Agent Reference Tool – 2016

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The Agent Reference Tool is designed to provide agents with additional information to reference Humana Programs, Opportunities, and Communications.

This Reference Tool can be used throughout the year for member questions.

If agents want more information or collateral on the topics listed below, they should call Agent Support at 800-309-3163.

In-Network Providers & Specialists

If the member has a Health Maintenance Organization (HMO) plan, they're (generally) required to choose an **in-network primary care physician/provider (PCP)** to get any benefits, except if they need emergency care.

Best ways to find an in-network doctor:

- An in-network doctor can be located on **Humana.com**
- Member can call Humana at the phone number on the back of their ID card
- Since paper Provider Directories are continually updated and may have changed since member received it, make sure member confirms their provider selection from the Directory using one of the two options above.

This is generally one of the highest drivers of agent complaints, so it is important to:

- Use the CORRECT network for the plan the member has selected. NOTE: There could be more than one HMO network so refer to the one FOR THAT PLAN.
- Explain that the PCP is the one who selects the specialist if needed. Even if a particular specialist is "in-network" does not guarantee that the enrollee can select them for specialist care.

Specialists:

For HMO plans, when the member's PCP feels that they need specialized treatment, he/she gives the member a referral to see a specialist or certain other providers. For some types of services, their PCP may need to get approval in advance from Humana (this is called getting "prior authorization").

It is very important for the member to get a referral from their PCP before they see a specialist or certain other providers. If they don't have a referral before they get services from a specialist, they may have to pay for those services themselves. If the specialist wants them to come back for more care, they should check first to be sure that the referral they got from their PCP for the first visit covers more visits. A "second or secondary" referral from a PCP may be necessary if the initial specialist desires to refer the member to an additional provider.

Members on PPO plans can go Out of Network, but they may have to pay more for the services they receive outside the network, and they may have to follow special rules prior to getting services in and/or out of network. Member should call Humana at the phone number on the back of their ID card if they have any questions.

Health Assessment

A few weeks after a member has been enrolled, a Humana associate will attempt to contact them via phone to welcome them to Humana and to complete a Health Assessment. The exact timing of these calls is based on when during the year the member enrolls.

The assessment consists of a series of health related questions which help Humana connect the member with programs that are available to them at no additional cost. These programs are designed to assist members in managing health-related conditions.

As their agent, you should assure your members that their responses to these questions will be kept confidential and will not affect their health insurance coverage or benefits in any way.

IMPORTANT: This Health Assessment conducted over the phone is not the same as the In-Home Health and Wellness Assessments program discussed on page 10 of this guide.

Vision Benefits

Many members will have EyeMed Vision for their routine wellness vision exam which includes refraction, dilation, glaucoma and diabetic screenings. However, Optomap is not covered and is the member responsibility should they prefer this option.

Post-cataract surgery is a Humana benefit.

There may be instances where the member might not have an EyeMed Vision routine wellness Mandatory Supplemental Benefit (MSB)/rider). In these instances, the member should call Humana at the number on the back of their medical ID card.

For the MSB/riders members, there's no separate vision ID card. And, there's no mention of EyeMed on the back of their medical ID card, only the VISxxx code listed on the back. In 2016, we received approval to have EyeMed added to the back of the ID card. So members will at least know it is EyeMed vision.

Humana/EyeMed Medicare MSB /riders (attached to the medical policy) are from **VIS731-799**. This includes EyeMed OSBs. Humana is tied to EyeMed's Select network. The EyeMed Select network offers retail locations LensCrafters, Pearle, Sears, JCPenney & Target Optical as well as a wide array of independent locations.

To locate an EyeMed Select network provider, members can:

- go to Humana.com > Find a doctor > Search type drop down select Vision > EyeMed Vision Care
- contact EyeMed customer service at 888-289-0595 or 866-392-6056. Customer Service hours are seven days a week: 7:30am to 11pm eastern time Monday through Saturday and 11am to 8pm eastern time Sunday.

