Humana Healthy Horizons®

HFS Illinois Department of Healthcare and Family Services



Humana Healthy Horizons® in Illinois Managed Long-Term Support Services Duals Specialty Program (MDSP) Member Handbook

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Important Contact Information	
Member Services	**800-787-3311 (TTY: 711)**
Online	Humana.com/IllinoisMDSP
Illinois CARES line	**800-345-9049**
Medicaid Transportation Management Transportation	**888-563-9877**
Case Management	**800-787-3311 (TTY: 711)**
Fraud, Waste, and Abuse Humana Special Investigations Hotline	**800-614-4126**
Grievance and Appeals	**800-787-3311 (TTY: 711)**

Welcome to the Humana Healthy Horizons in Illinois MDSP Plan!

Welcome to Humana Healthy Horizons in Illinois!

We are happy to have you as a member. Your health plan helps you get the care and support you need through Illinois Medicaid Managed Long Term Supports and Services Duals Specialty Program, also called MDSP.

We can help you understand your benefits, connect with care, and find support to help you stay safe, healthy, and as independent as possible.

We look forward to helping you make the most of your plan.

This handbook is here to help you learn how to use your benefits. We will walk through:

- Important contact information.
- First steps to being a member.
- How to get care.
- Your benefits.

Here are tools to help you get the most out of your health plan:

- **MyHumana** 
  - You can use the secure online portal and go to **www.humana.com/member/manage-your-account**
  - You can use our mobile app, MyHumana on the Go.
    - You're always on the go. That's why Humana has created the MyHumana app where you can:
      - Review your health services history.
      - Access your Humana member ID card instantly with a single tap.
      - Find a provider by specialty or location.
    - The MyHumana app can even use your location to find the closest in-network provider—no matter where you are.
    - Download the MyHumana app for:
      - iPhone by going to the **MyHumana App - App Store**
      - Android by going to **MyHumana - Apps on Google Play**

- **Find Care**
  - Go to **Findcare.humana.com**
  - Our Find Care tool makes it easy to find care.
  - All you need is your zip code and plan type.
    - If there is any information 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 directly to inquire.

- **Humana.com/Medicaid**
  - Go to **Humana.com/Medicaid** to:
    - Learn more about your benefits,
    - Use more tools,
    - Get forms online,
    - And more!

- **Humana Community Navigator**
  - Go to **hhh.findhelp.com** to find:
    - Food resources,
    - Utility services,
    - Housing help,
    - Transportation,
    - And more!

Member Services is here to help

Call Member Services at **800-787-3311 (TTY: 711)**. The call is free. If you use TTY, call **711**. We are open Monday through Friday, 8 a.m. to 8 p.m. Local Time.

You can call Member Services for help with:

- Choosing or changing your PCP,
- Questions about your benefits,
- Questions about services,
- Help with referrals,
- Replacing a lost ID card,
- Reporting the birth of a new baby,
- Reporting a change that may affect you or your family's benefits.

Help After Hours

If you need help after hours, call your primary care provider, also called your PCP. Your PCP has a plan to help you after hours or on weekends.

If you leave a message, please say how they can reach you. Your PCP will call you back as soon as possible.

If You Have an Emergency

If you have a medical emergency call **911** right away or go to the nearest emergency room.

If You Need Help in Another Language

For our customers with disabilities or limited English proficiency, we provide the following communication services at no cost when interacting with Humana.

- Over-the-phone interpretation is available in 150 languages
- American Sign Language interpreters (in person or via video)
- Linguistically-trained interpreters for visually-impaired customers
- Video interpretation from a smartphone or computer
- Teletype **(TTY)** services
- Written materials available in languages other than English, and in alternative formats including braille, audio, large print and accessible PDF

How to request an interpreter, assistance, or alternative formats

If you (or someone you're helping) have questions regarding your coverage, you have the right to get help and information in your language or alternative format at no cost. Please call Member Services to schedule interpretation for your appointments. Over the phone Interpretation and VRI are available 24/7. In-person interpretation must be scheduled 24 hours prior to appointment and is dependent on availability of an interpreter in the area.

To speak with an interpreter, request assistance or report a problem, please visit our **Humana Customer Care** page, call the number on the back of your member ID card, **800-787-3311 (TTY: 711)** or call Member Services **800-787-3311 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Local Time.

View **Multi-language support and contact information** in other languages.

Please see our **non-discrimination disclosure page** for a detailed description of our policy and program.

Visit our **accessibility support page** to learn more about Humana's commitment to web accessibility standards and support.

Hours of Service

Member Services is open Monday - Friday 8 a.m. – 8 p.m., Local Time. If you call when we are closed, please leave a message. We will call you back the next business day.

We want to hear what you think of us. If you have ideas about how we can be better, please let us know. We want you to be a happy and healthy member.

Humana is closed on these major holidays:

- New Year's Day
- Martin Luther King Jr. Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Thanksgiving Day
- The day after Thanksgiving
- Christmas Day

Eligibility

You may be able to join Humana Healthy Horizons MDSP through the state's Medicaid contract if you are:

- Are a senior or Age 21 or older at the time of enrollment;
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D;
- Receiving full Medicaid benefits;
- Eligible for and receiving long-term services based on assessed need for nursing facility level of care including:
  - Nursing Facility residents; or
  - Individuals participating in the following 1915 (c) waivers: Persons who are Elderly, Persons with Disabilities, Persons with HIV/AIDS, Persons with Brain Injury, and Persons residing in Supportive Living Facilities

Except those participants above that:

- Have comprehensive third party insurance;
- Reside in an ICF/MR facility;
- Are enrolled in the Adults with Developmental Disabilities HCBS waiver;
- Are enrolled in a partial benefits program;
- Are enrolled in the Illinois Breast and Cervical Cancer program;

- Are enrolled in the Health Benefits for Workers with Disabilities program;
- Are eligible only while pregnant and for a short time after delivery;
- Are eligible only through spend down; or
- Are an American Indian/Alaskan Native beneficiaries (may voluntarily enroll).

