

Humana Healthy Horizons in Louisiana Member Handbook

Plan year 2026

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Welcome!

You are now a member of Humana Healthy Horizons in Louisiana!

Welcome to Humana Healthy Horizons® in Louisiana. We are a Medicaid Managed Care Organization that is partnering with the Louisiana Department of Health (LDH) to provide services to Healthy Louisiana Members. We are committed to helping you reach your best health. Humana Healthy Horizons in Louisiana has a successful history in care delivery and health plan administration that is focused on a new kind of integrated care with the power to improve health and well-being. Our efforts are leading to a better quality of life for the people and communities we serve. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our Members.

We are proud to be your health plan and are committed to the resources and benefits listed in this Member Handbook. Most questions that you may have about your health plan, your providers, your benefits, and your rights as a Member of the Humana Healthy Horizons in Louisiana can be found here. We are here to help you understand how our health plan works and how to receive care from the high quality providers in Louisiana.

If you have questions or need help, you can find most information online at humana.com/healthylouisiana or you can call us at **1-800-448-3810 (TTY: 711)** to speak with any one of our Member service agents.

We look forward to helping you achieve your best health.



Rhonda Bruffy
Market Vice President
Humana Healthy Horizons® in Louisiana

How to Reach Us

Member Services Humana Healthy Horizons® in LA One Galleria Blvd., Suite 1000 Metairie, LA 70001 humana.com/healthylouisiana You can chat with us via MyHumana	1-800-448-3810 (TTY:711) M-F 7a.m. - 7p.m. Fax:1-888-251-1793 Email: LA_Medicaid_Member_Services@humana.com
24-Hour Nurse Line	1-800-448-3810 (TTY:711)
Louisiana Crisis Hub Line	1-855-242-2735 (TTY:711)
MCNA (dental services for members under age 21, Adult Waiver, Adult ICF/IDD population, and adult denture services)	1-855-702-6262 /TTY: 1-800-846-5277 M-F 7a.m . - 7p.m.
DentaQuest (dental services for members under age 21, Adult Waiver, Adult ICF/IDD population, and adult denture services)	1-800-685-0143 TTY: 711 M-F 7a.m.-7p.m.
Humana Fraud, Waste and Abuse	1-800-614-4126 (TTY: 711), 24 hours a day, 7 days a week, 365 days a year
Member Pharmacy Help Desk	1-800-448-3810 M-F 7 a.m. – 7 p.m. (TTY: 711)
Transportation	1 844-613-1638 M-F 7a.m. - 7p.m.
Case Management	1-800-448-3810 (TTY:711) M-F 7a.m. - 7p.m. Email: LAMCDCaseManagement@humana.com
Humana Beginnings Maternity Case Management	Email: LAMCDMaternity@humana.com
Louisiana Department of Health (LDH)	1-888-342-6207 M-F 8a.m. - 4:30p.m. (TTY 1-800-220-5404)
Superior Vision	1-800-879-6901 (TTY:711) M-F 7a.m. - 8p.m.

Hours of Service

Member Services is open 7a.m. to 7p.m., Monday through Friday. After business hours, or when our office is closed, such as major holidays, you can:

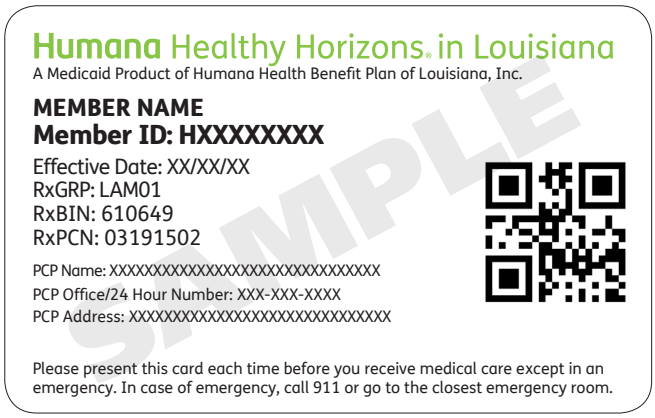
- Choose an option from our phone menu that meets your needs
- Access your records through MyHumana website at Humana.com/logon
- Leave a voice message when our office is closed and a representative will contact you on the next business day
- Email the specific department using the email addresses above

