

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

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- To your family and friends if you are unavailable to communicate, such as in an emergency
- 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 lifethreatening 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.

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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 privacyoffice@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 Humana by calling us at 1-866-861-2762 anytime.

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. 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

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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.
CHA HMO, Inc.
CarePlus
CarePlus Health Plans, Inc.
CompBenefits
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
CorpHealth
CorpHealth Inc.

CorpHealth Provider Link, Inc.
DentiCare, Inc.
Emphesys Insurance Company
Humana Dental Insurance Company
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 Medical Plan of Utah
Humana Wisconsin Health Organization
Insurance Corporation
Kanawha Insurance Company*
Managed Care Indemnity, 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[®]
Guidance when you need it most

Internal use only
Group number:

Employer Group Application

**ILLINOIS
HUMANA / HUMANADENTAL / COMPBENEFITS**

Please refer to your proposal to complete this application. This document will form part of any contract issued. Print clearly in black ink, and answer all questions or indicate "not applicable."

Your Business Profile

Business name _____ Federal tax ID number _____

Location address (not a P.O. Box) _____

City _____ State _____ Zip code _____ County _____

Do you have more than one location? No Yes

Billing address (if different) _____

City _____ State _____ Zip code _____ County _____

Nature of business or SIC number _____ Date company established _____

Business status: Corporation Partnership Sole Proprietorship Other: (explain) _____

Business phone number _____ Fax number _____

Management contact _____ Administrative contact _____

Management contact e-mail address _____

Management contact: Mother's maiden name _____
This will be used to gain access to the Employer Self-Service Center on www.Humana.com.

General Eligibility

Requested effective date _____ How many employees are on your payroll? _____

How many hours per week must your employees work to be eligible? (select between 20 and 40 hours) _____

Do you want to exclude a class of employees? No Yes
If yes, check class to exclude: (Options vary by plan. Refer to the Underwriting Requirements for each plan.)
 union non union hourly salary management non-management

How long must employees wait after hire date to become eligible? 0 days 30 days 60 days 90 days
 Other, specify: _____

How many employees are eligible for coverage? _____

New employee effective date provision: First of month following waiting period (required for Medical HMO or Prepaid Dental plans)
 Immediately following waiting period
On all plans, the employee termination date coincides with the effective date provision.

Is this employer required to comply with COBRA regulation? No Yes

Is this employer required to comply with state continuation regulation? No Yes

Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? No Yes
If yes, enter information below. Attach a separate sheet if necessary.

Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Date of qualifying event	Date COBRA or State Continuation coverage terminates

Employer Agreement

You the employer, understand, agree and represent:

- You have read this document and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records.
- You have received and reviewed a proposal and the applicable regulatory information required by your state.
- Neither you nor the agent/broker/producer has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company.
- The first month's estimated premium (which may include a monthly administrative fee), and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application before action is taken on this application. Unless we are informed differently, we will perform a one-time electronic check conversion of the first month's premium payment from the account and for the amount designated on the binder check.
- You will collect any employee contribution toward premium. Our acceptance of premium does not guarantee coverage.
- You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met.
- Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage.
- Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage.
- If choosing the HDHP Indexing plan, deductible and out of pocket amounts are established by IRS guidelines. Adjustments to these amounts by the IRS will be made to the policy, without notice, upon renewal of the group.

This document will form part of any contract issued. Coverage is not in effect unless and until you receive written notification from us.

If this application is declined, we will return the premium deposit submitted with this application.

Do not cancel any current group coverage until you receive written notice from us that we have issued coverage.

Dated on: _____
(month, date, year)

By: _____
(employer signature)

Dated at: _____
(city and state)

By: _____
(title)

Agent/Producer Information

1. Agent/Agency of Record (for commissions and correspondence):	2. Agent/Agency of Record (for split-commissions):
Name (print)	Name (print)
Tax ID / Social Security Number / Humana Agent Number	Tax ID / Social Security Number / Humana Agent Number
Commission split: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)	Percentage of sales: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)
1. Writing Agent/Producer:	2. Writing Agent/Producer:
Name (print)	Name (print)
Social Security Number	Social Security Number
Commission split: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)	Percentage of sales: <input type="radio"/> No <input type="radio"/> Yes If yes, percentage: (total should equal 100%)

General Agency

General agency information pertains to Agent/Agency of Record #1 Agent/Agency of Record #2

Name (print)

Tax ID / Humana Agent Number

Address

City

State

Zip code

As the Writing Agent/Producer, I acknowledge that I am responsible to meet with the employer submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the employer in the Regulatory Pre-enrollment Disclosure or other plan literature.

Writing Agent's Signature: _____ Date: _____

The following applies to all companies and products

The companies listed on this Employer Group Application, severally or collectively as the context may require, are referred to in this application as we, us and our.

You, the participating employer, policyholder, contractholder, or group plan sponsor, intend to establish, sponsor, and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

Small employer means a person, firm, corporation, partnership or association actively engaged in business, which employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year, unless otherwise provided under the state law. Entities that are affiliated companies or that are eligible to file a combined tax return for the purpose of taxation, are considered one employer.

You agree to make available your records which we determine are relevant to this application and group coverage for inspection by the Trustee, Administrator, us or our representative during your normal business hours.

As claims administrator with authority to make claim determinations as described in Section 503 of ERISA, we may make decisions under the Policy or Group Plan with respect to determining eligibility for coverage and paying claims for benefits, including deciding appeals of denied claims.

