healthcare Reform Information

While healthcare reform won't be in effect completely until years from now, some parts of the law are in force right now. Other parts have to do with the [2011] Medicare plans. [Learn more.](#)

Medicare Supplement Insurance Plans
 A Guide to Humana’s Medicare Supplement Plans

Humana’s Medicare Supplement plans help cover some of the costs not covered by Medicare Parts A and B, such as deductibles and coinsurance, so you have more predictable costs. You can keep the same doctors, you are still in the Medicare program, and you have all of your Medicare rights and protections. It should be noted that Medicare Supplement plans are not managed care.

Basic Benefits of Medicare Supplement plans

In most states*, policies are standardized into plans labeled A through N. All policies cover basic benefits, but each has additional benefits that vary by plan.** Medicare Supplement plans A through G provide benefits at higher premiums with limited out-of-pocket costs. Plans K through N are cost-sharing plans offering similar benefits at lower premiums with greater out-of-pocket costs. Some companies may offer additional innovative benefits.

	Plans - A, B, C, F, G	Plans - K, L	Plan N	High Deductible Plan F
Premiums	Moderate Premiums	Lower Premiums	Lower Premiums	Lowest Premium
Out-of-Pocket Costs	Lower out-of-pocket costs	Higher out-of-pocket costs, but subject to out-of-pocket annual limits.	Moderate out-of-pocket costs consisting of office visit and ER copays.	Highest out-of-pocket costs. Must pay first [\$2,000] before Humana pays anything.
Basic Benefits	Includes: <ul style="list-style-type: none"> <input type="checkbox"/> Medicare Part A coinsurance and hospital benefits <input type="checkbox"/> Medicare Part B coinsurance or copayment <input type="checkbox"/> First 3 pints of blood <input type="checkbox"/> Hospice care 	Includes: <ul style="list-style-type: none"> <input type="checkbox"/> Medicare Part A coinsurance and hospital benefits <input type="checkbox"/> Medicare Part B coinsurance or copayment <input type="checkbox"/> First 3 pints of blood <input type="checkbox"/> Hospice care 	Includes: <ul style="list-style-type: none"> <input type="checkbox"/> Medicare Part A coinsurance and hospital benefits <input type="checkbox"/> Medicare Part B coinsurance or copayment <input type="checkbox"/> First 3 pints of blood <input type="checkbox"/> Hospice care 	Includes: <ul style="list-style-type: none"> <input type="checkbox"/> Medicare Part A coinsurance and hospital benefits <input type="checkbox"/> Medicare Part B coinsurance or copayment <input type="checkbox"/> First 3 pints of blood <input type="checkbox"/> Hospice care

Enrollment is guaranteed if you meet [certain requirements](#). [Link: [Enrollment and Eligibility page](#)]

[Plans A and B](#)

Plan A provides basic coverage for hospitalization, medical expenses, and hospice care. Plan B includes the same basic benefits, plus coverage for your Part A deductible.

[Plans C](#)

Plan C offers more coverage than plans A or B. You get the basic benefits listed in the chart above, plus coverage for the Part B deductible, skilled nursing care and emergency care abroad.

[Plan F](#)

Plan F offers the basic benefits, plus coverage for both the Part A the Part B deductibles, skilled nursing care, emergency care abroad, and 100% of Part B excess charges (the difference between what a doctor or provider charges and the amount Medicare will pay up to Medicare's limiting amount.. Plan F also has a high-deductible option that can lower your premiums.

[Plan G](#)

Plan G includes basic benefits plus coverage for additional costs like Part B excess charges (charges above what Medicare pays) and emergency care abroad.

[Plans K and L](#)

These lower-premium policies cover a range of medical costs, including doctor's services and hospital care. The plan pays a percentage of your costs, and then you are responsible for a portion. Each plan has an out-of-pocket maximum, which limits the amount you will have to pay each year.

[Plan N](#)

Plan N is another lower-premium policy offering the same basic benefits; however, includes an office copayment of up to [\$20] and an emergency room copayment of up to [\$50]. The plan also covers costs such as Part B excess charges (charges above what Medicare pays) and emergency care abroad.

[Understanding Medicare Supplement Plans](#)

It's smart to study all the Medicare Supplement plans, before you decide which plan is best for you. Get the basics on eligibility, when you can apply, and how these plans work with Medicare Parts A and B.

[Need Prescription Drug Coverage?](#)

Humana's [Prescription Drug Plans](#) offer prescription drug coverage and can be purchased in addition to our Medicare Supplement plans. Or, check out Humana's Medicare Advantage plans, which offer medical and prescription drug coverage, all in one plan.

NOTE: Humana offerings may vary by state.

*If you live in Massachusetts, Minnesota or Wisconsin, your Medicare Supplement policy may be called something different than "Medicare Supplement Plans A through N."

**Medicare Supplement insurance policies may not fully cover all your medical costs. None of the standard Medicare Supplement plans cover:

- Long-term care to help you with daily tasks such as dressing, eating, etc.
- Vision or dental care
- Hearing aids
- Private-duty nursing
- Prescription drugs

You can apply for a Medicare Supplement insurance policy if you are a resident of a state where the policy is offered, enrolled in Medicare Parts A and B, age 65 or over or, in some states, under age 65 with a disability and/or end stage renal disease (plan offerings and eligibility vary by state). [Read more about Medicare Supplement eligibility requirements.](#)

[Link: <http://www.humana-medicare.com/medicare-supplement-plans/medicare-supplement-insurance-explained.asp>]

The purpose of this communication is the solicitation of insurance. Contact will be made by an insurance agent/producer or insurance company.

Not connected with or endorsed by the U.S. government or the federal Medicare program.

Medicare Supplement Plans A and B

Basic coverage at competitive prices

Plans A and B are designed to meet your basic needs in addition to [Medicare Parts A and B](#). [Link: <http://www.humana-medicare.com/medicare-information/original-medicare.asp>]

If you have unexpected medical expenses or need extended hospital care, these plans may help you pay for your additional medical expenses. Both Plan A and Plan B give you many of the same medical and hospitalization benefits with this distinction:

- If you choose Plan A, you will be responsible for paying both your Medicare Part A and Part B deductibles
- If you choose Plan B, you will be responsible for paying your Part B deductible only

Medicare Supplement Plan A

Medicare Supplement Plan A is ideal for people who want more coverage than Medicare Parts A and B, but don't anticipate using a lot of healthcare services. With this plan, you won't pay for extra coverage you might not use – but you could have some extra costs from time to time.

Medicare Supplement Plan A provides basic coverage for:

- **Hospitalization:** pays Part A coinsurance plus coverage for 365 additional days after Medicare benefits end
- **Medical Expenses:** pays Part B coinsurance – generally 20 percent of Medicare-approved expenses – or co-payments for hospital outpatient services
- **Blood:** pays for the first three pints of blood each year
- **Hospice care:** pays Part A coinsurance

Medicare Supplement Plan B

Like all other [Medicare Supplement plans](#) [link to [Medicare Supplement Plans overview page](#)], Humana's Plan B provides basic benefits for hospitalization and medical expenses. Besides the basic benefits, this plan adds a little bit more coverage for hospitalization. This plan might be a good fit if you want more coverage than Medicare Parts A and B, especially for hospital expenses.

Medicare Supplement Plan B provides basic coverage for:

- **Hospitalization:** pays Part A coinsurance plus coverage for 365 additional days after Medicare benefits end
- **Medical Expenses:** pays Part B coinsurance – generally 20 percent of Medicare-approved expenses – or co-payments for hospital outpatient services
- **Blood:** pays for the first three pints of blood each year
- **Hospice care:** pays Part A coinsurance

In addition to the basic benefits, Plan B also provides coverage for:

- Medicare Part A deductible for hospitalization

[column headers will link to plan pages]

Humana's Medicare Supplement Plans*

Benefits	A	B	C	F**	G	K	L	N
Medicare Part A Coinsurance and Coverage for Hospital Benefits	X	X	X	X	X	X	X	X - \$20 copay for office visits; \$50 copay for ER
Medicare Part B Coinsurance or Copayment	X	X	X	X	X	50%	75%	X
Blood (First Three Pints)	X	X	X	X	X	50%	75%	X
Hospice Care Coinsurance or Copayment	X	X	X	X	X	X	X	X
Skilled Nursing Facility Care Coinsurance			X	X	X	50%	75%	X
Medicare Part A Deductible		X	X	X	X			X
Medicare Part B Deductible			X	X				
Medicare Part B Excess Charges				100%	100%			
Foreign Travel Emergency (Up to Plan Limits)			X	X	X			X

*Plans offered vary by state.

**Humana also offers a High Deductible Plan F and may offer a Medicare Select Plan F in your area.

Medicare Supplement Plan C
More than basic care

If you want to be well-covered, and you're able to pay a little extra each month for your Humana [Medicare Supplement plan](#), you might consider Plan C. This plan offers coverage above the basic benefits and can provide you with the security of knowing that your primary medical needs may be met.

[[Link: Medicare Supplement Plans overview page](#)]

Plan C covers most of the costs you'd have to pay for medical expenses, but coverage is limited to Medicare-approved charges. This means that you may be responsible for paying additional out-of-pocket expenses if your doctors charge more than what is allowed by Medicare.

Medicare Supplement Plan C

Humana's Medicare Supplement Plan C is ideal for those who want predictable monthly expenses.

Medicare Supplement Plan C covers:

- **Basic benefits including**
 - Hospitalization: pays Part A coinsurance plus coverage for 365 additional days after Medicare benefits end
 - Medical Expenses: pays Part B coinsurance – generally 20 percent of Medicare-approved expenses – or co-payments for hospital outpatient services
 - Blood: pays for the first three pints of blood each year
 - Hospice care: pays Part A coinsurance

- **In addition to the basic benefits, Plan C also provides coverage for:**
 - Skilled nursing facility care
 - Medicare Part A deductible for hospitalization
 - Medicare Part B deductible for medical and hospital outpatient expenses
 - Travel-abroad medical emergency help

[column headers will link to plan pages]

Humana's Medicare Supplement Plans*

Benefits	A	B	C	F**	G	K	L	N
Medicare Part A Coinsurance and Coverage for Hospital Benefits	X	X	X	X	X	X	X	X - \$20 copay for office visits; \$50 copay for ER
Medicare Part B Coinsurance or Copayment	X	X	X	X	X	50%	75%	X
Blood (First Three Pints)	X	X	X	X	X	50%	75%	X

Hospice Care Coinsurance or Copayment	X	X	X	X	X	X	X	X
Skilled Nursing Facility Care Coinsurance			X	X	X	50%	75%	X
Medicare Part A Deductible		X	X	X	X			X
Medicare Part B Deductible			X	X				
Medicare Part B Excess Charges				100%	100%			
Foreign Travel Emergency (Up to Plan Limits)			X	X	X			X

*Plans offered vary by state.

**Humana also offers a High Deductible Plan F and may offer a Medicare Select Plan F in your area.

Medicare Supplement Plans F and G Protection against high out-of-pocket costs

Plans F and G are the only [Medicare Supplement insurance plans](#) that cover costs known as Medicare Part B excess charges. An excess charge is the difference between what a doctor or provider charges and the amount Medicare will pay. These plans will help protect you from additional out-of-pocket expenses should you need treatment that exceeds what Medicare will approve. Plan F also has a high-deductible option*. Plan G covers a percentage of Medicare Part B excess charges. [[Link: Medicare Supplement Plans overview page](#)]

Medicare Supplement Plan F*

With Medicare Supplement Plan F, you get the most complete coverage available. Because the plan covers costs in excess of Medicare-approved amounts, you may have no out-of-pocket costs for hospital and doctor's office care with this plan.

Medicare Supplement Plan F covers:

- **Basic benefits including**
 - Hospitalization: pays Part A coinsurance plus coverage for 365 additional days after Medicare benefits end
 - Medical Expenses: pays Part B coinsurance – generally 20 percent of Medicare-approved expenses – or co-payments for hospital outpatient services
 - Blood: pays for the first three pints of blood each year
 - Hospice care: pays Part A coinsurance

- **In addition to the basic benefits, Plan F also provides coverage for:**
 - Skilled nursing facility care
 - Medicare Part A deductible for hospitalization
 - Medicare Part B deductible for medical and hospital outpatient expenses
 - Medicare Part B excess charges (This is the difference between what a doctor or provider charges and the amount Medicare will pay up to Medicare's limiting amount)
 - Travel-abroad medical emergency help

*Plan F also has a high-deductible option. If you choose the high-deductible option on Medicare Supplement Plan F, you have to pay a deductible of [\$2,000] for [2010] before the plan pays anything. This amount can go up each year. High-deductible policies have lower premiums, but if you become sick, you'll have higher out-of-pocket costs. Depending on where you live, you may be eligible for Medicare Select Plan F.

Medicare Supplement Plan G

Available from Humana only in Connecticut, Medicare Supplement Plan G is a good fit for people who want some coverage for hospitalization, but are willing to pay the Part B deductible on their own.

Medicare Supplement Plan G covers:

- **Basic benefits including**

- Hospitalization: pays Part A coinsurance plus coverage for 365 additional days after Medicare benefits end
- Medical Expenses: pays Part B coinsurance – generally 20 percent of Medicare-approved expenses – or co-payments for hospital outpatient services
- Blood: pays for the first three pints of blood each year
- Hospice care:

- **In addition to the basic benefits, Plan G also provides coverage for:**

- Skilled nursing facility care
- Medicare Part A deductible for hospitalization
- Medicare Part B excess charges – 100 percent ([This is the difference between what a doctor or provider charges and the amount Medicare will pay](#))
- Travel-abroad medical emergency help

[column headers will link to plan pages]

Humana’s Medicare Supplement Plans*

Benefits	A	B	C	F**	G	K	L	N
Medicare Part A Coinsurance and Coverage for Hospital Benefits	X	X	X	X	X	X	X	X - \$20 copay for office visits; \$50 copay for ER
Medicare Part B Coinsurance or Copayment	X	X	X	X	X	50%	75%	X
Blood (First Three Pints)	X	X	X	X	X	50%	75%	X
Hospice Care Coinsurance or Copayment	X	X	X	X	X	X	X	X
Skilled Nursing Facility Care Coinsurance			X	X	X	50%	75%	X
Medicare Part A Deductible		X	X	X	X			X
Medicare Part B Deductible			X	X				
Medicare Part B Excess Charges				100%	100%			
Foreign Travel Emergency (Up to Plan Limits)			X	X	X			X

*Plans offered vary by state.

**Humana also offers a High Deductible Plan F and may offer a Medicare Select Plan F in your area.

Medicare Supplement Plans K, L, and N

Help manage your expenses

Plans K, L and N offer the same basic benefits as other Medicare Supplement insurance plans, but provide you with a lower monthly premium. In exchange for a lower premium, these cost-sharing plans cover less of the coinsurance and copayments than other Medicare Supplement plans. Plans K and L do offer an out-of-pocket maximum, which limits the amount you will have to pay each year.

In general, Plan K offers a lower monthly premium than Plan L, but offers higher coinsurance amounts and a higher annual out-of-pocket limit.

Medicare Supplement Plan K

With Medicare Supplement Plan K, the plan covers services similar to other Medicare Supplement insurance policies. However, instead of paying all your costs, the plan pays a percentage. If you have a serious illness or injury, you have the protection of an out-of-pocket annual limit. Once you reach this “cap” on your out-of-pocket costs, the plan pays 100 percent of Medicare-approved costs for the rest of the year. This plan is a good option if you prefer a lower premium but still want a fair amount of coverage for a wide variety of services.

