

# Notice of Privacy Practices

for your **personal** health and financial information

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.**

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. We at Humana value our relationship with you, and we take your personal privacy seriously.

This notice explains Humana's privacy practices, our legal responsibilities, and your rights concerning your personal and health information. We follow the privacy practices described in this notice and will notify you of any changes.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

## What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

## How does Humana protect my information?

In keeping with federal and state laws and our own policy, Humana has a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

## How does Humana use and disclose my information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments
- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, and determining premiums
- For performing underwriting activities
- To your plan sponsor to permit them to perform plan administration functions
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you
- To your family and friends if you are unavailable to communicate, such as in an emergency



# Notice of Privacy Practices *(continued)*

- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill Humana's obligations under any workers' compensation law or contract
- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

## **Will Humana use my information for purposes not described in this notice?**

In all situations other than described in this notice, Humana will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission.

## **What does Humana do with my information when I am no longer a Humana member or I do not obtain coverage through Humana?**

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through Humana. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

## **What are my rights concerning my information?**

The following are your rights with respect to your information:

- **Access** – You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- **Alternate Communications** – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life-threatening situation. We will accommodate your request if it is reasonable.
- **Amendment** – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- **Disclosure** – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. Effective April 1, 2003 or whenever you became a Humana member, Humana began maintaining these types of disclosures and will maintain this information for a period of six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- **Notice** – You have the right to receive a written copy of this notice any time you request.
- **Restriction** – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

# Notice of Privacy Practices *(continued)*

## **How do I exercise my rights or obtain a copy of this notice?**

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- E-mailing us at [privacy.office@humana.com](mailto:privacy.office@humana.com)

Send completed request form to:  
Humana Privacy Office  
P.O. Box 1438  
Louisville, KY 40202

## **What should I do if I believe my privacy has been violated?**

If you believe your privacy has been violated in any way, you may file a complaint with Human by calling us at: 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov). We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

## **PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION**

Humana and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

## **How does Humana collect information about me?**

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive

information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

## **What information does Humana receive about me?**

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our Website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

## **Where will Humana disclose my information?**

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

## **What can I prevent with an opt-out disclosure?**

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by Humana or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your Humana identification number or member account.

Your opt-out request will continue to apply until you revoke your request or terminate your membership.

## **How do I request an opt-out?**

At any time you can tell Humana not to share any of your personal information with affiliated companies that provide offers of non-Humana products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth, and your Humana member identification number. You can use any of the methods below to request or revoke your opt-out:

- Call us at 1-866-861-2762
- E-mail us at [privacyoffice@humana.com](mailto:privacyoffice@humana.com).

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- Send your opt-out request to us in writing:  
Humana Privacy Office  
P. O. Box 1438  
Louisville, KY 40202

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater protection.

The following affiliates and subsidiaries also adhere to Humana's privacy policies and procedures:

American Dental Providers of Arkansas, Inc.  
American Dental Plan of North Carolina, Inc.  
Cariten Insurance Company  
Cariten Health Plan  
CarePlus Health Plans, Inc.  
CompBenefits Company  
CompBenefits Dental, Inc.  
CompBenefits Insurance Company  
CompBenefits of Alabama, Inc.  
CompBenefits of Georgia, Inc.  
CorpHealth, Inc.  
CorpHealth Provider Link, Inc.  
DentiCare, Inc.  
EmpheSys, Inc.  
EmpheSys Insurance Company  
HumanaDental Insurance Company

Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.  
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.  
Humana Health Benefit Plan of Louisiana, Inc.  
Humana Employers Health Plan of Georgia, Inc.  
Humana Health Insurance Company of Florida, Inc.  
Humana Health Plan of Ohio, Inc.  
Humana Health Plan of Texas, Inc.  
Humana Health Plan, Inc.  
Humana Health Plans of Puerto Rico, Inc.  
Humana Insurance Company  
Humana Insurance Company of Kentucky  
Humana Insurance Company of New York  
Humana Insurance of Puerto Rico, Inc.  
Humana Medical Plan, Inc.  
Humana MarketPOINT, Inc.\*  
Humana MarketPOINT of Puerto Rico, Inc.\*  
Humana Medical Plan of Utah, Inc.  
Humana Wisconsin Health Organization Insurance Corporation  
Kanawha Insurance Company\*  
Managed Care Indemnity, Inc.  
Preferred Health Partnership, Inc.\*  
Preferred Health Partnership of Tennessee, Inc.  
The Dental Concern, Inc.  
The Dental Concern, Ltd.

\* These affiliates and subsidiaries are only covered by the Privacy Notice Concerning Financial Information section.

**HUMANA**<sup>®</sup>  
*Guidance* when you need it most

# Humana Employee Change Form

Please print clearly and fill in each applicable circle.

Current Medical Group number \_\_\_\_\_ Benefit number \_\_\_\_\_ Class/Division \_\_\_\_\_  
Current Dental Group number \_\_\_\_\_ Proposed Effective Date for change: \_\_\_ / \_\_\_ / \_\_\_\_\_  
Company name \_\_\_\_\_ Company city \_\_\_\_\_ State \_\_\_\_\_

## Employee Information and Changes

Please provide employee information and indicate all applicable employee changes.