Members need to inform the EyeMed Select network provider that they have EyeMed benefits. The provider will then validate them in the EyeMed system by name/dob and submit routine non-medical exam claim/materials to EyeMed.

If the member has an EyeMed PPO benefit with OON benefits, it's the member responsibility to submit an EyeMed OON claim form with an itemized receipt. This form can be found in MyHumana then clicking onto the EyeMed Vision link.

The Humana/EyeMed discount is automatically available to any medical or dental member. The discount is taken off at the provider office/point of sale and there is no claim submission. There is no generic ID card – members just need to tell the provider that they have the Humana/EyeMed discount.

NOTE: Members cannot utilize their funded benefit and discount within the same transaction.

MyHumana

With **MyHumana** the member can:

- View health benefits
- Find doctors, hospitals, and other health care providers in Humana's network
- Check on claims
- See how much has been spent on health care this year
- Look up the costs of common medical services and medicines
- Choose how they want to receive information from Humana
- Check their account information anytime, anywhere and from any device by visiting Humana.com or downloading the MyHumana Mobile app from the app store. Search "MyHumana" in the Google Play or App Store.

Go to **Humana.com** and click on the Register link.

Rx Guidance

Members should confirm their prescriptions are covered by Humana. To find the drugs Humana currently covers, members can:

- Review the **formulary** which is located on Humana.com. To get updated information about the drugs that Humana covers, visit **Humana.com/medicaredruglist**. The Drug List Search tool lets you search for your drug by name or drug type and will provide any additional formulary authorizations or exceptions.
- Call Humana at the phone number on the back of the their ID card
- Refer to their Prescription Drug Guide for coverage and formulary changes (received during Annual Enrollment Period)

NOTE: The Paper Directory is continually getting updated and might have changed since the member received it. Make sure the member confirms their drug(s) 'status' using one of the two options above.

For some prescription drugs, the member must get **prior authorization** from Humana before their plan will cover the cost.

- For any medications requiring prior authorization, members can call Humana at the phone number on the back of their ID card or have their doctor contact **Humana Clinical Pharmacy Review (HCPR) at 1-800-555-2546** between 8 a.m. and 6 p.m., Monday – Friday, to ask for approval for their medicine(s) that need prior authorization.
- If the member needs an **exception** to the coverage rules, they should submit a statement from their doctor supporting their request. Their Doctor can:
    - Call Humana Clinical Pharmacy Review (HCPR) at 1-800-555-2546
    - Fax the request to 1-877-486-2621 or
    - Mail to Humana Clinical Pharmacy Review (HCPR) ATTN: Medicare Coverage Determinations P.O. Box 33008 Louisville, KY 40232-3008.
- In some cases, Humana requires the member to first try certain drugs to treat the medical condition before another drug for that condition will be covered – this is called **step therapy**.
- For more information, please visit Humana.com/provider/medical-providers/pharmacy/

Members should use **In-network Pharmacies**, except under non-routine circumstances. Within the network, some plans may have **preferred or lower cost share pharmacies, such as Humana's mail delivery pharmacy** that offers the member lower copayments or coinsurance.

- In-Network and preferred or lower cost pharmacies can be located on **Humana.com**
- Member can call Humana at the phone number on the back of the their ID card

Please note: In some areas, member access to a preferred cost share pharmacy may be limited. Pursuant to the 2016 marketing guidelines, CMS requires a disclosure on Humana Prescription Drug Plan materials stating that the lower costs advertised may not be available at the pharmacy the beneficiary chooses to use. This applies to both the Humana Walmart Rx Plan and the Humana Preferred Rx Plan.

Prospective members living in areas with limited availability to preferred cost share pharmacies may still enroll in a Humana PDP. However, agents will need to make sure that those prospective members understand they will pay more if they plan to use pharmacies that offer standard cost sharing.

Generic Drugs may be available for a member's medication(s) that are often less expensive than brand-name drugs. If there is an interest:

- Members should ask their doctor whether a generic option is available.
- Members should tell their local pharmacist they want the generic drug their doctor approves when it's available.
- Members can log into **MyHumana**, the secure website on Humana.com, to get personalized information about generics and alternative medications, calculate drug cost and find out about savings with mail order.