Medicare Supplement Plan K covers:

- 100% coverage for Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end
- 100% Hospice coverage for Part A coinsurance
- 50% of Medicare-eligible expenses for the first three pints of blood
- 50% Part B coinsurance, except for preventive care services, which are covered 100%

In addition to the basic benefits, Plan K also provides coverage for:

- 50% coverage for Skilled Nursing Facility coinsurance
- 50% coverage for your Medicare Part A deductibles
- [\$4,620]out-of-pocket annual limit (The out-of-pocket annual limit will increase each year for inflation)

Medicare Supplement Plan L

Medicare Supplement Plan L is another option if you want a Medicare Supplement policy with an affordable premium, but still want a reasonable amount of coverage for a wide variety of services. This plan is similar to Plan K, except it:

- covers a higher percentage of your costs
- offers a lower annual out-of-pocket amount and out-of-pocket limit
- has a slightly higher monthly premium

Medicare Supplement Plan L covers:

- 100% coverage for Part A hospitalization coinsurance, plus coverage for 365 days after Medicare benefits end
- 100% Hospice coverage for Part A coinsurance
- 75 % of Medicare-eligible expenses for the first three pints of blood
- 75 % Part B coinsurance, except for preventive care services, which are covered 100%

In addition to the basic benefits, Plan L also provides coverage for:

- 75 % coverage for Skilled Nursing Facility coinsurance
- 75 % coverage for your Medicare Part A deductibles
- [\$2,310] out-of-pocket annual limit*

*The out-of-pocket annual limit will increase each year for inflation.

Medicare Supplement Plan N

Medicare Supplement Plan N provides more coverage than Plans K and L while still maintaining a lower premium than Plans A through G. The only out-of-pocket expenses incurred (after the plan's monthly premium) is a \$20 copay for office visits and a \$50 copay for ER. Plan N covers:

Basic benefits including

- Hospitalization: pays Part A coinsurance plus coverage for 365 additional days after Medicare benefits end
- Medical Expenses: pays Part B coinsurance excluding \$20 copay for office visits and \$50 copy for ER – generally 20 percent of Medicare-approved expenses – or co-payments for hospital outpatient services
- Blood: pays for the first three pints of blood each year
- Hospice: pays Part A coinsurance

In addition to the basic benefits, Plan N also provides coverage for:

- Skilled nursing facility care
- Medicare Part A deductible for hospitalization
- Travel-abroad medical emergency help

[column headers will link to plan pages]

Humana's Medicare Supplement Plans*

Benefits	A	B	C	F**	G	K	L	N
Medicare Part A Coinsurance and Coverage for Hospital Benefits	X	X	X	X	X	X	X	X - \$20 copay for office visits; \$50 copay for ER
Medicare Part B Coinsurance or Copayment	X	X	X	X	X	50%	75%	X

Blood (First Three Pints)	X	X	X	X	X	50%	75%	X
Hospice Care Coinsurance or Copayment	X	X	X	X	X	X	X	X
Skilled Nursing Facility Care Coinsurance			X	X	X	50%	75%	X
Medicare Part A Deductible		X	X	X	X			X
Medicare Part B Deductible			X	X				
Medicare Part B Excess Charges				100%	100%			
Foreign Travel Emergency (Up to Plan Limits)			X	X	X			X

*Plans offered vary by state.

**Humana also offers a High Deductible Plan F and may offer a Medicare Select Plan F in your area.

Understanding Medicare Supplement Plans Making an informed decision

It's smart to study the basics of Medicare Supplement Plans before you decide which plan is best for you. This page provides an overview of how Medicare Supplement insurance works with Medicare Parts A and B, including when you can apply, and who is eligible. Click on the links below to get answers.

[What do I need to know about Medicare Supplement plans?](#)

[Is prescription drug coverage included?](#)

[When is the best time to buy a Medicare Supplement plan?](#)

[What are the eligibility requirements?](#)

What do I need to know about Medicare Supplement plans?

Here are some basics on Medicare Supplement insurance plans:

- **You're still in the Medicare program** – When you purchase Medicare Supplement insurance, you don't replace or cancel your Medicare Parts A and B membership. You have all your Medicare rights and protections.
- **Plans are standardized** – The benefits from plan to plan are the same from every insurance company (some companies may offer innovative benefits) – so a Plan C from one company has the same medical coverage as a Plan C from any other. The difference is in the company, the quality of service, and the price. These features are what make Humana Medicare Supplement plans stand out from the rest.

Is prescription drug coverage included?

Medicare Supplement insurance plans sold after 2006 don't include coverage for prescription drugs. You can always consider a [Humana Medicare \(Part D\)](#) prescription drug plan. [Explore Humana's prescription drug plans.](#)

When is the best time to buy a Medicare Supplement plan?

The best time to buy is during your Medicare Supplement Open Enrollment Period. Your Medicare Supplement Open Enrollment Period lasts for six months. It starts on the first day of the month in which you are:

- Age 65 or older **and**,
- Enrolled in Medicare Part B

Get more information about [when to enroll in Medicare](#). [\[Link: When to enroll page\]](#)

Once your six-month Medicare Supplement Open Enrollment Period starts, it can't be changed. However, in some situations, you have the right to buy a Medicare Supplement policy outside of your Medicare Supplement Open Enrollment Period. In some states these plans may be available to

those under age 65. For those applying for a Medicare Supplement policy prior to age 65, your Medicare Supplement Open Enrollment Period begins on the first day you're enrolled in Medicare Part B.

Note: You can send your application for Medicare Supplement insurance before your Medicare Supplement Open Enrollment Period starts. If you have coverage that will end when you turn age 65, sending your application before open enrollment allows you to have continuous coverage without any breaks.

What are the requirements for Medicare Supplement plan eligibility?

You can apply for a Medicare Supplement plan insurance policy if you are:

1. A resident of a state where the policy is offered
2. Enrolled in Medicare Parts A and B
3. Age 65 or over or, in some states, under age 65 with a disability and/or end stage renal disease (plan offerings and eligibility vary by state).

Plus, you may qualify for guaranteed issue into a Medicare Supplement plan, regardless of your medical history, if you meet certain criteria such as applying during your Medicare Supplement Open Enrollment Period. Rules in some states may vary.

NOTE: Offerings may vary by state. Medicare Supplement plans are not managed care.

HEAD: What to Know Before You Enroll in a Humana Medicare Plan

SUBHEAD: Understand the differences in each plan in the Medicare enrollment process

You know that you need Medicare coverage. How do you decide what plan is best for you?

Should you purchase a Medicare prescription drug plan? Even though a drug plan can give you some relief from the high cost of medications, it might not be the best choice for everyone, as it does not provide medical coverage. An all-in-one Medicare Advantage plan may prove to be a better fit for your coverage needs.

Drug Benefits

[Medicare Advantage plans](#) [[link to Medicare Advantage Plans overview page](#)] – Many Medicare [Health Maintenance Organization \(HMO\)](#), [Preferred Provider Organization \(PPO\)](#), or [Private-Fee-for-Service \(PFFS\)](#) plans include prescription drug coverage, too. That means you get medical coverage and prescription drug coverage all in one plan.

[Medicare prescription drug plans](#) [[link to Prescription Plan overview page](#)] – Prescription drug plans can help you cover your prescription drug costs. Each Medicare prescription drug plan offers coverage at least as good as the Medicare minimum standard requirement. Some plans may offer more choices and have different premiums and costs depending on the benefits offered.

[Medicare Supplement insurance plans](#) [[link to Supplement Plan overview page](#)] – Medicare Supplement plans cannot include prescription drug coverage. If you want prescription drug coverage, you'll need to enroll in a separate stand-alone Medicare prescription drug plan.

Determining your premiums

Medicare Advantage plans – With a Medicare Advantage plan, you may pay a monthly plan premium to the insurer in addition to the Medicare premium you already pay. Many Medicare Advantage plans – including the majority of Humana's – also provide prescription drug coverage at no additional cost.

Prescription drug plans – With a Medicare prescription drug plan, you may pay a monthly plan premium to the insurer in addition to the Medicare premium you already pay. If you didn't sign up for drug coverage when you first became eligible, you may have a higher premium – as much as one percent more for every month you wait.

Medicare Supplement plans – With a Medicare Supplement plan, you pay a monthly plan premium to the insurer in addition to the Medicare premium you already pay. The premium may vary by plan type, your age group, your gender and/or where you live.

When you enroll and when your coverage is effective

Medicare Advantage plans – In most cases, your coverage becomes effective on the first day of the next month after you join.

- However, if you enroll in a [2011] plan between November 15 and December 31, your coverage will become effective January 1.

Prescription drug plans – In most cases, your coverage becomes effective on the first day of the next month after you join

- However, if you enroll in a [2011] plan between November 15 and December 31, your coverage will become effective January 1.

If you purchase a stand-alone prescription drug plan while you're enrolled in a Medicare Advantage plan with prescription drug coverage, you will be disenrolled automatically from your Medicare Advantage plan

Medicare Supplement plans – In most cases, your coverage becomes effective on the first day of the next month after you join – unless you request a different effective date. Your Medicare Supplement Open Enrollment Period continues for six months after you sign up for Medicare Part B or upon your 65th birthday. During this time a company must allow you to buy any Medicare Supplement plan offered in your state.

[Home](#) > [Enroll with Humana](#) > After You Enroll

After Enrollment in a Humana Medicare Plan

Next steps for receiving your Humana Medicare benefits

You've made your selection and enrolled in one of Humana's Medicare plans. Now you're eager to access your new benefits as quickly as possible. Here's a general idea of what to expect.

Once you've completed online enrollment, you're only a short time away from enjoying your Humana Medicare benefits.

Our online enrollment form gives you the chance to complete the entire enrollment process online. By enrolling online, you reduce your processing time.

1. Humana receives your completed and signed enrollment form

2. Depending on the plan you enrolled in, Humana does one of the following:

- a. **If you enrolled in one of Humana's Medicare Advantage plans or prescription drug plans, we send your completed enrollment form to the Centers for Medicare & Medicaid Services (CMS) for approval.** You will receive your new Humana ID card within [7-10 business days] after Humana gets CMS approval of your enrollment form. Take this card with you whenever you use any of the plan's benefits. You also will receive a Humana Welcome Kit that contains printed copy of your electronically signed enrollment form and plan benefit information.
- b. **If you purchased one of Humana's Medicare Supplement Insurance plans, we begin the process of issuing your policy and printing your new Humana ID card.** You will receive your new Humana ID card within [7-10 business days]. Take this card with you whenever you use any of the plan's benefits. You also will receive a copy of your electronically signed application form and plan benefit information. Your policy includes a 30-day free look period.

3. Coverage begins on your effective date. When you enroll determines this date.

If your plan includes [prescription drug coverage](#), and you need to fill prescriptions **after** your coverage begins but **before** you receive your ID card, take your online enrollment confirmation page and a copy of your enrollment form to your local Humana in-network retail pharmacy. Be sure to tell the pharmacist which Humana Medicare plan you chose.

Need Proof of Coverage?

[Member Resources](#) can help you

- Verify enrollment
- Obtain a letter of coverage]

For Current Humana Members

If you're currently a Humana member, visit Humana.com for [Medicare Tools & Resources](#).

[Link: http://www.humana.com/members/tools/how_to_renew.asp]

If you're looking for information on disenrolling from a Humana Medicare plan, you can read more in our FAQ section here: [Disenrollment Rights and Responsibilities](#) [Link: [FAQ](#)]. Or you can visit the [Humana.com disenrollment page.](#) [Link: <http://www.humana.com/TBD>].

Helping Someone Enroll in Humana's Medicare Advantage and Prescription Drug Plans Providing Medicare assistance to an eligible parent or senior

If your parent or loved one is considering a Medicare prescription drug, Medicare Advantage plan or Medicare Supplement plan, you may find yourself scrambling to understand how to enroll in a Medicare health plan.

- [Allow enough time](#) [anchor link 1]
- [Communication is key](#) [anchor link 2]
- [Determine medical needs](#) [anchor link 3]
- [Determine prescription drug needs](#) [anchor link 4]
- [Discuss preferences for doctor visits](#) [anchor link 5]
- [Determine current coverage and monthly payments](#) [anchor link 6]

Allow enough time [link 1]

Your goal is to help evaluate plan options, choose the right plan, and aid in the enrollment process. Allow adequate time to make the right coverage decision. Be patient and flexible as you find your way through the process.

Keep in mind that in most cases, coverage starts on the first day of the month after Humana receives the completed enrollment form.

Those who are new to Medicare and are turning 65 have a lot of decisions to make about healthcare benefits. You can find information on [Medicare plan options](#), when to enroll, Medicare basics and more! [Link: [Turning 65 page](#)]

Communication is key [link 2]

Bring together everyone who needs to be involved in the decision-making process. Explain the purpose of your getting together. Share what you have learned. Most importantly, ask questions.

Determine medical needs [link 3]

As you look at different plans, ask yourself these questions:

1. How much is the monthly premium?
2. How much is the deductible for different services?
3. How much is the copayment?
4. What is covered? What isn't?
5. What doctors can I visit?

If you're helping someone enroll who is on a budget or a fixed income, you may want to consider a Medicare Advantage plan. Medicare Advantage plans include drug coverage and fixed copayments. Humana offers three types of [Medicare Advantage plans](#).

Determine prescription drug needs [\[link 4\]](#)

Find out which drugs the person you're helping takes, including the generic and brand names, the dose, how often it's taken, and if their prescription is obtained by mail or at a retail pharmacy. Be sure to make a separate list for each parent, relative or friend.

Consider cost-saving opportunities and if the plan is right based on the person's financial needs.

Discuss preferences for doctor visits [\[link 5\]](#)

Will the person you're helping to enroll in a Medicare health plan choose a primary doctor from a network of Medicare-approved providers? A Medicare Advantage HMO, such as [Humana Gold Plus](#)[®], could be a good fit. [\[Link: Humana Gold Plus main page\]](#)

Want flexibility in choosing a doctor? Does the person you're helping spend part of the year in a different state? Consider a PPO or Private-Fee-for-Service (PFFS) plan, including [HumanaChoicePPO](#)[®] [\[Link: HumanaChoicePPO main page\]](#) and [Humana Gold Choice](#)[®]. [\[Link: Humana Gold Choice main page\]](#)

Medicare Supplement plans are also a good option for people who want flexibility in choosing providers. These plans can work seamlessly with Medicare Parts A and B to enhance coverage for doctor's office visits and other healthcare costs. Find out more about [Humana's Medicare Supplement insurance plans](#).

Determine current coverage and monthly payments [\[link 6\]](#)

Make sure the person you're helping doesn't already have prescription drug coverage through a former employer or other health insurance plan; otherwise, the Medicare beneficiary may automatically forfeit that other coverage.

Why Choose Humana

Good reasons to pick Humana for your Medicare coverage

With Humana's wide range of choices, you can pick the plan that fits your lifestyle, your coverage needs, and your pocketbook. Your choices include:

- [Medicare Advantage plans](#) with more benefits than Medicare Parts A and B, an affordable or no monthly premium, an extensive list of doctors in many areas, and predictable costs that are easy to budget. [\[Link: Medicare Advantage Plans overview page\]](#)
- [Medicare prescription drug plans](#) that can offer you relief from the high costs of medications. In most areas, Humana offers three stand-alone drug plans - so you can choose the one that best fits your needs and budget. [\[Link: Prescription Plan overview page\]](#)
- [Medicare Supplement insurance plans](#) that can work seamlessly with Medicare Parts A and B to help cover costs like Medicare deductibles and coinsurance [\[Link: Supplement Plan overview page\]](#)

Experience you can trust

As a Fortune [100] company with a [nearly 50-year] history in the health industry, we're committed to offering valuable benefits, outstanding wellness programs, and reliable customer service. Find out more about [our experience](#) [\[Link: experience page\]](#)

Services – at no cost to you

Humana has developed programs and services that can help you focus on wellness and prevention, which may save you money and keep you active for years to come.