There are two ways to enroll in MDSP Illinois:

- **Online:** Go to **https://www.enrollhfs.illinois.gov/en/combo-auth**.
- **By phone:** Call us at **877-912-8880 (TTY: 866-565-8576)**. The call is free.

Open Enrollment

Once a year, you can choose a different health plan. This time is called Open Enrollment.

Client Enrollment Services will send you a letter about 60 days before your anniversary date. Your anniversary date is one year after the day your health plan started.

You will have 60 days to change your health plan. You can make one plan change during this time by calling Client Enrollment Services **at 877-912-8880 (TTY: 866-565-8576)**.

After the 60 days are over, you will stay in your health plan for the next 12 months, even if you did not make a change.

If you have questions about joining or leaving Humana, please call Client Enrollment Services at **877-912-8880 (TTY: 866-565-8576)**.

Redetermination

Don't forget to renew your benefits. Every year, The Department of Healthcare and Family Services (HFS) conducts yearly redeterminations. Make sure you submit your redetermination on time to keep your MDSP coverage.

You may submit your redetermination using any one of the following options:

- Complete the electronic version of the redetermination online in ABE Manage My Case at **abe.Illinois.gov**; or
- Complete your Medical redetermination over the phone by calling **800-843-6154/866-324-5553 TTY**; or
- Fill out and sign the form and send it to HFS with any necessary verifications to:
  - Mail to **P.O. Box 19138**, Springfield, IL 62763; or
  - Fax the completed form and verifications to **844-736-3563**; or
  - If you want to complete your redetermination in person, call **800-843-6154/866-324-5553** TTY to find help near you or visit a Family and Community Resource Center (FCRC) closest to your home. You can find out where the nearest FCRC is by visiting **https://www.dhs.state.il.us/PAGE.ASPX?MODULE=12**.

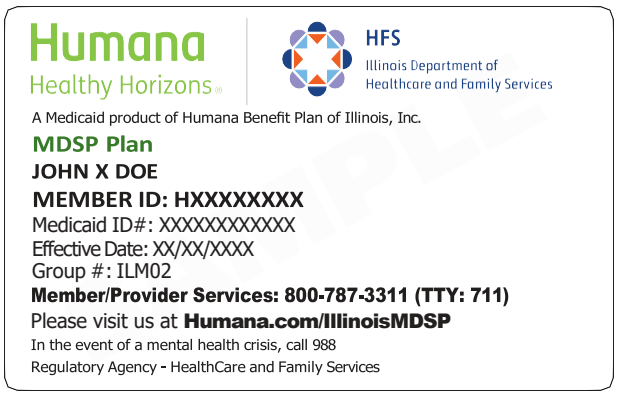
The earlier your redetermination is received, the earlier your eligibility can be determined to continue receiving medical benefits.

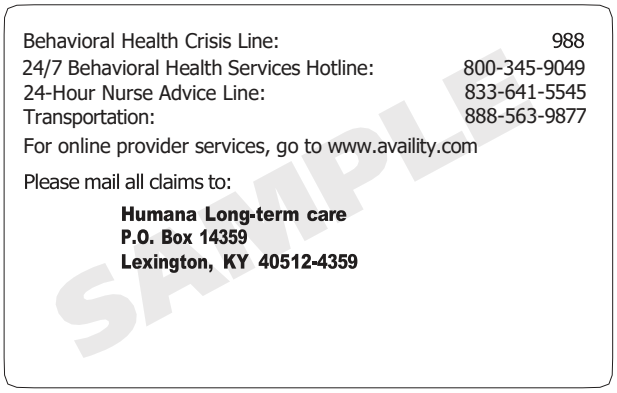
Once your form is received, your eligibility will be determined and you will get another notice explaining the decision.

*Beware of scams. Illinois will never ask you for money to renew or apply for Medicaid. Report scams to the fraud report website at **hfs.illinois.gov/oig/reportfraud** or the Medicaid fraud hotline at **844-453-7283/844-ILFRAUD**

You are a member, now what? Your First 4 steps to being a member

Step 1: Get your Humana ID Card.





- Your Humana ID card will be mailed to you with your welcome letter.
- Always keep your ID card with you.

Step 2: Create your online Myhumana account

- Go to **www.account.humana.com/registration**
- Choose "I'm a member" and select the "Start activation now" button
- Select your member type and enter your ID number, date of birth and zip code
- Enable 2-factor authentication so you can verify your identify when signing in
- Set up your profile
- Start learning about your benefits
  - Learn about Value Added Benefits

Step 3: Get regular care through a primary care provider

- Your Primary Care provider, or PCP, is your main doctor.
- Your PCP helps you:
  - Get checkups.

- Stay healthy.
- Treat illness.
- Manage long-term health needs.
- Find specialists.
- Understand your medicines.
- Plan your care.

- You can choose one PCP for your whole family or a different PCP for each family member.
- You might be able to see a specialist as a PCP.

The Humana MDSP plan does not cover primary care. For questions about your PCP or other primary care services call for medical coverage, contact your Medicare, Medicare Advantage or Medicaid Plan.

Step 4: Do your Health Risk Assessment

A Health Risk Assessment, or HRA is a simple health survey that takes about 5 minutes. This survey:

- Helps us learn more about you.
- Helps us learn about your health needs.

Once your HRA is done, if you qualify, a care coordinator will be assigned to you. The goal is to match your plan's benefits to your personal healthcare needs.



Get Care

When to go to urgent care or emergency care

When to go to an Urgent Care Center	When to go the Emergency Room
Urgent care is a great choice if you have a non-life-threatening illness or injury needing immediate treatment. You'll receive direct attention from doctors, nurses and other qualified medical professionals. Waiting times are usually shorter than in an emergency room and copays are often lower. Here are some of the conditions that urgent care is designed to treat: • Fevers • colds • Minor cuts and scraps • Earache	You should call **911** or go to the emergency room for any symptoms you may feel be a threat to your life or limbs. This may include • Stroke symptoms (sudden weakness, blurred vision, speech) • Heart attack • Open or severe bone fractures • Loss of consciousness • Difficulty Breathing • Severe bleeding If you believe you are having a behavioral health emergency call Illinois CARES **800-345-9049**

Post-Stabilization care is care you get after you receive emergency medical services. This care helps to improve or clear up your health issue or stop it from getting worse. For emergency care coverage and/or post stabilization care, contact your Medicare, Medicare Advantage or Medicaid Plan.