Humana Pharmacy

Members who have an ACTIVE BENEFIT should have the following information ready when they call or go online.

- Humana ID
- Medications (Name, strength, dosage, etc.)
- Physicians Name, Phone and Fax Number
- Amount of Medication left

	Humana Pharmacy	Humana Specialty Pharmacy™
How does a member enroll, start a new prescription or switch a prescription?	**Online:** Members can go to **HumanaPharmacy.com** and register **OR** log-in using their *My*Humana username and password If the member starts a new prescription on the website, Humana Pharmacy will contact the member's healthcare provider and will request a prescription for a 90-day supply of their medicines via fax. **By Phone:** Members can call Humana Pharmacy at **1-855-310-5799 (TTY: 711)** **New Humana enrollees can call Humana Pharmacy prior to their benefit being active if the member wants to learn more.** **By Mail:** Members can mail their paper prescriptions with a New Registration Order form (**HumanaPharmacy.com/forms**) to: Humana Pharmacy P.O. Box 745099 Cincinnati, OH 45274-5099 **Through Their Healthcare Provider:** Healthcare providers can send the member's prescriptions by: • E-prescribe and select ***"Humana Pharmacy Mail Delivery"*** • Fax 1-800-379-7617*	**By Phone:** Members can call a patient care coordinator at **1-800-486-2668** Humana's specialty pharmacy will enroll the member if he/she is a new customer and/or will reach out to his/her healthcare provider for a specialty prescription(s). **Through Their Healthcare Provider:** Healthcare providers can send the member's prescriptions by: • E-prescribe and select ***"Humana Specialty Pharmacy"*** • Call 1-800-486-2668 • Fax 1-877-405-7940*

* When the member's doctor faxes to prescriptions Humana Pharmacy or Humana Specialty Pharmacy, they need to fill out the Physician Fax Form or Referral Form (**HumanaPharmacy.com/forms**).

IMPORTANT FOR NEW MEMBERS: Let the member know that, if they have never filled thru mail order before and a physician sends Humana Pharmacy or Humana Specialty Pharmacy a prescription via fax or e-prescribe, the member's consent may be required before Humana Pharmacy can fill/send that medication. Consent can be applied by calling Humana Pharmacy, **1-800-968-2298**

Over the Counter (OTC) Benefits

For members with an OTC Benefit in their plan who live OUTSIDE of Florida, below are ways to receive a catalog and order form, as well as, ways to order their over the counter items.

How to Get a Catalog and/or Order Form	How to Order
By Phone: Members can call Humana Pharmacy at **1-855-211-8370** Online: Members can download the Catalog and Order form at **HumanaPharmacy.com/forms** NOTE: Members enrolled during AEP will receive information about their OTC benefit in a Health & Wellness kit that will be mailed in January. Inside the kit will be instructions on how to download the OTC benefit catalog from HumanaPharmacy.com. Members can also request a hardcopy of the catalog via a postage paid postcard included in the Health & Wellness kit. Members enrolling during the rest of the year (ROY) will receive OTC benefit information in their Health & Wellness kit mailed within the first month of their plan effective date.	Online: Members can go to HumanaPharmacy.com and register OR log in using their MyHumana username and password Members can order their OTCs online and the supplies will be shipped to their home via USPS Mobile App: Members can use their MyHumana username and password to order their OTCs using the Humana Pharmacy mobile app. Mail: Members can mail their order forms to Humana Pharmacy; PO Box 1197; Cincinnati, OH 45201-1197 Fax: Members can fax in their OTC order via the order form to: 800-379-7617 **Please Note:** **We recommend that members order their OTC Products via the website; it has the most up to date information on what products are in stock, and will prevent any delays in receiving orders.**

- Orders post-marked/received by the final day of the month will be counted toward the current month's benefit allowance unless otherwise noted on the order form.
- To ensure delivery of products in the current month, place order no later than the 20th of the month.
- Products will be delivered via USPS or UPS at no charge to the member.
- Monthly benefit allowance amount balances do not carry over to future months.
- If the order exceeds the plan's monthly allowance, members should include a check, money order, or enter credit card information during ordering to pay the remaining amount due. Failure to submit payment in full will lead to items being cancelled to bring the order total at or below the monthly benefit allowance.