- [MyHumana secure Website](#) - Use your personal, secure page on Humana's secure Website to find a wealth of health tips and topics, as well as your personal health record and medication history [\[Link: MyHumana\]](#)
- [SmartSummary[®] and SmartSummary Rx[®]](#) This monthly benefits record details your benefits history and includes suggestions on how to lower monthly spending [\[Link: SmartSummary\]](#)
- [Special clinical programs](#) - Humana's disease management programs can help you manage certain chronic health conditions [\[Link: Special Programs\]](#)

[Home](#) > [Why Choose Humana](#) > Our Experience

Our Experience

Humana's knowledge and preparation means confidence for you

Humana has been a trusted Medicare insurer for more than 20 years, helping the Medicare population with their health insurance needs.

We understand that you have many choices now, and we know you're looking for the best value for your healthcare dollars. We want to help make it easier for you to choose the plan that's right for your healthcare needs, your lifestyle, and your budget.

Committed to serving your needs

Humana makes it easy for you to find the information you're looking for, see what fits your requirements, and compare your options – so you can select health benefits with real confidence.

[Discover Humana's Medicare plans easy enrollment.](#) [\[Link: Humana's Medicare Plans\]](#)

Humana's highly skilled team is constantly striving to help members improve their health. We want to help you find the information you need to make confident choices whenever you seek healthcare services.

And we'll provide support to help you make those choices. Humana will continue to be with you as you sort out your Medicare options.

[Home](#) > Help

Humana Medicare Help

Need help? Humana has the answers

To make choosing a Humana Medicare plan easier, we have placed the answers to the many common Medicare questions close at hand. Follow one of the links below to get started:

[Frequently Asked Questions \[about Medicare\]](#) [Link: [main FAQ page](#)]

Have questions about Humana's Medicare Advantage, Medicare (Part D) prescription drug, or Medicare Supplement plans? Or ready to enroll and need to know how? [Find the answers in our Frequently Asked Medicare Questions.](#) [Link: [main FAQ page](#)]

[Medicare Glossary](#) [Link: [main glossary page](#)]

Want to find definitions for common Medicare terms and concepts? [Check out our glossary.](#) [Link: [main glossary page](#)]

[Questions about Enrollment](#) [Link: ["Enroll with Humana" page](#)]

Learn everything you need to know about [enrolling in a Humana Medicare plan.](#)

Already a Humana Member?

If you're a current Humana member, you can explore a variety of [member resources](#) or call the Customer Service phone number on the back of your Humana member ID card.

If you haven't received your Humana member ID card, please call one of the following Customer Service numbers:

If you have a Humana Medicare Advantage plan, call [1-800-457-4708]

If you have a Humana prescription drug plan, call [1-800-281-6918]

TTY users, call [1-800-833-3301]

[Monday – Sunday, 8 a.m. to 8 p.m., local time]

[Home](#) > [Help](#) > Frequently Asked Questions

Frequently Asked Questions About Medicare The answers you need

Get answers to the most frequently asked Medicare questions including questions about Medicare Advantage, Medicare (Part D) prescription drug, and Medicare Supplement plans. You can also get tips for using Humana's online enrollment tools and resources. Select a topic below to get started.

FAQ Topics:

- [Medicare Advantage Plans](#)
- [Medicare Prescription Drug Plans](#)
- [Medicare Supplement Plans](#)
- [Enroll with Humana](#)
- [More About Medicare](#)

FAQs: Medicare Supplement plans

Frequently Asked Questions About Medicare Supplement Plans

General Medicare Supplement Questions

- [What is a Medicare Supplement plan?](#)
- [What Medicare Supplement plans does Humana offer?](#)
- [Am I eligible to purchase a Medicare Supplement plan?](#)
- [Does a Medicare Supplement plan replace Medicare Parts A and B?](#)
- [What are the open enrollment dates?](#)
- [What if my open enrollment period is over?](#)
- [How can I apply for a Humana Medicare Supplement plan?](#)
- [When does my coverage begin?](#)
- [Can my Humana Medicare Supplement plan be cancelled?](#)
- [Do I have to take a physical examination when I apply for a Humana Medicare Supplement plans?](#)

Medicare Supplement Costs

- [How do I pay my premiums?](#)
- [Will my premium change?](#)

Medicare Supplement Coverage

- [Do I have to use certain doctors?](#)
- [How can I find out which services are covered by the plan I am most interested in?](#)
- [Do Humana's Medicare Supplement plans cover prescription drugs?](#)

General Medicare Supplement Questions

Q. What is a Medicare Supplement plan?

A Medicare Supplement insurance plan helps cover the costs that are left unpaid after Medicare Parts A and B pay their portion of your healthcare expenses. Medicare Supplement policies pay only for services Medicare considers medically necessary. Payments are generally based on the Medicare-approved charge. The policy might not fully cover all of your medical costs.

Medicare Supplement policies are available from private insurance companies. While the costs of these policies may vary, individual insurance companies must provide the same standardized benefits.

Q. What Medicare Supplement plans does Humana offer?

Humana offers plans A, B, C, D, F, High Deductible F, F Select, G, K, L, and N. Plan offerings vary by state.

*Massachusetts, Minnesota, and Wisconsin do not offer the standard alphabetized plan menu.

Q. Am I eligible to purchase a Medicare Supplement plan?

If you're enrolled in Medicare Part A and Part B, you're probably eligible to buy a Medicare Supplement policy. During your Medicare Supplement Open Enrollment Period – for people 65 or older, that's six months after you sign up for Medicare Part B – a company must allow you to buy any Medicare Supplement plan offered. In some states these plans may be available to those under age 65.

Q. Does a Medicare Supplement plan replace Medicare Parts A and B?

Unlike a Medicare Advantage plan, which is an alternative option to Medicare Parts A and B, Medicare Supplement plans are purchased in addition to your Medicare Parts A and B benefits.

Q. What are the open enrollment dates?

There are no specific enrollment dates for a Medicare Supplement plan. The best time to buy a insurance policy is during your Medicare Supplement Open Enrollment Period which lasts six months. It starts on the first day of the month in which you are BOTH age 65 or older AND enrolled in Medicare Part B. . In some states, these plans may be available to those under age 65. For those enrolling in a Medicare Supplement plan prior to the age of 65, your Medicare Supplement Open Enrollment Period begins on the first day you're enrolled in Medicare Part B. Once your Medicare Supplement Open Enrollment Period starts it cannot be changed. Find more details at [Medicare Supplement Enrollment and Eligibility](#).

During this period you cannot be denied coverage, nor be made to wait before coverage begins.

Q. What if my open enrollment period is over?

You can still apply for a Medicare Supplement plan after your Medicare Supplement Open Enrollment Period has expired. However, your application may be subject to medical underwriting (i.e., a review of your medical history and current health) unless you qualify under guaranteed issue rights.

You also may have the right to buy a Medicare Supplement policy outside of your Medicare Supplement Open Enrollment Period if you lose certain types of health coverage. In general, this right is for [63] days from the date coverage ends or from the date you receive notice that your coverage will end. You must provide proof of the loss of your previous coverage. Otherwise, applying after your guaranteed issue period has expired may subject your application to medical underwriting which will help determine if your application will be accepted. More details can be found at Medicare Supplement Enrollment and Eligibility.

Q. How can I apply for a Humana Medicare Supplement plan?

Depending on where you live, you can enroll fast and secure on our Website. For details on how, visit our [Enroll Online](#) [link to Enroll Online page] page. You can also enroll with the help of one of our licensed agents/producer at the number at the bottom of the page.

Q. When does my coverage begin?

In general, your coverage begins on the first day of the month after Humana receives your completed application – unless you request a later effective date, or you applied prior to your Medicare Part A or B effective date.

Q. Can my Humana's Medicare Supplement plan be cancelled?

Medicare Supplement coverage is guaranteed renewable for life, which means Humana cannot cancel your policy because of your age or health. Your policy may be cancelled if you fail to pay any monthly plan premium.

Q. Do I have to take a physical examination when I apply for a Humana Medicare Supplement plan?

No, but you may need to answer health questions depending on where you live. Responses to medical questions are not required if you are applying during open enrollment or qualify for guaranteed issue.

Medicare Supplement Costs

Q. How do I pay my premiums?

In addition to the monthly Medicare Part B premium to Medicare, you pay a premium to the insurance company that provides your coverage. Humana offers several ways to pay, including automatic bank account withdrawal or credit card. You also have the option of a coupon book. Choosing automatic bank withdrawal or credit card as your payment method, results in a [\$2] discount to your monthly plan premium.

Q. Will my premium change?

Premium changes are dependent on the type of policy you purchase. For example, if your policy is issued as an “attained-age” policy, your premium will increase as you age. Premiums are also annually adjusted to reflect changes in Medicare.

Medicare Supplement Coverage

Q. Do I have to use certain doctors?

No. With a Medicare Supplement plan, you have the flexibility to choose any doctor or hospital who accepts Medicare.

Q. How can I find out which services are covered by the plan I am most interested in?

Medicare Supplement policies are standardized into 10 plans, labeled “A” through “N,” each with its own set of benefits. Plan A covers the most basic benefits: coinsurance for hospitalization plus coverage for 365 additional days after Medicare benefits end; coinsurance or copayments for medical expenses like doctor office visits and outpatient services; if you require blood transfusion, coverage for the first three pints of blood you receive; and pays for the Part A coinsurance associated with hospice care. Plans B through G cover all the services of Plan A, plus one or more additional costs such as coinsurance for a skilled nursing facility, your Part A deductible, or your Part B deductible. Plans K, L and N cover similar services as plans A-G, but the costs for the basic benefits are different.

For information about what a specific plan covers, enter your ZIP code at the bottom of this page. You will be taken to the Plan Comparison section of our Website where you can get detailed information on the plans in your area.

Q. Do Humana’s Medicare Supplement plans cover prescription drugs?

No. If you’re buying a Medicare Supplement plan and want prescription drug coverage, you’ll need to enroll in a separate Medicare Part D plan. Some supplement plans sold before 2006 included drug coverage; people who had already purchased those plans were allowed to keep the same coverage.

FAQs: Enroll with Humana
Medicare Plan Enrollment with Humana

Enrolling

- [How do I enroll in a plan?](#)
- [What information do I need to have ready before I enroll?](#)
- [Can a child or guardian enroll a parent in a Medicare Advantage, Medicare prescription drug, or Medicare Supplement plan?](#)
- [What happens to my Medicare card?](#)

Enrolling in Humana's Medicare Advantage Plans

- [I will be turning 65 in a few months. When can I enroll in one of Humana's Medicare Advantage plans?](#)
- [What factors should I consider when choosing a Medicare health plan?](#)
- [When will Humana's Medicare Advantage plan coverage begin?](#)
- [I currently have a Medicare Supplement plan. Can I enroll in a Medicare Advantage plan?](#)
- [I have Medicare Parts A and B. Can I enroll in a Medicare Advantage plan?](#)

Enrolling in Humana's Prescription Drug Plans

- [Do I need to sign up for Medicare prescription drug coverage?](#)
- [Can I enroll in a prescription drug plan? I have a Medicare Supplement plan.](#)
- [Can I enroll in a prescription drug plan? I have Medicare \(Part A and B\).](#)

Enrolling in Humana's Medicare Supplement Plans

- [When will my Medicare Supplement plan coverage begin?](#)
- [Can I apply for a Medicare Supplement plan? I have a Medicare Advantage plan.](#)
- [Can I apply for a Medicare Supplement plan? I have a Medicare prescription drug plan.](#)

Enrolling

Q. How do I enroll in a plan?

Once you have entered your Zip code you can view available plans in your area. You can enroll in Humana's Medicare Advantage, prescription drug or Medicare Supplement plans by clicking on the "Enroll" button next to the plan you'd like to enroll in. Once you enter the online enrollment section, you will confirm your selection and answer additional questions before reviewing and submitting your enrollment form.

Q. What information do I need to have ready before I enroll?

You'll need your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. Also, depending on the payment method you choose, you may need to have your bank account or credit card number handy.

Q. Can a child or guardian enroll a parent in a Medicare Advantage, Medicare prescription drug, or Medicare Supplement plan?

Yes. Our Website allows someone serving as Power of Attorney (POA), translator, or witness to fill out the online enrollment form. If a Power of Attorney is enrolling someone for our Medicare Advantage or prescription drug plans, the POA must cover the ability to make healthcare decisions and is usually referred to as a “Durable Power of Attorney for Healthcare” or “Healthcare Power of Attorney.” If a Power of Attorney is enrolling someone for our Medicare Supplement plans, the POA must cover the ability to make insurance decisions and is usually referred to as a “Durable Power of Attorney” or “Power of Attorney.”

Q. What happens to my Medicare card?

If you have Medicare Parts A & B, you’ll need to show your Medicare card when you receive healthcare services.

If you have a Medicare Advantage plan, you should keep your Medicare card in a safe place – but you don’t have to carry it with you. Instead, present your Humana member ID card to doctor’s offices, pharmacies, and other healthcare providers.

If you have a separate Medicare Supplement or Medicare prescription drug plan, you’ll receive additional cards that you should keep with you at all times.

Enrolling in Humana’s Medicare Advantage Plans

Q. I will be turning 65 in a few months. When can I enroll in one of Humana’s Medicare Advantage plans?

You may enroll anytime during the first three months immediately preceding the month your enrollment in Medicare Parts A and B becomes effective. This time is called your Initial Coverage Election Period. It generally coincides with the month you turn 65 years old; however, some people choose to delay Part B coverage for a while if they have other coverage through their employer. In that case, it would be the month that your Part B coverage goes into effect, assuming you already have Part A.

Q. What factors should I consider when choosing a Medicare Advantage plan?

Before you select a plan, carefully consider the following questions. Your answers will help guide you to the plan that’s right for you.

- Do you already have a doctor you like?
- Are you choosing a new doctor?
- Is freedom to choose doctors and hospitals very important to you?
- Do you need a prescription drug plan?
- Do you have health problems today or old problems that may recur?
- What drugs does the plan cover?
- Does your doctor feel comfortable with the plan’s guidelines for your treatment?

Q. When will Humana’s [Medicare Advantage](#) plan coverage begin? [[link to Medicare Advantage overview page](#)]

Coverage is usually effective on the first day of the month after Humana receives your completed and signed enrollment form. We’ll send you a letter confirming your coverage after the Centers for

Medicare & Medicaid Services (CMS) approves your enrollment. Please continue your current coverage until you receive our confirmation letter. If you are scheduled for surgery or another medical treatment, you might want to delay your enrollment until after the procedure, simply to eliminate billing confusion for you and your providers.

Q. I currently have a Medicare Supplement plan [[link to Medicare Supplement overview page](#)]. Can I enroll in a Medicare Advantage plan?

Yes, but there's no need to have both. You would have to pay both plan premiums and you get no benefit from your supplement while you are in a Medicare Advantage plan. If you join a Medicare Advantage plan, your Medicare supplement policy can't pay any deductibles, copayments, or coinsurance under your Medicare plan.

Q. I have Medicare Parts A and B. Can I enroll in a Medicare Advantage plan?

If you're enrolled in Medicare Part A and B, you can enroll in a Medicare Advantage plan between November 15 and December 31.

Enrolling in Humana's [Prescription Drug Plans](#) [[link to Medicare part D overview page](#)]

Q. Do I need to sign up for Medicare prescription drug coverage?

The answer depends on your medical and financial situation. Think about your needs and what's important to you. The costs of prescriptions continue to increase, so a prescription drug plan may help control your costs. Remember, if you were eligible to join Medicare Part D by May 15, 2006, and did not do so, you may have to pay a penalty for joining the plan later and that penalty increases each month.

