2022

Annual Notice of Changes

HumanaChoice
R7315-001 (Regional PPO)

Region 10
States of Alabama and Tennessee

Humana®

Thank you for being a Humana member

We believe the simplest way to help you feel your best is to do what's right by you. That means going above and beyond what you may expect. We call this human care, and it's one of the reasons millions* of people have chosen Humana for their Medicare plan.

We hope you would like to keep your current Humana plan. If so, you don't need to do anything; it will automatically renew on January 1, 2022.

Plan for the 2022 Medicare Annual Election Period

- **See how your plan is changed.** Review this Annual Notice of Changes (ANOC) document for upcoming changes to your HumanaChoice R7315-001 (Regional PPO) in 2022. These could mean differences in medical coverage and costs like premium, copays, deductibles and coinsurance.

- **Know that this document doesn't include all your benefits.** The ANOC highlights plan changes but does not include a full list of your plan benefits. Starting October 15, see your 2022 Evidence of Coverage (EOC) at **Humana.com/PlanDocuments** for a complete listing. See the back panel of this document for more instructions.

- **Keep your current Humana member ID card.** Humana does not issue new ID cards each plan year for members choosing to remain on their current Humana Medicare plan. You will only receive a new ID card if some plan information is different, like your copay, the card's information changes, or you select a different plan for 2022.

*Source for the size of our membership population: 2020 Humana Inc. Annual Report 2/11/2021

HumanaChoice R7315-001 (Regional PPO) offered by Humana Insurance Company

Annual Notice of Changes for 2022

You are currently enrolled as a member of HumanaChoice R7315-001 (Regional PPO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1 and 2 for information about benefit and cost changes for our plan.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

OMB Approval 0938-1051 (Expires: February 29, 2024)

- If you don't join another plan by December 7, 2021, you will be enrolled in HumanaChoice R7315-001 (Regional PPO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2021**
   - If you don't join another plan by **December 7, 2021**, you will be enrolled in HumanaChoice R7315-001 (Regional PPO).
   - If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Care number at 1-800-457-4708 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m. seven days a week from October 1 – March 31 and 8 a.m. to 8 p.m. Monday-Friday from April 1 - September 30.
- This information is available in different formats, including braille, large print, and audio. Please call Customer Care at the number listed above if you need plan information in another format.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About HumanaChoice R7315-001 (Regional PPO)

- HumanaChoice R7315-001 (Regional PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Humana Insurance Company. When it says "plan" or "our plan," it means HumanaChoice R7315-001 (Regional PPO).
- Out-of-network/non-contracted providers are under no obligation to treat HumanaChoice R7315-001 (Regional PPO) members, except in emergency situations. Please call our Customer Care number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

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Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for HumanaChoice R7315-001 (Regional PPO) in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at **Humana.com/PlanDocuments**. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)		2022 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly plan premium (See Section 1.1 for details.)	**$0**		**$0**	
Deductible	**$250** combined in-network and out-of-network	**$250** combined in-network and out-of-network	**$250** combined in-network and out-of-network	**$250** combined in-network and out-of-network
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: **$3,400**	From network and out-of-network providers combined: **$5,100**	From network providers: **$3,400**	From network and out-of-network providers combined: **$5,100**
Doctor office visits	Primary care visits: **$10** copayment per visit Specialist visits: **$30** copayment per visit	Primary care visits: **30%** of the total cost per visit Specialist visits: **30%** of the total cost per visit	Primary care visits: **$10** copayment per visit Specialist visits: **$30** copayment per visit	Primary care visits: **30%** of the total cost per visit Specialist visits: **30%** of the total cost per visit

Cost	2021 (this year)		2022 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**$550** copayment per stay	**30%** of the total cost	**$550** copayment per stay	**30%** of the total cost

Annual Notice of Changes for 2022
Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 - Changes to the Monthly Premium

Cost	**2021** (this year)	**2022** (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	**$0** Your plan will reduce your monthly Medicare Part B premium by up to **$9**.	**$0** Your plan will reduce your monthly Medicare Part B premium by up to **$6**.