You understand and agree that failure to remit and pay premium when due will be considered a default in premium payment, and that coverage will be terminated by us, following a grace period of 31 days from the date of non-payment of premium. We may terminate your coverage according to the termination section of the Policy or Group Plan. Except for non-payment of

premium or when a group or individual is not or has not been eligible for coverage, you will be provided with a 30 day advance written notice, unless a greater period is expressly specified in the Policy. If coverage is terminated by us for non-payment of premium, you will still owe and we will collect all due premium including premium for the grace period.

You understand and agree that your coverage is renewed on a monthly basis subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law, after your insurance has been in effect under the Policy for six consecutive months. You will receive advance written notice.

For you to remain eligible for the Policy or Group Plan, the eligibility, underwriting and participation requirements must be maintained, for each respective coverage. Failure to maintain the plan eligibility, underwriting and participation requirements will terminate your coverage under the Policy or Group Plan. Other termination provisions are stated in the Policy or Group Plan. Based upon our standard underwriting practice, we may require an employee or dependent to submit Evidence of Health Status. We have the right to use the information provided by you and any applicant (employee or dependent) to determine whether coverage will be provided, to determine eligibility and to establish appropriate premiums. Any health related information that has been provided will not be used to decline medical coverage unless permitted by law.

The following applies to medical products insured by Humana Insurance Company

You, the participating employer, apply to participate in the Employers Health Insurance Benefits Trust (No. 1 and/or No. 3) for insurance coverage, which may be modified from time to time, as underwritten by us.

If you are accepted, you acknowledge and agree on behalf of all persons who obtain insurance coverage through or under your application to the Trust, that the Trust Agreement, the provisions of the Trust, or any other written instrument the trustee signs on behalf of the Trust are fully binding upon you. The principal duties of the trustee are to hold the insurance policy(ies) through which insurance coverage is provided for employers in accordance with the terms of

the Trust Agreement or any other written instrument which the trustee signs on behalf of the Trust.

The Trust Agreement, any other written instrument and the insurance policy(ies), are available for inspection by you or by any covered person through or under your participation in the Trust, during normal business hours at our home office. You further understand and agree that the Trust and Trustee are not insurers. You may withdraw from the Trust at any time subject to certain premium obligations described in the Employer Agreement section, thus terminating your insurance coverage, provided written notice of termination is received by us prior to the requested termination date.

HUMANA[®]
Guidance when you need it most

HMO plans offered by Humana Health Plan, Inc. PPO, Classic medical plans, Life and Short-Term Income Protection plans insured or administered by Humana Insurance Company.

HUMANA[®]
Specialty Benefits

Dental PPO and Traditional Preferred plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Dental prepaid plans and AdvantagePlus dental plans offered and administered by CompBenefits Dental, Inc. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

Please refer to your proposal to complete this application. This document will form part of any contract issued. Print clearly in black ink, and answer all questions or indicate "not applicable."

Plan Selection

Is this a SmartSuite selection? No Yes

	Plan 1	Plan 2
Plan Name (as shown on your proposal)		
Coinsurance:	Participating (In) : % ____/____/____ Non-participating (Out): % ____/____/____	Participating (In) : % ____/____/____ Non-participating (Out): % ____/____/____
Deductible:	Participating (In): \$ Non-participating (Out): \$	Participating (In): \$ Non-participating (Out): \$
Annual Maximum:	\$	\$
Preventive Services Deductible Options:	<input type="radio"/> Apply Deductible <input type="radio"/> Waive Deductible	<input type="radio"/> Apply Deductible <input type="radio"/> Waive Deductible
Periodontic/Endodontic Options:	<input type="radio"/> Basic <input type="radio"/> Major	<input type="radio"/> Basic <input type="radio"/> Major
Orthodontia Options:	<input type="radio"/> Child Only: Lifetime Orthodontia Maximum \$ _____ <input type="radio"/> Adult And Child: Lifetime Orthodontia Maximum \$ _____	
Composite Fillings for Molars:	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Implant Coverage:	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Out of network reimbursement options:	<input type="radio"/> Maximum allowable fee <input type="radio"/> In-network fee schedule	
Open Enrollment:	<input type="radio"/> No <input type="radio"/> Yes	

Underwriting Requirements

- Underwriting approval is required to offer more than one dental carrier to your employees.
- Dental coverage is available to employers with two or more enrolled employees.
- If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists.
- Minimum employer contribution toward employee premium is 25%. This minimum does not apply to Voluntary coverage.
- Retiree coverage is available to employers with 26 or more enrolled employees.
- Minimum age for retiree coverage is 65 for employers with 26 to 50 enrolled employees and must be at least 50 for 51+ enrolled employees.
- Excluded class options: hourly, salary, union, non-union, management, non-management.
- If you do not maintain eligibility, underwriting, and participation requirements, we will terminate your coverage.

Participation requirements:

Eligible Employees	Participation
2+ (Employer Pays 100% of Premium)	100%
2+ (Employees Contribute to Premium)	75%
2+ Eligible Employees with Spousal Waiver	50%

Voluntary Participation Requirements:

Eligible Employees	Participation
Traditional Preferred, PPO, Preventive Plus	
2+ Employees	Two enrolled employees or 25% whichever is greater.
Advantage Plus	
10+ Employees	Ten enrolled employees or 25% whichever is greater
Prepaid	
2+ Employees	Two or more enrolled employees
Prepaid with orthodontia coverage	
10 + employees	Ten or more employees

Group Information

How much will you contribute to premium? Employee _____% Dependent _____%

Are you offering dental coverage to retirees? No Yes If yes, required age: _____ Minimum years of service: _____

Did you have prior group dental coverage? No Yes
If yes, submit most recent carrier billing with effective and termination dates.

Did your prior dental coverage include orthodontia? No Yes

Will your employees have access to another carrier's dental coverage by virtue of their employment with you? No Yes
If yes, name of carrier: _____