Q. Can I enroll in a prescription drug plan? I have a Medicare Supplement plan.

Yes, but if the Medicare Supplement policy covers prescription drugs, the drug coverage must be removed from the Medicare Supplement policy. Humana's Medicare Supplement plans do not come with drug coverage, so you can enroll in one of Humana's prescription drug plans and Humana's Medicare Supplement plans.

Q. Can I enroll in a prescription drug plan? I have Medicare Parts A and B.

If you're entitled to Part A and/or enrolled in Part B of Medicare, you're eligible to join a prescription drug plan.

Enrolling in Humana's Medicare Supplement Plans

Q. When will my Medicare Supplement plan coverage begin?

Your coverage is usually effective on the first day of the month after Humana receives your completed and signed application form. Please continue your current coverage until you receive our policy.

Q. Can I apply for a Medicare Supplement plan? I have a Medicare Advantage plan.

Unless you indicate that your Medicare Advantage coverage is ending, it is illegal for anyone to sell you a Medicare Supplement plan.

Q. Can I apply for a Medicare Supplement plan? I have a Medicare prescription drug plan.

Yes, you can apply for a Medicare Supplement plan if you're already enrolled in a Prescription drug plan.

If you have more questions, you may want to see

- [Selecting your Medicare plan](#)
- [Estimate your Medicare prescription drug costs](#)
- [How to enroll](#)
- [After you enroll](#)

FAQs More about Medicare
Medicare Information and Common Questions

- [What is Medicare Parts A and B?](#)
- [What is Medicare Advantage?](#)
- [What is a Medicare Advantage HMO plan?](#)
- [What is a Medicare Advantage PPO plan?](#)
- [What is a Medicare Advantage PFFS plan?](#)
- [What is a Medicare prescription drug \(Part D\) plan?](#)
- [What is a Medicare Supplement plan?](#)
- [How do I know if I have Medicare Parts A and B?](#)
- [Can you help me compare Original Medicare to the Medicare Advantage plans?](#)
- [Where can I get more information about Medicare Advantage plans, prescription drug plans, Medicare Supplement plans and my Social Security benefits?](#)
- [What is the Medicare Modernization Act?](#)
- [What are the basic parts of the Medicare program now?](#)
- [What's the difference between traditional Medicare and Medicare prescription drug coverage?](#)

Q. What is [Medicare Parts A and B](#) [[link to Medicare Parts A and B page](#)]

Medicare is a federal health insurance program for people 65 years old or over and for certain disabled people under 65 years of age. You are automatically enrolled in Medicare hospital insurance (Part A) when you apply for Social Security benefits – usually upon reaching 65 years of age. Part A covers inpatient care in a hospital or a limited stay in a skilled nursing facility. Part B covers physician and outpatient hospital services. The premium you pay for Part B is deducted from your Social Security benefits.

Medicare pays for many healthcare services and supplies, but it doesn't cover all of your healthcare costs. For example, you pay a deductible for each hospital stay and coinsurance anytime you use the services of a physician or surgeon. Also, drug coverage is limited. Because Medicare rarely pays the full cost of covered services, you may want to consider a Medicare Advantage or Medicare Supplement plan.

Q. What is [Medicare Advantage](#) [[link to Medicare Advantage Plans overview page](#)]?

A Medicare Advantage-health plan is an alternative to Original Medicare and was created by the Balanced Budget Act of 1997 and the Medicare Modernization Act of 2003. Medicare Advantage plans include:

- * Medicare Health Maintenance Organization plans (HMO)
- * Medicare Preferred Provider Organization plans (PPO)
- * Medicare Private-Fee-for-Service plans (PFFS)

Medicare Advantage plans feature prescription drug benefits, fixed costs, limits on out-of-pocket expenses, and worldwide coverage for emergency and urgent care.

Q. What is a Medicare Advantage HMO plan? [\[link to Humana HMO page\]](#)

An HMO is an alternative to Original Medicare that features specific lists of doctors, hospitals, and other providers that you must use to receive benefits. HMOs often provide additional benefits not found in Original Medicare, including coverage for deductibles, steep reductions in coinsurance when you see a doctor, a drug benefit plan, and wellness or fitness programs. If you select a Medicare Advantage HMO, it is an alternative to your Original Medicare coverage. However, you can return to Original Medicare down the road if you wish. [How Humana's HMO plans work.](#) [\[link to HMO page\]](#)

Q. What is a Medicare Advantage PPO plan? [\[link to Humana PPO page\]](#)

With a Medicare Advantage PPO, you can see any doctor you want. However, if you use a doctor who participates in the network, you get a better benefit and lower copayment/coinsurance than if you visit a non-network doctor. Plus, referrals aren't needed, and you don't have to see a primary care physician first. In addition to prescription drug benefits, Medicare Advantage PPOs may offer other benefits such as dental, vision, and nutritional supplements. If you select a Medicare Advantage PPO, it is an alternative to your Original Medicare coverage. However, you can return to Original Medicare down the road if you wish. [How Humana's PPO plans work.](#) [\[link to PPO page\]](#)

Q. What is a Medicare Advantage PFFS Plan? [\[link to Humana PFFS page\]](#)

PFFS plans feature limits on out-of-pocket expenses, coverage for emergency and urgent care, and in most cases, a prescription drug benefit. If you select a PFFS plan, it is an alternative to your Original Medicare coverage. However, you can return to Original Medicare down the road if you wish. [How Humana's PFFS plans work.](#) [\[link to PFFS page\]](#)

Q. What is a Medicare prescription drug (Part D) plan? [\[link to Humana PDP page\]](#) Medicare prescription drug coverage is insurance that covers both brand-name and generic prescription drugs at participating pharmacies in your area. Medicare prescription drug coverage provides protection for people who have very high drug costs or from unexpected prescription drug bills in the future.

Q. What is a [Medicare Supplement plan](#)? [\[link to Supplement Plan overview page\]](#)

A Medicare Supplement insurance plan helps cover the costs that are left unpaid after Medicare Parts A and B pay their portion of your healthcare expenses. Unlike a Medicare Advantage plan, which is an alternative to your Medicare Parts A and B benefits, a Medicare Supplement plan is purchased in addition to your Medicare Parts A and B benefits.

Medicare Supplement policies are standardized into 10 plans – labeled “A” through “N,” each with its own set of benefits. Plan A covers the most basic benefits. These basic benefits are also covered in each of the remaining Medicare Supplement plans – B through N. Plans B through N provide additional coverage beyond the basics.

Medicare Supplement policies are sold by private insurance companies. While the costs of these policies may vary, individual insurance companies must provide the same standardized. Some companies may offer innovative benefits. To purchase a policy, in general you must be enrolled in Medicare Part A and Part B. In addition to paying the monthly Medicare Part B premium to Medicare, you will have to pay a premium to the insurance company providing your coverage.

Q. How do I know if I have Medicare Parts A and B?

Look at the “Is Entitled To” section of your red, white, and blue Medicare card. If you have Part A, “HOSPITAL (PART A)” is printed on your card. If you have Part B, “MEDICAL (PART B)” is printed on your card.

Q. Can you help me compare Medicare Parts A and B to the Medicare Advantage plans?

	Medicare Parts A and B (managed by the government)	Medicare Advantage (sponsored by the government and offered by private insurers, including Humana)
Benefits	Part A - Inpatient hospital	Inpatient hospital and provider services, plus additional benefits such as vision and dental
	Part B - Doctors' services	
Premium	Part A - \$0 for people who have worked 40+ quarters	Monthly plan premium varies by plan and geographic area. Some plans have no additional monthly premium.
	Part B – [\$110.50] per month (in [2010])	
Types of plans	Fee-for-service	Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Private Fee for Service (PFFS), and specialty plans
Is additional - coverage necessary?	Many people choose to purchase an additional policy from private insurance company, at added cost	No - not needed because benefits are extensive
Billing procedures	Provider bills Medicare first, insurance second	Simplified administration - in most cases, provider bills only the Medicare Advantage insurance company

Q. Where can I get more information about Medicare Advantage plans, prescription drug plans, Medicare Supplement plans, and my Social Security benefits?

* Centers for Medicare & Medicaid Services
 7500 Security Blvd.
 Baltimore, MD 21244-1850
 1-800-633-4227
 TTY 1-877-486-2048
 24 hours a day; 7 days a week
www.medicare.gov

* Social Security Administration
Office of Public Inquires
Windsor Park Blvd.
6401 Security Blvd.
Baltimore, MD 21235
1-800-772-1213
TTY 1-800-325-0778
7 a.m. – 7 p.m.
www.ssa.gov

* Railroad Retirement Board
Chicago District Office
844 N. Rush Street
Ninth Floor
Chicago, IL 60611-2092
1-800-808-0772
TTY 312-751-4701
24 hours a day, 7 days a week
www.rrb.gov

Q. What is the Medicare Modernization Act?

The Medicare Modernization Act – or “MMA” – introduced the most sweeping changes to Medicare since the program was first signed into law in 1965. The full name of the Act is Medicare Prescription Drug Improvement and Modernization Act of 2003.

The changes went into effect January 1, 2006, providing you more choices in Medicare coverage – including prescription drug benefits. At its core, the Medicare Modernization Act extends prescription drug coverage to everyone who has Medicare. This prescription drug benefit is known as “Medicare Part D.”

Q. What are the basic parts of the Medicare program now?

There are four parts to Medicare.

Medicare Part A is hospital insurance – including hospital stays, rehabilitative nursing facilities, home healthcare, and hospice. Most people don’t have to pay a premium for Part A because it was prepaid through their payroll tax while they were working.

Part B is medical insurance – including doctors’ services and outpatient care. There is a monthly premium for Part B. If you don’t sign up for Part B when you first become eligible at age 65 or when you have been disabled for two years and you decide you need to join in the future, you may have to pay a penalty for each year you didn’t belong.

Medicare Part C is the Medicare Advantage plan. With this option, you can opt to have your Medicare Parts A and B provided by a private company like Humana.

Medicare Part D is prescription drug coverage. In one way, Part D is like Part B: If you don’t join at age 65, you may have to pay a penalty when you do join.

Q. What's the difference between traditional Medicare and Medicare prescription drug coverage?

Original Medicare covers hospital costs under Part A and medical costs like doctor's office visits under Part B. Medicare Part D provides benefits for prescription drugs obtained at a pharmacy – a growing part of many peoples' healthcare budgets.

Prescription drug plan coverage differs from Original Medicare in two ways: (1) It is available only through private insurance companies like Humana and (2) you have to use certain providers, called in-network pharmacies, to take advantage of your coverage.

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Medicare Glossary from Humana
Your online Medicare Resource Center

As you read about Medicare plans in various publications or online, you'll see some of the same words or phrases – over and over.

If you're not sure what those terms mean, this glossary will help.

Keep it handy for future reference.

[A – D](#)

A – D includes definitions for words such as actual charge through durable medical equipment (DME).

[E – H](#)

E – H includes explanations of election period through hospital insurance.

[I – L](#)

I – L defines words ranging from individual allowance to lock-in period.

[M – P](#)

M – P explains phrases such as mail-order pharmacy through primary care physician (PCP).

[Q – T](#)

Q – T covers words such as qualified Medicare beneficiary (QMB) through treatment.

[U – Z](#)

U – Z explains words such as urgently needed care through worldwide coverage (foreign travel benefit).

Medicare Glossary A – D from Humana
Medicare Terms and Definitions Explained

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A

ACTUAL CHARGE

The amount of money a doctor or supplier charges for a specific medical service or supply. Because Medicare and insurance companies usually negotiate lower rates for members, this amount is often more than the “approved amount” you and Medicare actually pay.

ADMISSION

Entry into a facility as a registered inpatient according to the rules and regulations of the facility. An admission ends when you are discharged or released from the facility.

ADMITTING PHYSICIAN

The doctor responsible for admitting a patient to a hospital or other inpatient health facility.

ADVANCE COVERAGE DECISION

A decision a Private-Fee-for-Service plan makes on whether a certain service is covered under the plan.

ADVANCED IMAGING

Radiology tests that use complex, highly developed, non-invasive technology to view the interior of the body. Examples include CT scans, ultrasound, MRA, and MRI tests.

AMBULATORY CARE

All types of health services that do not require an overnight hospital stay.

AMBULATORY SURGICAL CENTER

A place other than a hospital that does outpatient surgery – also known as an “in and out” center. At an ambulatory surgery center, you may stay for only a few hours or for one night.

ANNUAL DEDUCTIBLE

The amount of covered expenses you must pay before your insurance plan pays benefits. In Medicare, the annual deductible is the amount you must pay for healthcare before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year. See the definitions for [benefit period](#), [Medicare Part A](#), and [Medicare Part B](#).

ANNUAL ELECTION PERIOD

November 15 through December 31 of each year. Usually, this is the only time when Medicare Advantage health plans and prescription drug plans are open and accepting new members, other than those who are newly eligible. Medicare Supplement plans are open for enrollment year-round if you meet [certain requirements](#). See the definition for [Medicare Supplement insurance](#).

ANNUAL PLAN PREMIUM

The total amount you pay for a Humana Medicare plan during the calendar year.

APPEAL

A special kind of complaint you make if you disagree with a decision to deny a request for healthcare services or payment for services you already received. You can also make a complaint if you disagree with a decision to stop services you are receiving. For example, you may ask for an appeal if Medicare doesn't pay for an item or service you think you should be able to get. Medicare Advantage and Medicare prescription drug plan carriers, as well as Original Medicare, must follow a specific process when you ask for an appeal.

APPROVED AMOUNT

The fee Medicare sets as reasonable for a covered medical service. This amount is what you and Medicare pay for a service or supply. The amount may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

ASSIGNMENT

In the Original Medicare plan, this term means a doctor agrees to accept Medicare's approved amount as full payment. If you are in the Original Medicare plan, you can save money by going to a doctor who accepts assignment – but you may still have some costs, such as coinsurance. See the definitions for [actual charge](#), [approved amount](#), and [coinsurance](#).

ASSISTED LIVING

A type of living arrangement where personal care services such as meals, housekeeping, transportation, and assistance with activities of daily living are available as needed to people who still live on their own in a residential facility. In most cases, assisted living residents pay a regular monthly rent plus additional fees for services they get.

ATTENDING PHYSICIAN

The licensed doctor who has primary responsibility for the patient's medical care and treatment.

AUTHORIZATION

A verbal or written approval from the health plan. To receive coverage for some services, members must get authorization before they receive care.

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B

BALANCE BILLING

A situation under Private-Fee-for-Service plans where some physicians can charge and bill you 15 percent more than the plan's payment amount for services.

BENEFICIARY

A person who has health insurance through the Medicare or Medicaid program.

BENEFITS

The Medicare-approved services provided by an insurance policy. In a health plan, benefits are the coverage amounts for healthcare services you receive, such as doctor's office visits, etc.

BENEFIT MAXIMUM

The largest dollar amount your health plan will pay toward your medical costs over the course of a plan year.

BENEFIT PERIOD

An interval of time during which you are admitted to a hospital or skilled nursing facility. The benefit period begins the day you go to the facility and ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins.

BENEFIT SUMMARY

A brief description or outline of your plan's coverage, including the amounts or percentage you pay for certain services, the amounts or percentage your plan pays, and the services for which coverage is limited or excluded.

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C

CALENDAR YEAR

The 12-month period that begins on January 1 and ends on December 31. When you first become covered under a policy, the first calendar year begins for you on the effective date of your policy and ends on the following December 31.

CATASTROPHIC ILLNESS

A very serious and costly health problem that could be life threatening or cause life-long disability. The cost of medical services for this type of condition could cause you financial hardship if you are not properly insured.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

The federal agency that runs the Medicare program. In addition, CMS works with the states to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high-quality healthcare.

