Humana Healthy Horizons in Florida Member Handbook 2025

Humana
Healthy Horizons®
in Florida

Effective date: February 1, 2025

“If you do not speak English, call us at 800-477-6931 (TTY: 711). We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can talk with you in your language.”

Spanish: Si usted no habla inglés, llámenos al 800-477-6931 (TTY: 711). Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

French: **Si vous ne parlez pas anglais,** appelez-nous au 800-477-6931 (ATS: 711). Nous avons accès à des services d’interprétariat pour vous aider à répondre aux questions dans votre langue. Nous pouvons également vous aider à trouver un prestataire de soins de santé qui peut communiquer avec vous dans votre langue.

Haitian Creole**: Si ou pa pale lang Anglè,** rele nou nan 800-477-6931 (TTY: 711). Nou ka jwenn sèvis entèprèt pou ou, epitou nou kapab ede reponn kesyon ou yo nan lang ou pale a. Nou kapab ede ou jwenn yon pwofesyonèl swen sante ki kapab kominike avèk ou nan lang ou pale a.”

Italian: **“Se non parli inglese** chiamaci al 800-477-6931 (TTY: 711). Disponiamo di servizi di interpretariato e siamo in grado di rispondere alle tue domande nella tua lingua. Possiamo anche aiutarti a trovare un fornitore di servizi sanitari che parli la tua lingua.”

Russian: **«Если вы не разговариваете по-английски,** позвоните нам по номеру 800-477-6931 (TTY: 711). У нас есть возможность воспользоваться услугами переводчика, и мы поможем вам получить ответы на вопросы на вашем родном языке. Кроме того, мы можем оказать вам помощь в поиске поставщика медицинских услуг, который может общаться с вами на вашем родном языке».

Vietnamese: **“Nếu bạn không nói được tiếng Anh,** hãy gọi cho chúng tôi theo số 800-477-6931 (TTY: 711). Chúng tôi có quyền truy cập vào các dịch vụ thông dịch viên và có thể giúp trả lời các câu hỏi của bạn bằng ngôn ngữ của bạn. Chúng tôi cũng có thể giúp bạn tìm một nhà cung cấp dịch vụ chăm sóc sức khỏe có thể nói chuyện với bạn bằng ngôn ngữ của bạn.”

Humana Healthy Horizons in Florida is a Medicaid product of Humana Medical Plan, Inc.

Important Contact Information

Member Services Help Line	800-477-6931	Available 24 hours
Member Services Help Line TTY	TTY: 711	Available 24 hours
Website	www.Humana.com/FLMedicaid	
Address	3501 SW 160 AVE Miramar, FL 33027	

Transportation Services: Non-Emergency	ModivCare 866-779-0565
Humana LTC Member Services	888-998-7732
Humana Clinical Case Management	800-393-8858
Behavioral Health	888-778-4651
Dental	Contact your case manager directly or at 800-477-6931 for help with arranging these services.
Over the counter (OTC) Program	CenterWell Pharmacy™ 800-526-1490
Hearing	Hear USA 877-664-9353
Vision	**Statewide Optometry/Routine Vision** iCare Health Solutions 855-373-7627 https://MyiCarehealth.com/ To find an ophthalmology provider, call Humana Customer Care at 800-477-6931 (TTY: 711), Monday – Friday, 8 a.m. – 8 p.m., Eastern time or visit Humana.com/FloridaDocuments to view the provider directory for your area.
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	800-96-ABUSE (800-962-2873) TTY: 711 or 800-955-8771 https://www.myflfamilies.com/services/abuse/abuse-hotline/how-report-abuse
For Medicaid Eligibility	866-762-2237 TTY: 711 or 800-955-8771 https://www.myflfamilies.com/medicaid#ME
To report Medicaid Fraud and/or Abuse.	888-419-3456 https://apps.ahca.myflorida.com/mpi-complaintform/
To file a complaint about a health care facility	888-419-3450 http://ahca.myflorida.com/MCHQ/Field_Ops/CAU. shtml

To request a Medicaid Fair Hearing	877-254-1055 239-338-2642 (fax) MedicaidHearingUnit@ahca.myflorida.com
To file a complaint about Medicaid services	877-254-1055 TDD: 866-467-4970 http://ahca.myflorida.com/Medicaid/complaints/
To find information for elders	800-96-ELDER (800-963-5337) http://www.elderaffairs.org/doea/arc.php
To find out information about domestic violence	800-799-SAFE (1-800-799-7233) TTY: 800-787-3224 http://www.thehotline.org/
To find information about health facilities in Florida	https://quality.healthfinder.fl.gov/
To find information about urgent care	You may talk to a nurse, 24 hours a day, by calling Member Services at 800-477-6931 (TTY: 711)
For an emergency	9-1-1 Or go to the nearest emergency room
Nurse Advice Line	You may talk to a nurse, 24 hours a day, by calling Member Services at 800-477-6931 (TTY: 711)

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Welcome to Humana Healthy Horizons Statewide Medicaid Managed Care Plan

Humana Healthy Horizons has a contract with the Florida Agency for Health Care Administration (Agency) to provide health care services to people with Medicaid. This is called the **Statewide Medicaid Managed Care (SMMC) Program**. You are enrolled in our SMMC plan. This means we will offer you Medicaid services. We work with a group of health care providers to help meet your needs.

There are many types of Medicaid services you can receive in the SMMC program. You can receive medical services, like doctor visits, labs, and emergency care, from a **Managed Medical Assistance (MMA)** plan. If you are an elder or adult with disabilities, you can receive nursing facility and home and community-based services in a **Long-Term Care (LTC)** plan. If you have a certain health condition, like AIDS, you can receive care that is designed to meet your needs in a **Specialty** plan.

If your child is enrolled in the Florida KidCare **MediKids** program, most of the information in this handbook applies to you. We will let you know if something does not apply.

This handbook will be your guide for all health care services available to you. You can ask us any questions or get help making appointments. If you need to speak with us, just call us at 800-477-6931 (TTY: 711).

Section 1: Your Plan Identification Card (ID card)

You should have received your ID card in the mail. Call us if you have not received your card or if the information on your card is wrong. Each member of your family in our plan should have their own ID card.

Always carry your ID card and show it each time you go to a health care appointment or the hospital. Never give your ID card to anyone else to use. If your card is lost or stolen, call us so we can give you a new card.

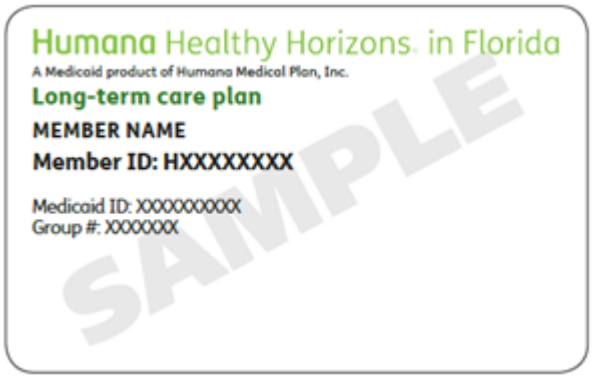
Your ID card will look like this:

If you are enrolled in the Humana Healthy Horizons **Medical Plan**.

Your core benefits can be found in the Medical Core Benefits section within this handbook. Your additional benefits can be found in the Expanded Benefits section of this Handbook.

Your ID card will look like this:

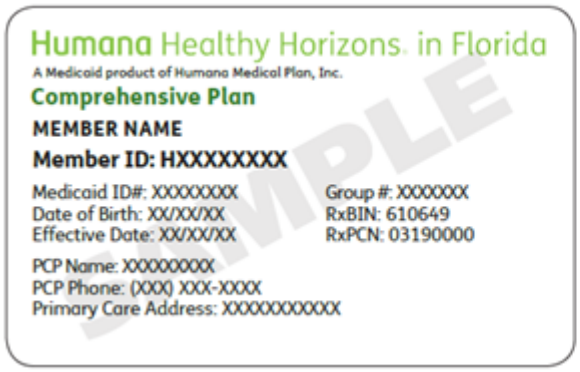
If you are enrolled in the Humana Healthy Horizons **Long-Term Care Plan**.



Your core benefits can be found in the Long-Term Care Core Benefits section within this handbook. Your additional benefits can be found in the LTC Expanded Benefits section within this handbook.

Your ID card will look like this:

If you are enrolled in both a **Humana Medical and Long-Term Care Plan**.



Your core medical benefits can be found in the Medical Core Benefits section within this handbook. Your additional medical benefits can be found in the Expanded Benefits section within this handbook. Your Long-Term Care core benefits can be found in the Long-Term Care Core Benefits section within this handbook. Your additional Long-Term Care benefits can be found in the LTC Expanded Benefits section within this handbook.

Your ID card will look like this:

If you are enrolled in both a **Humana Medical and Specialty Plan**.

Your core benefits can be found in the Medical Core Benefits section within this Handbook. Your additional benefits can be found in the Expanded Benefits section within this handbook.

Your ID card will look like this:

If you are enrolled in both a **Humana Medical & Long-Term Care Plan & SMI or HIV**.

Your core benefits can be found in the Medical Core Benefits section within this handbook. Your additional medical benefits can be found in the Expanded Benefits section within this handbook. Your Long-Term Care benefits can be found in the Long-Term Care Benefits section within this handbook and your additional Long-Term Care benefits can be found in the LTC Expanded Benefits section of this handbook. If you are enrolled in the Specialty plan or in a HIV/AIDS Specialty plan, your additional benefits can be found in the Expanded Benefits section within this handbook.

Section 2: Your Privacy

Your privacy is important to us. You have rights when it comes to protecting your health information, such as your name, Plan identification number, race, ethnicity, language, gender, sexual orientation, and other things that identify you. We will not share any health information about you that is not allowed by law.

If you have any questions, call Member Services. Our privacy policies and protections are:

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. We protect this information in all formats including electronic, written, and oral information.

How do we protect your information?

In keeping with federal and state laws and our own policy, we have 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 do we use and disclose your 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. 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 such as to allow your plan sponsor to obtain bids from other health plans. We will not share detailed health information to your plan sponsor unless you provide us your permission, or your plan sponsor has certified they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you if you have not opted out as described below

- 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, provided 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 whether 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 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 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?

In all situations other than described in this notice, we 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. The following uses and disclosures will require an authorization:

- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of protected health information

What do we do with your information when you are no longer a member, or you do not obtain coverage through us?

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 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?

The following are your rights with respect to your 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, 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. We maintain this information and make it available to you for a period of six years at your request. 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.

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 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 866-861-2762 at any time
- Accessing our website at Humana.com and going to the bottom of the webpage to the Privacy Practices link
- E-mailing us at privacyoffice@humana.com

Send completed request form to:

Humana Inc.

Privacy Office 003/10911

101 E. Main Street

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 us by calling us at: 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. 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.

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 member protection.

What will happen if my private information is used or disclosed inappropriately?

You have a right to receive a notice that a breach has resulted in your unsecured private information being inappropriately used or disclosed. We will notify you in a timely manner if such a breach occurs.

Section 3: Getting Help from Our Member Services

Our Member Services Department can answer all your questions. We can help you choose or change your Primary Care Provider (PCP for short), find out if a service is covered, get referrals, find a provider, replace a lost ID card, report the birth of a new baby, and explain any changes that might affect you or your family's benefits.

Contacting Member Services

You may call us at 800-477-6931, or TTY:711, Monday to Friday, 8 a.m. to 8 p.m., but not on State approved holidays (like Christmas Day and Thanksgiving Day). When you call, make sure you have your identification card (ID card) with you so we can help you. (If you lose your ID card, or if it is stolen, call Member Services.)

Contacting Member Services after Hours

If you call when we are closed, please leave a message. We will call you back the next business day. If you have an urgent question, you may call our 24-Hour-Nurse Advice Line at 800-477-6931 (TTY: 711). Our nurses are available to help you 24 hours a day, 7 days a week.

Our Website

To get detailed information about your specific plan, please log in to your MyHumana account. If this is your first time, please download the MyHumana app or visit MyHumana.com online to activate your account. MyHumana is your secure online portal where you can change your doctor, view claims and plan details, and update your account information with us.

Section 4: Do You Need Help Communicating?

If you do not speak English, we can help. We have people who help us talk to you in your language. We provide this help for free.

For people with disabilities: If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a provider's office is wheelchair accessible or has devices for communication. Also, we have services like:

- Telecommunications Relay Service. This helps people who have trouble hearing or talking to make phone calls. Call 711 and give them our Member Services phone number. It is 800-477-6931. They will connect you to us
- Information and materials in large print, audio (sound); and braille
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability

All of these services are provided free to you.

Section 5: When Your Information Changes

If any of your personal information changes, let us know as soon as possible. You can do so by calling Member Services. We need to be able to reach you about your health care needs.

The Department of Children and Families (DCF) needs to know when your name, address, county, or telephone number changes as well. Call DCF toll free at 866-762-2237 (TTY 800-955-8771) Monday through Friday from 8 a.m. to 5:30 p.m. You can also go online and make the changes in your Automated Community Connection to Economic Self Sufficiency (MyACCESS) account at https://myaccess.myflfamilies.com/. If you receive Supplemental Security Income (SSI), you must also contact the Social Security Administration (SSA) to report changes. Call SSA toll free at 800-772-1213 (TTY 800-325- 0778), Monday through Friday from 8 a.m. to 7 p.m. You may also contact your local Social Security office or go online and make changes in your Social Security account at https://secure.ssa.gov/RIL/SiView.do.