Section 1.2 - Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	**2021** (this year)		**2022** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from network providers count toward your in-network maximum out-of-pocket amount. **Combined maximum out-of-pocket amount** Your costs for covered medical services (such as copays and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	**$3,400**	**$5,100** combined in-network and out-of-network	**$3,400** Once you have paid **$3,400** out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.	**$5,100** combined in-network and out-of-network Once you have paid **$5,100** out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 - Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at **Humana.com/PlanDocuments**. You may also call Customer Care for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 - Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart* (*what is covered and what you pay*), in your *2022 Evidence of Coverage*.

Services received at Rural Health Clinics, Federally Qualified Health Clinics, and Critical Access Hospitals may be subject to the Primary Care Physician or Specialist copay or coinsurance, as applicable, for 2022.

Opioid treatment program services
Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:
- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	**2021** (this year)		**2022** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Acupuncture for chronic low back pain	**$30** copayment 12 visits for members with chronic low back pain with authorization, up to a maximum of 20 visits with additional authorization.	**30%** of the total cost 12 visits for members with chronic low back pain with authorization, up to a maximum of 20 visits with additional authorization. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.	**$30** copayment 20 visits for members with chronic low back pain with authorization.	**30%** of the total cost 20 visits for members with chronic low back pain with authorization. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Health essentials kit	Covered	Not Covered	Not Covered	Not Covered
Hearing services • Supplemental hearing benefits:	**HER944** **$0** copayment for fitting, routine hearing exams up to 1 per year. **$0** copayment for adjustments up to 2 per year. **$399** copayment for Advanced level hearing aid up to 1 per ear per year. **$699** copayment for Premium level hearing aid up to 1 per ear per year. Note: Includes 48 batteries per aid and 3 year warranty. Fitting and adjustments are covered for 1 year after TruHearing hearing aid purchase.	**HER944** **$0** copayment for fitting, routine hearing exams up to 1 per year. **$0** copayment for adjustments up to 2 per year. **$399** copayment for Advanced level hearing aid up to 1 per ear per year. **$699** copayment for Premium level hearing aid up to 1 per ear per year. Note: Includes 48 batteries per aid and 3 year warranty. Fitting and adjustments are covered for 1 year after TruHearing hearing aid purchase.	**HER944** **$0** copayment for routine hearing exams up to 1 per year. **$0** copayment for follow-up provider visits up to unlimited per year. **$399** copayment for each Advanced level hearing aid up to 1 per ear per year. **$699** copayment for each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty. Unlimited follow-up provider visits during first year following	**HER944** **$0** copayment for routine hearing exams up to 1 per year. **$0** copayment for follow-up provider visits up to unlimited per year. **$399** copayment for each Advanced level hearing aid up to 1 per ear per year. **$699** copayment for each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty. Unlimited follow-up provider visits during first year following

Cost	2021 (this year)		2022 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
		TruHearing provider must be used for in and out-of-network hearing aid benefit. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.	TruHearing hearing aid purchase.	TruHearing hearing aid purchase. TruHearing provider must be used for in and out-of-network hearing aid benefit. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

SECTION 2 Administrative Changes

Cost	2021 (this year)	2022 (next year)
Medical vision benefits Medicare-covered eye refractions during a specialist medical visit For additional details please refer to the *Evidence of Coverage*	Refractions not covered	Refractions not covered
Routine vision benefits Eye refractions through Mandatory Supplemental vision benefits *NOTE: Eye refractions **will not** be covered if billed separate from a routine vision exam	Routine vision includes an eye exam with refraction	Refraction is only covered when billed as part of the routine exam*

SECTION 3 Deciding Which Plan to Choose

Section 3.1 - If you want to stay in HumanaChoice R7315-001 (Regional PPO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our plan for HumanaChoice R7315-001 (Regional PPO).