CERTAIN REQUIREMENTS

To be eligible for a Medicare Supplement plan, you must have Medicare Part A and Part B. You are guaranteed the right to buy a Medicare Supplement policy if you are in your Medicare Supplement Open Enrollment Period or covered under a protection. Your Medicare Supplement Open Enrollment Period, for Medicare Supplement plans, lasts six months. It starts on the first day of the month in which you are BOTH age 65 or older AND enrolled in Medicare Part B. Once your Medicare Supplement Open Enrollment Period starts it cannot be changed. Federal law doesn't require insurance companies to sell Medicare Supplement policies to those under age 65. However, some states may require Medicare Supplement insurance companies to sell you a Medicare Supplement policy even if you are under age 65. To find out more, check with your state insurance department.

CLAIM

A request for payment for services and benefits you received. Claims are also called bills for all Part A and Part B services billed through private insurance companies. The word claim is also used for Part B physician/supplier services billed through the private insurance companies. See definitions for [Medicare Part A](#) and [Medicare Part B](#).

COINSURANCE

The percentage of billed charges you may have to pay after you pay any plan deductibles. The coinsurance payment is a percentage of the cost of the service. For instance, your health plan might pay 70 percent of billed charges, and your coinsurance payment is the remaining 30 percent.

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF)

A facility that provides a full range of rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

COORDINATION OF BENEFITS

A process for determining which plan or insurance policy pays first if a person has more than one health plan or insurance policy that covers the same benefits. If one of the plans is a Medicare health plan, federal law may decide who pays first. Also called cross-over.

COPAYMENT

The flat amount you pay to a healthcare provider or pharmacy at the time of service. Copayments vary depending on your plan and the services you receive. Copayments do not reduce your annual deductible or out-of-pocket maximums.

COST SHARING

The amounts you pay for medical care yourself – for example, a copayment, coinsurance, or deductible.

COVERED BENEFIT

A health service or item your health plan pays for either partially or fully.

COVERED SERVICES

Services a health plan pays for in part or in full, as defined and limited by statute. For instance, Medicare Supplement plan covered services include most doctor's services, care in outpatient departments of hospitals, diagnostic tests, durable medical equipment, ambulance services, and other health services that are not covered by Medicare Part A.

CREDITABLE COVERAGE (Medicare Supplement Plans)

Certain kinds of previous health insurance coverage that can be used to shorten a pre-existing condition waiting period under a Medicare Supplement policy.

CREDITABLE COVERAGE (Prescription Drug Plans)

Prescription drug coverage (like from an employer or union) that pays out, on average, as much as or more than Medicare's standard prescription drug coverage.

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D

DAYS SUPPLY

The amount of days the prescribed medication is to last – for example, a 30-day supply or 90-day supply.

DEDUCTIBLE

The total amount you must pay for healthcare before your health plan begins to pay.

DIAGNOSTIC SERVICES

An examination, test, study, or procedure performed to identify the condition that is causing symptoms or to determine the status of a condition. Most diagnostic services take place in an outpatient setting, although some may require a hospital admission or overnight stay in a hospital or diagnostic facility.

DISABLED ENROLLEE

An individual under age 65 who has been entitled to disability benefits for at least two years and who is enrolled in Medicare Part B.

DISCLOSURE

Release or divulgence of information by an entity to persons or organizations outside of that entity.

DISENROLL

To end your coverage with a health plan.

DOSE

Measured portion of medicine – for instance, 30 milligrams or 100 milligrams.

DRUG DISCOUNT PROGRAM

A program that allows members to receive a discount on medications not covered by their pharmacy benefit plan.

DRUG LIST

A list of medications your plan covers – also known as a formulary. Humana's Medicare Drug List shows which drugs are covered and which drug tier they're in – Preferred Generic, Preferred Brand, Non-Preferred Brand, or Specialty. See the definition for [drug tiers](#).

DRUG TIERS

Some plans place prescription drugs together in a group, or tier. With most plans, the amount you pay at the pharmacy depends on the tier for the drug.

DUAL ELIGIBLES

People who are entitled to Medicare and also eligible for Medicaid.

DURABLE MEDICAL EQUIPMENT (DME)

Certain purchased or rented items prescribed by a healthcare provider to be used in a patient's home. Examples of durable medical equipment Medicare covers when medically necessary: hospital beds, iron lungs, oxygen equipment, seat lift equipment, and wheelchairs.

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Medicare Glossary E – H from Humana Understand Common Medicare Phrases

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E

EFFECTIVE DATE

The date your coverage begins.

ELECTION

An enrollment in or voluntary disenrollment from a Medicare Advantage plan, Medicare prescription drug plan, or Original Medicare.

ELECTION PERIOD

The time when an eligible individual can choose a Medicare plan through a private insurer or Original Medicare.

ELIGIBILITY/MEDICAID

Refers to the process where the state decides a person is qualified for healthcare coverage through the Medicaid program.

ELIGIBILITY: MEDICARE PART A

You are eligible for Medicare Part A – Medicare’s hospital insurance – with no premium if:

- You are 65 or older and you are receiving, or are eligible for, retirement benefits from Social Security or the Railroad Retirement Board
- You are under 65 and you have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements
- You or your spouse had Medicare-covered government employment
- You are under 65 and have End-Stage Renal Disease (ESRD)

If you are not eligible for premium-free Medicare Part A, you can buy Part A by paying a monthly premium if:

- You are age 65 or older and
- You are enrolled in Part B and
- You are a resident of the United States, and are either a citizen or an alien lawfully admitted for permanent residence who has lived in the United States continuously during the five years immediately before the month in which you enroll

ELIGIBILITY: MEDICARE PART B

You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible for Part B if you are not eligible for premium-free Part A, but are age 65 or older AND a resident of the United States or a citizen or an alien lawfully admitted for permanent residence. In this case, you must have lived in the United States continuously during the five years immediately before the month during which you enroll in Part B.

EMERGENCY CARE

Care given for a medical situation where you believe your health is in serious danger.

EMERGENCY ROOM (Hospital)

A portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.

END-STAGE RENAL DISEASE (ESRD)

Permanent kidney failure requiring dialysis or a kidney transplant.

ENROLLMENT PERIOD

A certain range of days when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

ESTIMATED RETAIL PRICE

Average cost of a drug on the “open market.” This price is calculated from a national average wholesale price and does not take into account a prescription drug benefit, the actual cost of a specific drug, mail-order savings, or possible reimbursements to the dispensing pharmacy. Pricing may vary by pharmacy and by the specific quantity, strength, and dosage of the medication. Contact your pharmacy for details on pricing. Because retail pricing is subject to change, you may not know your actual cost until you fill the prescription.

EVIDENCE OF COVERAGE

A complete list of your benefits under a Medicare Advantage plan.

EXCLUSIONS

Items or services a health plan doesn't cover, such as long-term care and custodial care in a nursing or private home.

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F

FEDERAL EMPLOYEE HEALTH BENEFITS

A benefits program for federal employees, retirees and their survivors. Contact the U.S. Office of Personnel Management if you have questions about your Federal Employee Health Benefits

FORM

The way a medication is administered – for instance, a tablet or vial.

FORMULARY

A list of medications your plan covers – also known as a Drug List. Humana's Medicare Drug List shows which drugs are covered and which drug tier they're in – Preferred Generic, Preferred Brand, Non-Preferred Brand, or Specialty. See the definition for [drug tier](#).

FREESTANDING RADIOLOGY FACILITY

A healthcare facility – usually in a building separate from a hospital or operating independently of a hospital – that provides certain imaging studies to help detect or diagnose a medical problem. Tests available may include scans such as MRI, CAT, and PET, as well as ultrasound and X-ray studies. Test results are interpreted by Board-certified radiologists and reported to the referring physician.

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G

GRIEVANCE

A complaint about the way your healthcare provider is giving care. For example, you may file a grievance if you have a problem with the cleanliness of a healthcare facility, calling the plan, staff behavior, or operating hours. A complaint about a treatment or coverage decision should be filed as an appeal. See the definition for [appeal](#).

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H

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

Also sometimes called the “Kassebaum-Kennedy” law, HIPAA expands your healthcare coverage if you lose your job or if you move from one job to another. HIPAA protects you if you have pre-existing medical conditions or you have a problem getting health coverage and believe the problem is because of your past or present health. HIPAA also:

- Limits how companies can use your pre-existing medical conditions to keep you from getting health insurance coverage
- Usually gives you credit for health coverage you have had in the past
- May give you special help with group health coverage when you lose coverage or have a new dependent
- In general, guarantees your right to renew your health coverage

HIPAA does not replace the states’ roles as primary regulators of insurance

HEALTH MAINTENANCE ORGANIZATION (HMO)

Get more information on [Humana Gold Plus® HMO plans](#).

A type of Medicare Advantage Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan’s list except in an emergency. Your costs may be lower than in Original Medicare.

HMO PLAN

See the definition for [Health Maintenance Organization \(HMO\)](#).

HOME HEALTHCARE

Skilled nursing care and certain other healthcare you get in your home for the treatment of an illness or injury.

HOSPICE

A special way of caring for people who are terminally ill. Hospice care includes physical care for the patient, as well as counseling for the patient and his or her family. Hospice care is covered under Medicare Part A.

HOSPITAL

An institution that provides inpatient, outpatient, emergency, diagnostic and therapeutic services, and participates in and is eligible for payments under the Medicare program. The term “hospital” does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in the routines of daily living.

HOSPITAL INSURANCE (PART A)

The part of Medicare that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home healthcare.

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Medicare Glossary I - L from Humana
Explanations of Commonly Used Medicare Terminology

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I

IN-AREA

Healthcare providers and services that are available to members in the geographic area served by a specific health plan.

INDIVIDUAL ALLOWANCE

The amount Humana pays toward the cost of a covered prescription drug.

INITIAL COVERAGE ELECTION PERIOD (ICEP)

The three months immediately before you are entitled to Medicare Part A and enrolled in Part B. During this time you can choose a Medicare health plan.

INITIAL ENROLLMENT PERIOD (IEP)

The first chance you have to enroll in Part B. Your IEP is a seven-month period that begins three months before the month you are first eligible for Medicare Part B. For most people, the IEP begins three months before the month you turn age 65. It ends three months after you turn age 65. The Initial Enrollment Period is different from the Initial Coverage Election Period. See definitions for [Eligibility: Medicare Part A](#) and [Initial Coverage Election Period](#).

INJURY

Bodily harm directly resulting from an accident that did not take place at work.

IN-NETWORK PROVIDER

A healthcare provider – such as a doctor, hospital, other medical facility, or pharmacy – that has agreed to charge a set rate for members of a health benefits plan. Providers on the list of network members are also called participating providers. Your network choices may vary, depending on your plan and where you live. With PPO and HMO plans, you can reduce your costs by using in-network providers – also known as participating providers.

IN-NETWORK COVERAGE

Benefit amounts when you use healthcare providers who have agreed to charge a set rate for Humana members – also called participating providers. Your network choices may vary, depending on your plan and where you live.

INPATIENT

A patient who is registered for a bed in a healthcare facility and charged for room and board.

INPATIENT CARE

Healthcare you receive when you are admitted to a hospital.

INPATIENT HOSPITAL

A facility, other than psychiatric, that admits patients and primarily provides the following services by or under the supervision of physicians: diagnostic services, surgical and non-surgical therapeutic services, and rehabilitation services.

INPATIENT HOSPITAL DEDUCTIBLE

The amount a Medicare beneficiary is responsible for paying before Medicare Part A pays benefits for inpatient hospital services furnished during an illness.

INPATIENT HOSPITAL SERVICES

These services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

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L

LIFETIME MAXIMUM BENEFIT

The total dollars a health plan will pay, per covered member, for the lifetime of the coverage.

LIFETIME RESERVE DAYS

The 60 additional days of hospital confinement benefits provided by Part A of Medicare that you can use after the first 90 days of hospital confinement benefits during a Medicare benefit period. Lifetime Reserve Days may be used only once during your lifetime. See the definitions for [benefit period](#).

LIMITATIONS

Items or services a health plan doesn't cover in some circumstances.

LOCK-IN PERIOD

People with a Medicare Advantage and prescription drug plans are "locked-in," meaning they can only switch Medicare plans during certain times of the year unless they qualify for special circumstances. The lock-in period runs from April 1 to November 14.

LONG-TERM CARE HOSPITAL

A hospital that has an average inpatient length of stay greater than 25 days.

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Medicare Glossary M – P from Humana
Common Medicare Language Fully Explained

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M

MAIL-ORDER PHARMACY

A convenient way to save time and money filling prescriptions you take regularly. *RightSourceRx*SM, Humana's preferred prescription home delivery by mail service, may offer you a 90-day supply of your prescription medication for either 2.5 times or 3 times your current monthly cost, depending on your Medicare plan – and you don't have to leave home to go the pharmacy. *RightSourceRx* is one option you can explore. Humana has other mail-order pharmacies in our network you may choose from.

If you are a member of a qualified State Pharmaceutical Assistance Program, please contact the program to verify that *RightSourceRx* will coordinate with that program.

MANAGED CARE ORGANIZATION

Entities that serve Medicare or Medicaid beneficiaries by having a network of employed or affiliated providers. The term generally includes Health Maintenance Organization, Preferred Provider Organization, and Private-Fee-for-Service plans.

MAXIMUM ANNUAL BENEFIT (MAB)

The maximum dollar amount a health plan will pay during a plan period. The plan period is usually your effective date through the end of the calendar year.

MAXIMUM MEDICAL OUT-OF-POCKET

The most money you will be required to pay a year for deductibles and coinsurance, in addition to regular premiums.

MAXIMUM PLAN BENEFIT COVERAGE

The maximum dollar amount a health plan will pay during a benefit period. Medicare plans have a Maximum Plan Benefit Coverage limit only for service categories where the plan offers enhanced benefits.

MEDICAID

A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most healthcare costs are covered if you qualify for both Medicare and Medicaid.

MEDICAL INSURANCE (Medicare Part B)

Insurance to cover medical expenses such as doctors' services, outpatient hospital services, and a number of other non-hospital medical services and supplies.

MEDICALLY NECESSARY

Healthcare services or supplies that are appropriate for a particular sickness or injury. To be considered medically necessary, a healthcare service or item must be consistent with the symptoms and treatment of the injury or sickness. It also needs to be within the standards of good medical practice in the area and the most appropriate level of care that can be provided to you safely. Also, medically necessary services cannot be solely for your convenience or the convenience of a doctor or hospital.

MEDICARE

The federal health insurance program available to people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (ESRD) – permanent kidney failure with dialysis or a transplant.

MEDICARE ADVANTAGE HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN

See the definition for [Health Maintenance Organization \(HMO\)](#).

MEDICARE ADVANTAGE ORGANIZATION

A state-licensed public or private entity that meets Centers for Medicare & Medicaid Services (CMS) requirements to hold a Medicare Advantage contract.

MEDICARE ADVANTAGE PLAN

A health plan offered by a private insurer as an alternative to Original Medicare. Medicare Advantage plans feature fixed costs, limits on out-of-pocket expenses with most plans, and worldwide coverage for emergency and urgent care. Plans can come with or without prescription drug coverage. Plan types include:

- Health Maintenance Organization plans (HMO)
- Preferred Provider Organization plans (PPO)
- Private-Fee-for-Service plans (PFFS)

MEDICARE ADVANTAGE HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN

See the definition for [Health Maintenance Organization \(HMO\)](#).

MEDICARE ADVANTAGE PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

See the definition for [Preferred Provider Organization \(PPO\)](#).

MEDICARE ADVANTAGE PRIVATE-FEE-FOR-SERVICE (PFFS) PLAN

See the definition for [Private-Fee-for-Service \(PFFS\)](#).