Section 6: Changes to your Health Plan

If your health plan experiences a significant change that affects you as an enrollee, it is the plan's responsibility to inform you (the enrollee) at least 30 days before the intended effective date of the change.

Section 7: Your Medicaid Eligibility

You must be covered by Medicaid and enrolled in our plan for Humana Healthy Horizons to pay for your health care services and health care appointments. This is called having **Medicaid eligibility**. If you receive SSI, you qualify for Medicaid. If you do not receive SSI, you must apply for Medicaid with DCF.

Sometimes things in your life might change, and these changes can affect whether you can still have Medicaid. It is very important to make sure that you have Medicaid before you go to any appointments. Just because you have a Plan ID Card does not mean you still have Medicaid. Do not worry! If you think your Medicaid has changed or if you have any questions about your Medicaid, call Member Services. We can help you check on your coverage.

If you Lose your Medicaid Eligibility

If you lose your Medicaid and get it back within 180 days, you will be enrolled back into our plan.

If you have Medicare

If you have Medicare, continue to use your Medicare ID card when you need medical services (like going to the doctor or the hospital), but also give the provider your Medicaid Plan ID card too.

If you are having a baby

If you have a baby, he or she will be covered by us on the date of birth. Call Member Services to let us know that your baby has arrived, and we will help make sure your baby is covered and has Medicaid right away. It is helpful if you let us know you are pregnant before your baby is born to make sure your baby has Medicaid. Call DCF toll free at 866-762-2237 while you are pregnant. If you need help talking to DCF, call us. DCF will make sure, your baby has Medicaid from the day he or she is born. They will give you a Medicaid number for your baby. Let us know the baby's Medicaid number when you get it.

Section 8: Enrollment in Our Plan

Initial Enrollment

When you first join our plan, you have 120 days to try our plan. If you do not like it for any reason, you can enroll in another SMMC plan in the same region. Once those 120 days are over, you are enrolled in our plan for the rest of the year. This is called being **locked-in** to a plan. Every year you have Medicaid and are in the SMMC program, you will have an open enrollment period.

Open Enrollment Period

Each year, you will have 60 days when you can change your plan if you want. This is called your open enrollment period. The State's Enrollment Broker will send you a letter to tell you when your open enrollment period is.

You do not have to change plans during your open enrollment period. If you do choose to leave our plan and enroll in a new one, you will start with your new plan at the end of your **open enrollment period**. Once you are enrolled in the new plan, you are locked-in until your next open enrollment period. You can call the Enrollment Broker at 877-711- 3662 (TDD 866-467-4970).

Enrollment in the SMMC Long-Term Care Program

The SMMC Long-Term Care (LTC) program provides nursing facility services and home and community-based care to elders and adults (ages 18 years and older) with disabilities. Home and community-based services help people stay in their homes, with services like help with bathing, dressing, and eating; help with chores; help with shopping; or supervision.

We pay for services that are provided at the nursing facility. If you live in a Medicaid nursing facility full-time, you are probably already in the LTC program. If you don't know, or don't think you are enrolled in the LTC program, call Member Services. We can help you.

The LTC program also provides help for people living in their home. But space is limited for these in-home services, so before you can receive these services, you have to speak to someone who will ask you questions about your health. This is called a screening. The Department of Elder Affairs' Aging and Disability Resource Centers (ADRCs) complete these screenings. Once the screening is complete, the ADRC will notify you about your wait list placement or provide you with a list of resources if you are not placed on the wait list. If you are placed on the wait list and a space becomes available for you in the LTC program, the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program will ask you to provide more information about yourself to make sure you meet other medical criteria to receive services from the LTC program. Some enrollees do not have to complete the screening or wait list process if they meet all other LTC program eligibility requirements. For more information on Screening Exceptions in the LTC Program, visit the Agency's web page at https://ahca.myflorida.com/Medicaid/statewide_mc/ltc_scrn.shtml. For example:

1. Are you 18, 19, or 20 years old?

2. Do you have a chronic debilitating disease or condition of one or more physiological or organ systems?

3. Do you need 24-hour-per-day medical, nursing, or health supervision or intervention?

If you said "yes" to all three questions, you may contact Humana to request an assessment for the LTC program. Once you are enrolled in the LTC program, we will make sure you continue to meet

requirements for the program each year.

You can find the phone number for your local ADRC using the following map. They can also help answer any other questions that you have about the LTC program. Visit https://ahca.myflorida.com/Medicaid/statewide_mc/smmc_ltc.shtml for more information.

Enrollment in our Serious Mental Illness (SMI) Specialty Plan

Our SMI Specialty Plan is designed to help members who have one or a combination of the following conditions:

- Psychotic Disorders
- Bipolar Disorders
- Major Depression
- Schizo-Affective Disorder
- Delusional Disorders
- Obsessive-Compulsive Disorder

In addition to all the benefits and services of our MMA Plan, members in our SMI Specialty Plan also have the following:

- Additional Expanded Benefits just for SMI Specialty Plan members (see SMI Specialty Expanded Benefits section below)
- Care Coordination support from SMI Trained Staff
- Increased access to providers who specialize in treating members with SMI, including accredited Behavioral Health Homes and Patient Centered Medical Homes

While our SMI Specialty Plan is designed to help members with SMI, a member with SMI may choose not to enroll in a Specialty Plan. They may choose an MMA Plan (and LTC Plan, if eligible) instead.

Enrollment in our HIV/AIDS Specialty Plan

Our HIV/AIDS Specialty Plan is designed to help members who are diagnosed with Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS).

In addition to all the benefits and services of our MMA Plan, members in our HIV/AIDS Specialty Plan also have the following:

- Additional Expanded Benefits just for SMI Specialty Plan members (see SMI Specialty Expanded Benefits section below)
- Care Coordination support from SMI Trained Staff

While our HIV/AIDS Specialty Plan is designed to help members with HIV/AIDS, a member with HIV/AIDS may choose not to enroll in a Specialty Plan. They may choose an MMA Plan (and LTC Plan, if eligible) instead.

Section 9: Leaving Our Plan (Disenrollment)

Leaving a plan is called **disenrolling**. By law, people cannot leave or change plans while they are locked-in except for specific reasons. If you want to leave our plan while you are locked-in, call the State's Enrollment Broker to see if you would be allowed to change plans.

You can leave our plan at any time for the following reasons (also known as **For Cause Disenrollment reasons**[1]):

- We do not cover a service for moral or religious reasons
- You live in and get your Long-Term Care services from an assisted living facility, adult family care home, or nursing facility provider that was in our network but is no longer in our network

[1] For the full list of For Cause Disenrollment reasons, please see Florida Administrative Rule 59G-8.600: https://www.flrules.org/gateway/RuleNo.asp?title=MANAGEDCARE&ID=59G-8.600

You can also leave our plan for the following reasons, if you have completed our grievance and appeal process[2]:

- You receive poor quality of care, and the Agency agrees with you after they have looked at your medical records
- You cannot get the services you need through our plan, but you can get the services you need through another plan
- Your services were delayed without a good reason

If you have any questions about whether you can change plans, call Member Services at 800-477-6931 (TTY: 711) or the State's Enrollment Broker at 877-711-3662 (TDD 866-467-4970).

Removal from Our Plan (Involuntary Disenrollment)

The Agency can remove you from our plan (and sometimes the SMMC program entirely) for certain reasons. This is called **involuntary disenrollment**. These reasons include:

- You lose your Medicaid eligibility
- You move outside of where we operate, or outside the State of Florida
- You knowingly use your Plan ID card incorrectly or let someone else use your Plan ID card
- You fake or forge prescriptions
- You or your caregivers behave in a way that makes it hard for us to provide you with care
- You are in the LTC program and live in an assisted living facility or adult family care home that is not home-like and you will not move into a facility that is home-like[3]
- If the Agency removes you from our plan because you broke the law or for your behavior, you cannot come back to the SMMC program.

Section 10: Managing Your Care

If you have a medical condition or illness that requires extra support and coordination, we may assign a case manager to work with you. Your case manager will help you get the services you need. The case manager will work with your other providers to manage your health care. If we provide you with a case manager and you do not want one, call Member Services to let us know.

If you are in the ***LTC program or Specialty program***, we will assign you a case manager. You must have a case manager if you are in the ***LTC program or Specialty program***. Your case manager is your go-to person and is responsible for coordinating your care. This means they are the person who will help you figure out what ***LTC or specialty plan services*** you need and how to get them.

If you have a problem with your care, or something in your life changes, let your case manager know and they will help you decide if your services need to change to better support you.

Changing Case Managers

If you want to choose a different case manager, call Member Services. There may be times when we will have to change your case manager. If we need to do this, we will send a letter to let you know

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[2] To learn how to ask for an appeal, please turn to Section 17, Member Satisfaction.

[3] This is for Long-Term Care program enrollees only. If you have questions about your facility's compliance with this federal requirement, please call Member Services or your case manager.

and we may give you a call.

Important Things to Tell Your Case Manager

If something changes in your life or you don't like a service or provider, let your case manager know. You should tell your case manager if:

- You don't like a service
- You have concerns about a service provider
- Your services aren't right
- You get new health insurance
- You go to the hospital or emergency room
- Your caregiver can't help you anymore
- Your living situation changes
- Your name, telephone number, address, or county changes

Request to Put Your Services on Hold

If something changes in your life and you need to stop your service(s) for a while, let your case manager know. Your case manager will ask you to fill out and sign a Consent for Voluntary Suspension Form to put your service(s) on hold.

Section 11: Accessing Services

Before you get a service or go to a health care appointment, we must make sure you need the service and that it is medically right for you. This is called **prior authorization.** To do this, we look at your medical history and information from your doctor or other health care providers. Then we will decide if that service can help you. We use rules from the Agency to make these decisions.

Providers in Our Plan

For the most part, you must use doctors, hospitals, and other health care providers that are in our **provider network**. Our provider network is the group of doctors, therapists, hospitals, facilities, and other health care providers that we work with. You can choose from any provider in our provider network. This is called your **freedom of choice**. If you use a health care provider that is not in our network, you may have to pay for that appointment or service.

You will find a list of providers that are in our network in our provider directory, along with important information such as address, phone numbers, specialty, and other qualifications. If there is any information you want that is not included in the directory such as the residency of the provider or the medical school they attended, please contact the provider office to ask. If you want a copy of the provider directory, call 800-477-6931 (TTY: 711) to get a copy or visit our website at Humana.com/FindADoctor.

If you are in the LTC program, your case manager is the person who will help you choose a service provider who is in our network for each of your services. Once you choose a service provider, they will contact them to begin your services. This is how services are **approved** in the LTC program. Your case manager will work with you, your family, your caregivers, your doctors and other providers to make sure that your LTC services work with your medical care and other parts of your life.

Providers Not in Our Plan

There are some services that you may be able to get from providers who are not in our provider network.

These services are:

- Family planning services and supplies
- Women's preventative health services, such as breast exams, screenings for cervical cancer, and prenatal care
- Treatment of sexually transmitted diseases
- Emergency care

If we cannot find a provider in our provider network for these services, we will help you find another provider that is not in our network. Remember to check with us first before you use a provider that is not in our provider network. If you have questions, call Member Services.

When We Pay for Your Dental Services

Your dental plan will cover most of your dental services, but some services may be covered by Humana Healthy Horizons.

Contact Member Services at 800-477-6931 (TTY: 711) for help with arranging these services.

What Do I Have to Pay For?

You may have to pay for appointments or services that are not covered. A covered service is a service we must provide in the Medicaid program. All the services listed in this handbook are covered services. Remember, just because a service is covered, does not mean you will need it. You may have to pay for services if we did not approve it first.

If you get a bill from a provider, call Member Services. Do not pay the bill until you have spoken to us. We will help you.

Services for Children[4]

We must provide all medically necessary services for our members who are ages 0 – 20 years old. This is the law. This is true even if we do not cover a service or the service has a limit. As long as your child's services are medically necessary, services have:

- No dollar limits; or
- No time limits, like hourly or daily limits

Your provider may need to ask us for approval before giving your child the service. Call Member Services if you want to know how to ask for these services.

Services Covered by the Medicaid Fee-for-service Delivery System, Not Covered Through Humana Healthy Horizons

The Medicaid fee-for-service program is responsible for covering the following services, instead of

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[4] Also known as "Early and Periodic Screening, Diagnosis, and Treatment" or "EPSDT" requirements.

Humana Healthy Horizons covering these services:

- County Health Department (CHD) Certified Match Program
- Developmental Disabilities Individual Budgeting (iBudget) Home and Community Based Services Waiver
- Familial Dysautonomia (FD) Home and Community-Based Services Waiver
- Hemophilia Factor-related Drugs
- Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/ IID)
- Medicaid Certified School Match (MCSM) Program
- Model Home and Community-Based Services Waiver
- Newborn Hearing Services
- Prescribed Pediatric Extended Care
- Substance Abuse County Match Program

This Agency webpage provides details about each of the services listed above and how to access these services: http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/ Covered_Services_HCBS_Waivers.shtml.

Moral or Religious Objections

If we do not cover a service because of a religious or moral reason, we will tell you that the service is not covered. In these cases, you must call the State's Enrollment Broker at 877-711-3662 (TDD 866-467-4970). The Enrollment Broker will help you find a provider for these services.

Section 12: Helpful Information About Your Benefits

Choosing a Primary Care Provider (PCP)

If you have Medicare, please contact the number on your Medicare ID card for information about your PCP.

One of the first things you will need to do when you enroll in our plan is choose a PCP. This can be a doctor, nurse practitioner, or a physician assistant. You will contact your PCP to make an appointment for services such as regular check-ups, shots (immunizations), or when you are sick. Your PCP will also help you get care from other providers or specialists. This is called a **referral.** You can choose your PCP by calling Member Services.