Section 3.2 - If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, there may be a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from HumanaChoice R7315-001 (Regional PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from HumanaChoice R7315-001 (Regional PPO).
- To **change to Original Medicare without a prescription drug plan,** you must either:
  - Send us a written request to disenroll. Contact Customer Care if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2022.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 8, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

A State Health Insurance Assistance Program (SHIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. State Health Insurance Assistance Program (SHIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call your State Health Insurance Assistance Program at the number listed in "Exhibit A" in the back of this booklet.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).
- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance from your state ADAP program. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.
- If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. The name and phone numbers for the ADAP program are in "Exhibit A" in the back of this booklet. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP program (the name and phone numbers for this organization are in "Exhibit A" in the back of this booklet).

SECTION 7 Questions?

Section 7.1 - Getting Help from HumanaChoice R7315-001 (Regional PPO)

Questions? We're here to help. Please call Customer Care at 1-800-457-4708. (TTY only, call 711.) We are available for phone calls from 8 a.m. to 8 p.m. seven days a week from Oct. 1 – Mar. 31 and 8 a.m. to 8 p.m. Monday-Friday from Apr. 1 - Sept. 30. Calls to these numbers are free.

Read your 2022 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage* for HumanaChoice R7315-001 (Regional PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at **Humana.com/PlanDocuments**. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at **Humana.com/PlanDocuments**. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*).

Section 7.2 - Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare.)

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Exhibit A- State Agency Contact Information

This section provides the contact information for the state agencies referenced in this Annual Notice of Changes. If you have trouble locating the information you seek, please contact Customer Care at the phone number on the back cover of this booklet.

Alabama	
SHIP Name and Contact Information	Alabama Department of Senior Services 201 Monroe Street Suite 350 Montgomery,AL 36104 1-877-425-2243 (toll free) 1-334-242-5594 (fax) http://www.alabamaageline.gov/
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd. Suite 900 Tampa,FL 33609 1-888-317-0751 711 (TTY) 1-844-878-7921 (Fax) https://www.keproqio.com/
State Medicaid Office	Alabama Medicaid Agency 501 Dexter Avenue P.O Box 5624 Montgomery,AL 36103-5624 1-800-362-1504 (toll free) 1-334-242-5000 (local) http://www.medicaid.alabama.gov/
AIDS Drug Assistance Program	Alabama AIDS Drug Assistance Program, HIV/AIDS Division, Alabama Department of Public Health, The RSA Tower 201 Monroe Street Suite 1400 Montgomery,AL 36104 1-866-574-9964 1-334-206-6221 (fax) http://www.alabamapublichealth.gov/hiv/adap.html

Tennessee	
SHIP Name and Contact Information	Tennessee Commisssion on Aging & Disability -TN SHIP 502 Deaderick St 9th Floor Nashville,TN 37243-0860 1-877-801-0044 (toll free) 1-615-741-2056 (local) 1-800 848-0299 (toll free TDD) http://tnmedicarehelp.com/%20or%20http:/www.tn.gov/aging/
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd. Suite 900 Tampa,FL 33609 1-888-317-0751 711 (TTY) 1-844-878-7921 (Fax)
State Medicaid Office	TennCare (Medicaid) 310 Great Circle Road Nashville,TN 37243 1-800-342-3145 (toll free) 1-877-779-3103 (toll free TTY) 1-855-259-0701 (Spanish) 1-615-532-7322 (fax) http://www.tn.gov/tenncare/
AIDS Drug Assistance Program	Tennessee HIV Drug Assistance Program (HDAP) TN Department of Health, HIV/STD Program 710 James Robertson Parkway, 4th Floor, Andrew Johnson Tower Nashville,TN 37243 1-615-741-7500 1-800-525-2437 (toll free) http://tn.gov/health

Notice of Privacy Practices for your personal health 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.