MEDICARE-APPROVED AMOUNT

This is the amount Medicare and you pay to a doctor or supplier for a service or supply. It may be less than the actual amount charged by a doctor or supplier.

MEDICARE BENEFITS

Health insurance available under Medicare Part A and Part B – also known as Original Medicare.

MEDICARE COVERAGE

Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). See the definitions for [Medicare Part A \(Hospital Insurance\)](#) and [Medicare Part B \(Medical Insurance\)](#).

MEDICARE-ELIGIBLE EXPENSES

Expenses that are:

- Considered as covered by Medicare
- Recognized by Medicare as being reasonable and necessary
- Paid by Medicare NOT solely due to deductible or copayment provisions of the Medicare Act or because a maximum allowed under Medicare coverage has been exhausted

In determining if an expense is reasonable and necessary, Medicare considers the usual charge in the area where you live as well as the medical need for the treatment provided.

MEDICARE HANDBOOK

A booklet with information on such things as how to file a claim and what type of care is covered under the Medicare program. All Medicare beneficiaries receive this handbook when they first enroll in the program.

MEDICARE PART A (Hospital Insurance)

Federal insurance to cover hospital expenses such as room and board and other inpatient hospital services.

MEDICARE PART B (Medical Insurance)

Federal insurance to cover medical expenses such as doctors' services, outpatient hospital services, and a number of other non-hospital medical services and supplies.

MEDICARE PART C (Medicare Advantage Plans)

Health benefits coverage offered by a Medicare Advantage Organization. You receive a specific set of health benefits at a uniform premium and uniform level of cost-sharing. Part C is available to all Medicare beneficiaries residing in a plan's service area.

MEDICARE PART D (Prescription Drug Coverage)

Optional Medicare prescription drug coverage offered through private companies and organizations. You can get Part D coverage through a Medicare-approved stand-alone drug plan or a Medicare Advantage HMO, PPO, or PFFS plan that includes drug coverage.

MEDICARE PREMIUMS

The monthly premium you pay for your Medicare Part A or Medicare Part B coverage.

MEDICARE REQUIRED DRUGS AND SUPPLIES

Certain prescription drug products Medicare requires private insurers to cover.

MEDICARE SAVINGS PROGRAMS

Programs that help millions of people with Medicare save money each year. States have programs for people with limited incomes and resources that pay Medicare premiums. Some programs may also pay your Original Medicare deductibles and coinsurance.

MEDICARE SELECT INSURANCE PLAN

A type of Medicare Supplement policy that may require you use hospitals and, in some cases, doctors within its network to be eligible for full benefits. Contact your state insurance department for more information.

MEDICARE SUPPLEMENT INSURANCE PLAN

A policy sold by a private insurance company that helps cover the costs that are left unpaid after Medicare Parts A and B pays its portion of your healthcare expenses. Medicare Supplement policies pay only for services Medicare considers medically necessary. Payments are generally based on the Medicare-approved charge. The policy might not fully cover all of your medical costs.

Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A through D, F, G, and Plan K through N. While the costs of these policies may vary, individual insurance companies must provide the same standardized benefits as outlined by law. Some companies may offer additional innovative benefits.

Get more information on [Humana's Medicare Supplement plans](#).

MEDICARE + CHOICE

Appears on: Enrollment – Enrollee Information

The previous name for Medicare health plans offered by private insurers; now called Medicare Advantage.

MEDICARE SUPPLEMENT OPEN ENROLLMENT PERIOD

A one-time-only, six-month period when federal law allows you to buy any Medicare Supplement policy you want that is sold in your state. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you can't be denied a Medicare Supplement policy or charged more due to past or present health problems. Some states may have additional open enrollment rights under state law.

MONTHLY PREMIUM

The monthly payment to an insurance company or a healthcare plan for healthcare coverage in addition to your Medicare Part A or Part B premium.

MY DRUG LIST

Prescriptions you select in the Rx Calculator so you can estimate your costs. If you take a drug now or expect to take the drug, you can put the medication on "My Drug List" by clicking on the "Add a Drug" button.

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NETWORK

A group of healthcare providers who have agreed to charge a set rate for members of a health benefits plan. Providers on this list are also called participating providers. Your network choices may vary, depending on your plan and where you live.

NON-COVERED SERVICE

The service:

- Does not meet the requirements of a Medicare benefit category
- Is not reasonable and necessary, as defined by statute 1862 (a)(1)
- Is excluded from coverage for other statutory reasons

NON-FORMULARY DRUGS

Drugs that are not included on a plan-approved list.

NON-NETWORK (Medicare Advantage Plans)

Doctors, hospitals, pharmacies, and other healthcare professionals or suppliers who do not belong to a health plan's provider network. See the definition for [network](#).

NON-PARTICIPATING PHARMACY (Medicare Advantage Plans and Medicare Prescription Drug Plans)

See definition for [out-of-network pharmacy](#).

NON-PARTICIPATING PHYSICIAN (Medicare Advantage Plans)

See definition for [out-of-network doctor](#).

NON-PREFERRED BRAND DRUG

Higher-cost brands that include drugs with preferred generic or therapeutic alternatives. Also includes some self-administered injectable medications.

NURSING FACILITY

A facility that primarily provides skilled nursing care and related services to residents, other than those with mental disabilities. Services provided may be either:

- Rehabilitation for people who are injured, disabled, or sick
- Regular, health-related care services above the level of custodial care-

NURSING HOME

A residence that provides a room, meals, and help with activities of daily living and recreation. Generally, nursing home residents have physical or mental problems that keep them from living on their own. They usually require daily assistance.

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O

OCCUPATIONAL THERAPY

Services to help you return to usual activities – such as bathing, preparing meals and housekeeping – after an illness. These services can be either inpatient or outpatient.

ORIGINAL MEDICARE PLAN

A pay-per-visit health plan that lets you go to any doctor, hospital, or other healthcare supplier who accepts Medicare and is accepting new Medicare patients. Medicare pays its share of the Medicare-approved amount, and you pay your share – coinsurance plus the deductible. See the definitions for [coinsurance](#) and [deductible](#).

OUT-OF-AREA

Services provided to members of a Medicare Advantage plan by providers who have no contractual or other relationship with the plan.

OUT-OF-NETWORK

Doctors, hospitals, pharmacies, and other healthcare professionals or suppliers who do not belong to a health plan's provider network. See the definition for [network](#).

OUT-OF-NETWORK

The healthcare provider is not on the list of preferred providers for the health benefits plan.

OUT-OF-NETWORK BENEFIT

Generally, an out-of-network benefit gives you the option to use a doctor, specialist, or hospital that is not a part of the plan's contracted network. In some cases, your out-of-pocket costs may be higher for an out-of-network benefit.

OUT-OF-NETWORK DOCTOR

A primary care physician or specialist who does not belong to a health plan's provider network. In some cases, your out-of-pocket costs may be higher for an out-of-network doctor. See the definition for [network](#).

OUT-OF-NETWORK PHARMACY

A pharmacy that is not under contract with Humana. If you use an out-of-network pharmacy:

- You may pay a much larger share of the total cost of your care through deductible and coinsurance.
- You pay toward a separate deductible. Even if you have met your deductible for use of in-network providers, it does not count toward the separate deductible you pay if you got to an out-of-network pharmacy.
- In addition to paying coinsurance, you may be billed by an out-of-network provider for the amount not covered by your insurance plan.

OUT-OF-POCKET COSTS

Healthcare costs that you pay on your own because they are not covered by your Medicare plan or other insurance.

OUTPATIENT

Someone who receives medical services or supplies while not confined in a hospital.

OUTPATIENT CARE

Medical or surgical care that does not include an overnight hospital stay.

OUTPATIENT HOSPITAL SERVICES

Medicare or surgical care that Medicare Part B helps pay for and does not include an overnight hospital stay, including:

- Blood transfusions
- Certain drugs
- Hospital-billed laboratory tests
- Mental healthcare
- Medical supplies such as splints and casts
- Emergency room or outpatient clinic, including same-day surgery
- X-rays and other radiation services

OUTPATIENT SERVICES

A service you get in one day – 24 hours – at a hospital outpatient department or community mental health center.

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P

PART A (Original Medicare)

See the definition for [Medicare Part A \(Hospital Insurance\)](#)

PART B (Original Medicare)

See the definition for [Medicare Part B \(Medical Insurance\)](#)

PART C (Medicare Advantage plans)

See the definition for [Medicare Part C \(Medicare Advantage Plans\)](#)

PART D (Medicare prescription drug coverage)

See the definition for [Medicare Part D \(prescription drug coverage\)](#)

PARTICIPATING HOSPITALS

For people with Original Medicare, these are hospitals that participate in the Medicare program.

PARTICIPATING PHYSICIAN OR SUPPLIER

For people with Original Medicare, this is a doctor or other provider who agrees to accept all Medicare claims. These providers accept “Medicare assignment.” They may bill you only for the Original Medicare deductible and your coinsurance or copayment amounts.

PATIENT ADVOCATE

A person whose job is to speak on a patient’s behalf and help patients get any information or services they need.

PCP

See the definition for [Primary Care Physician](#).

PDP

See the definition for [prescription drug plan](#).

PERMANENT MAILING ADDRESS

The address where you currently reside. This is considered to be your primary residence.

PFFS PLAN

See the definition for [Private-Fee-for-Service \(PFFS\)](#).

PHARMACY COINSURANCE

The set percentage you pay of the total cost of your prescription drug. When you go to an in-network pharmacy, your coinsurance is based on the Humana-approved charge, which may be less than the original charge.

PHARMACY COPAYMENT

The set amount you pay when you receive a prescription drug. A copayment can range from a few dollars to a few hundred dollars depending on the type of drug you receive.

PHYSICAL THERAPY

Treatment of injury and disease by mechanical means such as heat, light, exercise, and massage.

PHYSICIAN

A licensed medical practitioner who is practicing within the scope of his or her license and whose services are required to be covered by the laws of the jurisdiction where the treatment is given.

PLAN PREMIUM

Your monthly payment to Humana for healthcare coverage or prescription drug coverage, in addition to your Medicare Part A or Part B premiums.

POWER OF ATTORNEY

A medical power of attorney is a document that lets you appoint someone you trust to make decisions about your medical care. This type of advance directive also may be called a healthcare proxy, an appointment of healthcare agent or a durable power of attorney for healthcare.

PPO PLAN

See the definition for [Preferred Provider Organization \(PPO\)](#).

PRE-EXISTING CONDITION

A condition for which a doctor gave you medical advice, recommended treatment, or provided treatment within six months before the effective date of your insurance plan.

PREFERRED BRAND DRUG

Medications manufactured by one manufacturer that are typically lower-cost among all brand-name drugs.

PREFERRED GENERIC DRUG

Drugs that are chemically the same as brand-name drugs with regard to their active ingredients, dosage, safety, strength, how they are taken, and what they are used to treat. Since generics work the same way in your body, they have the same risks and benefits as the brand-name medications. A generic drug is called by its “chemical” name instead of a “brand” name and is typically sold at a lower price. Talk to your doctor about your medication options. In most cases, your doctor can prescribe a generic drug instead of the brand-name drug, saving you money when you fill the prescription.

PREFERRED PROVIDER ORGANIZATION (PPO)

A Medicare Advantage plan that gives you two ways to receive medical services. You can use doctors, hospitals, and other healthcare providers in the plan’s network and pay less for your care. Or you have the option of going outside the network, but you will pay more for your healthcare services. Get more information on [HumanaChoicePPO® plans](#).

PREMIUM

The payment to Medicare, an insurance company, or a healthcare plan for healthcare coverage. Most people pay their premium monthly.

PRESCRIPTION DRUG GUIDE

A list of the medications covered by Humana's prescription drug benefits. See the definition for [Drug List](#).

PRESCRIPTION DRUG PLAN

Optional Medicare drug coverage offered through private insurance companies – also known as a “PDP” or Medicare Part D. PDPs have a monthly plan premium in addition to the Medicare premium you already pay. PDP plan benefits vary, but companies offering these plans are required to offer benefits as good as or better than Medicare's standard requirement.

PREVENTIVE CARE/ PREVENTIVE SERVICES

Care to keep you healthy or to prevent illness – for example, colorectal cancer screenings, yearly mammograms, and flu shots.

PRIMARY CARE

A basic level of care usually given by doctors who work with general and family medicine, internal medicine, pregnant women, and children. A nurse practitioner, a state-licensed registered nurse with special training, can also provide this basic level of healthcare.

PRIMARY CARE PHYSICIAN (PCP)

The doctor you see first for most health problems. He or she makes sure you get the care you need to be healthy. He or she also may talk with other doctors and healthcare providers about your care and refer you to them. In many Health Maintenance Organization (HMO) plans, you must see your primary care physician before you see any other healthcare provider.

PRIOR AUTHORIZATION

Your doctor must obtain approval from Humana before the service or prescription will be covered.

PRIVATE-FEE-FOR-SERVICE (PFFS) PLAN

With a Private-Fee-for-Service (PFFS) plan, you can visit any Medicare doctor, specialist, or hospital that accepts Medicare payment and accepts the terms, conditions and payment rate of the Humana Gold Choice[®] (PFFS) plan. Get more information on [Humana Gold Choice \(PFFS\) plans](#).

PROCEDURE

Something done to fix a health problem or to learn more about it – for example, surgery, tests, or putting in an intravenous line.

PROVIDER

A person or facility that offers healthcare services – for example, a doctor, hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, non-physician provider, laboratory, supplier, etc. Generally, a provider is licensed or certified and practices within the scope of his or her license or certification.

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Medicare Glossary Q – T from Humana
Understand Frequently Used Medicare Keywords

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Q

QUALIFIED MEDICARE BENEFICIARY (QMB)

A Medicaid program for people who need help paying for Medicare services. The beneficiary must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A premiums, Part B premiums, and Original Medicare deductibles and coinsurance amounts for Medicare services.

QUANTITY

The drug amount your doctor prescribes – for example, 30 tablets.

QUANTITY LIMIT

[Appears on: Rx Calculator]

A limit on coverage based on the length of time or amount that can be dispensed for this medication to ensure the appropriate dose and usage based on the FDA label recommendations.

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REFERRAL

A written OK from your primary care physician for you to see a specialist or to receive certain services.

RESPIRE CARE

Temporary or periodic care provided in a nursing home, assisted living residence, or other type of long-term care program so the usual caregiver can rest or take some time off.

ROUTINE PHYSICAL EXAM

A type of doctor's office visit that may include:

- Discussing your lifestyle – diet, stress level, exercise, etc.
- Reviewing your medical and family health history
- Performing a system examination – heart, lungs, throat, thyroid, ears, skin, joints, etc.
- Checking your height, weight, blood pressure, and pulse

The exam could also include lab studies and other tests or screenings appropriate for your age and gender, such as a mammogram or prostate specific antigen blood test, an electrocardiogram (EKG), and immunizations.

ROOM AND BOARD

All the services a facility provides on its own behalf, including room, meals, and all general services and activities needed for the care of inpatients.

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S

SERVICE AREA

The geographic area where a health plan accepts members. For Medicare plans that require you to use in-network doctors and hospitals, it is also the area where services are provided. The plan may disenroll you if you move out of the plan's service area.

SKILLED CARE

A type of healthcare given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care.

SKILLED NURSING CARE

A level of care that must be given or supervised by Registered Nurses – for example, intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound. Any service that could be done safely by an average non-medical person without the supervision of a Registered Nurse is not considered skilled care.

SKILLED NURSING FACILITY (SNF)

A facility that meets specific regulatory certification requirements and primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services, but does not provide the level of care or treatment available in a hospital.