South Florida Members have an option to use Humana's pharmacy or they may obtain their OTC products at our PrescribeIT retail pharmacies. They can call **1-800-526-1490** for additional information.

Dual Eligible Outreach

Humana has a department which assists members in applying for the Medicare Savings Program. This program is run through each state's Medicaid department. If the member applies and is approved for the program, depending on their income and the level of assistance they qualify for through Medicaid, the member's Part B premium will be paid for by their state. For 2015, this means the member will see an additional $104.90 go into their checking account each month from their Social Security check. Members will also be considered dual eligible once approved.

Each state sets their own guidelines for eligibility and raises income and asset limits on a yearly basis. Humana Dual Eligible Outreach associates will provide an initial eligibility screening to members. If a member appears to qualify, the associate will then complete the application over the phone with the member and mail it out to the member for signature and completion.

Interested and potentially eligible members should be referred to the dual eligible department's direct line, **1-800-889-0550.** Additional information can be found at **go/deo**.

Stars Maximization

"Stars" is a Centers for Medicare and Medicaid Services (CMS) program to improve quality for Medicare Advantage members.

CMS provides quality related information to Medicare members to help them choose the highest quality plans available in their area. To do this, CMS measures how well plans perform on more than 40 measures.

Each contracted plan receives a quality rating that summarizes all categories and measures into a single star rating. Quality ratings are assigned at the contract level and every Medicare Advantage plan covered under the same contract receives the same rating. Humana measures success by year-over-year improvement in the Stars scores as well as our performance in comparison to the rest of the industry as reported by CMS.

In this chart, notice the year-over-year improvement in Humana's overall Stars rating. Based on the data currently posted to the CMS website, Humana has the second highest Stars rating of all publicly traded plans. In addition, 2.6M Humana members are in 4+ rated plans. More than any other competitor!

Parent Company	BY 2014	BY 2015	BY 2016	'15 vs '14 %Diff	'16 vs '15 %Diff	Avg. %Diff
Kaiser	4.99	4.99	4.99	0%	0%	0%
Humana	3.82	4.00	4.16	5%	4%	5%
Aetna	3.53	4.10	4.02	16%	-3%	7%
Cigna	3.38	3.78	3.84	12%	1%	7%
United Health	3.32	3.44	3.47	4%	1%	2%
Wellpoint	3.35	3.27	3.38	-2%	3%	0%

Note: Star score values are weighted by August 2014, September 2013, August 2012 enrollment for BY 2016, 2015, and 2014, respectively

- Consolidated contracts published in the CMS Plan Crosswalk for Humana & competitors are included
  1. Humana consolidations in 2015 move 10% of current membership into 4+ rated plans
  2. Aetna consolidations in 2015 move 14% of current membership into 4+ rated plans
  3. UnitedHealth has made statements related to consolidation activity. However, not included as no activity was found in the Plan Crosswalk

NOTE: Agents are not to use this data to make comparisons with competitor's plans when meeting with clients.

Stars plan ratings are published yearly prior to open enrollment. More than 40 measures are rated across approximately 30 Humana contracts. Measures, measurement calculations and thresholds are reviewed and may be modified by CMS each year, retroactively. These measures are calculated with data that comes from multiple sources and are measured across different measurement period timeframes.

Benefits of high Star ratings are:

- High member perception of plan
- Higher bonus/rebate dollars

Benefits of 5 Star rating are:

- Ability to sell 5 star plans all year
- Eligibility for special enrollment period

Penalties of Low Star ratings are:

- Potential termination of contract
- Warning signals published if less than 3 Stars for 3 or more years
- Receipt of CMS Corrective Action Plan requests / Notice of Non-conformance
- CMS could limit expansion

Medicare Surveys

Throughout the year, the member might receive a **CAHPS (Consumer Assessment of Healthcare Providers) or HOS (Health Outcomes Survey) survey** from CMS or Humana. These surveys ask consumers and patients to report on and evaluate their health and their experiences with health care. Members selected for the HOS survey will receive a follow-up two years later in order for a comparison of ratings to be made.