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_ Social Security number \_\_\_\_\_

**Change Medical benefit/class to:** Benefit number: \_\_\_\_\_ Class/Division: \_\_\_\_\_

**Change or Select Employee Primary Care Physician** (HMO and POS only):

Primary care physician: \_\_\_\_\_ Physician ID: \_\_\_\_\_

**Change Dental benefit/class to:** Benefit number: \_\_\_\_\_ Class/Division: \_\_\_\_\_

**Change or Select Employee Primary Care Dentist** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):

Primary dentist: \_\_\_\_\_ Facility number: \_\_\_\_\_

**Change Basic Life benefit/class to:** Benefit number: \_\_\_\_\_ Class/Division: \_\_\_\_\_

**Change Basic Life Beneficiary:** Group number: \_\_\_\_\_

Primary beneficiary name: Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Secondary beneficiary name: Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

**Change Voluntary Life Beneficiary:** Group number: \_\_\_\_\_

Primary beneficiary name: Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Secondary beneficiary name: Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

**Change Vision benefit/class to:** Benefit number: \_\_\_\_\_ Class/Division: \_\_\_\_\_

**Cancel My Coverage** for the following products:  Medical  Dental  Basic Life  Voluntary Life  Short-term Income Protection  
 Vision  Health Savings Account (HSA)  Health Care FSA  Dependent Care FSA

## Qualifying Event Information

Please indicate the qualifying event date and reason for employee or dependent changes below.

**Qualifying event date:** \_\_\_ / \_\_\_ / \_\_\_\_\_

**Reason for change:**

- |   |  |   |
|---|--|---|
| <input type="radio"/> Re-hire                               | <input type="radio"/> Marriage         | <input type="radio"/> Spouse terminates employment                          |
| <input type="radio"/> Employer contribution ceases          | <input type="radio"/> Legal separation | <input type="radio"/> Spouse's employer terminates coverage                 |
| <input type="radio"/> Dependent birth / adoption            | <input type="radio"/> Divorce          | <input type="radio"/> Spouse changes from full-time to part-time employment |
| <input type="radio"/> Dependent change to full-time student | <input type="radio"/> Spouse deceased  | <input type="radio"/> Other: _____  |

## Change Address Information

**Address change applies to:**

Employee only  Employee and all covered dependents

Only for the following dependent (please print full name): Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

New street address \_\_\_\_\_ Apt / Suite / PO Box number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ County \_\_\_\_\_

Email address \_\_\_\_\_ Phone number \_\_\_\_\_

Group Number

Social Security Number

**Dependent Changes**

Please complete this section for all dependent changes.

**1** Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_ Date of birth \_\_/\_\_/\_\_\_\_

Social Security number \_\_\_\_\_ Gender:  Female  Male Relationship:  Spouse  Child  Other: \_\_\_\_\_

Dependent status (if applicable):  Full-time student  Disabled If disabled, indicate reason: \_\_\_\_\_

**Add** or  **Delete** dependent to/from my current plan for the following products:  Medical  Dental  Basic Life  
 Voluntary Life  Vision

**Change or Select Primary Care Physician** (HMO and POS only):  
 Primary care physician: \_\_\_\_\_ Physician ID: \_\_\_\_\_

**Change or Select DHMO** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):  
 Primary dentist: \_\_\_\_\_ Facility number: \_\_\_\_\_

**2** Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_ Date of birth \_\_/\_\_/\_\_\_\_

Social Security number \_\_\_\_\_ Gender:  Female  Male Relationship:  Spouse  Child  Other: \_\_\_\_\_

Dependent status (if applicable):  Full-time student  Disabled If disabled, indicate reason: \_\_\_\_\_

**Add** or  **Delete** dependent to/from my current plan for the following products:  Medical  Dental  Basic Life  
 Voluntary Life  Vision

**Change or Select Primary Care Physician** (HMO and POS only):  
 Primary care physician: \_\_\_\_\_ Physician ID: \_\_\_\_\_

**Change or Select DHMO** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):  
 Primary dentist: \_\_\_\_\_ Facility number: \_\_\_\_\_

**3** Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_ Date of birth \_\_/\_\_/\_\_\_\_

Social Security number \_\_\_\_\_ Gender:  Female  Male Relationship:  Spouse  Child  Other: \_\_\_\_\_

Dependent status (if applicable):  Full-time student  Disabled If disabled, indicate reason: \_\_\_\_\_

**Add** or  **Delete** dependent to/from my current plan for the following products:  Medical  Dental  Basic Life  
 Voluntary Life  Vision

**Change or Select Primary Care Physician** (HMO and POS only):  
 Primary care physician: \_\_\_\_\_ Physician ID: \_\_\_\_\_

**Change or Select DHMO** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):  
 Primary dentist: \_\_\_\_\_ Facility number: \_\_\_\_\_

**4** Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_ Date of birth \_\_/\_\_/\_\_\_\_

Social Security number \_\_\_\_\_ Gender:  Female  Male Relationship:  Spouse  Child  Other: \_\_\_\_\_

Dependent status (if applicable):  Full-time student  Disabled If disabled, indicate reason: \_\_\_\_\_

**Add** or  **Delete** dependent to/from my current plan for the following products:  Medical  Dental  Basic Life  
 Voluntary Life  Vision

**Change or Select Primary Care Physician** (HMO and POS only):  
 Primary care physician: \_\_\_\_\_ Physician ID: \_\_\_\_\_

**Change or Select DHMO** (applicable to AL, AZ, CA, FL, GA, IL, IN, KS, KY, MO, NC, OH, TN, TX and WV only):  
 Primary dentist: \_\_\_\_\_ Facility number: \_\_\_\_\_

**Signature** - please sign below if requesting changes

Employee or legal representative signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name and relationship of legal representative: \_\_\_\_\_