Need help getting to care?

- Emergency Transportation
  - If you have a medical emergency dial **911**.
  - Call **911** if you need emergency transportation.
  - You don't need prior approval in an emergency.
- Non-emergency medical transportation
  - Humana works with Medicaid Transportation Management (MTM) to get you where you need to go.
  - If you need a ride to your health care visit or to plan-approved locations call **888-563-9877** Monday – Friday 8 a.m. – 8 p.m. Local Time. This call is free.

Your Benefits

Smartphone

You can get 1 free smartphone with monthly talk, text, and data per household for members 21 and older who qualify for the Federal Lifeline Program.

Behavioral Health Services

Behavioral health care can help if you are dealing with stress, sadness, drug or alcohol use, or a mental health crisis. The care you need depends on what is going on in your life. Some services may need approval before you get them. Please call Member Services at **800-787-3311 (TTY: 711)**. to check.

Some of the Behavioral health services covered include:

- Alcohol or drug treatments
- Adaptive Behavioral Health (ABS) Services for those under the age of 21 diagnosed with Autism Spectrum Disorder
- Care during a hospital stay
- Community-based behavioral health
- Behavioral Health Crisis Line
- Crisis services
- Day treatment at hospital
- Intensive outpatient program
- Medication assisted treatment
- Outpatient services: medication management therapy, and counseling
- Residential rehab
- Telehealth

Behavioral Health Crisis Line

If you, your child, or someone you know needs help right away, call the IL CARES Hotline at **800-345-9049**.

Call if you are worried about someone's safety or if they may need care at a hospital for mental health needs.

The CARES Hotline is open **24 hours a day, 7 days a week, all year**. You can call whether you have Medicaid or not.

When you call, a CARES worker will talk with you about what is happening. They will ask questions to see what kind of help is needed.

If the person can get mobile crisis help, CARES will send a crisis worker to where the person is. The worker will arrive within 2 hours.

Health Risk Assessment

Each year you will complete a Health Risk Assessment, also called an HRA. The HRA asks questions about your health and daily habits. It helps us learn:

- What health needs you may have
- If you have health risks
- If you may need extra support from a Care Coordinator

To complete your HRA:

- Schedule your HRA with your care coordinator by calling Member Services **800-787-3311 (TTY: 711)**

Care Coordination

A care coordinator is like a health care coach. They can help you manage your care and use your benefits. Your care coordinator can:

- Meet you in person or by phone,
- Listen to your questions or concerns,
- Help you get care and services,
- Help find health problems early,
- Help set up care with your doctor,
- Help you, your family, or your caregiver understand your health needs, medicines, treatments.

Humana has different care coordination programs to fit your needs. If you want to learn more about different care coordination services like complex case management or disease management, self-refer, or opt out of the Complex Case Management Program, call Member Services. **800-787-3311 (TTY: 711)**.

Transition of care

With Humana Healthy Horizons in Illinois MDSP you are eligible for transition of care services. We help you move safely from one care setting to another. This may happen when you leave:

- A hospital
- A skilled nursing facility
- Another care setting

Covered Services

We want to help you get the care and services you need. First, we will check to see if your plan covers the service. If it is covered, our nurses will review your medical records and may talk with your doctor. This helps us decide if the service is needed for your health.

Here is a list of covered services:

Medical Services	Humana benefit limitations
Alcohol and Substance Abuse Rehabilitation Services	Coverage is subject to medical necessity and level of care criteria
Durable Medical Equipment and Prosthetic Devices	Covered when medically necessary
Long-Term Care (LTC) Supportive Living Facility (SLF) – Dementia Care	Covered for members 65 and older who have a diagnosis of Alzheimer's disease or related form of dementia
Long-Term Care (LTC) Services	• Intermediate • Skilled • Nursing Facility - Skilled
Mental Health Rehabilitation Option Services	• Team-based services • Crisis services • General services
Non-Emergency Medical Transportation (NEMT)	Transportation to and from a source of medical care
Nursing Care Services	Covered
Nursing Facility Services	Must meet Nursing-Facility Level of Care (NFLOC)

Covered Home and Community Based Services

Humana has five Home and Community-Based Services (HCBS) waiver programs for people who qualify through the Illinois Department of Healthcare and Family Services.

These programs help people stay in their own home or live in a community setting instead of moving to a nursing home or other facility.

HCBS waiver services are offered in addition to your plan’s benefits.

Humana does not decide if you qualify for HCBS services. The State of Illinois makes that decision using the Determination of Need (DON) assessment.

Here is a list of the HCBS Waiver Program Services

HCBS Waiver Program	Services	Provider Must Obtain Prior Authorization
Department on aging (DOA) Persons who are elderly	• Adult day service • Adult day service transportation • Automated Medication Dispenser • Homemaker • Personal emergency response system (PERS)	You may need a prior authorization from us before you get covered services
Division of Rehabilitation Services (DRS) Persons with Disabilities, HIV/ AIDS	• Adult Day Service • Adult day service transportation • Environmental Accessibility Adaptations- Home • Home Delivered Meals • Home Health Aide • Homemaker • Individual Provider • Nursing - Intermittent • Nursing – Skilled (RN and LPN) • Occupational Therapy • Personal Emergency Response System (PERS) • Physical Therapy • Respite • Specialized Medical Equipment and Supplies • Speech Therapy	You may need a prior authorization from us before you get covered services