These surveys are important as they gather valid and reliable clinically meaningful data that have many uses, such as for targeting quality improvement activities and resources and monitoring health plan performance. CMS surveys are anonymous and personal information is not shared with Humana.

How You Can Help Stars Maximization

- During everyday conversations, encourage the member to:
  - Take advantage of their plan covered preventive screenings and to get their annual flu vaccine
  - Take a list of medications or take all their medications to every doctor visit and talk with their doctor if they are not taking their medications as prescribed
  - Share advantages of mail order pharmacy usage and/or benefits of 90 day prescriptions and encourage members to discuss high risk medications and generic prescription options with their physician
  - Talk with their doctor about all health concerns, even if they might be embarrassed, especially fall prevention, bladder control and mental / physical health tips
  - Contact Humana customer service if they have any trouble getting doctor appointments or getting their needed prescription drugs
  - Always contact Humana directly with any questions, issues, or to change their demographic information (address, phone number, etc.) using the number found on the back of their card
  - Consider health reminders and beneficial medical information that may be received directly from Humana or CMS via mail or phone

- Attend Stars education and training sessions when offered
  - Gain an understanding of Stars and why it's important to Humana, your region and your business
- Provide feedback by emailing StarsFeedback@humana.com

Health Coaching

Humana Health Coaching provides individuals with the expert guidance, support, and personal attention needed to make positive, healthy changes and bring balance to their lives. Through coaching, individuals develop a plan for success and create healthy habits that help to maintain new and healthy lifestyles into the future. Typical areas of focus include

weight management, nutrition, fitness, tobacco cessation, and stress management, frequently addressed in conjunction with the management of blood pressure, cholesterol, blood glucose and back pain.

Members can enroll in coaching by logging on to **Humana.com**, clicking on "Get Healthy," and then "Health Coaching."

HumanaVitality members can enroll telephonically by calling **855-852-9451.**

Other Humana Medicare members can also enroll telephonically by calling **855-852-9451.**

Note: Access to coaching depends on the Medicare member's Humana or HumanaVitality benefit plan

HumanaVitality & Humana Rewards Programs

CMS Incentives/Rewards Guidelines for Medicare Advantage Plans: Information about incentives/rewards programs may be discussed pre-enrollment directly to members as long as it's in conjunction with the member's plan benefits. According to CMS guidelines, Agents should not simply focus on one specific incentive or reward program but reference all rewards and incentives offered by the Plan.

Vitality HealthyFood™ cannot be discussed in pre-enrollment to members.

Humana Rewards Program and **HumanaVitality®** are wellness incentive programs available at no additional cost.

Topic	Additional Details
Humana Medicare Rewards Description	Gives members the opportunity to earn gift card rewards for getting preventive healthcare screenings and exams. To find out more, members can visit **Humana.com/MedicareRewards** or call **1-800-968-2281**.
Humana Medicare Rewards Communications	Communication pieces are sent to eligible members during their progress through the program.
HumanaVitality Description	Gives members the opportunity to earn Vitality Bucks® for completing healthy activities like getting preventive screenings and exercising. Vitality Bucks can be redeemed for items in the HumanaVitality Mall.
HumanaVitality Online	Members are encouraged to participate in the HumanaVitality program online. They can login to MyHumana and they will see a tab for HumanaVitality. Once members are on the website, they are encouraged to take the HumanaVitality Health Assessment, which will provide personalized results about their current health status, what they can do to improve their health, and opportunities to earn more Vitality Bucks by completing the recommended goals and activities. They will also receive their Vitality Age™ which will tell the member if they are living younger or older than their actual age. Members' responses to the HumanaVitality Health Assessment are completely confidential.
HumanaVitality through mail	If members do not have internet access or do not feel comfortable using a computer, they can participate in the HumanaVitality program using paper and mail. They can submit a request for a paper HumanaVitality Health Assessment. This request form, along with a postage paid return envelope, is included in their Welcome Kit. These members will also receive goals and recommended activities, as well as a paper catalog in the mail that contains all of the items they can redeem in the HumanaVitality Mall.