If you would prefer to have a PCP that has the same cultural, ethnic or racial background as you, ask if one is available when calling Member Services.

You can choose a different PCP for each family member, or you can choose one PCP for the entire family. If you do not choose a PCP, we will assign a PCP for you and your family.

You can change your PCP at any time. To change your PCP, call Member Services.

Choosing a PCP for Your Child

You can pick a PCP for your baby before your baby is born. We can help you with this by calling Member Services. If you do not pick a PCP by the time your baby is born, we will pick one for you. If you want to change your baby's PCP, call us.

It is important that you select a PCP for your child to make sure they get their Well Child Visits each year. Well Child Visits are for children 0 – 20 years old. These visits are regular check-ups that help you and your child's PCP know what is going on with your child and how they are growing. Your child may also receive shots (immunizations) at these visits. These visits can help find problems and keep your child healthy[5].

You can take your child to a pediatrician, family practice provider, or other health care provider.

You do not need a referral for well child visits. Also, there is no charge for well child visits.

Specialist Care and Referrals

Sometimes, you may need to see a provider other than your PCP for medical problems like special conditions, injuries, or illnesses. Talk to your PCP first. Your PCP will refer you to a specialist. A **specialist** is a provider who works in one health care area.

If you have a case manager, make sure you tell your case manager about your **referrals**. The case manager will work with the specialist to get you care.

Second Opinions

You have the right to get a **second opinion** about your care. This means talking to a different provider to see what they have to say about your care. The second provider will give you their point of view. This may help you decide if certain services or treatments are best for you. There is no cost to you to get a second opinion.

Your PCP, case manager or Member Services can help find a provider to give you a second opinion. You can pick any of our providers. If you are unable to find a provider with us, we will help you find a provider that is not in our provider network. If you need to see a provider that is not in our provider network for the second opinion, we must approve it before you see them.

Urgent Care

Urgent Care is not Emergency Care. Urgent Care is needed when you have an injury or illness that must be treated within 48 hours. Your health or life are not usually in danger, but you cannot wait to see your PCP, or it is after your PCP's office has closed.

If you need Urgent Care after office hours and you cannot reach your PCP, you can talk to a nurse 24 hours a day by calling Member Services at 800-477-6931 (TTY: 711).

You may also find the closest Urgent Care center to you by going to our website at www.humana.com/medicaid/online-tools/find-a-doctor to view the provider directory or by calling Member Services at 800-477-6931 (TTY: 711).

Hospital Care

If you need to go to the hospital for an appointment, surgery or overnight stay, your PCP will set it up. We must approve services in the hospital before you go, except for emergencies. We will not pay for hospital services unless we approve them ahead of time or it is an emergency.

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[5] For more information about the screenings and assessments that are recommended for children, please refer to the "Recommendations for Preventative Pediatric Health Care – Periodicity Schedule" at Periodicity Schedule (aap.org)

If you have a case manager, they will work with you and your provider to put services in place when you go home from the hospital.

Emergency Care

You have an emergency medical condition when you are so sick or hurt that your life or health is in danger if you do not get medical help right away. Some examples are:

- Broken bones
- Bleeding that will not stop
- You are pregnant, in labor and/or bleeding
- Trouble breathing
- Suddenly unable to see, move, or talk

Emergency services are those services that you get when you are very ill or injured.

These services try to keep you alive or to keep you from getting worse. They are usually delivered in an emergency room.

If your condition is severe, call 911 or go to the closest emergency facility right away. You can go to any hospital or emergency facility. If you are not sure if it is an emergency, call your PCP. Your PCP will tell you what to do.

The hospital or facility does not need to be part of our provider network or in our service area. You also do not need to get approval ahead of time to get emergency care or for the services that you receive in an emergency room to treat your condition.

If you have an emergency when you are away from home, get the medical care you need. Be sure to call Member Services when you are able and let us know.

Filling Prescriptions

We cover a full range of prescription medications. We have a list of drugs that we cover. This list is called our **Preferred Drug List**. You can find this list on our Web site at www.humana.com/medicaid/florida-medicaid/coverage/pharmacy or by calling Member Services.

We cover **brand name** and **generic** drugs. Generic drugs have the same ingredients as brand name drugs, but they are often cheaper than brand name drugs. They work the same. Sometimes, we may need to approve using a brand name drug before your prescription is filled.

We have pharmacies in our provider network. You can fill your prescription at any pharmacy that is in our provider network. Make sure to bring your Plan ID card with you to the pharmacy.

The list of covered drugs may change from time to time, but we will let you know if anything changes.

Specialty Pharmacy Information

Humana Healthy Horizons covers specialty drugs at all network pharmacies. Some drugs may not be available at every pharmacy and may only be available through a specialty mail order pharmacy. Please contact Member Services at 800-477-6931 or (TTY: 711) for help in getting your covered specialty drug at a network pharmacy.

Behavioral Health Services

There are times when you may need to speak to a therapist or counselor, for example, if you are having any of the following feelings or problems:

- Always feeling sad
- Not wanting to do the things that you used to enjoy
- Feeling worthless
- Having trouble sleeping
- Not feeling like eating
- Alcohol or drug abuse
- Trouble in your marriage
- Parenting concerns

We cover many different types of behavioral health services that can help with issues you may be facing. You can call a behavioral health provider for an appointment. You can get help finding a behavioral health provider by:

- Calling 888-778-4651
- Looking at our provider directory
- Going to our website www.Humana.com/FLMedicaid Someone is there to help you 24 hours a day, 7 days a week.

You do not need a referral from your PCP for behavioral health services.

If you are thinking about hurting yourself or someone else, call 911. You can also go to the nearest emergency room or crisis stabilization center, even if it is out of our service area. Once you are in a safe place, call your PCP if you can. Follow up with your provider within 24-48 hours. If you get emergency care outside of the service area, we will make plans to transfer you to a hospital or provider that is in our plan's network once you are stable.

Member Reward Programs

We offer programs to help keep you healthy and live a healthier life (like losing weight or quitting smoking). We call these **healthy behavior programs**. You can earn rewards while participating in these programs. Our plan offers the following programs:

Go365 for Humana Healthy Horizons in Florida

Available at no extra cost to members, Go365 for Humana Healthy Horizons® encourages members to keep up with their personal well-being goals. With Go365, members earn rewards for taking healthy actions and redeem for e-gift cards.

To earn rewards, you must:

Download the Go365 for Humana Healthy Horizons app from iTunes/Apple Shop or Google Play on a mobile device.

Create an account to access and engage in the program Members who are 18 and older can register to create a Go365 account. You must have your Medicaid Member ID.

Members under the age of 18 must have a parent or guardian register on their behalf to participate and engage with the program. The person completing the registration process on behalf of a minor must have the minor's Medicaid Member ID.

If you have a **MyHumana** account, you can use the same login information to access Go365, after you download the app.

For each eligible Go365 activity completed, you can earn rewards and then redeem the rewards for gift cards in the Go365 in-app mall. Rewards earned through Go365 have no cash value and must be earned and redeemed prior to the reward expiration date.

Call Go365 at **888-225-4669** (TTY: 711) to learn more.

Learn more about rewardable activities

Members who are enrolled in either an MMA Plan (Medical), Comprehensive (MMA and Long-Term Care), SMI or HIV/AIDS Specialty Plan can earn rewards for completing healthy activities such as working with a Wellness Coach, getting preventive screenings and going to prenatal and postpartum visits. Rewards can be redeemed for e-gift cards through the Go365 Mall in the app. Below is a chart of rewardable activities For the full list, visit www.humana.com/medicaid/florida.

Activity	Reward criteria	Reward amount
Annual Well Visit	Complete an Annual Wellness Visit with a primary care provider (PCP). Applies to members 18 years and older.	**$20 in rewards** per year, upon receipt of claim
Mammogram Cancer Screening	Get a mammogram. Applies to female members 40 and older. High-risk members under 40 years old are also eligible for rewards. Physician written order (referral) may be required for mammogram screening. Check with your Primary Care Physician or OB/GYN	**$20 in rewards** per year, upon receipt of claim
Cervical Cancer Screening	Get a cervical cancer screening as part of a routine pap smear. Applies to female members 21 and older. Members have open access for OB-GYN visits and do not require a referral from a Primary Care Physician	**$20 in rewards** per year, upon receipt of claim
Colorectal Cancer Screening	Get a colorectal cancer screening as recommended by your PCP. Applies to members 45 and older. Physician written order (referral) may be required for colorectal cancer screening. Check with your Primary Care Physician (PCP)	**$20 in rewards** per year, upon receipt of claim

Health Risk Assessment (HRA)	The HRA can be done in 1 of 4 ways: 1. Complete through the Go365 for Humana Healthy Horizons app, or 2. Fill out and send back the HRA in the envelope from your welcome kit, or 3. 800.611.1467 **(TTY: 711)**, Monday – Friday, 8 a.m. – 7 p.m., Eastern time, or 4. Create a MyHumana account and complete and submit the HRA online (via desktop only). Applies to all members.	**$20 in rewards** if completed within the first 90 days of enrollment. **$10 in rewards** if completed after the first 90 days of enrollment. One reward per new enrollment
HumanaBeginnings[1]	Pregnant members enroll and complete the HumanaBeginnings® program. • Prenatal component and/or • Postpartum component Applies to pregnant females 13 and older.	**$20 in rewards** per pregnancy
Postpartum Visit[1]	Complete 1 postpartum visit with your provider within 7 to 84 days after delivery. Available to all pregnant female members.	**$15 in rewards** per pregnancy
Prenatal Visit[1]	Complete a prenatal visit during your first trimester or within 42 days of enrollments with Humana. Available to all pregnant female members.	**$15 in rewards** per pregnancy
Substance Abuse Disorder Counseling	Work with a case manager over the phone to get help with substance abuse. • $15 for enrolling and completing 3 sessions within 3 months of the first session. • $15 for completing 3 additional sessions (6 sessions total) within 6 months of enrolling. • Outpatient Program: $20 for active participation in an outpatient program for 28-30 days Available to members 18 years and older. Enroll by calling **800-229-9880 (TTY: 711)**	**Up to $50 in rewards** per member per year

Weight Management Program[2]	Work with a coach over the phone to reach or keep a healthy weight. • $10 for enrolling and submitting a PCP form. • $30 for completing coaching, six calls total, within 12 months of enrolling To enroll, call **855-330-8053 (TTY: 711)**. When prompted, select option two. Applies to all members 12 and older. Parent/Guardian consent required for members 12 – 17 years old.	**Up to $40 in rewards** per member per year
Tobacco Cessation Program[3]	Work with a coach over the phone to quit smoking or vaping. • $25 for completing 2 calls within 45 days of enrolling in coaching • $25 for completing 6 more calls (8 total) within 12 months of enrolling in coaching Enroll by calling **855-330-8053 (TTY: 711)**. When prompted, select option one. Applies to members 12 and older. Parent/Guardian consent required for members 12 – 17 years old. Nicotine replacement therapy is available to members 18 and older.	**Up to $50 in rewards** per member per year
Well-Child Visit	Complete a wellness visit with a pediatrician. Applies to members ages 0 – 17.	**$20 in rewards** per year, upon receipt of claim

How to redeem your rewards

After completing any of the healthy activities listed above:

- Download the Go365 app. Make sure to choose the one that says Humana Healthy Horizons in the name.
- Add eligible minors to your account.
- Find your available rewards in the Go365 for Humana Healthy Horizons app.
- Access the Go365 Mall in the app.
- Redeem your rewards for e-gift cards.

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[1] Members do not have to enroll and complete the HumanaBeginnings Program to earn rewards for prenatal and/or postpartum visits with their OB-GYN

[2] The intention is for the Weight management program to be completed in six (6) months but will allow up to 12 months to complete six (6) sessions

[3] The intention is for Tobacco cessation program to be completed in seven (7) months but will allow up to 12 months to complete eight (8) sessions

Go to humana.com/medicaid/Florida or call **888-225-4669 (TTY: 711)** for more information about Go365 for Humana Healthy Horizons.

DISCLAIMERS

Go365 for Humana Healthy Horizons is available to all who meet the requirements of the program. Rewards are not used to direct you to select a certain provider. Rewards may take 90 to 180 days or greater to receive. Rewards are non-transferable to other plans or programs. You will lose access to the Go365® app and the earned incentives and rewards if you voluntarily disenroll from Humana Healthy Horizons or lose eligibility for more than one-hundred eighty (180) days. At the end of the year (December 31), those with continuous enrollment will have 90 days to redeem their rewards.

Rewards have no cash value. The monetary amounts listed above are reward values, not actual dollars. For some rewards, your doctor has to tell us that you completed the healthy activity. Once we get this information from your doctor, you will see in the app the option to redeem the reward. For any reward you qualify to earn during the current plan year, we must get confirmation from your doctor by no later than March 15 of the following year.

Gift cards cannot be used to purchase prescription drugs or medical services that are covered by Medicare, Medicaid, or other federal healthcare programs; gambling, alcohol; tobacco; e-cigarettes; or firearms. Gift cards must not be converted to cash. Rewards may be limited to once per year, per activity. See description for details.

Wellness coaches do not offer medical, financial, or other professional advice, and should not be used in place of consulting a licensed professional. You should consult with an applicable licensed professional to determine what is right for you.

Chronic Disease Management Programs

We have special programs available that will help you if you have one of these conditions.