Division of Rehabilitation Services (DRS) Persons with Brain Injury	• Adult Day Service • Adult day service transportation • Behavioral Services (M.A. and Ph.D.) • Environmental accessibility Adaptations-Home • Habilitation-Day • Home Delivered Meals • Home Health Aide • Homemaker Services • Individual Provider • Nursing – Intermittent • Nursing – Skilled (RN and LPN) • Occupational Therapy • Personal Emergency Response System (PERS) • Physical Therapy • Prevocational Services • Respite • Specialized Medical Equipment and Supplies • Speech Therapy • Supported Employment	You may need a prior authorization from us before you get covered services
Healthcare and Family Services (HFS) supportive living program	• Assisted Living	You may need a prior authorization from us before you get covered services

Non Covered Services

• All kids application agent (valid on provider file only) • Anesthesia Services • Audiology Services • Capitation Services • Case Management • Chiropractic Services • Clinic Services (Physical Rehabilitation) • Clinical Laboratory Services • Continuous Care Nursing • DCFS Rehab Option Services • DCFS Targeted Case Management Services	• DD/MI Non-Acute Care – Hospital Residing • Dental Services • Development Therapy, Orientation and Mobility Services (Waivers) • DSCC Counseling/Fragile Children • Early Intervention Services • Emergency Ambulance Transportation • Exceptional Care • Family planning services • Fluoride Varnish • General Clinic Services • General Inpatient

• Genetic Counseling • Healthy Kids Services • Home Care • Home Health Aides • Home Health Services • Inpatient Hospital Services (ESRD) • Inpatient Hospital Services (General) • Inpatient Hospital Services (Physical Rehabilitation) • Inpatient Hospital Services (Psychiatric) • Juvenile Rehabilitation • LTC – MI Recipient ages 22-64 • LTC – MR Recipient – Inappropriately Placed • LTC – MR Recipient between ages 21-65 • LTC – Specialized Living Center – Intermediate MR • LTC Full Medicare Coverage • LTC – Developmental training (level I) • LTC – Developmental training (level II) • LTC – Developmental training (level III) • LTC – ICF/MR • LTC – ICF/MR skilled pediatric • Medical Supplies • Mental Health Clinic Option Services • Midwife Services • Nurse Practitioners Services • Nursing service • Occupational Therapy Services • Optical Supplies • Optometric Services	• Other Behavioral Health Services • Outpatient Services (ESRD) • Outpatient Services (General) • Pharmacy Services (Drug and OTC) • Physical Therapy Services • Physician Services • Physicians Psychiatric Services • Podiatric Services • Portable x-ray services • Psychiatric Clinic Services (Type A) • Psychiatric Clinic Services (Type B) • Psychiatric Drugs • Psychologist service • Rehabilitation option service (special LEA service) • Respite Care • Sitter Services • Skilled Care – Hospital Residing • Social work service • SOPF – MI recipient non-matchable • SOPF – MI recipient over 64 years of age • SOPF – MI recipient over 64 years of age • SOPF – MI recipient under 22 years of age • Speech Therapy/Pathology Services • Subacute Care Program • Targeted case management service (early intervention) • Targeted case management service (mental health) • Transplants

Humana does not deny coverage for services or benefits because of moral or religious objections.

If you are not sure if a service is covered please contact Member Services at **800-787-3311 (TTY: 711)**.

Prior Authorization

Some services need prior approval from Humana before you get them. This is called prior authorization. This helps make sure the service is covered and needed for your health.

A service is medically necessary if it helps to:

- Save your life
- Keep you from getting very sick or disabled
- Find out what is wrong
- Treat an illness, injury, or disease
- Help you do daily activities like eating, dressing, and bathing

We will not pay for services from a provider that is not part of the Illinois network. You must get a prior authorization from us before getting the services.

You can ask for prior authorization for a service by:

- Completing prior authorization form located at provider.humana.com/coverage-claims/prior-authorizations/prior-authorization-lists and mailing it to:

  P.O. Box 14822

  Lexington, KY 40512-4822

- Calling Member Services at **800-787-3311 (TTY: 711)**
- Contacting your Care Manager if you have one.

Prior authorization is required for all out-of-network and all out-of-state care not related to emergency or post-stabilization services.

We may do a post-service utilization management review, which may include asking for medical records and reviewing claims for consistency with medical policies; clinical payment and coding policies; and accuracy of payment.

Grievance and Appeals

We hope you are happy with the service you get. If you are unhappy with anything about your care or service, please contact us. You have the right to file grievances and appeals.

A grievance and an appeal are not the same:

- A grievance is a complaint about something else. For example, you may be unhappy with Humana, a provider, or the service you receive.
- An appeal is when you ask Humana to review a decision we made to deny a benefit or service.

You can use the grievance or appeal process based on the problem you are having. During an appeal or State Fair Hearing, you can ask for copies of papers about your case. These copies are free. To ask for them, call Member Services at **800-787-3311 (TTY: 711)**.

Grievances

If you are unhappy with Humana or one of our providers, you have the right to file a grievance. You can file a grievance at any time.

You can file a grievance by

- Calling Member Services.
- Submitting a request online. Go to **resolutions.humana.com/grievances-appeals-forms/member-info**
- Faxing your grievance to **888-599-2730**
- Writing us a letter.
- Mailing your form or letter to:

  Humana Healthy Horizons in Illinois
  Attn: Grievance and Appeals department
  P.O. Box 14163
  Lexington, KY 40512-4163

  - If you write a letter please include:
    - Your first and last name,
    - Your member number from the front of your Humana ID Card,
    - Your address,
    - Your phone number,
    - Any information that helps explain the problem.
- Other people can also help you file a grievance such as:
  - Someone you choose to help you, if you give written permission.
  - Your legal guardian.
  - A provider you choose to help you, if you give written permission.
  - An interpreter.

What happens next

We will send you a letter letting you know we got your grievance. This letter will tell you we get your grievance. We will send you a letter with our decision within 90 calendar days.

You will not be treated unfairly

Humana will not take negative action against:

- A member who files a grievance,
- A provider who supports a member's grievance,
- A provider who files a grievance for a member, if the member gave written permission.

Appeals

If you are unhappy with a benefit denial or action we take, you or your authorized representative can file an appeal. You must file your appeal within 60 calendar days from the date on the denial letter which is called the Notice of Adverse Benefit Determination.