We may change our privacy practices and the terms of this notice at any time, as allowed by law. Including 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 includes both medical information and personal information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information. This includes information created or received by a healthcare provider or health plan. The information relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

How do we protect your information?
We have a responsibility to protect the privacy of your information in all formats including electronic, written and oral 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 employees about our privacy program and procedures

How do we use and disclose your information?
We 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

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, coordinating your care, improving quality, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform, plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission or your plan sponsor has to certify they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you. If you have opted out as described below, we will not contact you.
- To your family and friends if you are unavailable to communicate, such as in an emergency
- To your family and friends or any other person you identify. This applies if the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation

- To public health agencies, if we believe that 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 help with disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill our 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 we use your information for purposes not described in this notice?
We will not use or disclose your information for any reason that is not described in this notice, without your written permission. You may cancel your permission at any time by notifying us in writing. The following uses and disclosures will require your written permission:
- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of personal and health information

What do we do with your information when you are no longer a member?
Your information may continue to be used for purposes described in this notice. This includes when you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?
We are committed to responding to your rights request in a timely manner
- Access - You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. If you request copies, we may charge you a fee for the labor for copying, supplies for creating the copy (paper or electronic) and postage.
- Adverse Underwriting Decision - If we decline your application for insurance, you have the right to be provided a reason for the denial.
- Alternate Communications - To avoid a life- threatening situation, you have the right to receive your information in a different manner or at a different place. 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 that 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. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- Notice - You have the right to request and receive a written copy of this notice any time.
- Restriction - You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.

What types of communications can I opt out of that are made to me?
- Appointment reminders
- Treatment alternatives or other health-related benefits or services
- Fundraising activities

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 forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- Send completed request form to:
  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

* This right applies only to our Massachusetts residents in accordance with state regulations.

If I believe that my privacy has been violated, what should I do?
If you believe that your privacy has been violated you may file a complaint with us 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 for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also e-mail your complaint to OCRComplaint@hhs.gov. If you elect to file a complaint, your benefits will not be affected and we will not punish or retaliate against you in any way.

We support your right to protect the privacy of your personal and health information.

We follow 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, we follow the law, rule, or regulation which provides greater protection.

We are required by law to abide by the terms of this notice currently in effect.

What will happen if my information is used or disclosed inappropriately?
We are required by law to provide individuals with notice of our legal duties and privacy practices regarding personal and health information. If a breach of unsecured personal and health information occurs, we will notify you in a timely manner.

The following affiliates and subsidiaries also adhere to our privacy program and procedures:

Arcadian Health Plan, Inc.
CarePlus Health Plans, Inc.
Cariten Health Plan, Inc.
CHA HMO, Inc.
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
DentiCare, Inc.
Emphesys Insurance Company
HumanaDental Insurance Company
Humana Benefit Plan of Illinois, Inc.
Humana Benefit Plan of South Carolina, Inc.
Humana Benefit Plan of Texas, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Company of New York, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of California, 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 Medical Plan of Michigan, Inc.
Humana Medical Plan of Pennsylvania, Inc.
Humana Medical Plan of Utah, Inc.
Humana Regional Health Plan, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Go365 by Humana for Healthy Horizons
Managed Care Indemnity, Inc.
The Dental Concern, Inc.

Effective 9/2013

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę nika'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

The information you need is just a click away

These member documents give you more information about your plan coverage:

- Evidence of Coverage: Details about your overall plan, including benefits and costs
- Provider Directory: List of providers in your plan's network

Starting October 15, 2021, you can view and search these 2022 plan documents at **Humana.com/PlanDocuments**. Here, you can see the most up-to-date information about your plan. It's easy to search, so you can find the information you are looking for quickly.

We're here for you. If you need help using these online tools, please call the number on the back of your Humana member ID card for support.

To get paper copies of these documents by mail, submit your request online at the website above, or call our automated system at **800-457-4708 (TTY: 711)**, 24 hours a day, seven days a week. Please have your Humana member ID card ready when you call. When asked for the reason you've called, say "Evidence of Coverage" and/or "Provider Directory." Please allow up to two weeks to receive the documents by mail.

Humana Inc.
PO Box 14168
Lexington, KY 40512-4168

R7315001000ANOC22

Important information about changes to your Medicare Advantage health plan

Look inside

Here's a summary of your **HumanaChoice R7315-001 (Regional PPO)** that takes effect on January 1, 2022.

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Humana.com
1-800-457-4708 (TTY: 711)