Cancer and Cancer Prevention: Cancer diagnosis is scary, but Humana is here to help Humana has nurses trained in oncology to help you throughout your cancer treatment.

They can help guide you through treatment options, provide information and support you during your treatment. They're available to help you make informed choices about your medical care.

This program is a phone-based service, but different from an on-call nurse hotline. You speak to the same nurse every time — a nurse who takes the time to know your personal story.

Nurses share information on symptom control, diet and resources for cancer support programs. They're offered from the start of your diagnosis and throughout the course of your treatment. Nurses will work with your schedule, and what you tell us won't change your health benefits, coverage or rates. Know that health information you share during talks with your nurse will not be shared. This program is offered as part of your medical plan at no additional cost to you!

Humana provides this support to help you reach your health goals.

Diabetes and Diabetes Prevention: The Diabetes Disease Management program gives you facts about your diabetes. A plan is developed to help you improve behaviors and coping skills, while providing needed support and resources. It uses a different approach to get the best possible therapeutic results based on review of your needs, ongoing care monitoring, evaluation, and tailored member and practitioner interventions.

Depression and Depression Prevention (including suicide prevention): The Depression and Depression Prevention (including suicide prevention) Management program provides you with knowledge about Depression and Depression Prevention and helps to develop a member-specific plan of care to assist in the development of improved health-related behaviors and coping skills, while providing needed support and resources. The program uses a different approach to achieve the best possible therapeutic outcomes based on review of the member's needs, ongoing care monitoring, evaluation, and tailored member and practitioner interventions.

Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and HIV prevention: The HIV/AIDS Disease Management program provides you with knowledge about your HIV/AIDS and develops a member-specific plan of care to assist in the development of improved health-related behaviors and coping skills, while providing needed support and resources. The program uses a different approach to achieve the best possible therapeutic outcomes based on review of the member's needs, ongoing care monitoring, evaluation, and tailored member and practitioner interventions.

Sickle Cell Disease: The Sickle Cell Disease Management program provides you with knowledge about your sickle cell disease and develops a member-specific plan of care to assist in the development of improved health-related behaviors and coping skills, while providing needed support and resources. The program uses a different approach to achieve the best possible therapeutic outcomes based on review of your needs, ongoing care monitoring, evaluation, and tailored member and practitioner interventions.

Chronic Obstructive Pulmonary Disease (COPD): The COPD Disease Management program provides you with knowledge about your COPD and develops a member specific plan of care to assist in the development of improved health-related behaviors and coping skills, while providing needed support and resources. The program uses a different approach to achieve the best possible therapeutic outcomes based on review of your needs, ongoing care monitoring, evaluation, and tailored member and practitioner interventions.

Congestive Heart Failure (CHF): The CHF Disease Management program provides you with knowledge about your CHF and develops a member-specific plan of care to assist in the development of improved health-related behaviors and coping skills, while providing needed support and resources. The program uses a different approach to achieve the best possible therapeutic outcomes based on review of the member's needs, ongoing care monitoring, evaluation, and tailored member and practitioner interventions.

HIV/AIDS: The HIV/AIDS Disease Management program provides you with knowledge about your HIV/AIDS and develops a member-specific plan of care to assist in the development of improved health-related behaviors and coping skills, while providing needed support and resources. The program uses a different approach to achieve the best possible therapeutic outcomes based on review of the member's needs, ongoing care monitoring, evaluation, and tailored member and practitioner interventions.

If you have one of the above diseases, ask your PCP for a Disease Management Program referral or you can self-refer by any of the below methods:

- Phone: Call Humana at 800-229-9880. Hours of Operation: Monday – Friday, 8:30 a.m. – 5 p.m., Eastern time
- Website: http://www.Humana.com/FloridaCoverage
- If you would like to provide feedback on the Disease Management program or have a complaint, please contact: 800-229-9880

If you have one of the above diseases, ask your PCP for a Disease Management Program referral or

you can self-refer by any of the below methods:

- Phone: Call Humana at 800-229-9880. Hours of Operation: Monday – Friday, 8:30 a.m. – 5 p.m., Eastern time
- Website: http://www.Humana.com/FloridaCoverage
- If you would like to provide feedback on the Disease Management program or have a complaint, please contact: 800-229-9880

Quality Enhancement Programs

We want you to get quality health care. We offer additional programs that help make the care you receive better. The programs are:

Domestic Violence Program

Your PCP should screen you for signs of domestic violence during your visit for preventive care. You can also get educational materials from your PCP. Call your PCP or Member Services at 800-477-6931 (TTY: 711) to find out more.

Pregnancy Prevention Program

We can refer you to community pregnancy prevention programs that are open to you. You can use them no matter what your age, gender, pregnancy status, or parental consent. Call your PCP or Member Services at 800-477-6931 (TTY: 711) to find out more.

Prenatal/Postpartum Program

We have a before - and after - pregnancy program called HumanaBeginnings. You will have a case manager who will help you through your pregnancy and give you learning materials. The program also provides incentives, or ways to keep you on track, for healthy behaviors. When you have your baby, you will get more information about family planning from your case manager and your PCP. They will also refer you to the Healthy Start and Women, Infants, and Children (WIC) programs. Call your PCP or HumanaBeginnings at 800-322-2758, extension 1394119 (TTY: 711) to find out more.

Children's program

Humana Healthy Horizons can refer you to children's programs in your local area that help prevent health problems and give early healthcare services to families with children aged 0 – 5 years old. Humana Healthy Horizons also teams with your PCP to help you keep your children healthy. Talk to your PCP about these programs in your area or call 800-229-9880, extension 1500478 (TTY: 711) to find out more.

Behavioral Health Services

For behavioral health services, please call the behavioral healthcare provider in your area. Behavioral health services are available to you without a referral from your PCP. The behavioral healthcare provider in your area can give you a list of common problems with behavior and they can talk to you about how to recognize the problems.

For more information call 888-778-4651.

Fall Risk Prevention

We have a Fall Risk Prevention process that involves screening, assessment, and care planning. A case manager will handle this process with you and provide education on fall prevention and appropriate service referrals.

New Medical Treatment

Sometimes new treatments work very well and sometimes they do not. Some can even have bad side effects. We track new medical research. This is how we decide new benefits for your health plan. If you think a new medical technology or treatment might help you, call your PCP. Your PCP will work with us to see if it can help you and will be covered by us.

Complex Case Management

Medicaid members may be eligible to get Complex Case Management services if they have experienced multiple hospitalizations and/or have complex medical needs that require frequent and ongoing assistance. Complex Case Management is provided to Medicaid members by Humana nurses specially trained in case management. A team of Physicians, Social Workers and Community Service Partners are on hand to help make sure your needs are met and all efforts are made to improve and optimize your overall health and well-being. The case management program is optional.

To get additional information about the Complex Case Management Program, self-refer or opt out of the Complex Case Management Program, you may contact our Health Services Department at 800-229-9880.

It is also important to understand that:

Prior authorization is done to make sure that you need the service and that it is medically right for you. Rewards are not given to doctors, other health care providers or individuals who make these decisions, for denying coverage of services. Any rewards for these decision makers do not encourage decisions that result in under use of services.

You also have a right to tell us about changes you think we should make.

To get more information about our quality enhancement program or to give us your ideas, call Member Services.

Section 13: Your Plan Benefits: Managed Medical Assistance Services

The table below lists the medical services that are covered by our Plan. Remember, you may need a referral from your PCP or approval from us before you go to an appointment or use a service. Services must be medically necessary for us to pay for them[6].

There may be some services we do not cover but might be covered by Medicaid. There are some services your State has determined are medically appropriate and can be provided in place of a covered service or setting under the State plan. These are called “In Lieu of Services (ILOS).” To find out about these benefits, call the Agency Medicaid Help Line at 877-254-1055.

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[6] You can find the definition for Medical Necessity at http://ahca.myflorida.com/medicaid/ review/General/59G_1010_Definitions.pdf

If you need a ride to any of these services, we can help you. You can call ModivCare at 866-779-0565 to schedule a ride.

If there are changes in covered services or other changes that will affect you, we will notify you in writing at least 30 days before the date the change takes place. If you have questions about any of the covered medical services, please call Member Services.

Medical Core Benefits Chart			
Service	**Description**	**Coverage/Limitations**	**Prior Authorization**
Addictions Receiving Facility Services	Services used to help people who are struggling with drug or alcohol addiction	As medically necessary and recommended by us: • For members 21 and older • Annual allowance of up to 45 days You pay nothing	May need prior authorization
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover medically necessary blood or skin allergy testing and up to 156 doses per year of allergy shots You pay nothing	May need prior authorization
Ambulance Transportation Services	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities	Covered as medically necessary. You pay nothing	May need prior authorization for non- emergency ambulance transportation
Ambulatory Detoxification Services	Services provided to people who are withdrawing from drugs or alcohol	As medically necessary and recommended by us: • 3 hours per day • Annual maximum of 30 days You pay nothing	May need prior authorization
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)	Covered as medically necessary. You pay nothing	May need prior authorization
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures	Covered as medically necessary. You pay nothing	May need prior authorization
Assistive Care Services	Services provided to adults (ages 18 and older) help with activities of daily living and taking medication	We cover 365/366 days of services per year, as medically necessary. You pay nothing	May need prior authorization

Behavior Analysis (BA)	Structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.	We cover recipients under the age of 21 years requiring medically necessary services	
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders	We cover, as medically necessary: • One initial assessment per year • One reassessment per year • Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day) You pay nothing	May need prior authorization
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0 – 18) enrolled in a DCF program	We cover 365/366 days of medically necessary services per year, including therapy, support services and aftercare planning. You pay nothing	May need prior authorization
Cardiovascular Services	Services that treat the heart and circulatory (blood vessels) system	We cover the following as prescribed by your doctor, when medically necessary: • Cardiac testing • Cardiac surgical procedures • Cardiac devices You pay nothing	May need prior authorization
Child Health Services Targeted Case Management	Services provided to children (ages 0 - 3) to help them get health care and other services OR Services provided to children (ages 0 – 20) who use medical foster care services	Your child must be enrolled in the DOH Early Steps program OR Your child must be receiving medical foster care services You pay nothing	No prior authorization required
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs	We cover, as medically necessary: • 24 patient visits per year, per member • X-rays You pay nothing	May need prior authorization

Clinic Services	Health care services provided in a county health department, federally qualified health center, or a rural health clinic	You pay nothing to a federally qualified health center or rural health clinic visit, medically necessary	May need prior authorization
Community- Based Wrap- Around Services	Services provided by a mental health team to children who are at risk of going into a mental health treatment facility	As medically necessary and recommended by us: • For members aged 0 to 20 • Up to 10 hours of treatment as needed per week for up to 4 months You pay nothing	May need prior authorization
Crisis Stabilization Unit Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us: • For members 21 and older • Annual allowance of up to 45 days You pay nothing	No prior authorization required
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys	We cover the following as prescribed by your treating doctor, when medically necessary: • Hemodialysis treatments • Peritoneal dialysis treatments You pay nothing	May need prior authorization
Drop-In Center Services	Services provided in a center that helps homeless people get treatment or housing	As medically necessary and recommended by us: • For members 21 and older • Up to 365 days per year You pay nothing	May need prior authorization
Durable Medical Equipment and Medical Supplies Services	Medical equipment is used to manage and treat a condition, illness, or injury. Durable medical equipment is used repeatedly, and includes things like wheelchairs,braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away	As medically necessary, some service and age limits apply. Call 800-477-6931 or TTY: 711 for more information. You pay nothing	May need prior authorization

Early Intervention Services	Services to children ages 0 - 3 who have developmental delays and other conditions	We cover as medically necessary: • One initial evaluation per lifetime, completed by a team • Up to 3 screenings per year • Up to 3 follow-up evaluations per year • Up to 2 training or support sessions per week You pay nothing	No prior authorization required
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency	Covered as medically necessary. You pay nothing	No prior authorization required
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness	We cover medically necessary: • One adult health screening (check-up) per year • Well-child visits are provided based on age and developmental needs • One visit per month for people living in nursing facilities • Up to two office visits per month for adults to treat illnesses or conditions You pay nothing	May need prior authorization
Family Therapy Services	Services for families to have therapy sessions with a mental health professional	We cover medically necessary: • Up to 26 hours per year You pay nothing	May need prior authorization
Family Training and Counseling for Child Development	Services to support a family during their child's mental health treatment	As medically necessary and recommended by us: • Up to 4 hours per day You pay nothing	May need prior authorization
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system	We cover: • Covered as medically necessary You pay nothing	May need prior authorization
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system	We cover: • Covered as medically necessary You pay nothing	May need prior authorization
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional	We cover as medically necessary: • Up to 39 hours per year You pay nothing	May need prior authorization

Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs	We cover hearing tests and the following as prescribed by your doctor, when medically necessary: • Cochlear implants • One new hearing aid per ear, once every 3 years • Repairs • See Expanded Benefit section after this section for more details You pay nothing	May need prior authorization
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury	We cover, when medically necessary: • Up to 4 visits per day for pregnant recipients and recipients ages 0-20 • Up to 3 visits per day for all other recipients You pay nothing	May need prior authorization
Hospice Services	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers	• Covered as medically necessary You may have Patient Responsibility for hospice services whether living at home, in a facility, or in a nursing facility	May need prior authorization
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional	We cover as medically necessary: • Up to 26 hours per year You pay nothing	No prior authorization required
Infant Mental Health Pre and Post Testing Services	Testing services by a mental health professional with special training in infants and young children	As medically necessary and recommended by us: • For members aged 0 to 5 • 10 hours per year You pay nothing	May need prior authorization