You can file an appeal by:

- Calling Member Services.
- Submitting a request online.
- Faxing your appeal.
- Mail your form or letter to:

  Humana Healthy Horizons in Illinois
  Attn: Grievance and Appeals department
  P.O. Box 14163
  Lexington, KY 40512-4163

  - If you send a letter, please include:
    - Your first and last name
    - Your member number from the front of your Humana ID Card
    - Your address
    - Your phone number
    - Any information that helps explain the problem

What happens after you file an appeal

We will send you a letter letting you know we got your appeal. After we review your appeal, we will send you a letter within 15 business days with our decision.

Your Rights During the Appeal

You or your authorized representative may:

- Look at the information used to make the decision.
- Send us more information during the appeal.

- Review your case file before and during the appeal. We will give this to you at no cost. Your case file may include:
    - Medical records,
    - Other papers and records,
    - New information used for your appeal.

Expedited Appeals

If you feel waiting could seriously harm your health, you can ask for a faster appeal. This is also called an expedited appeal. You may qualify for an expedited appeal if a delay could seriously harm your:

- Life.
- Health.
- Ability to get better or keep functioning as well as possible.

If your appeal qualifies, we will make a decision within 24 hours or sooner if your health needs it.

If your request does not qualify, we will review it as a standard appeal within 15 business days. If this happens we will:

- Try to tell you right away by phone.
- Send you a written notice within 2 calendar days.

If we need more time

Sometimes we may need more time to review your appeal. If that happens we may extend the time by up to 14 calendar days;

If we need more time we will:

- Try to tell you right away by phone.
- Send you a written notice within 2 calendar days.
- Explain why the extra time is in your best interested.
- Tell you if we need more information.
- Make a decision no later than 14 days after asking for more information.
- Tell you that you can file a grievance if you do not agree with the delay.

Sending more information

You can send us more information to support your appeal. This may include:

- Medical Records,

- A note from your provider,
- Other information that supports your appeal.

You can send us more information:

- By phone.
- In person.
- In writing.

You can send this information with your appeal or at any time during the appeal process.

For a standard appeal, we must receive the information within 15 business days after we get your appeal.

For an expedited appeal, we must receive the information within 24 hours after we get your appeal.

You will not be treated unfairly

Humana will not take negative action against:

- A member who files a grievance.
- A provider who supports a member's grievance.
- A provider who files a grievance for a member, if the member gave written permission.

Continuation of Benefits during the appeal process

In some cases, you can ask to keep getting your services while your appeal or Medicaid Fair Hearing is being reviewed. You may ask to keep your services if all of these are true:

- You are already getting the services that are being reduced, stopped or paused,
- The services were ordered by an approved provider,
- The original approval for the services has not ended yet.

You must ask to keep your services within 10 calendar days from the date of your Notice of Adverse Benefit Determination Letter.

You can also ask on or before the date we told you your services would be reduced stopped or paused.

If your request for continuation of benefits is approved

If your request is approved, your services will continue until one of these things happens:

- The original approval period of your services ends,
- You cancel your appeal,

- You do not ask for an appeal or a Medicaid Fair Hearing with continued benefits within 10 calendar days from the date on Humana Healthy Horizon's decision letter, or;
- A judge at the Medicaid Fair Hearing makes a decision that is not in your favor.

If your appeal is denied

- If the judge agrees with Humana's decision to deny the service. You may have to pay for the services you received during the appeal or hearing.
- You can ask for a State Medicaid Fair Hearing if your appeal is denied.
    - If you ask for the hearing and request continued services within 10 calendar days from the date on your appeal decision letter, your services may continue during the Medicaid Fair Hearing process.

Medicaid State Fair Hearings

You have the right to ask for a Medicaid State Fair Hearing after you finish the Humana appeal process. You can also ask for a hearing if Humana does not give you an appeal decision on time:

- Within 30 calendar days for a standard appeal
- Within 72 hours for an expedited appeal

You, your approved representative, or a provider with your written permission can ask for a hearing. You must ask for the hearing within 120 days from the date on your appeal letter.

How to ask for a State Fair Hearing

You can ask for a hearing related to your medical services or items, or Elderly Waiver Community Care Program (CC) service by:

- Phone: **855-418-4421 TTY: 800-526-5812**
- Fax: **(312) 793-2005**
- Email: **HFS.FairHearings@illinois.gov**
- Online: **https://abe.illinois.gov/abe/access/appeals**
- By mail:

  Illinois Department of Healthcare and Family Services Bureau of Administrative Hearings
  69 W. Washington Street, 4th floor
  Chicago, IL 60602

You can ask for a hearing related to mental health services or items, substance abuse services, persons with disabilities wavier services, Traumatic Brain Injury Waiver Services, HIV/AIDS Waiver services, or any Home Services Program (HSP) Service by:

- Phone: **800-435-0774 TTY: 877-734-7429**

- Fax: **(312) 793-3387**
- Online **https://abe.illinois.gov/abe/access/appeals**
- By mail

  Illinois Department of Human Service Bureau of Hearings

  69 W. Washington Street, 9th floor

  Chicago, IL 60602

  Fax: **(312)-793-3387**

  Email **DHS.BAH@illinois.gov**

Who will handle the hearing?

Your hearing will be led by an Impartial Hearing Officer who is approved to conduct State Fair Hearings. This person is neutral. That means the hearing office does not work for you or for Humana when making the hearing decision.

What happens after you ask for a State Fair Hearing?

After you ask for a hearing, the hearing office will send you a letter.

This letter will tell you:

- The date of the hearing.
- The time of the hearing.
- The place of the hearing, if it is in person.
- Other important details about the hearing process.

Please read this letter carefully. It will explain what to do next. Your hearing may be held:

- In person
- By phone
  - If the hearing is by phone, be sure to give the best phone number to reach you during business hours.
  - The hearing may be recorded.
- In another approved way

If you need help or special support

If you need special help for the hearing, tell the hearing office as soon as possible. This may include help such as:

- Language help
- Interpreter services

- Help for a hearing or vision disability
- Other help as needed

You can also have someone help represent you at the hearing. This person may be:

- A friend
- A family member
- A lawyer
- Another person you choose

You must give written permission for that person to represent you, unless that person is your legal guardian or is otherwise allowed by law.