A skilled nursing facility is an institution that meets all of the following requirements:

- It must primarily and continuously provide, for a fee, skilled nursing care and related services to persons recovering from an injury or sickness. Such care must be provided on an inpatient basis.
- It must provide 24-hour-a-day nursing services by or under the supervision of graduate Registered Nurses.
- It must maintain a daily medical record of each inpatient.
- It must provide each patient with a planned program of medical care and treatment by or under the supervision of a physician.
- It must be approved as a skilled nursing facility under the Medicare program or be qualified to receive such approval if requested.

SPECIAL CIRCUMSTANCES

Situations that, according to the Centers for Medicare & Medicaid Services, allow a person to make a coverage change. These special circumstances include, but are not limited to:

- Making a permanent move to a new Medicare Advantage plan or prescription drug plan service area
- Enrollment into or out of an employer group health plan sponsored by a Medicare Advantage plan
- Medicare entitlement is made retroactive
- Individual is dually eligible for both Medicare and Medicaid benefits
- Loss of creditable prescription drug coverage

SPECIAL ELECTION PERIOD

A set time that a beneficiary can change Medicare plans or return to Original Medicare. Examples of special election situations are:

- You move outside the service area
- Your Medicare Advantage Organization violates its contract with you
- The organization does not renew its contract with the Centers for Medicare & Medicaid Services (CMS)

Other exceptional conditions may exist, as determined by CMS.

SPECIAL ENROLLMENT PERIOD (SEP)

A set time when you can sign up for Medicare Part B if you did not take Part B during the Initial Enrollment Period because you or your spouse were employed and had group health plan coverage through the employer or union. You can sign up at any time you are covered under the group plan. You have eight months from the time employment or group coverage ends to sign up. The eight-month SEP starts the month after the employment ends or the group health coverage ends, whichever comes first.

SPECIALIST

A doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.

SPECIALTY DRUG

Highest cost drugs, including high technology and self-administered injectable medications.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLMB)

A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.

SUMMARY OF BENEFITS

A brief description or outline of your coverage, including the amounts or percentage you pay for certain services, the amounts or percentage your plan pays, and the services for which coverage is limited or excluded.

SUPPLIER

Generally, any company, person, or agency that gives you a medical item or service, like a wheelchair or walker.

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T

TERMS AND CONDITIONS OF PAYMENT (PFFS plans)

Any Medicare doctor, specialist, or hospital that accepts Medicare payment and accepts the terms, conditions and payment rate of the Humana Gold Choice[®] (PFFS) plan.

THERAPEUTIC ALTERNATIVE

Drugs that aren't exactly the same as another drug, but can serve as a substitution with the full expectation that they will produce the same clinical effect and safety profile as the prescribed product.

TRANSLATOR

Someone who translates the enrollment documentation to the enrollee and who is fully competent in both English and the enrollee's native language.

TRICARE

The Department of Defense's worldwide healthcare program for active duty and retired uniformed services members and their families. TRICARE For Life is available for all dual TRICARE-Medicare-eligible uniformed services retirees and Medicare-eligible family members under age 65 who are also entitled to Medicare Part A because of a disability or chronic renal disease.

TOTALLY DISABLED

When, because of injury or sickness, you aren't able to perform your occupation or any occupation for which you are fit by reason of education, training, or experience.

TREATMENT

Something done to help with a health problem – for example, medicine or surgery.

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Medicare Glossary U – Z from Humana
Regularly Used Medicare Vocabulary Explanations

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U

URGENTLY NEEDED CARE

Care you receive for a sudden illness or injury that needs medical attention right away, but is not life threatening. Care should generally be provided by your primary care physician unless you are out of the service area.

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V

VALUE-ADDED SERVICES

Extra services you get through a Medicare Advantage or Medicare prescription drug plan in addition to your plan benefits.

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W

WAITING PERIOD

The time between when you sign up with a Medicare plan and when the coverage starts.

WITNESS

Appears on: Enrollment – Enrollee Information

Someone who participates in the enrollment process with someone who is visually or speech impaired and can confirm that the enrollee understood the information to the best of his or her knowledge.

WORLDWIDE COVERAGE

Humana’s Medicare Advantage plans cover emergency care worldwide.

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Y

YOU PAY

Appears on: My Rx Coverage page

Your projected out-of-pocket costs – including copayments, coinsurance, and any amount over and above a given prescription allowance – for prescription drugs in a particular category, or “tier.”

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Legal Information

[Legal Information for Humana's Medicare Supplement plans](#)

Legal Information for Medicare Supplement Plans

This Humana Website is intended to provide information to Humana Medicare Supplement insurance customers about their healthcare and about the products and services offered by Humana. Information contained in this site is general in nature. It is not meant to replace or be used in addition to the advice of healthcare professionals. If you have specific healthcare needs, or for complete information, please see a doctor or other healthcare provider.

Although Humana has made every effort to ensure that the contents of this site are correct and complete, Humana cannot be responsible for the accuracy of information contained herein. For the most current information available from Humana – only including updates made to-date – please contact a Customer Care specialist using the telephone number on your ID card. For non-Humana members, please contact Customer Service at 1-800-4HUMANA.

Product and Service Descriptions

The product and service descriptions, if any, provided on the Humana Website are not intended to constitute offers to sell or solicitations in connection with any product or service. All products are not available in all areas and are subject to applicable laws, rules, and regulations.

Linking to other sites

Links to various other Websites from this site are provided for your convenience only and do not constitute or imply endorsement by Humana Inc. of these sites, any products or services described on these sites, or of any other material contained therein. Humana Inc. disclaims responsibility for their content and accuracy.

Information on this Website may contain inaccuracies or errors. Information may be changed or updated without notice. Humana Inc. only provides periodic updates to this site; therefore, any information presented may be out of date.

It should be noted that Medicare Supplement plans are not managed care.

Licensure

Licensure Information

[Licensure Information for Humana's Medicare Supplement Plans](#)

Licensure Information for Medicare Supplement Plans

Licensure Information for Medicare Supplement Insurance Plans

Medicare Supplement Insurance plans issued by Humana Insurance Company, Humana Insurance Company of Kentucky, Humana Health Benefit Plan of Louisiana, Inc., Humana Health Insurance Company of Florida, Inc., Humana Insurance of Puerto Rico, Inc., Humana Insurance Company of New York. Policy Form Series MESM10 or state equivalent.

Humana Insurance Company

Humana Insurance Company is licensed to do business and offer Medicare Supplement plans in the following states and territories:

AK, AL, AR, AZ, CA, CO, CT, DC, DE, GA, HI, IA, ID, IL, IN, KS, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WV, WI, WY.

Humana Insurance Company of Kentucky

Humana Insurance Company of Kentucky is licensed to do business and offer Medicare Supplement plans in Kentucky.

Humana Health Benefit Plan of Louisiana, Inc.

Humana Health Benefit Plan of Louisiana, Inc. is licensed to do business and offer Medicare Supplement plans in Louisiana.

Humana Health Insurance Company of Florida, Inc.

Humana Health Insurance Company of Florida, Inc. is licensed to do business and offer Medicare Supplement plans in Florida.]

Humana Insurance Company of New York

Humana Insurance Company of New York is licensed to do business and offer Medicare Supplement plans in New York.]

Humana Insurance of Puerto Rico, Inc.

Humana Insurance of Puerto Rico, Inc. is licensed to do business and offer Medicare Supplement plans in Puerto Rico.]

California Insurer Identity and Licensure Information

Humana Insurance Company

Insurer's name as it appears on its California Certificate of Authority: Humana Insurance Company.
Insurer identification number as it appears on the Insurer's California Certificate of Authority: 07566.

State in which the Insurer is domiciled: Wisconsin.

Insurer's principal place of business: Green Bay, Wisconsin.

Insurer's National Association of Insurance Commissioners (NAIC) Number: 119-73288.

Contact Information

Humana Inc. can be contacted at the following address or telephone number.

Telephone Contact

[1-800-4HUMANA]

[1-800-448-6262]

Postal Contact

[Humana Correspondence Office

P.O. Box 14611

Lexington, KY 40512-4611]

2011 Plans are now available for comparison

Review and compare Humana Medicare plans. Find your plan before enrollment begins November 15!

Find a plan

Enter your ZIP code to view plans available in your area. You can compare benefits, estimate costs and enroll online.

[Find a Plan >](#)

Find out what you need to know

Find out more about your Medicare options and Humana's Medicare plans.

- [Understand Medicare basics](#)
- [Discover the Humana difference](#)
- [Learn about enrollment](#)
- [View Drug List](#)



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Telephone

Toll Free: 1 - 800 - 611 - 1481
TTY Users: 711

Hours

8 a.m. to 8 p.m., seven days a week

[View All Available Plans](#)

[Find a Doctor](#)

[Find a Hospital](#)

Humana Offers 13 Medicare Plans in your ZIP Code ##### [Change ZIP Code](#)

Medicare Advantage and Prescription Drug Plans

Medicare Supplement Plans

[Compare Plans](#) Select up to 3 plans to compare.

Humana Medicare Supplement Plans

Humana Medicare Supplement Plan A View Details			
Annual Medical Deductible	Hospital Deductible Per Benefit Period	Maximum Medical Out-of-Pocket:	Monthly Premium:
\$155.00	\$1,100.00	N/A	Get Quote

Humana Medicare Supplement Plan B View Details			
Annual Medical Deductible	Hospital Deductible Per Benefit Period	Maximum Medical Out-of-Pocket:	Monthly Premium:
\$155.00	\$0.00	N/A	Get Quote

Humana Medicare Supplement Plan C View Details			
Annual Medical Deductible	Hospital Deductible Per Benefit Period	Maximum Medical Out-of-Pocket:	Monthly Premium:
\$0.00	\$0.00	N/A	Get Quote

Humana Medicare Supplement Plan F View Details			
Annual Medical Deductible	Hospital Deductible Per Benefit Period	Maximum Medical Out-of-Pocket:	Monthly Premium:
\$0.00	\$0.00	N/A	Get Quote

Humana Medicare Supplement High Deductible Plan F View Details			
Annual Plan Deductible:		Maximum Medical Out-of-Pocket:	Monthly Premium:
\$2,000.00		N/A	Get Quote

Humana Medicare Supplement Plan K View Details			
Annual Medical Deductible	Hospital Deductible Per Benefit Period	Maximum Medical Out-of-Pocket:	Monthly Premium:
\$155.00	\$550.00	\$4,620.00*	Get Quote

Humana Medicare Supplement Plan L View Details			
Annual Medical Deductible	Hospital Deductible Per Benefit Period	Maximum Medical Out-of-Pocket:	Monthly Premium:
\$155.00	\$275.00	\$2,310.00*	Get Quote

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*Once you meet the annual out-of-pocket limit, the plan pays 100% of the Medicare Part A and Part B copayments and coinsurance for the rest of the calendar year. Charges from your doctor that exceed Medicare-approved amounts, called "excess charges," aren't covered and don't count toward the out-of-pocket limit. You will have to pay these excess charges. The out-of-pocket annual limit can increase each year because of inflation.

Additional Resources

- [Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare](#)

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Humana Medicare Supplement Plan

Humana Medicare Supplement Plan A

Summary

Plan Type: Medicare Supplement Plan

Annual Medical Deductible:	Hospital Deductible Per Benefit Period:	Maximum Medical Out-of-Pocket:	Monthly Premium:
\$155.00	\$1,100.00	N/A	Get Quote
Annual Premium:	Estimated Rx Costs:	Estimated Medical Costs:	Estimated Total Annual Costs:
Get Quote	No Rx Coverage	<input type="button" value="Calculate"/>	= <input type="text"/>

Prescription Drug Details

Rx Coverage: No Rx Coverage

Medicare Supplement Plans do not include prescription drug coverage. You can enroll in Prescription Drug Plan separately ([How to Enroll](#)), or you can see the additional Benefits section for Rx discount information.

Physician Details

There are no networks with Medicare Supplement Plans. You may choose any doctor or health care provider who accepts Medicare. There are also no referrals required visit a Specialist.

Physician and Hospital Costs

Primary Care Copayment:	Specialist Copayment:	Hospital Copayment:
\$0.00 Copay per visit	\$0.00 Copay per visit	\$0.00

After you pay the Medical (Part B) deductible.

Once you have paid \$155.00 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Hospital Information

There are no networks with Medicare Supplement Plans. You may choose any hospital or health care organization that accepts Medicare. There are also no referrals required visit a Specialist.

The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Humana grievance process.

Additional Services

- [24 Hour Nurse Advice Line](#)
- [Fitness Program](#)
- [Rx Discount](#)
- [Vision Discount](#)

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The benefits displayed are not a complete listing of every service we cover. For a complete list of covered benefits, limitations and exclusions, please contact us by the number at the bottom of this page.

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

Medicare Supplement premium rate quotes are monthly. Rates provided are subject to change and are dependent on varying factors such as the effective date you choose and your age at the time of issue. Once issued, your policy will include your initial premium. Keep in mind that you will be provided a 30 day right to examine your policy and you may return your policy if you are not fully satisfied. Humana will refund your premium less any claims paid. Medicare Supplement plans are not managed care plans.

The products and services described are not offered nor guaranteed under our Medicare Supplement insurance policies and are not subject to the Medicare appeals process. These products and services are not insurance benefits. Any disputes regarding these products and services may be subject to the Humana grievance process. Participation of fitness centers varies by state.

The programs described are not insurance and are neither contractually offered nor guaranteed under Humana Medicare Supplement insurance policies. Participation of fitness centers varies by state.

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Humana Medicare Supplement Plan

Humana Medicare Supplement Plan B

Summary

Plan Type: Medicare Supplement Plan

Annual Medical Deductible:	Hospital Deductible Per Benefit Period:	Maximum Medical Out-of-Pocket:	Monthly Premium:
\$155.00	\$0.00	N/A	Get Quote

Annual Premium:	Estimated Rx Costs:	Estimated Medical Costs:	Estimated Total Annual Costs:
Get Quote	No Rx Coverage	<input type="button" value="Calculate"/>	= <input type="text"/>

Prescription Drug Details

Rx Coverage: No Rx Coverage

Medicare Supplement Plans do not include prescription drug coverage. You can enroll in Prescription Drug Plan separately ([How to Enroll](#)), or you can see the additional Benefits section for Rx discount information.

Physician Details

There are no networks with Medicare Supplement Plans. You may choose any doctor or health care provider who accepts Medicare. There are also no referrals required visit a Specialist.

Physician and Hospital Costs

Primary Care Copayment:	Specialist Copayment:	Hospital Copayment:
\$0.00 Copay per visit	\$0.00 Copay per visit	\$0.00

After you pay the Medical (Part B) deductible.

Once you have paid \$155.00 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Hospital Information

There are no networks with Medicare Supplement Plans. You may choose any hospital or health care organization that accepts Medicare. There are also no referrals required visit a Specialist.

The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Humana grievance process.

Additional Services

- [24 Hour Nurse Advice Line](#)
- [Fitness Program](#)
- [Rx Discount](#)
- [Vision Discount](#)

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Medicare Supplement premium rate quotes are monthly. Rates provided are subject to change and are dependent on varying factors such as the effective date you choose and your age at the time of issue. Once issued, your policy will include your initial premium. Keep in mind that you will be provided a 30 day right to examine your policy and you may return your policy if you are not fully satisfied. Humana will refund your premium less any claims paid. Medicare Supplement plans are not managed care plans.