Inpatient Hospital Services	Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	We cover the following inpatient hospital services based on age and situation, when medically necessary: • Up to 365/366 days for recipients ages 0-20 • Up to 45 days for all other recipients (extra days are covered for emergencies) You pay nothing	May need prior authorization
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or diseases	• Covered as medically necessary You pay nothing	May need prior authorization
Laboratory Services	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases	• Covered as medically necessary You pay nothing	May need prior authorization
Medical Foster Care Services	Services that help children with health problems who live in foster care homes	Must be in the custody of the Department of Children and Families You pay nothing	No prior authorization required
Behavioral Health Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	• Covered as medically necessary You pay nothing	May need prior authorization
Medication Management Services	Services to help people understand and make the best choices for taking medication	• Covered as medically necessary You pay nothing	May need prior authorization
Mental Health Partial Hospitalization Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from mental illness	As medically necessary and recommended by us: • For members 21 and older • Up to 30 days annually You pay nothing	May need prior authorization
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses	Covered as medically necessary You pay nothing	May need prior authorization
Mobile Crisis Assessment and Intervention Services	A team of health care professionals who provide emergency mental health services, usually in people's homes	As medically necessary and recommended by us: • Up to 24 hours per year, with a maximum of 2 hours per day You pay nothing	May need prior authorization

Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system	• Covered as medically necessary You pay nothing	May need prior authorization
Non- Emergency Transportation Services	Transportation to and from all of your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles	We cover the following services for recipients who have no transportation: • Out-of-state travel • Transfers between hospitals or facilities • Escorts when medically necessary You pay nothing	May need prior authorization
Nursing Facility Services	Medical care or nursing care that you get while living full-time in a nursing facility. This can be short-term rehabilitation stay or long-term	• We cover 365/366 days of services in nursing facilities as medically necessary	May need prior authorization
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap, as medically necessary: • One initial evaluation per year • Up to 210 minutes of treatment per week • One initial wheelchair evaluation per 5 years We cover for people of all ages, as medically necessary: • Follow-up wheelchair evaluations, one at delivery and one 6-months later You pay nothing	Initial evaluation- No prior authorization required. Ongoing treatment- Prior authorization required
Oral and Maxillofacial Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity	• Covered as medically necessary You pay nothing	May need prior authorization
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	• Covered as medically necessary You pay nothing	May need prior authorization

Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	• Emergency services are covered as medically necessary • Non-emergency services cannot cost more than $1,500 per year for recipients ages 21 and over • See the Expanded Benefit section after this section for additional details You pay nothing	May need prior authorization
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided	• Covered as medically necessary. Some service limits may apply You pay nothing	May need prior authorization
Physical Therapy Services	Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap, as medically necessary: • One initial evaluation per year • Up to 210 minutes of treatment per week • One initial wheelchair evaluation per 5 years We cover for people of all ages, as medically necessary: • Follow-up wheelchair evaluations, one at delivery and one 6-months later You pay nothing	Initial evaluation- No prior authorization required. Ongoing treatment- Prior authorization required
Podiatry Services	Medical care and other treatments for the feet	We cover, as medically necessary: • Up to 24 office visits per year • Foot and nail care • X-rays and other imaging for the foot, ankle and lower leg • Surgery on the foot, ankle or lower leg You pay nothing	May need prior authorization
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider	We cover, as medically necessary: • Up to a 34-day supply of drugs, per prescription • Refills, as prescribed You pay nothing	No prior authorization required
Private Duty Nursing Services	Nursing services provided in the home to people ages 0 to 20 who need constant care	We cover, as medically necessary: • Up to 24 hours per day You pay nothing	May need prior authorization

Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ or other areas	We cover, as medically necessary: • 10 hours of psychological testing per year You pay nothing	May need prior authorization
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores	We cover, as medically necessary: • Up to 480 hours per year You pay nothing	May need prior authorization
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs or CAT scans They also include portable x-rays	• Covered as medically necessary You pay nothing	May need prior authorization
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions	Covered as medically necessary You pay nothing	May need prior authorization
Reproductive Services	Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family	We cover medically necessary family planning services. You can get these services and supplies from any Medicaid provider; they do not have to be a part of our Plan. You do not need prior approval for these services. These services are free. These services are voluntary and confidential, even if you are under 18 years old. You pay nothing	May need prior authorization
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system	We cover medically necessary: • Respiratory testing • Respiratory surgical procedures • Respiratory device management You pay nothing	May need prior authorization

Respiratory Therapy Services	Services for recipients ages 0-20 to help you breathe better while being treated for a respiratory condition, illness or disease	We cover medically necessary: • One initial evaluation per year • One therapy re-evaluation per 6 months • Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day) • See Expanded Benefit section below this section for additional details You pay nothing	Initial evaluation- No prior authorization required. Ongoing treatment- Prior authorization required
Self-Help/Peer Services	Services to help people who are in recovery from an addiction or mental illness	As medically necessary and recommended by us: • Up to 70 hours per year, with a maximum of 4 hours per day You pay nothing	May need prior authorization
Specialized Therapeutic Services	Services provided to children ages 0- 20 with mental illnesses or substance use disorders	We cover the following medically necessary: • Assessments • Foster care services • Group home services You pay nothing	May need prior authorization
Speech- Language Pathology Services	Services that include tests and treatments help you talk or swallow better	We cover the following medically necessary services for children ages 0-20: • Communication devices and services • Up to 210 minutes of treatment per week • One initial evaluation per year We cover the following medically necessary services for adults: • One communication evaluation per 5 years You pay nothing	Initial evaluation- No prior authorization required. Ongoing treatment- Prior authorization required
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital	• Covered as medically necessary for children ages 0-20 You pay nothing	May need prior authorization

Substance Abuse Intensive Outpatient Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from substance use disorders	As medically necessary and recommended by us: • For members 16 and older • Up to 4 days per week for 9 weeks You pay nothing	May need prior authorization
Substance Abuse Short-term Residential Treatment Services	Treatment for people who are recovering from substance use disorders	As medically necessary and recommended by us: • For members 21 and older • Up to 30 days annually You pay nothing	May need prior authorization
Therapeutic Behavioral On- Site Services	Services provided by a team to prevent children ages 0-20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility	We cover medically necessary services: • Up to 9 hours per month You pay nothing	May need prior authorization
Transplant Services	Services that include all surgery and pre- and post-surgical care	Covered as medically necessary You pay nothing	May need prior authorization
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover the following medically necessary services when prescribed by your doctor: • Two pairs of eyeglasses for children ages 0-20 • One frame every two years and two lenses every 365 days for adults ages 21 and older • Contact lenses • Prosthetic eyes See Expanded Benefit section below this section for addition details You pay nothing	May need prior authorization
Visual Care Services	Services that test and treat conditions, illnesses and diseases of the eyes	• Covered as medically necessary You pay nothing	May need prior authorization

Your Plan Benefits: Expanded Benefits

Expanded benefits are extra goods or services we provide to you, free of charge. Call Member Services at 800-477-6931 (TTY: 711) to ask about getting expanded benefits.

To find your plan type, look on the front of your ID Card we mailed to you. You can also refer to the ID Card section of this handbook on page 7.

Expanded Benefits Chart				
Service	**Description**	**Coverage/Limitations**	**Prior Authorization**	**Plan Type on ID Card**
Adult Additional Primary Care Services	Primary care provider visits	Non-pregnant adult members Age 21 and older, unlimited primary care provider visits You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Adult Visual Aid Services	Eye care services	Adult members Age 21 and older, the plan covers • 1 eye exam a year and one of the following: • 1 set of frames a year, member pays any cost over $75 for luxury frames • A 6-month supply of contact lenses with a doctor's prescription You pay nothing unless you select luxury frames that cost over $75	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Baby and Me Meals	Meals delivered to your home.	Up to 2 pre-cooked home-delivered meals per day for 10 weeks for pregnant women who are high risk You pay nothing	Care Manager approval required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Behavioral Health Housing Assistance	Assistance with housing related items	Adult members Age 18 and older who are homeless, at imminent risk of becoming homeless, or members transitioning from a behavioral health inpatient or residential facility without stable housing in the community may be eligible for housing assistance up to $2,500 once per lifetime. Member must: • Meet the Housing and Urban Development (HUD) definition of homeless: literally homeless; imminent risk of homelessness; homelesshomeless under other Federal statues; or	Care Manager approval required	• Specialty Plan (for SMI Specialty Plan only) • Specialty Comprehensive Plan (for SMI Specialty Plan only)

Behavioral Health Housing Assistance (continued)	Assistance with housing related items	fleeing/attempting to flee domestic violence • Be engaged in either Humana's Care Management program or a targeted case management program within the community, or a community housing case manager • Be engaged with a plan housing specialist, housing provider and/or local continuum of care • Be able to continue paying for their living expenses upon award of this one-time benefit • Voluntarily consents to housing assistance • Be ambulatory or able to self-transfer from wheelchair to bed and back if needed • Does not exhibit severe suicidal, homicidal, or acute mood symptoms/thought disorder, in imminent danger of harm to self or others, nor requires more intensive level of care You pay nothing	Care Manager approval required	• Specialty Plan (for SMI Specialty Plan only) • Specialty Comprehensive Plan (for SMI Specialty Plan only)
Convertible Car Seat or Portable Crib	Get a car seat or portable crib	Pregnant members who enroll and actively participate in our HumanaBeginnings Care Management program and complete a comprehensive assessment and at least 1 follow-up call with a HumanaBeginnings Care Manager can select 1 convertible car seat or portable crib per infant, per pregnancy You pay nothing	Care Manager approval required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan

Criminal Expungement Services	Get money spent on expungement services	Members ages 18 and older can receive reimbursement of up to $75 for criminal record expungement, as allowed per www.fdle.state.fl.us/Seal-and-Expunge-Process, per lifetime You will be refunded	Plan approval required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Day Trip - Meal Reimbursement/ Allowance	Get money spent on meals during medical trips returned	Adult members Age 21 and older, up to $1000 a year ($200 daily limit) for same-day medical trips more than 100 miles from home You will be refunded	Care Manager approval required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Disaster Preparedness Meals	Help with food before or after a disaster	1 box of 14 shelf-stable meals before or after a natural disaster, twice per year. • Member must not live in a residential or nursing facility • The Governor must declare the disaster for the member to be eligible for the meals You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Doula Services	Receive support and assistance during pregnancy	Doula assistance to provide emotional and physical support to the laboring mother and her family: • 5 Prenatal visits • 1 Birth coaching assistance during vaginal delivery • 3 Postpartum visits You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Durable Medical Equipment Services and Supplies	Medical supplies and equipment	Adult members Age 21 and older that are under care management with blood pressure monitoring included in their care plan, may receive 1 digital blood pressure cuff every 3 years. You pay nothing	Care Manager approval required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan

Expanded Prenatal/ Perinatal Services	Care before and after pregnancy	For members Age 10-59, the plan covers: • 14 prenatal visits for low-risk pregnancies and 18 prenatal visits for high-risk pregnancies. • 3 postpartum visits within 90 days following delivery • 1 well-woman visit between 90 days and 12 months following delivery in preparation to transition the member back to their primary care medical home • Non-hospital grade breast pump - 1 per 2 years, rental • Hospital grade breast pump - 1 rental per year You pay nothing	Prior authorization required for hospital grade breast pump	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Financial Literacy Coaching	Financial Literacy	Members Age 16 and older: • Up to 6 life coaching sessions for money management/ budgeting. You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
GED Testing	Preparation and testing	For members Age 16 and older GED test preparation assistance, including a bilingual advisor, access to guidance and study materials, and unlimited use of practice tests. Test preparation assistance, including tutoring, is provided virtually to allow maximum flexibility for members. Also includes test pass guarantee to provide members multiple attempts at passing the test. You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan

Hearing Services for Adults	Services to help you hear	You are covered for medically necessary hearing screenings and diagnostic testing. Adult members Age 21 and older, the plan covers: • 1 hearing aid assessment, fitting, checking, and evaluation every 2 years • 1 in ear monaural hearing aid per ear each year • 1 hearing aid, all other types, per ear every 2 years Call Hear USA at 877-664-9353 for a hearing provider near you You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Home Delivered Meals	Service to deliver healthy meals to your home	Adult members Age 18 and older, 14 meals delivered to your home once per year You pay nothing	Care Manager approval required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Home-Based Asthma Interventions	Items to help reduce in-home asthma triggers	Adult asthmatic members Age 21 and older, in our Care Management or Disease Management programs can receive an allowance of up to $250 per year for allergen free bedding and/or an air purifier You pay nothing	Care Manager approval required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Hospital Services – Outpatient	Outpatient Services	Adult members Age 21 and older, no dollar limit on services You pay nothing	May need prior authorization or a referral for hospital outpatient services	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan

Housing Assistance	Assistance with housing related items	Adult members Age 18 and older up to $500 per household per year (unused allowance does not roll over to the next year) to assist with the following housing expenses: • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water, gas or internet (late payment notice required) • Trailer Park and lot rent if this is your permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority • Member must not live in a residential facility or nursing facility • Funds will not be paid directly to the member • If the bill is in the spouse's name, a marriage certificate may be submitted as proof You pay nothing	Plan approval required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Housing Supports	Physical adaptation to a member's home or vehicle	Families of children up to Age 21, in a nursing facility preparing to transition their child home may receive up to $50,000 per lifetime for home readiness projects, such as physical adaptations to their home or vehicle. You pay nothing	Care Manager approval required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan

Humana Tranquility Goods	Items to help reduce trauma	Members Age 6 to 18 can receive supplies to calm the impact of trauma including a sound machine, light therapy products, or weighted pillow/ blankets. Once per year. Members can qualify through the following event/diagnosis: Children/Adolescents with an emotional and/or behavioral diagnosis, such as Acute Stress Disorder, Disinhibited Social Engagement Disorder, Adjustment Disorder, Unclassified and Unspecified Trauma Disorder, Reactive Attachment Disorder, and/or PTSD You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Maternal and Infant Virtual Care	Virtual resources	Pregnant members and new moms up to one year after delivery may access a certified lactation consultant via appointment through a video-enabled call routing system. You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Newborn Circumcision	Newborn Circumcision	Your male baby is covered, 1 per lifetime for members Age 0 to 28 days old You pay nothing.	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan (for HIV/AIDS Specialty Plan only) • Specialty Comprehensive Plan (for HIV/ AIDS Specialty Plan only)

Non Medical Transportation (NMT) for Behavioral Health Parent/ Guardian	Non medical transportation	For members Age 18 and under, 4 in-state round trips (8 in-state one- way trips) per month for a member's parent and/or guardian to visit the member while in a behavioral health residential setting or a statewide inpatient psychiatric program (SIPP). Excludes members' parents and guardians that have their own means of transportation. You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan (for SMI Specialty Plan only) • Specialty Comprehensive Plan (for SMI Specialty Plan only)
Non Medical Transportation (NMT) Social Needs	Non medical transportation	Adult members Age 18 and older up to 6 round trips (12 one-way trips) up to 30 miles for non- medical transportation per year to locations such as job/vocational training, social support groups, wellness classes, WIC and SNAP appointments, and food banks. This benefit also offers transportation to locations providing social benefits and community integration for members such as community and neighborhood centers, parks, recreation areas, and churches. You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Nutrition Shakes	Nutritional shakes	Members living with HIV deemed malnourished by their provider and unable to prepare meals, may receive a package of 21 nutritional shakes twice per year. You pay nothing	Care Manager approval required	• Medical Plan • Comprehensive Plan • Specialty Plan (for HIV/AIDS Specialty Plan only) • Specialty Comprehensive Plan (for HIV/ AIDS Specialty Plan only)

Occupational Therapy for Adults	Therapy treatments that help you improve your ability to do things in your daily life	Adult members Age 21 and older are covered for: • 1 evaluation/re-evaluation per year • Up to 7 therapy units per week • Application of casting or strapping - Members who have been evaluated by an occupational therapist may receive a maximum of 3 casting or strapping services a week per their treatment plan. Services must be clinically indicated; evidence based; and not experimental. • Wheelchair evaluation and fitting by an occupational therapist - If a member has a change in their medical condition, they may receive up to 5 wheelchair evaluations and/or fittings by an occupational therapist every 5 years You pay nothing	Initial evaluation- No prior authorization required. Ongoing treatment- Prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Over-the-Counter (OTC) Medications and Supplies	Allowance to purchase over the counter products	$50 per month allowance enables households to purchase products that support common occurring conditions such as: • Pain relivers • Diaper rash cream • Cough and cold relief medicine First aid equipment that do not require prescriptions. Unused amounts do not roll over to the next month. You pay nothing	No authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan

Pathway Licensure and/or Certification	Allowance for professional licensure and/or certification	Pathway members Age 16 and older who are participating in Humana's workforce management program may receive financial assistance with covering the cost of professional licensure and/or certification for the following professions: • Licensed practical nurse - up to $105 (Department of Health) • Barber - up to$155 (Department of Business and Professional Regulation) • Cosmetology - up to $55 - (Department of Business and Professional Regulation) • Child care home license - up to $75 (Department of Children & Families) Member must submit evidence they completed the education and/or training required by profession. Allowance is limited to once per year. You pay nothing	Plan approval required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan

Physical Therapy for Adults	Therapy treatments that help you improve your ability to do things in your daily life	Adult members Age 21 and older are covered for: • 1 evaluation/re-evaluation per year • Up to 7 therapy units per week • Application of casting or strapping - Members who have been evaluated by a physical therapist may receive a maximum of 3 casting or strapping services a week per their treatment plan. Services must be clinically indicated; evidence based; and not experimental. • Wheelchair evaluation and fitting by a physical therapist • If a member has a change in their medical condition, they may receive up to 5 wheelchair evaluations and/or fittings by a physical therapist every 5 years You pay nothing	Initial evaluation- No prior authorization required. Ongoing treatment- Prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Post Discharge Meal	Meals delivered to your home.	14 refrigerated home-delivered meals following discharge from an inpatient or residential facility. No limit on the number of discharges per year. You pay nothing	Care Manager approval required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Respiratory Therapy for Adults	Therapy to help you breathe better	Adult members Age 21 and older are covered for: • 1 evaluation/re-evaluation per year and • 1 therapy treatment per day You pay nothing	Initial evaluation- No prior authorization required Ongoing treatment- Prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan

Respite Services for Enrollees on HBCS Waiver Waiting List	Respite services	Members with a caregiver who are on a waiver waiting list for home and community-based services (HCBS) may be eligible for up to 60 hours of respite services per year Member must not live in a residential or nursing facility You pay nothing	Care Manager approval required	• Medical Plan • Comprehensive Plan
Respite Services for Medically Complex Children	Respite services	Members ages 20 and under, may be eligible for up to 240 hours of respite services per year to afford temporary relief to family caregivers. Respite care services are provided on a short-term basis as a temporary support to the recipient's family. It may be provided in the absence of or for relief of the recipient's family. Respite care may be used to meet a range of recipient needs. These include: 1. Family emergencies. 2. Planned absences, such as vacations, hospitalizations, or business trips. 3. Relief from the stresses of caregiving; and 4. Giving the child respite from his family. Respite care may be provided in the recipient's home, place of residence or a Nursing Facility. Members must first exhaust services covered through HCBS Waivers they are enrolled on. You pay nothing	Care Manager approval required	• Medical Plan • Comprehensive Plan

Return to Home Meals for Families of Nursing Facility Children	Meals delivered to your home.	Home-delivered meals for family members of nursing facility members, up to age 30 if they began living in a nursing facility before reaching 21 years of age, when transitioning to the home. Members may receive up to 2 meals per day for 1 week. Family members must primarily reside in the member's home. You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan
Smartphone Service	Smartphone services to help you stay connected	Smartphones can provide easy access to health related information and enable members to stay connected to their care team and health plan. Humana members that qualify for the Federal Lifeline program are eligible to receive a free smartphone with monthly talk minutes, text and data. You pay nothing.	Call Member Services for more information at 800-477-6931 (TTY: 711). No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Sports Physical	Sports physical	1 sports physical per year for members Age 6 to 18 You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Swimming Lessons	Drowning prevention lesson	Members up to Age 21 are covered for swimming lessons up to $200 a year. This is limited to 1,000 enrollees per year. You will be refunded	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan

Therapy for Families of Nursing Facility Children	Individual/ group therapy for family members	Family members of nursing facility members, up to age 30 if they began living in a nursing facility before reaching 21 years of age, transitioning to the home may receive individual/group therapy as needed 3 months prior to and up to 1 year after transition. Family members must primarily reside in the member's home. You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan
Transition Assistance Deposit for Nursing Facility Children	Assistance with housing related items	Members, up to age 30 if they began living in a nursing facility before reaching 21 years of age, may be eligible to receive up to $1,500 per lifetime to assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board. • Security deposits required to obtain a lease on an apartment or home. • Coverage for utilities including set up fees or deposits, first month coverage, or back payments. • First months and last month's rent as required by landlord for occupancy or housing maintenance. • Services necessary for the individual's health and safety, such as pest eradication Services must be identified as reasonable and necessary in the members individualized housing. Members must first exhaust services covered through HCBS Waivers they are enrolled on. You pay nothing	Care Manager approval required	• Medical Plan • Comprehensive Plan

Virtual Exercise Classes	Virtual resources	Members living with HIV can access virtual fitness classes including over 1,000 on-demand classes across multiple exercise modalities including high-intensity interval training (HIIT), core-strength, cycling, yoga, and other specialty fitness classes. Classes will be offered in a wide variety of intensities and class lengths (from 5 minutes to 60 minutes) to help members achieve their health and wellness goals. The digital fitness content will include adaptive workouts and classes suitable for those with chronic conditions and mobility challenges. This virtual offering will improve accessibility of exercise programming and address barriers (transportation, mobility, etc.) that may prevent members from engaging in in-person fitness. You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan (for HIV/AIDS Specialty Plan only) • Specialty Comprehensive Plan (for HIV/AIDS Specialty Plan only)
Waived Copayments	Member cost for covered services	No copays on any services for all members You pay nothing	No authorization required to waive the copay	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan
Youth Academic Support	Tutoring Services for members in kindergarten through 12th grade (ages 5 - 19)	Access to online tutoring services up to 2 hours per week as well as ACT/SAT test preparation for members in kindergarten through 12th grade (ages 5 - 19) You pay nothing	No prior authorization required	• Medical Plan • Comprehensive Plan • Specialty Plan • Specialty Comprehensive Plan

Your Plan Benefits: Pathways to Prosperity

The Plan shall assess members who may be experiencing barriers to employment, economic self-sufficiency, and independence gain access to care coordination/case management services and health-related social needs, such as housing assistance, food sustainability, vocational training, and educational support services.

Section 14: Cost Sharing for Services

Cost sharing means the portion of costs for certain covered services that is your responsibility to pay. Cost sharing can include coinsurance, copayments, and deductibles. If you have questions about your cost sharing requirements, please contact Member Services.

Section 15: Long-Term Care (LTC) Program Helpful Information

(Read this section if you are in the LTC program. If you are not in the LTC program, skip to Section 17)

Starting Services

It is important that we learn about you so we can make sure you get the care that you need. Your case manager will set up a time to come to your home or nursing facility to meet you.

At this first visit, your case manager will tell you about the LTC program and our Plan. She or he will also ask you questions about:

- Your health.
- How you take care of yourself.
- How you spend your time.
- Who helps takes care of you; and
- Other things.

These questions make up your **initial assessment.** The initial assessment helps us learn about what you need to live safely in your home. It also helps us decide what services will help you the most.

Developing a Plan of Care

Before you can begin to get services under the LTC program, you must have a **person-centered plan of care (plan of care)**. Your case manager makes your plan of care with you. Your plan of care is the document that tells you all about the services you get from our LTC program. Your case manager will talk to you and any family members or caregivers you want to include to decide what LTC services will help. They will use the initial assessment and other information to make a plan that is just for you. Your plan of care will tell you:

- What services you are getting
- Who is providing your service (your service providers)
- How often you get a service
- When a service starts and when it ends (if it has an end date)
- What your services are trying to help you do. For example, if you need help doing light housekeeping tasks around your house, your plan of care will tell you that an adult companion care provider comes 2 days a week to help with your light housekeeping tasks.
- How your LTC services work with other services you get from outside our Plan, such as from Medicare, your church or other federal programs
- Your **personal goals**

We don’t just want to make sure that you are living safely. We also want to make sure that you are happy and feel connected to your community and other people. When your case manager is making your plan of care, they will ask you about any **personal goals** you might have. These can be

anything, really, but we want to make sure that your LTC services help you accomplish your goals. Some examples of personal goals include:

- Walking for 10 minutes every day
- Calling a loved one once a week
- Going to the senior center once a week
- Moving from a nursing facility to an assisted living facility

You or your **authorized representative** (someone you trust who is allowed to talk to us about your care) must sign your plan of care. This is how you show you agree with the **services** on **your plan of care.**

Your case manager will send your PCP a copy of your plan of care. They will also share it with your other health care providers.

Updating your Plan of Care

Every month your case manager will call you to see how your services are going and how you are doing. If any changes are made, she or he will update your plan of care and get you a new copy.

Your case manager will come to see you in person to review your plan of care every 90 days (or about 3 months). This is a good time to talk to them about your services, what is working and isn't working for you, and how your goals are going. They will update your plan of care with any changes. Every time your plan of care changes, you or your authorized representative must sign it.

Remember, you can call your case manager any time to talk about problems you have, changes in your life, or other things. Your case manager or a health plan representative is available to you when you need them.

Your Back-Up Plan

Your case manager will help you make a **back-up plan**. A back-up plan tells you what to do if a service provider does not show up to give a service. For example, your home health aide did not come to give you a bath.

Remember, if you have any problems getting your services, call your case manager.

Section 16: Your Plan Benefits: Long-Term Care Services

The table below lists the Long-Term care services covered by our Plan. Remember, services must be medically necessary for us to pay for them[7].

If there are changes in covered services or other changes that will affect you, we will notify you in writing at least 30 days before the effective date of the change.

If you have any questions about any of the covered Long-Term care services, please call your case manager or Member Services.