Get ready for the hearing

Before the hearing, both sides may send in information to support their case. At least 3 business days before the hearing, you should receive Humana's evidence. This is the information Humana plans not use at the hearing. A copy will also be sent to the hearing officer. You must also send your information at least 3 business days before the hearing to:

- The hearing officer
- Humana (if required)

This may include:

- Medical records
- Letters from your provider
- Other papers that support your case
- A list of witnesses who will speak for you

It is important to send all of your information on time so it can be reviewed before the hearing.

Your rights during the hearing process

During the State Fair Hearing process, you may:

- Explain why you disagree with the decision.
- Send in more information.
- Review the information used in your case.
- Have someone represent you.
- Ask questions about the hearing process.

If you need copies of records related to your case, ask them as early as possible.

If you ask for a Medicaid State Fair Hearing and want your Humana benefits or services to continue during the hearing process, you must ask Humana within 10 calendar days from the date on our appeal decision letter.

Your benefits may continue until one of these happens:

- The original approval period ends.
- You cancel your appeal or hearing request.
- A final hearing decision is made that is not in your favor.
- You do not ask for continued benefits on time.

If the final decision agrees with Humana, you may have to pay for the services you received while your benefits continued.

When you will get a decision

You will usually get a decision within 90 days.

If the decision says Humana must cover the service, we will approve it as quickly as your health needs, but no later than 72 hours after we get the decision.

The Hearings Office will send you the final decision in a letter. You may also be able to see it online through your ABE Appeals Account.

If you kept getting services during the hearing and the final decision agrees with Humana, you may have to pay for those services.

External Review

Within 30 calendar days after the date on the Humana appeal decision notice, you may choose to ask for a review by someone outside of Humana. This is called an "external review". The outside reviewer must meet the following requirements:

- Board-Certified provider with the same or similar specialty as your treating provider.
- Currently practicing.
- Have no financial interest in the decision.
- Does not know you and will not know your identity during the review.

External review is not available for appeals related to services received through:

- The persons who are elderly waiver.
- The persons with disabilities waiver.
- The Traumatic Brain Injury Waiver.

- The HIV/AIDS waiver.
- The home services program.

Your letter must ask for an external review and can be submitted by completing the form and mailing your request in writing to:

Department of Insurance, Office of Consumer Health Information
4800 Wabash Avenue
Springfield, Illinois 62711
Email: **DOI.externalreview@illinois.gov**
Online: **https://idoihelpcenter.illinois.gov/s/**

What Happens Next

- We will review your request to see if it meets the qualifications for an external review. We have five business days to do this. We will send you a letter letting you know if your request meets these requirements.
- You have five business days from the letter we send you to send any additional information about your request to the external reviewer.

The external reviewer will send you and/or your representative and Humana a letter with their decision within five calendar days of receiving all the information they need to complete their review.

Expedited External Review

If the normal time frame for an external review could jeopardize your life or your health, you and/or your authorized representative can ask for an expedited external review. You can do this over the phone or in writing.

To ask for an expedited external review:

- Call Member Services at **877-850-4740 (toll free) / 866-323-5321 (TDD/TTY)**
- Ask in writing. You can only ask once for an external review about a specific action. Send your letter to:

  Department of Insurance, Office of Consumer Health Information
  4800 Wabash Avenue
  Springfield, Illinois 62711
  Email: **DOI.externalreview@illinois.gov**
  Online: **https://idoihelpcenter.illinois.gov/s/**

What Happens Next

- Once we receive a phone call or letter asking for an expedited external review, we will immediately review your request to see if it qualifies for an expedited external review. If it does, we will contact you or your representative.
- We will also send the necessary information to the external reviewer so they can begin their review. As quickly as your health condition requires, but no more than two business days after receiving all needed information, the external reviewer will make a decision about your request.
- They will verbally let you and/or your representative know what their decision is.
- They will also follow up with a letter including the decision to you and/or your authorized representative within 48 hours.

Utilization Management

We do not reward providers or our own associates for denying coverage or services. We do not offer financial rewards to our associates that affects their decisions. We do not deny or limit the amount, length of time or scope of the service only because of the diagnosis or type of illness or condition. Any financial incentives for decision makers do not encourage decisions that result in under use of services.

Rights and Responsibilities

Member Rights

As a Humana plan member, you have:

- A right to Exercise the Enrollee's rights, and that the exercise of those rights will not adversely affect the way the Enrollee is treated.
- A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- A right to be treated with respect and recognition of their dignity and their right to privacy.
- A right to Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- A right to participate with practitioners in making decisions about their health care.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about the organization or the care it provides.
- A right to make recommendations regarding the organization's member rights and responsibilities policy.
- A right to Refuse Treatment.

- A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Member Rights and Personal Information

You have the right to take the following actions related to your protected information:

- Requesting an accounting of disclosures of protected health information for reasons outside of payment and health plan operations.
- Receiving an authorization form for any proposed use of your protected health information outside of routine payment and health plan operations.
- Requesting an alternate form of communication of protected health information if the release of a portion or all of the information could endanger life or health.
- Filing a complaint regarding an alleged breach of privacy.
- Agreeing or objecting regarding Humana's intent to release your protected information outside of payment or health plan operations.
- Requesting an amendment or correction of your protected information to a designated record created by Humana.
- Requesting access to inspect and copy information.
- Requesting Humana restrict the use and disclosure of your protected information and maintaining the right to terminate the restriction request.

Disenrollment

You can try us out for 90 days. You may leave Humana and join another health plan at any time during the first 90 days after you begin to receive health plan benefits. You don’t have to have a reason to switch plans.

You can also switch health plans once every 12 months. This change happens through open enrollment.

If you want to leave Humana at any other time, you can do so only with a good reason (good cause). Some examples of good cause include:

- You move out of the service area.
- The plan does not cover the service enrollee seeks, because of moral or religious objections.