Topic	Additional Details
Vitality HealthyFood™	Vitality HealthyFood™ is available at no additional cost to all Humana Vitality members. Vitality HealthyFood™ is a Value Added Items and Services (VAIS) in which Medicare Advantage

Description	members earn 10% savings on Great For You™ healthier foods purchased at Walmart®. Healthier foods are defined in Walmart's "Great For You" program, which consists of fresh fruits & vegetables, as well as lean meats, lean dairy, healthy oils, etc. in Walmart's Great Value brand. Members should look for the Great For You icon on products and shelving. Medicare members can also get $10 added to their Vitality HealthyFood Shopping Card when they get two preventive screenings. $5 for the first screening and another $5 for a second screening. To request a Vitality HealthyFood Shopping Card, members must accept the Vitality HealthyFood™ Terms & Conditions (T&Cs), which can be done either online by logging in to MyHumana or "offline" by signing and returning a paper T&C form. Accepting the T&Cs will enable a Vitality HealthyFood™ Shopping Card to be mailed to members.

In-Home Health and Well-being Assessments

Humana's In-home Health and Well-being Assessments (IHWA) program is managed through the Medicare Risk Adjustment team and is operationalized through five clinical IHWA vendors Matrix, Censeo, Your Home Advantage, Advance Health and Peak.

The IHWA program is focused on providing a no-cost assessment focused on preventative care and increasing early detection of some common health conditions. The results, which are provided to the member's designated Primary Care Physician (PCP)/Specialist, will provide a more complete picture of the member's current health status.

The benefits to our members receiving the In-home Health and Well-being Assessment, even if they are considered healthy, are tremendous:

- Free screenings that could identify unknown health risks
- Communication with their current doctor and Humana's clinical programs to provide services necessary to maintain a healthy lifestyle
- Emphasis on documentation and data accuracy to ensure their complete health history is properly recorded

Members are not targeted specifically because they are dealing with an issue currently, but to help with issues that may come up in the future. Through the use of sophisticated analytical models, Humana and its IHWA Partners, work with markets to identify eligible membership populations. The IHWA partners send out a letter and follow-up with a phone call to schedule an in-home assessment. Not every eligible member will receive an outreach.

The assessments are performed by licensed clinicians: physicians, physician assistants or a nurse practitioner. The clinicians will arrive at the member's home with a visible ID to ensure the member can validate the clinicians' identity. An IHWA takes on average, about an hour. During the assessment the clinician will conduct a brief, non-invasive, physical exam. The member is encouraged to have a family member/friend present during the assessment. Based on the outcome of the assessment, members may be referred to Humana clinical programs for further coaching.

In the event you have additional questions, you can find more information on the Health Services Organization SharePoint site: **www.humana.com/homevisit**

Family and Friend Caregivers

While caring for a family member, friend, or spouse may not seem like a defined role, if you're helping someone with their healthcare, you're part of a large and growing population of caregivers. A **Family and Friend Caregiver** can:

- Talk on member's behalf to Humana about your plan
- Keep track of member's benefits and claims
- Get answers to healthcare questions
- Get member care in an emergency
- Receive information and advice on caregiving from Humana

To obtain consent for a friend or family caregiver, a member can:

1. Once registered on MyHumana, complete the Consent for Release of Protected Health Information (PHI) form via the Accounts and Settings page.
2. Print the form from **humana.com/phi,** fill it out completely and sign it, and return to Humana following the instructions on the bottom of the form.