Long-Term Care Core Benefits Chart		
Service	**Description**	**Prior Authorization**
Adult Companion Care	This service helps you fix meals, do laundry and light housekeeping. You pay nothing	May need prior authorization
Adult Day Health Care	Supervision, social programs, and activities provided at an adult day care center during the day. If you are there during mealtimes, you can eat there. You pay nothing	May need prior authorization
Assistive Care Services	These are 24-hour services if you live in an adult family care home. You pay nothing	May need prior authorization
Assisted Living	These are services that are usually provided in an assisted living facility. Services can include housekeeping, help with bathing, dressing, and eating, medication assistance, and social programs.	May need prior authorization
Attendant Nursing Care	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury You pay nothing	May need prior authorization
Behavioral Management	Services for mental health or substance abuse needs You pay nothing	May need prior authorization
Caregiver Training	Training and counseling for the people who help take care of you You pay nothing	May need prior authorization
Care Coordination/ Case Management	Services that help you get the services and support you need to live safely and independently. This includes having a case manager and planning of care that lists all the services you need and receive. You pay nothing	May need prior authorization
Home Accessibility/ Adaptation Services	This service makes changes to your home to help you live and move in your home safely and more easily. It can include changes like installing grab bars in your bathroom or a special toilet seat. It does not include major changes like new carpeting, roof repairs, plumbing systems, etc. You pay nothing	May need prior authorization

Home Delivered Meals	This service delivers healthy meals to your home. You pay nothing	May need prior authorization
Homemaker Services	This service helps you with general household activities, like meal preparation and routine home chores. You pay nothing	May need prior authorization
Hospice	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	May need prior authorization
Intermittent and Skilled Nursing	Extra nursing help if you do not need nursing supervision all the time or need it at a regular time You pay nothing	May need prior authorization
Medical Equipment and Supplies	Medical equipment is used to help manage and treat a condition, illness, or injury. Medical equipment is used repeatedly, and includes things like wheelchairs, braces, walkers, and other items. Medical supplies are used to treat and manage conditions, illnesses, or injury. Medical supplies include things that are used and then thrown away, like bandages, gloves, and other items. You pay nothing	May need prior authorization
Medication Administration	Help taking medications if you can't take medication by yourself You pay nothing	May need prior authorization
Medication Management	A review of all the prescription and over-the-counter medications you are taking You pay nothing	May need prior authorization
Nutritional Assessment/Risk Reduction Services	Education and support for you and your family or caregiver about your diet and the foods you need to eat to stay healthy You pay nothing	May need prior authorization
Nursing Facility Services	Nursing facility services include medical supervision, 24-hour nursing care, help with day-to-day activities, physical therapy, occupational therapy, and speech-language pathology	May need prior authorization

Personal Care	These are in-home services to help you with: • Bathing • Dressing • Eating • Personal Hygiene You pay nothing	May need prior authorization
Personal Emergency Response Systems (PERS)	An electronic device that you can wear or keep near you that lets you call for emergency help anytime You pay nothing	May need prior authorization
Respite Care	This service lets your caregivers take a short break. You can use this service in your home, an Assisted Living Facility or a Nursing Facility. You pay nothing	May need prior authorization
Occupational Therapy	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house. You pay nothing	Initial evaluation- No prior authorization required. Ongoing treatment- Prior authorization required
Physical Therapy	Physical therapy includes exercises, stretching, and other treatments to help your body get stronger and feel better after an injury, illness, or because of a medical condition. You pay nothing	Initial evaluation- No prior authorization required. Ongoing treatment- Prior authorization required
Respiratory Therapy	Respiratory therapy includes treatments that help you breathe better. You pay nothing	Initial evaluation- No prior authorization required. Ongoing treatment- Prior authorization required
Speech Therapy	Speech therapy includes tests and treatments that help you talk or swallow. You pay nothing	Initial evaluation- No prior authorization required. Ongoing treatment- Prior authorization required
Transportation	Transportation to and from all your LTC program services. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles. You pay nothing	May need prior authorization

Long-Term Care Participant Direction Option (PDO)*

You may be offered the Participant Direction Option (PDO). You can use PDO if you use any of these services and live in your home:

- Attendant care services
- Homemaker services

- Personal Care services
- Adult companion care services
- Intermittent and skilled nursing care services

PDO lets you **self-direct** your services. This means you get to choose your service provider and how and when you get your service. You have to hire, train, and supervise the people who work for you (your direct service workers).

You can hire family members, neighbors, or friends. You will work with a case manager who can help you with PDO.

If you are interested in PDO, ask your case manager for more details. You can also ask for a copy of the PDO Guidelines to read and help you decide if this option is the right choice for you.

Your Plan Benefits: LTC Expanded Benefits

Expanded benefits are extra services we provide to you at no cost. Talk to your case manager about getting expanded benefits.

Service	Description	Coverage/Limitations	Prior Authorization
Adult Visual Aid Services	Services for vision	You are covered for medically necessary services members Age 21 and older, the plan covers: • 1 eye exam per year and one of the following: • 1 set of frames per year; member pays any cost over $75 for luxury frames • A 6-month supply of contact lenses with a doctor's prescription You pay nothing unless you select luxury frames that cost over $75	No prior authorization required

Assisted Living Facility – Bed Hold Expansion	Up to 30-day bed hold	Members Age 18 and older, your bed will be saved for up to 30 days each time you leave an assisted living facility (ALF) or adult family care home (AFCH) • You must plan to go back to the ALF/AFCH • You must pay your room and board and share of payments when you are away • You must live in the ALF/ AFCH for at least 30 days between each time you leave • The ALF/AFCH must tell Humana you have left within 24 hours You pay nothing	Prior authorization and Care Manager approval required
Assisted Living Facility - Move- In Basket	A move-in basket with up to $50 worth of items, once per lifetime.	Members Age 18 and older and currently living in an assisted living facility (ALF) or those who transition/move into an ALF. Members can pick between two baskets: Basket 1: An insulated tumbler, rainbow medication tray, and plush Sherpa home throw blanket inside a clear casual tote bag Basket 2: A bottle holder, green carabiner, copper vacuum insulated bottle, Arctic Zone thermal copper mug and a domino set inside a black tote bag You pay nothing	Care Manager Approval Required
Behavioral Health - Individual Therapy Sessions to Caregivers	Individual Therapy Sessions to Caregivers	As needed, for family caregivers of members Age 18 and older You pay nothing	No prior authorization required
Day Trip - Meal Reimbursement/ Allowance	Get money spent on meals during medical trips returned	Members Age 21 and older, up to $1000 a year for same-day medical trips more than 100 miles from home You will be refunded	Care Manager approval required

Durable Medical Equipment Services and Supplies	Medical supplies and equipment	You are covered for the following: Members Age 21 and older that are under care management with blood pressure monitoring included in their care plan, may receive 1 digital blood pressure cuff every 3 years You pay nothing	Care Manager approval required
Fall Prevention Kit	Items to help prevent falls in the home	Members Age 18 and older who are at risk for falls may receive a Fall Prevention kit once per lifetime. Kit contains: • Non-Slip Socks • Reacher/Grabber • Bath Mat • Stair Treads Member must not reside in a residential facility or nursing facility You pay nothing	Care Manager approval required
Hearing Services for Adults	Services for hearing	You are covered for medically necessary hearing screenings and diagnostic testing. For members Age 21 and older, the plan covers: • 1 hearing aid assessment, fitting, checking, and evaluation every 2 years • 1 in ear monaural hearing aid per ear annually • 1 hearing aid, all other types, per ear every two 2 years Call Hear USA at 877-664- 9353 for a hearing provider near you You pay nothing	No prior authorization required
Hospital Services - Outpatient	Outpatient Hospital Services	Members Age 21 and older, no monetary limit on outpatient services. You pay nothing	May need prior authorization or a referral for hospital outpatient services
Non Medical Transportation for LTC	Non-Emergency Transportation	Members Age 21 and older, this benefit covers 2 roundtrip services per month. The trips must be within your local area. This benefit is for members who live in a home or community- based setting You pay nothing	Care Manager approval required

Over-the- Counter (OTC) Medications and Supplies	Over the Counter (OTC) Drug Allowance	$50 per month allowance enables households to purchase products that support common occurring conditions such as: • Pain relivers • Diaper rash cream • Cough and cold relief medicine • First aid equipment that do not require prescriptions. Unused amounts do not roll over to the next month. You pay nothing	No prior authorization required
Smartphone Service	Smartphone services to help you stay connected	Smartphones can provide easy access to health related information and enable members to stay connected to their care team and health plan. Humana members that qualify for the Federal Lifeline program are eligible to receive a free smartphone with monthly talk minutes, text and data. You pay nothing.	For more information call Member Services at 800-477-6931 (TTY: 711). No prior authorization required

Support to Stay in Community Living	Helps with paying for things like housing and other living costs	$1,000 allowance to support LTC members Age 18 and older to remain in their home or transition into an assisted living facility (ALF). Once per lifetime. Approved expenses may include utilities (gas, water, electric), internet, furniture, or rent with a long-term financial plan. Members must meet the following criteria: • Member must live in the community and be at risk for long-term institutional placement • Member must live alone or with spouse (other living situations may be approved on a case-by-case basis upon Care Manager review) • Member must show proof of potential loss of dwelling or risk of losing home due to inability to pay utilities, late bills/ disconnection notices, etc. • Benefit allowed only for items that place member at risk for custodial placement • Benefit cannot be used concurrently with SMI Specialty Housing Assistance benefit You pay nothing	Care Manager approval required
Transition Assistance into Community Living	Helps with paying for things like housing and other living costs	Members Age 18 and older who are moving from a nursing facility into their own home may receive up to up to $5,000 per lifetime. • Assistance for paying with security and utility deposits, household furnishings/supplies, and moving expenses • Member must be responsible for their own living expenses You pay nothing	Care Manager approval required
Waived copayments	Member cost for covered services	No copays on any services for all members	No authorization required to waive the copay

Section 17: Member Satisfaction

Complaints, Grievances, and Plan Appeals

We want you to be happy with us and the care you receive from our providers. Let us know right away if at any time you are not happy with anything about us or our providers. This includes if you do not agree with a decision we have made.

	What You Can Do:	What We Will Do:
If you are not happy with us or our providers, you can file a **Complaint**	You can: • Call us at any time. Member Services 800-477-6931 (TTY: 711)	We will: • Try to solve your issue within 1 business day
If you are not happy with us or our providers, you can file a **Grievance**	You can: • Use our online form to file a grievance at https://resolutions. humana.com/ grievances-appeals- forms/file-a-report • Write us or call us at any time. • Call us to ask for more time to solve your grievance if you think more time will help. P.O. Box 14546 Lexington, KY 40512-4546 Member Services 800-477-6931 (TTY: 711)	We will: • Review your grievance and send you a letter with our decision within 30 days. If we need more time to solve your grievance, we will: • Send you a letter with our reason and tell you about your rights if you disagree.
If you do not agree with a decision we made about your services, you can ask for an **Appeal**	You can: • Use our online form to file an appeal, write us, or call us and follow up in writing, within 60 days of our decision about your services. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. P.O. Box 14546 Lexington, KY 40512-4546 • Use our online appeal tracker to check the status of a medical appeal Member Services 800-477-6931 (TTY: 711)	We will: • Send you a letter within 5 business days to tell you we received your appeal. • Help you complete any forms. • Review your appeal and send you a letter within 30 days to answer you.

If you think waiting for 30 days will put your health in danger, you can ask for an **Expedited or "Fast" Appeal**	You can: • Write us or call us within 60 days of our decision about your services. P.O. Box 14546 Lexington, KY 40512-4546 Fax 855-336-6220 Member Services 800-477-6931 (TTY: 711)	We will: • Give you an answer within 48 hours after we receive your request. • Call you the same day if we do not agree that you need a fast appeal and send you a letter within 2 days.
If you do not agree with our appeal decision, you can ask for a **Medicaid Fair Hearing****	You can: • Write to the Agency for Health Care Administration Office of Fair Hearings. • Ask us for a copy of your medical record. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. **You must finish the appeal process before you can have a Medicaid Fair Hearing.	We will: • Provide you with transportation to the Medicaid Fair Hearing, if needed. • Restart your services if the State agrees with you. If you continued your services, we may ask you to pay for the services if the final decision is not in your favor.

Online Grievance or Appeal form

Use our online form to file a grievance or appeal. When filling out the form, please provide as much information as possible.

After you file a grievance or appeal with our online form at https://resolutions.humana.com/grievances-appeals-forms/file-a-report

- You will get a confirmation email with details of your submission
- You can get information about the status of any grievance or appeal you submit through our form:
- By calling the number on the back of your Member ID card to check the status of a grievance
- Use our online appeal tracker to check the status of a medical appeal

Fast Plan Appeal

If we deny your request for a fast appeal, we will transfer your appeal into the regular appeal time frame of 30 days. If you disagree with our decision not to give you a fast appeal, you can call us to file a grievance.

Medicaid Fair Hearings (for Medicaid Members)

You may ask for a fair hearing at any time up to 120 days after you get a Notice of Plan Appeal Resolution by calling or writing to:

Agency for Health Care Administration Medicaid Fair Hearing Unit
PO Box 7237
Tallahassee, FL 32314-7237

877-254-1055 (toll-free)
239-338-2642 (fax)
MedicaidFairHearingUnit@ahca.myflorida.com

If you request a fair hearing in writing, please include the following information:

- Your name
- Your member numbers
- Your Medicaid ID number
- A phone number where you or your representative can be reached

You may also include the following information, if you have it:

- Why you think the decision should be changed
- The service(s) you think you need
- Any medical information to support the request
- Who you would like to help with your fair hearing

After getting your fair hearing request, the Agency will tell you in writing that they got your fair hearing request. A hearing officer who works for the State will review the decision we made.

If you are a Title XXI MediKids member, you are not allowed to have a Medicaid Fair Hearing.

Review by the State (for MediKids Members)

When you ask for a review, a hearing officer who works for the State reviews the decision made during the Plan appeal. You may ask for a review by the State any time up to 30 days after you get the notice. **You must finish your appeal process first.**

You may ask for a review by the State by calling or writing to:

Agency for Health Care Administration PO Box 7237
Tallahassee, FL 32314-7237
877 254-1055 (toll-free)
239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

After getting your request, the Agency will tell you in writing that they got your request.