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Humana Medicare Supplement Plan

Humana Medicare Supplement Plan C

Summary

Plan Type: Medicare Supplement Plan

Annual Medical Deductible:	Hospital Deductible Per Benefit Period:	Maximum Medical Out-of-Pocket:	Monthly Premium:
\$0.00	\$0.00	N/A	Get Quote
Annual Premium:	Estimated Rx Costs:	Estimated Medical Costs:	Estimated Total Annual Costs:
Get Quote	+ No Rx Coverage	+ <input type="button" value="Calculate"/>	= <input type="text"/>

Prescription Drug Details

Rx Coverage: No Rx Coverage

Medicare Supplement Plans do not include prescription drug coverage. You can enroll in Prescription Drug Plan separately ([How to Enroll](#)), or you can see the additional Benefits section for Rx discount information.

Physician Details

There are no networks with Medicare Supplement Plans. You may choose any doctor or health care provider who accepts Medicare. There are also no referrals required visit a Specialist.

Physician and Hospital Costs

Primary Care Copayment:	Specialist Copayment:	Hospital Copayment:
\$0.00 Copay per visit	\$0.00 Copay per visit	\$0.00

Hospital Information

There are no networks with Medicare Supplement Plans. You may choose any hospital or health care organization that accepts Medicare. There are also no referrals required visit a Specialist.

The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Humana grievance process.

Additional Services

- [24 Hour Nurse Advice Line](#)
- [Fitness Program](#)
- [Rx Discount](#)
- [Vision Discount](#)

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Medicare Supplement premium rate quotes are monthly. Rates provided are subject to change and are dependent on varying factors such as the effective date you choose and your age at the time of issue. Once issued, your policy will include your initial premium. Keep in mind that you will be provided a 30 day right to examine your policy and you may return your policy if you are not fully satisfied. Humana will refund your premium less any claims paid. Medicare Supplement plans are not managed care plans.

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The programs described are not insurance and are neither contractually offered nor guaranteed under Humana Medicare Supplement insurance policies. Participation of fitness centers varies by state.

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Humana Medicare Supplement Plan

Humana Medicare Supplement Plan F

Summary

Plan Type: Medicare Supplement Plan

Annual Medical Deductible:	Hospital Deductible Per Benefit Period:	Maximum Medical Out-of-Pocket:	Monthly Premium:
\$0.00	\$0.00	N/A	Get Quote

Annual Premium:	Estimated Rx Costs:	Estimated Medical Costs:	Estimated Total Annual Costs:
Get Quote	+ No Rx Coverage	+ <input type="button" value="Calculate"/>	= <input type="text"/>

Prescription Drug Details

Rx Coverage: No Rx Coverage

Medicare Supplement Plans do not include prescription drug coverage. You can enroll in Prescription Drug Plan separately ([How to Enroll](#)), or you can see the additional Benefits section for Rx discount information.

Physician Details

There are no networks with Medicare Supplement Plans. You may choose any doctor or health care provider who accepts Medicare. There are also no referrals required visit a Specialist.

Physician and Hospital Costs

Primary Care Copayment:	Specialist Copayment:	Hospital Copayment:
\$0.00 Copay per visit	\$0.00 Copay per visit	\$0.00

Hospital Information

There are no networks with Medicare Supplement Plans. You may choose any hospital or health care organization that accepts Medicare. There are also no referrals required visit a Specialist.

The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Humana grievance process.

Additional Services

- [24 Hour Nurse Advice Line](#)
- [Fitness Program](#)
- [Rx Discount](#)
- [Vision Discount](#)

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Medicare Supplement premium rate quotes are monthly. Rates provided are subject to change and are dependent on varying factors such as the effective date you choose and your age at the time of issue. Once issued, your policy will include your initial premium. Keep in mind that you will be provided a 30 day right to examine your policy and you may return your policy if you are not fully satisfied. Humana will refund your premium less any claims paid. Medicare Supplement plans are not managed care plans.

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The programs described are not insurance and are neither contractually offered nor guaranteed under Humana Medicare Supplement insurance policies. Participation of fitness centers varies by state.

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Humana Medicare Supplement Plan

Humana Medicare Supplement High Deductible Plan F

Summary

Plan Type: Medicare Supplement Plan

Annual Plan Deductible:	Maximum Medical Out-of-Pocket:	Monthly Premium:	
\$2,000.00	N/A	Get Quote	
Annual Premium:	Estimated Rx Costs:	Estimated Medical Costs:	Estimated Total Annual Costs:
Get Quote	+ No Rx Coverage	+ <input type="button" value="Calculate"/>	= <input type="text"/>

Prescription Drug Details

Rx Coverage: No Rx Coverage

Medicare Supplement Plans do not include prescription drug coverage. You can enroll in Prescription Drug Plan separately ([How to Enroll](#)), or you can see the additional Benefits section for Rx discount information.

Physician Details

There are no networks with Medicare Supplement Plans. You may choose any doctor or health care provider who accepts Medicare. There are also no referrals required visit a Specialist.

Physician and Hospital Costs

Primary Care Copayment:	Specialist Copayment:	Hospital Copayment:
\$0.00 Copay per visit	\$0.00 Copay per visit	\$0.00
After you pay the Plan's deductible.		After you pay the Plan's deductible.
Benefits will not begin until you have paid the amount of \$2,000.00. This deductible includes costs that would normally be paid by the policy.		Benefits will not begin until you have paid the amount of

Hospital Information

There are no networks with Medicare Supplement Plans. You may choose any hospital or health care organization that accepts Medicare. There are also no referrals required visit a Specialist.

The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Humana grievance process.

Additional Services

- [24 Hour Nurse Advice Line](#)
- [Fitness Program](#)
- [Rx Discount](#)
- [Vision Discount](#)

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The benefits displayed are not a complete listing of every service we cover. For a complete list of covered benefits, limitations and exclusions, please contact us by the number at the bottom of this page.

Medicare Supplement premium rate quotes are monthly. Rates provided are subject to change and are dependent on varying factors such as the effective date you choose and your age at the time of issue. Once issued, your policy will include your initial premium. Keep in mind that you will be provided a 30 day right to examine your policy and you may return your policy if you are not fully satisfied. Humana will refund your premium less any claims paid. Medicare Supplement plans are not managed care plans.

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The programs described are not insurance and are neither contractually offered nor guaranteed under Humana Medicare Supplement insurance policies. Participation of fitness centers varies by state.

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Humana Medicare Supplement Plan

Humana Medicare Supplement Plan K

Summary

Plan Type: Medicare Supplement Plan

Annual Medical Deductible:	Hospital Deductible Per Benefit Period:	Maximum Medical Out-of-Pocket:	Monthly Premium:
\$155.00	\$550.00	\$4,620.00*	Get Quote
Annual Premium:	Estimated Rx Costs:	Estimated Medical Costs:	Estimated Total Annual Costs:
Get Quote	+ No Rx Coverage	+ <input type="button" value="Calculate"/>	= <input type="text"/>

Prescription Drug Details

Rx Coverage: No Rx Coverage

Medicare Supplement Plans do not include prescription drug coverage. You can enroll in Prescription Drug Plan separately ([How to Enroll](#)), or you can see the additional Benefits section for Rx discount information.

Physician Details

There are no networks with Medicare Supplement Plans. You may choose any doctor or health care provider who accepts Medicare. There are also no referrals required visit a Specialist.

Physician and Hospital Costs

Primary Care Copayment:	Specialist Copayment:	Hospital Copayment:
\$0.00 Copay per visit	\$0.00 Copay per visit	\$0.00

After you pay the Medical (Part B) deductible.

Once you have paid \$155.00 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Hospital Information

There are no networks with Medicare Supplement Plans. You may choose any hospital or health care organization that accepts Medicare. There are also no referrals required visit a Specialist.

The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Humana grievance process.

Additional Services

- [24 Hour Nurse Advice Line](#)
- [Fitness Program](#)
- [Rx Discount](#)
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*Once you meet the annual out-of-pocket limit, the plan pays 100% of the Medicare Part A and Part B copayments and coinsurance for the rest of the calendar year. Charges from your doctor that exceed Medicare-approved amounts, called "excess charges," aren't covered and don't count toward the out-of-pocket limit. You will have to pay these excess charges. The out-of-pocket annual limit can increase each year because of inflation.

The benefits displayed are not a complete listing of every service we cover. For a complete list of covered benefits, limitations and exclusions, please contact us by the number at the bottom of this page.

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

Medicare Supplement premium rate quotes are monthly. Rates provided are subject to change and are dependent on varying factors such as the effective date you choose and your age at the time of issue. Once issued, your policy will include your initial premium. Keep in mind that you will be provided a 30 day right to examine your policy and you may return your policy if you are not fully satisfied. Humana will refund your premium less any claims paid. Medicare Supplement plans are not managed care plans.

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Humana Medicare Supplement Plan

Humana Medicare Supplement Plan L

Summary

Plan Type: Medicare Supplement Plan

Annual Medical Deductible:	Hospital Deductible Per Benefit Period:	Maximum Medical Out-of-Pocket:	Monthly Premium:
\$155.00	\$275.00	\$2,310.00*	Get Quote
Annual Premium:	Estimated Rx Costs:	Estimated Medical Costs:	Estimated Total Annual Costs:
Get Quote	+ No Rx Coverage	+ <input type="button" value="Calculate"/>	= <input type="text"/>

Prescription Drug Details

Rx Coverage: No Rx Coverage

Medicare Supplement Plans do not include prescription drug coverage. You can enroll in Prescription Drug Plan separately ([How to Enroll](#)), or you can see the additional Benefits section for Rx discount information.

Physician Details

There are no networks with Medicare Supplement Plans. You may choose any doctor or health care provider who accepts Medicare. There are also no referrals required visit a Specialist.

Physician and Hospital Costs

Primary Care Copayment:	Specialist Copayment:	Hospital Copayment:
\$0.00 Copay per visit	\$0.00 Copay per visit	\$0.00

After you pay the Medical (Part B) deductible.

Once you have paid \$155.00 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Hospital Information

There are no networks with Medicare Supplement Plans. You may choose any hospital or health care organization that accepts Medicare. There are also no referrals required visit a Specialist.

The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Humana grievance process.

Additional Services

- [24 Hour Nurse Advice Line](#)
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*Once you meet the annual out-of-pocket limit, the plan pays 100% of the Medicare Part A and Part B copayments and coinsurance for the rest of the calendar year. Charges from your doctor that exceed Medicare-approved amounts, called "excess charges," aren't covered and don't count toward the out-of-pocket limit. You will have to pay these excess charges. The out-of-pocket annual limit can increase each year because of inflation.

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

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Get a Quote

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If you do not want to view Medicare Supplement Plans, you may [view other available plans](#) in this Zip Code.

Help Us Quote Your Medicare Supplement Premium

Please answer the following questions so we can quote your monthly premium for the Medicare supplement plan in your area.

*** Gender:** * Required Fields

Male Female

*** Date of Birth:**

January 1 1940

*** Medical Insurance (Part B):**

January 2005

Please select the date that you would like your coverage to begin.

*** Desired Coverage Start Date:**

December 1, 2010

*** Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed acceptance?**

Yes No
[Not Sure](#)

*** Have you used tobacco products within the last 12 months?**

Yes No

*** Did you have Medicare Coverage prior to age 65?**

Yes No
[Not Sure](#)

[Compare Rates](#)

More About Medicare Supplement Plans

A Medicare Supplement plan helps cover the additional costs left unpaid after Medicare parts A and B pays a portion of your healthcare expenses.

Humana offers a range of Medicare Supplement plans, from basic benefits to more complete coverage. Your premium may vary based upon the plan you choose, your age group, your gender or where you live.

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Help Us Quote Your Medicare Supplement Premium

Please answer the following questions so we can quote your monthly premium for the Medicare supplement plan in your area.

*** Gender:** * Required Fields

Male Female

*** Date of Birth:**

January 1 1940

*** Medical Insurance (Part B):**

January 2011

Changing your Medical Insurance (Part B) effective date has impacted your Desired Coverage Start Date. Please select a new date.

Please select the date that you would like your coverage to begin.

*** Desired Coverage Start Date:**

January 1, 2011

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More About Medicare Supplement Plans

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In order to compare Medicare Supplement Plans, you must first provide the following information so that we can quote your monthly plan premium

If you do not want to view Medicare Supplement Plans, you may [view other available plans](#) in this Zip Code.

Help Us Quote Your Medicare Supplement Premium

Please answer the following questions so we can quote your monthly premium for the Medicare supplement plan in your area.

*** Gender:** * Required Fields

Male Female

*** Date of Birth:**

January 1 1950

Based on the Date of Birth you entered, you are not eligible to enroll in Humana's Medicare Supplement plans at this time. In general, you may apply on our website up to three months prior to your 65th birthday, with coverage beginning the month you turn 65. Please return at that time to complete an application. If you would like to view rates for Humana's Medicare Supplement plans, [click here](#) to see current preferred rates for those 65 years of age. Please note that you may not be eligible for a preferred rate at your time of enrollment.

More About Medicare Supplement Plans

A Medicare Supplement plan helps cover the additional costs left unpaid after Medicare parts A and B pays a portion of your healthcare expenses.

Humana offers a range of Medicare Supplement plans, from basic benefits to more complete coverage. Your premium may vary based upon the plan you choose, your age group, your gender or where you live.

Telephone

Toll Free: 1 - 800 - 645 - 7322
TTY Users: 711

Hours

8 a.m. to 8 p.m., seven days a week

[home](#) | [help](#) | [site map](#) | [contact us](#)

[View All Available Plans](#)

[Find a Doctor](#)

[Find a Hospital](#)

Get a Quote

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Help Us Quote Your Medicare Supplement Premium

Please answer the following questions so we can quote your monthly premium for the Medicare supplement plan in your area.

*** Gender:** * Required Fields

Male Female

*** Date of Birth:**

January 1 1940

*** Medical Insurance (Part B):**

October 2011

Based on your Medical Insurance (Part B) date, you are not eligible to enroll in Humana's Medicare Supplement plans at this time. In general, you may apply on our website up to three months prior to your Medical Insurance (Part B) effective date, with coverage beginning the month of your Part B effective date. Please return at that time to complete an application. If you would like to view rates for Humana's Medicare Supplement plans, [click here](#) to see current preferred rates for those 65 years of age. Please note that you may not be eligible for a preferred rate at your time of enrollment.

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Not Sure

Do you qualify for Guaranteed Acceptance ?

In some situations, you have a guaranteed issue right to buy a Medicare Supplement policy if you lose certain kinds of health coverage. The following are examples of scenarios which may qualify you for guaranteed issue:

1. You are in a Medicare Advantage Plan and the plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area.
2. You have employer group health coverage or union coverage that is ending.
3. You have Original Medicare and a Medicare SELECT policy and you move out of the Medicare SELECT policy's service area.
4. You joined a Medicare Advantage Plan or PACE when you were first eligible for Medicare at age 65 and within the first year of joining, you decide you want to switch to Original Medicare.
5. You dropped a Medicare Supplement policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time; you have been in the plan for less than a year, and you want to switch back.
6. Your Medicare Supplement insurance company goes bankrupt and you lose your coverage, or your Medicare Supplement policy coverage otherwise ends through no fault of your own.
7. You leave a Medicare Advantage Plan, or drop a Medicare Supplement policy, because the company hasn't followed the rules or it misled you.

Some states provide additional Medicare Supplement protections. Please call us if you have any questions.

Not Sure

Did you have Medicare coverage prior to age 65?

If you received your Medicare card prior to age 65, and your Hospital (Part A) or Medical (Part B) date is before your 65th birthday, answer yes.

To determine your Hospital (Part A) or Medical (Part B) date, reference your Medicare card (see sample).

MEDICARE			HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)				
NAME OF BENEFICIARY				
JANE DOE				
MEDICARE CLAIM NUMBER		SEX		
000-00-0000-A		FEMALE		
IS ENTITLED TO:		EFFECTIVE DATE:		
HOSPITAL	(PART A)	07-01-1986		
MEDICAL	(PART B)	07-01-1986		
SIGN HERE _____				