*If member wants Humana to mail a PHI consent form to them, they can call Customer Care at **1-800-457-4708**

HumanaFirst Nurse Advice Line

HumanaFirst® Nurse Advice Line provides member with a team of registered nurses standing by 24 hours a day, 7 days a week to provide personal guidance, information, and support. HumanaFirst is a quick and confidential way for members to decide whether to visit their provider, seek urgent or emergency care, or begin treatment at home. HumanaFirst also eliminates unnecessary calls or visits to providers and helps prevent inappropriate trips to the emergency room.

Nurse Line number: **1-800-622-9529**

SilverSneakers

Quick Overview

- Available in most Medicare Advantage (MA) and Medicare Supplement markets
- A comprehensive network of fitness centers
- Physical, Social and educational components

Topic	Additional Details
Participating Fitness Centers	See **www.silversneakers.com** for a list of available fitness centers.
Medicare Supplement	Medicare Supplement members have access to SilverSneakers.
PDP Members and Fitness Programs	***Humana does not offer any exercise program to Prescription Drug Plan (PDP) members***. Customer Care Specialists (CCS) should not advise members they are eligible for these programs.
Steps	**SilverSneakers Steps** is available to Humana Medicare Advantage Prescription Drug (MAPD) and

	Medicare Supplement members that live greater than 15 miles from a fitness center at no additional cost. Members that frequently travel as well as members that do not drive can contact SilverSneakers at 1-888-423-4632 for enrollment information.
Silver and Fit	Silver&Fit is no longer part of the Humana Fitness Program.

Special Needs Plans (SNP)

Medicare **Special Needs Plans** – also called "SNPs" – are a type of Medicare Advantage plan. Medicare Special Needs Plans are designed for people who are eligible for both Medicare and Medicaid or have specific diseases or conditions. Special Needs Plans tailor benefits, provider choices, and drug formularies – lists of covered drugs – to meet the needs of the groups they serve. Members can join a Special Needs Plan if they have Medicare Parts A and B, live in the plan's service area, and meet the plan's eligibility requirements.

Each special needs plan operates under a Model of Care, a specialized structure for care management that enables them to provide coordinated care for special needs members. Members are assigned a care manager who ensues that specific needs are met. The care manager also serves as the single point of contact and leads a team of experienced professionals who provide support for members.

To receive more information/training on SNPs, contact Agent Support: 1-800-309-3163

Chronic Condition Special Needs (C-SNP) Plans

There is a special enrollment process for C-SNP plans. The steps below should be followed when enrolling an applicant into a C-SNP plan.

Point-of-Sale Actions-

Step 1: Agents should help the enrollee complete the **prequalification form** at the time of sale. This form includes health questions that the enrollee must answer, and the form must be received with the application in order to process the enrollment.

The **Pre-Qual Form** in its carbon copy style layout, can be ordered via **Agent Support 1-800-309-3163 opt.1/opt.5**. Ask for Item # GNHHWAW and both the 2015 English and Spanish versions will be available to order. **SNP forms will be included in the Summary of Benefits when ordering a SNP plan.**

Note: When using a PDF version of the Pre-Qual Form, you would need to fill out both copies manually in order to have one for sending to Membership Services, and one to leave behind for the member to retain.

Step 2: Agents should speak to the prospective member about the requirement of the **Verification of Chronic Condition** (VCC) form. This form is sent to the enrollee via mail as an attachment to the acknowledgement of enrollment letter. The prospective enrollee must ensure that their physician or physician's office staff completes and signs the form. This form must be received by Humana within the first month of coverage.

Step 3: Agents should go over the **SNP Enrollment Checklist** with the applicant. The Checklist can be ordered through **Agent Support 1-800-309-3163 opt.1/opt.5. SNP forms will be included in the Summary of Benefits when ordering a SNP plan.**

Step 4: Once the application is complete, meaning the plan selection and PCP selection is made and the application is signed, agents may offer to assist enrollee with his/her first appointment. If the enrollee agrees, the sales agent dials the selected

physician's office number and hands the phone to the enrollee to make their own appointment. Once the appointment is scheduled, the sales agent needs to write the appointment date and time on a Humana appointment reminder for the enrollee to place in a prominent place in their home, like on their refrigerator.