Continuation of Benefits for Medicaid Members

If you are now getting a service that is going to be reduced, suspended or terminated, you have the right to keep getting those services until a final decision is made for your **Plan appeal or Medicaid fair hearing**. If your services are continued, there will be no change in your services until a final decision is made.

If your services are continued, and our decision is not in your favor, we may ask you to pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

To have your services continue during your appeal or fair hearing, you must file your appeal and ask

to continue services within this timeframe, whichever is later:

- 10 days after you receive a Notice of Adverse Benefits Determination (NABD), or
- On or before the first day that your services will be reduced, suspended or terminated

Section 18: Your Member Rights

As a recipient of Medicaid and a member in a Plan, you also have certain rights. You have the right to:

- Be treated with courtesy and respect
- Always have your dignity and privacy considered and respected
- Receive a quick and useful response to your questions and requests
- Know who is providing medical services and who is responsible for your care
- Know what member services are available, including whether an interpreter is available if you do not speak English
- Know what rules and laws apply to your conduct
- Be given easy to follow information about your diagnosis, and openly discuss the treatment you need, choices of treatments and alternatives, risks, and how these treatments will help you regardless of cost or benefit coverage
- Participate in making choices with your provider about your health care, including the right to say no to any treatment, except as otherwise provided by law
- Be given full information about other ways to help pay for your health care
- Know if the provider or facility accepts the Medicare assignment rate
- To be told prior to getting a service how much it may cost you
- Get a copy of a bill and have the charges explained to you
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for any health emergency that will get worse if you do not get treatment
- Know if medical treatment is for experimental research and to say yes or no to participating in such research
- Make a complaint when your rights are not respected
- Ask for another doctor when you do not agree with your doctor (second medical opinion)
- Get a copy of your medical record and ask to have information added or corrected in your record, if needed
- Have your medical records kept private and shared only when required by law or with your approval
- Decide how you want medical decisions made if you can’t make them yourself (advanced directive)
- To file a grievance about any matter other than a Plan’s decision about your services.
- To appeal a Plan’s decision about your services
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan
- Speak freely about your health care and concerns without any bad results
- Freely exercise your rights without the Plan or its network providers treating you badly
- Get care without fear of any form of restraint or seclusion being used as a means of coercion,

discipline, convenience or retaliation

- Receive information about the Plan, its services, its providers and member rights and responsibilities
- Receive information on beneficiary and plan information
- Obtain available and accessible services covered under the Plan (includes In Lieu of Services (ILOS))
- Make recommendations about the Plan's rights and responsibilities statement

LTC Members have the right to:

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Receive services in a home-like environment regardless of where you live
- Receive information about being involved in your community, setting personal goals and how you can participate in that process
- Be told where, when and how to get the service(s) you need
- To be able to take part in decisions about your health care
- To talk openly about the treatment options for your conditions, regardless of cost or benefit
- To choose the programs you participate in and the providers that give you care

Section 19: Your Member Responsibilities

As a recipient of Medicaid and a member in a Plan, you also have certain responsibilities. You have the responsibility to:

- Give accurate information about your health to your Plan and providers
- Understand your health conditions and work with your provider to make treatment goals
- Tell your provider about unexpected changes in your health condition
- Talk to your provider to make sure you understand a course of action and what is expected of you
- Listen to your provider, follow instructions for care that you have agreed to, and ask questions
- Keep your appointments, and notify your provider if you will not be able to keep an appointment
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions
- Make sure payment is made for non-covered services you receive
- Follow health care facility conduct rules and regulations
- Treat health care staff and case manager with respect
- Tell us if you have problems with any health care staff
- Use the emergency room only for real emergencies
- Notify your case manager if you have a change in information (address, phone number, etc.)
- Have a plan for emergencies and access this plan if necessary for your safety
- Report fraud, abuse and overpayment

LTC Members have the responsibility to:

- Tell your case manager if you want to disenroll from the Long-Term Care program

- Agree to and participate in the annual face-to-face assessment, quarterly face-to- face visits and monthly telephone contact with your case manager

Section 20: Other Important Information

Patient Responsibility for Long-Term Care (LTC) or Hospice Services

If you receive LTC or hospice services, you may have to pay a "share in cost" for your services each month. This share in cost is called "patient responsibility." The Department of Children and Families DCF) will mail you a letter when you become eligible (or to tell you about changes) for Medicaid LTC or hospice services. This letter is called a "Notice of Case Action" or "NOCA." The NOCA letter will tell you your dates of eligibility and how much you must pay the facility where you live, if you live in a facility, towards your share in the cost of your LTC or hospice services.

To learn more about patient responsibility, you can talk to your LTC case manager, contact the DCF by calling 866-762-2237 toll-free, or visit the DCF Web page at https://www.myflfamilies.com/medicaid (scroll down, review the links on the left side of the webpage and select the document entitled 'SSI-Related Medicaid Program Fact Sheet').

Indian Health Care Provider (IHCP) Protection

Indians are exempt from all cost sharing for services furnished or received by an IHCP or referral under contract health services

Emergency Disaster Plan

Disasters can happen at any time. To protect yourself and your family, it is important to be prepared. There are three steps to preparing for a disaster: 1) Be informed; 2) Make a Plan; and 3) Get a Kit. For help with your emergency disaster plan, call Member Services or your case manager. The Florida Division of Emergency Management can also help you with your plan. You can call them at 850-413-9969 or visit their website at www.floridadisaster.org.

For LTC members, your case manager will assist you in creating a disaster plan.

Tips on How to Prevent Medicaid Fraud and Abuse:

- DO NOT share personal information, including your Medicaid number, with anyone other than your trusted providers.
- Be cautious of anyone offering you money, free or low-cost medical services, or gifts in exchange for your Medicaid information.
- Be careful with door-to-door visits or calls you did not ask for.
- Be careful with links included in texts or emails you did not ask for, or on social media platforms.

Fraud/Abuse/Overpayment in the Medicaid Program

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at:

https://apps.ahca.myflorida.com/mpi-complaintform/

You can also report fraud and abuse to us directly by contacting the Special Investigations Unit Hotline at 800-614-4126 (TTY: 711), Monday through Friday, 7:00 a.m. – 3:00 p.m. Central Time.

Abuse/Neglect/Exploitation of People

You should never be treated badly. It is never okay for someone to hit you or make you feel afraid. You can talk to your PCP or case manager about your feelings.

If you feel that you are being mistreated or neglected, you can call the Abuse Hotline at 800-96-ABUSE (800-962-2873) or for TTY/TDD at 800-955-8771.

You can also call the hotline if you know of someone else that is being mistreated. Domestic Violence is also abuse. Here are some safety tips:

- If you are hurt, call your PCP
- If you need emergency care, call 911 or go to the nearest hospital. For more information, see the section called EMERGENCY CARE
- Have a plan to get to a safe place (a friend's or relative's home)
- Pack a small bag, give it to a friend to keep for you

If you have questions or need help, please call the National Domestic Violence Hotline toll free at 800-799-7233 (TTY 800-787-3224).

Advance Directives

An **advance directive** is a written or spoken statement about how you want medical decisions made if you can't make them yourself. Some people make advance directives when they get very sick or are at the end of their lives. Other people make advance directives when they are healthy. You can change your mind and these documents at any time. We can help you get and understand these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

1. A Living Will
2. Health Care Surrogate Designation
3. An Anatomical (organ or tissue) Donation

You can download an advanced directive form from this website: https://quality.healthfinder.fl.gov/report-guides/advance-directives.

Make sure that someone, like your PCP, lawyer, family member, or case manager knows that you have an advance directive and where it is located.

If there are any changes in the law about advance directives, we will let you know within 90 days. You don't have to have an advance directive if you do not want one.

If your provider is not following your advance directive, you can file a complaint with Member Services at 800-477-6931 (TTY: 711) or the Agency by calling 888-419-3456.

Getting More Information

You have a right to ask for information. Call Member Services or talk to your case manager about what kinds of information you can receive for free. Some examples are:

- Your member records
- A description of how we operate
- A comparison of plans Healthcare Effectiveness Data and Information Set (HEDIS®) results: https://www.humana.com/medicaid/florida-medicaid/member-support/ measuring-performance
- To tell us about changes or get a printed copy of the Humana Quality Improvement (QI) program, mail a request to the following address: Humana Quality Operations and Compliance Department, Progress Report, 321 West Main, WFP 20, Louisville, KY 40202 or call Member Services

Section 21: Additional Resources

Floridahealthfinder.gov

The Agency is committed to its mission of providing "Better Health Care for All Floridians". The Agency has created a website www.FloridaHealthFinder.gov where you can view information about Florida home health agencies, nursing facilities, assisted living facilities, ambulatory surgery centers and hospitals. You can find the following types of information on the website:

- Up-to-date licensure information
- Inspection reports
- Legal actions
- Health outcomes
- Pricing
- Performance measures
- Consumer education brochures
- Living wills
- Quality performance ratings, including member satisfaction survey results

The Agency collects information from all Plans on different performance measures about the quality of care provided by the Plans. The measures allow the public to understand how well Plans meet the needs of their members. To see the Plan report cards, please visit https://quality.healthfinder.fl.gov/ Facility-Provider/Medicaid- ReportCard?&type=-13.

Elder Housing Unit

The Elder Housing Unit provides information and technical assistance to elders and community leaders about affordable housing and assisted living choices. The Florida Department of Elder Affairs maintains a website for information about assisted living facilities, adult family care homes, adult day care centers and nursing facilities at https://elderaffairs.org/programs-services/housing-options/ as well as links to additional Federal and State resources.

MediKids Information

For information on MediKids coverage please visit: http://ahca.myflorida.com/medicaid/Policy_and_ Quality/Policy/program_policy/FLKidCar e/MediKids.shtml

Aging and Disability Resource Center

You can also find additional information and assistance on State and federal benefits, local programs and services, legal and crime prevention services, income planning or educational opportunities by

contacting the Aging and Disability Resource Center.

Independent Consumer Support Program

The Florida Department of Elder Affairs also offers an Independent Consumer Support Program (ICSP). The ICSP works with the Statewide Long-Term Care Ombudsman Program, the ADRC and the Agency to ensure that LTC members have many ways to get information and help when needed. For more information, please call the Elder Helpline at 800-96-ELDER (800-963-5337) or visit https://elderaffairs.org/programs- services/medicaid-long-term-care-services/statewide-medicaid-managed-care-long-term- care-program/.

Section 22: Forms

You can get a copy of the forms listed below by going to https://www.humana.com/medicaid/florida-medicaid/member-support/documents-forms

Examples:

OTC Order Form

Prescription drug reimbursement claim form

Grievance/Appeal request form

Appointment of Representative form

Consent for Release of PHI

Living will

Advanced directive

Organ donation form

Care management assessments

ENGLISH: This information is available for free in other languages and formats. Please contact our Customer Service number at **800-477-6931**. If you use **TTY**, call **711**, Monday – Friday, 8 a.m. to 8 p.m.

SPANISH: Esta información está disponible gratuitamente en otros idiomas y formatos. Comuníquese con nuestro Servicio al Cliente llamando al **800-477-6931**. Si usa un **TTY**, marque **711**. El horario de atención es de lunes a viernes de 8 a.m. a 8 p.m.

CREOLE: Enfòmasyon sa a disponib gratis nan lòt lang ak fòma. Tanpri kontakte nimewo Sèvis Kliyan nou an nan **800-477-6931**. Si ou itilize **TTY**, rele **711**, Lendi - Vandredi, 8 a.m. a 8 p.m.

FRENCH: Ces informations sont disponibles gratuitement dans d'autre langues et formats. N'hésitez pas à contacter notre service client au **800-477-6931**. Si vous utilisez un appareil de télétype **(TTY)**, appelez le **711** du lundi au vendredi, de 8h00 à 20h00.

ITALIAN: Queste informazioni sono disponibili gratuitamente in altre lingue e formati. La preghiamo di contattare il servizio clienti al numero **800-477-6931**. Se utilizza una telescrivente **(TTY)**, chiami il numero **711** dal lunedì al venerdì tra le 8 e le 20:00.

RUSSIAN: Данную информацию можно получить бесплатно на других языках и в форматах. Для этого обратитесь в отдел обслуживания клиентов по номеру **800-477-6931**. Если Вы пользователь **TTY**, звоните по номеру **711** с понедельника по пятницу, с 8.00 до 20.00.

Call If You Need Us

If you have questions or need help reading or understanding this document, call us at **800-477-6931 (TTY: 711)**. We are available Monday through Friday, from 8 a.m. to 8 p.m. Eastern time. We can help you at no cost to you. We can explain the document in English or in your first language. We can also help you if you need help seeing or hearing. Please refer to your Member Handbook regarding your rights.

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, ethnicity, marital status, religion, or language. 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 **800-477-6931** 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 their 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, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you.
800-477-6931 (TTY: 711)

Humana provides free auxiliary aids, when necessary to ensure an equal opportunity to participate. Services such as Non-English, video, and sign language interpretation, along with written information in alternative formats are provided to members free of charge.

Humana Healthy Horizons in Florida is a Medicaid product of Humana Medical Plan, Inc.

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **800-477-6931 (TTY: 711)**.

Español: (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **800-477-6931 (TTY: 711)**.

Kreyòl Ayisyen: (French Creole): ATANSYON: Si w pale Kreyòle Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **800-477-6931 (TTY: 711)**.

Tiếng Việt: (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **800-477-6931 (TTY: 711)**.

Questions?

Call Enrollee Services at 800-477-6931 (TTY: 711).

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