If you have a good cause reason to disenroll from Humana, you must submit your request using the grievance process. We will review the request within 10 days from when you filed the grievance. If you are unhappy with the disenrollment decision, we will refer the request to the Client Enrollment Services for the final decision. Humana Healthy Horizons in Illinois does not deny coverage for services or benefits because of moral or religious objections.

You could become ineligible

You may have to leave Humana if you:

- Change MCOs during open enrollment.
- Move out of the service area.
- Have other insurance or are in spend-down status.
- Become an inmate of a public institution.

Advance Directives

You have the right to make choices about your health care. An advance directive is a legal form that tells your doctors, health plan, and loved ones what care you want if you become too sick to make or share your own decisions.

Advance directives are optional. You can talk with your doctor, family, or someone you trust before completing one.

In Illinois, there are 4 types of advance directives:

- **Health Care Power of Attorney**: This lets you pick someone to make your health care decisions if you are too sick to decide for yourself. You can print one from the Illinois Department of Public Health (IDPH) website: **https://bit.ly/idphpowerofattorneyhealthcareform**
- **Living Will**: This tells your doctor and other providers what type of care you want if you are terminally ill. "Terminally ill" means your condition will not get better.
- **Mental Health Preference**: This lets you decide if you want to receive some types of mental health treatment that might be able to help you.
- **Do-Not-Resuscitate/Practitioner Orders for Life-Sustaining Treatment (DNR/POLST)**: This tells your family, your doctors and other providers what you want to do in case your heart or breathing stops. It can also be used to write down your wishes for life-sustaining treatment.

Guardianship

What is a guardian?

- A guardian is an adult chosen by a court to legally be in charge of another person.

When will a guardian be chosen?

- A court will choose a guardian for someone who no longer can make safe choices. This is usually due to legal or mental incapacity. In certain situations, a minor also may have a guardian chosen for them.

Who can become a guardian?

- Any adult can seek to have guardianship appointed for another person. Usually, guardianship is requested by a family member.

Who appoints a guardian?

- Only a court can choose a guardian. The court that chooses a guardian is your local court. This could differ based on where you live. Call your local Health and Family services, local court, local lawyer, or local legal aid service for more information.

If you have any questions regarding guardianship, you should consult a qualified legal professional. This information is provided for general information purposes and is not intended to be legal advice.

Fraud, Waste and Abuse

What are fraud, waste and abuse?

Fraud is generally defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program. (18 U.S.C. § 1347)

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

Abuse is payment for items or services when there is no legal entitlement to that payment and the individual or entity has not knowingly and/or intentionally misrepresented facts to obtain payment.

How to report fraud, waste and abuse

If you suspect fraud, waste or abuse in the healthcare system, you must report it to Humana and we'll investigate. Your actions may help improve the healthcare system and reduce costs for our members, customers and third parties.

To report suspected fraud, waste or abuse, you can contact Humana in one of these ways:

- **Phone**: **800-614-4126**
- **Fax: 920-339-3613**

- **E-mail: siureferrals@humana.com**
- **Mail**: Humana, Special Investigation Unit, 1100 Employers Blvd., Green Bay, WI 54344
- **Ethics Help Line: 877-5-THE-KEY (877-584-3539)**
- **Ethics Help Line reporting website**: www.ethicshelpline.com opens in new window

You have the option for your report to remain anonymous. All information received or discovered by the Special Investigations Unit (SIU) will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., state and federal authorities, Humana corporate law department, market medical directors or Humana senior management).

Another option is to submit the Special Investigations Referral Form online, by filling out the form using the link below.

- **Investigations Referral Form**

If you are a medical, dental or pharmacy provider, and have a concern previously reported to SIU, you can follow up by filling out the Request to contact SIU form.

- **Request to Contact SIU Form (English)**
- **Request to Contact SIU Form (Spanish)**

Definitions

Appeal means a request for your health plan to review a decision again.

Co-payment means a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Durable Medical Equipment means equipment and supplies ordered by a health care provider for everyday or extended use.

Emergency Medical Condition means an illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation means ambulance services for an emergency medical condition.

Emergency Room Care means the emergency services you get in an emergency room.

Emergency Services means the evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services means health care services that your health insurance or plan doesn't pay for or cover.

Grievance means a complaint that you communicate to your health plan.

Habilitation Services and Devices means services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance is a contract that requires your health insurer to pay some, or all of your health care costs in exchange for a premium.

Health plan means an organization made up of doctors, hospitals, pharmacies, providers of long-term services and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.

Home Health Care means health care services a person receives at home.

Hospice Services means services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization means care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care means care in a hospital that usually doesn't require an overnight stay.

Medically Necessary means health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network means the facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Pharmacy means a pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them 'network pharmacies' because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider means 'Provider' is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them 'network providers' when they agree to work with the health plan and accept our payment and not charge our members an extra amount.

Non-Participating Provider is a provider who doesn't have a contract with your health insurer or plan to provide services to you. You will pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a 'tiered' network and you must pay extra to see some providers.

Out of Network means providing a beneficiary with the option to access plan services outside of the plan's contracted network of providers. In some cases, a beneficiary's out-of-pocket costs may be higher for an out-of-network benefit.

Participating Provider - We call them 'participating providers' when they agree to work with the health plan and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use participating providers to get covered services.

Participating providers are also called 'network providers.'

Physician Services are health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan - A plan is the pairing of the health insurance benefits under a product, provider network, and service area.

Preauthorization means a decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. It is sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium means the amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage means health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs means drugs and medications that by law require a prescription.

Primary Care Physician - means a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Primary Care Provider means a physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Prior Authorization means a decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. It is sometimes called preauthorization, prior approval, or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization is not a promise your health insurance or plan will cover the cost.

Provider - 'Provider' is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

Rehabilitation Services and Devices means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care means nursing services provided within the scope of the Illinois Nurse Practice Act (225 ILCS 65/50-1 et seq.) by registered nurses, licensed practical nurses or vocational nurses licensed to practice in the State.