Post-Enrollment Actions-

Agents should work with their local Market Office to keep up with their new C-SNP member's condition verification status. The Corporate Enrollment team will supply a list of members during the second month of enrollment whom have not completed the VCC form process during the 1st month of enrollment and supply that to the Market Office.

During the second month of enrollment, Agents should continuously follow up with C-SNP enrollees who have not yet had a physician or physician's office staff complete and fax their verification (VCC) forms to Humana.

If C-SNP members have not had their chronic condition verified by a physician's office within their first 2 months of enrollment, they will be involuntarily disenrolled from the plan.

Dual Eligible Special Needs (D-SNP) Plans

A dual eligible SNP is a type of Medicare Advantage plan for beneficiaries who are entitled to Medicare and Medicaid. However, just because a person has Medicare and Medicaid does not necessarily make them eligible for a Humana plan. Medicaid assigns eligibility levels based upon beneficiaries' income and resources. Each D-SNP plan has requirements based on the Medicaid assigned eligibility level. D-SNP plans provide value to duals by offering a Model of Care, larger provider network, and often times additional Mandatory Supplemental Benefits, such as dental, hearing, vision, over-the-counter, member assistance program, and more. D-SNP members use the plan network and are not restricted to Medicaid-certified providers. Duals have an open SEP, so they can enroll and change plans from month to month.

Appendix

Additional programs are listed below that are not referenced in the New Member Call talking points. Some of these programs are not available in all areas or on all plans. Nevertheless, agents should be familiar with these programs because some members may receive communications regarding them.

Direct members to call the customer service number on the back of their Humana ID card if they need additional detail.

Member Assistance Program (MAP)

Member Assistance Program (MAP) provides easy, nonthreatening help with both trained counselors available by phone and a website full of resources, all available at no additional cost to members.

Trained MAP counselors give members live telephonic support. They're a listening ear for members in hard life moments – dealing with grief, loss, loneliness, caregiving, or coping with illness.

MAP is a service available to all Humana MA and MAPD members.

Members can access MAP online by looking under Tools and Forms in MyHumana, or by logging on to HumanaActiveOutlook.com. There is a link to the MAP website on the left-hand side of the home page. The counselor hotline is: 1-800-767-6171 (TTY: 711).

Humana Well Dine

Humana Well Dine® offers qualified members on many plans healthy meals delivered to their home after an inpatient stay in a hospital or skilled nursing facility. To confirm eligibility, members can call **1-866-96MEALS (1-866-966-3257)**.

Humana Well Dine also offers meals for many Chronic Special Needs Plan members with Diabetes Mellitus, Chronic Heart Failure, or Cardiovascular Disorders with a Doctor's approval. A HumanaCares Nurse will be in contact with qualified members with additional information.

QuitNet

QuitNet® helps members kick the tobacco habit for good – offered at no extra cost to most Humana Medicare members. To find out more, members can call **1-888-572-4074**.

SmartSummary

A **SmartSummary Statement** is a personalized monthly statement that puts all the member's health and financial information in one place.

Receiving a SmartSummaryRx	As part of the member's Medicare PDP coverage through Humana, each month they have a claim, they will receive a Medicare SmartSummaryRx Statement to help manage past purchases and decisions while proactively planning for future spending and decisions.
Medical SmartSummary	Members with medical claims in a prior month will receive a medical SmartSummary. This SmartSummary will display all medical claims during the previous month and replace the black and white EOB's.
How to Receive a SmartSummaryRx or medical SmartSummary	The member can choose to receive a SmartSummary Statement in a paper version mailed to them or they can choose to access their SmartSummary Statement by going to MyHumana at **www.Humana.com**. ***Note:*** To access a Medicare SmartSummary or Medicare SmartSummaryRx Statement online, members must register at the **MyHumana** registration link on the Web site.
What to Do with SmartSummaryRx or Medical SmartSummary	Members may want to keep their monthly SmartSummary Statement to make it easier to review their benefits, track their costs, and manage their healthcare budget. SmartSummary also includes personalized health tips and savings opportunities.