Skilled Nursing Facility (SNF) Care means the skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Social Determinants of Health are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.

Specialist: A doctor who provides health care for a specific disease or part of the body.

Urgent Care means care for an illness, injury or condition serious enough that a reasonable person would seek care right away but not so severe as to require emergency room care.

Auxiliary aids and services, free of charge, are available to you. 1-800-787-3311 (TTY: 711), Monday through Friday, from 8:00 a.m. to 8:00 p.m., Central time.

Humana Inc. and its subsidiaries comply with Section 1557 by providing free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English Call the number above to receive free language assistance services.

Español (Spanish) Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

Polski (Polish) Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

繁體中文 (Traditional Chinese) 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

한국어 (Korean) 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Tagalog (Tagalog – Filipino) Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

العربية(Arabic) اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

Русский (Russian) Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

ગુજરાતી (Guj ar at i) મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કોલ કરો.

اردو)Urdu(: مفت لسانی اعانت کی خدمات موصول کرنے کے لیے درج بالا نمبر پر کال کریں۔

Tiếng Việt (Vietnamese) Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

Italiano (Italian) Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

ह दी (Hindi) भाषा सहायता सेवाएं मुफ्त में प्राप्त करने केलिए ऊपर केनंबर पर कॉि करें।

Français (French) Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Ελληνικά (Greek) Καλέστε τον παραπάνω αριθμό για να λάβετε δωρεάν υπηρεσίες γλωσσικής υποστήριξης.

Deutsch (German) Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

This notice is available at Humana.com/IllinoisAccessibility
Humana Healthy Horizons in Illinois is a Medicaid Product of Humana Benefit Plan of Illinois, Inc.
ILHN62REN

Insurance ACE Notice of Privacy Practices

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

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

This Notice of Privacy Practices applies to all entities that are part of the Insurance ACE, an Affiliated Covered Entity under HIPAA. The ACE is a group of legally separate covered entities that are affiliated and have designated themselves as a single covered entity for purposes of HIPAA. A complete list of the members of the ACE is available at **https://huma.na/insuranceace**.

We may change our privacy practices and the terms of this notice at any time, as allowed by law, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is nonpublic personal or health information?

Nonpublic personal or health information includes both medical information and personal information, like your name, address, telephone number, Social Security number, account numbers, payment information, or demographic information. The term "information" in this notice includes any nonpublic personal and health information. This includes information created or received by a healthcare provider or health plan. The information relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

How do we collect information about you?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information do we receive about you?

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

How do we protect your information?

We have a responsibility to protect the privacy of your information in all formats including electronic and oral information. We have administrative, technical, and physical safeguards in place to protect your information in various ways including:

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

How do we use and disclose your information?

We use and disclose your information:

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

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care.
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For healthcare operation activities, including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform plan administration functions such as eligibility, enrollment, and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission, or your plan sponsor must certify they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you. If you have opted out, we will not contact you.
- To your family and friends if you are unavailable to communicate, such as in an emergency.
- To your family and friends, or any other person you identify. This applies if the information is directly relevant to their involvement with your healthcare or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation.
- To public health agencies, if we believe that there is a serious health or safety threat.
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence.

– continued to next page

Insurance ACE Notice of Privacy Practices – continued

- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For law enforcement purposes, to military authorities and as otherwise required by law.
- To help with disaster relief efforts.
- For compliance programs and health oversight activities.
- To fulfill our obligations under any workers' compensation law or contract.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For research purposes in limited circumstances and provided that they have taken appropriate measures to protect your privacy.
- For procurement, banking, or transplantation of organs, eyes, or tissue.
- To a coroner, medical examiner, or funeral director.

Additional restrictions on use and disclosure for specific types of information:

- Some federal and state laws may restrict the use and disclosure of certain sensitive health information such as: Substance Use Disorder ("SUD") subject to 42 CFR Part 2 ("Part 2") records; Biometric Information; Child or Adult Abuse or Neglect including Sexual Assault; Communicable Diseases; Genetic Information; HIV/AIDS; Mental Health; Reproductive Health; and Sexually Transmitted Diseases

  If we receive SUD Part 2 records, we will not use or disclose such records, or provide testimony relaying the content of such records, in any civil, criminal, administrative, or legislative proceeding against you unless such disclosure is based on your written consent (separate from your consent for any other use or disclosure), or a court order after notice and an opportunity to be heard is provided to you, as provided by Part 2. A court order authorizing the use or disclosure of SUD Part 2 Records must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Will we use your information for purposes not described in this notice?

We will not use or disclose your information for any reason that is not described in this notice, without your written permission. You may cancel your permission at any time by notifying us in writing.

The following uses and disclosures will require your written permission:

- Most uses and disclosures of psychotherapy notes and SUD counseling notes
- Marketing purposes
- Sale of personal and health information
- Medical information that is disclosed pursuant to this Notice to an entity that is not a HIPAA-covered entity or business associate, may be subject to disclosure by the recipient and may no longer be protected by federal or state privacy laws (such as HIPAA).

What do we do with your information when you are no longer a member?

Your information may continue to be used for purposes described in this notice. This includes when you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

We are committed to responding to your rights request in a timely manner.

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. As required under applicable law, we will make this personal information available to you or to your designated representative.
- Adverse Underwriting Decision – If we decline your application for insurance, you have the right to be provided a reason for the denial.
- Alternate Communications – To avoid a life-threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request correction of any of this personal information through amendment or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion of the information in dispute, or of our refusal to make such correction after further investigation.
  If we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute.*
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- Notice – You have the right to request and receive a written copy of this notice any time.
- Restriction – You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.

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

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Insurance ACE Notice of Privacy Practices – continued

If I believe that my privacy has been violated, what should I do?

If you believe that your privacy has been violated, you may file a complaint with us by calling us at **866-861-2762** any time. You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also email your complaint to **OCRComplaint@hhs.gov**. If you elect to file a complaint, your benefits will not be affected, and we will not punish or retaliate against you in any way.

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

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

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

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

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



Questions?

Call Member Services at 800-787-3311





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