State Medicaid ID Card

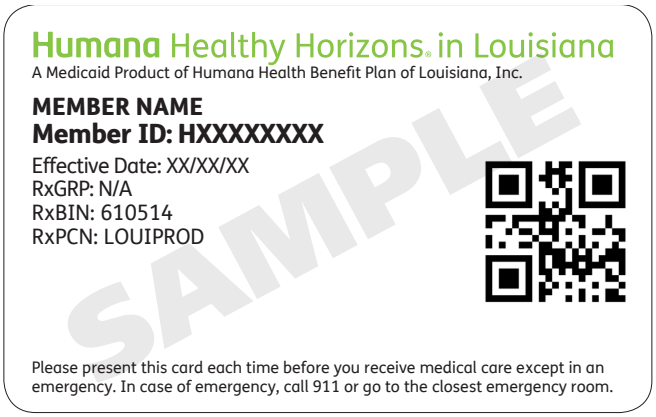
The LDH issues you an ID card when you become eligible for Medicaid. This card will stay the same no matter what health plan you are enrolled with.

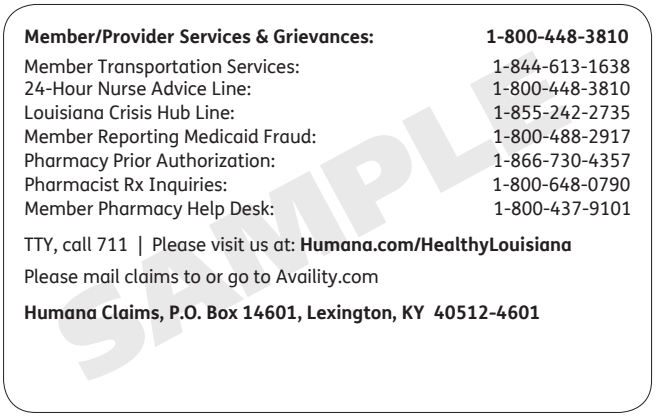
Humana Member ID Card

Humana gives all Members an ID card. Here's an example of what your card will look like.









The front side has personal information and back side of the card has important Humana phone numbers. Every person in your family who is a member will get their own card. Each card is good for as long as you are a member of Humana or until we send you a new one.

If you have Medicare as well, your Medicaid benefits may be limited to only certain benefits. For dual eligible Members, your ID card will list your PCP as “Medicaid Secondary”. For members who are eligible for behavioral health services only, your Medicaid benefits are limited to only certain benefits and your ID card will not include PCP information.

Tools for Easy Access

MyHumana App

Use your Humana plan on the go with the free MyHumana mobile app. The app allows you to safely use your mobile device to:

- Review your latest health summary including status, summary and detailed information
- 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 current location to locate the closest in-network provider no matter where you are

Download the MyHumana App for iPhone or Android by going to the App Store or Google Play.

**May require location sharing enabled on your phone.*

MyHumana Account 

Your MyHumana account is a private, personal online account that can help you get the most out of your Member experience. You can get to your MyHumana account on your mobile device or on your computer by visiting Humana.com. Sign-in with your username and get access to key coverage information as well as useful member tools and resources.

To get started, click the Sign In button at the top, or if you haven't registered, you'll need to create an account by going to Humana.com/logon and select the "Register now" link below the "Not registered?" heading.

Always Keep Your Member ID Card

Never let anyone else use your Member ID card. Be sure to show both your State Medicaid ID Card as well as your Humana Member ID Card each time you get health care services. You need them when you:

- See your doctor
- See any other healthcare provider
- Go to an emergency room
- Go to an urgent care center
- Go to a hospital
- Get mental health or substance use treatment
- Get medical supplies
- Get a prescription
- Have medical tests

Be sure to have a picture ID with you. Your doctor or provider may ask you for your Humana card and a picture ID.

When you call us, please have the Member ID number on your Humana Member ID card available. This will help us serve you faster. Call Member Services if:

- You have not received your Humana ID card
- Any of the information on the card is wrong
- You lose your card
    - o You can also view and download a copy by going to Humana.com or downloading the Humana App
- You have a baby so we can send you a Member ID card for your baby
- You have any questions on how to use your Humana Member ID card

Member Services

Call Member Services or visit humana.com/healthylouisiana to learn more about:

- Benefits or eligibility
- If prior approval is necessary before getting a service

- What services are covered and how to use them
- How to get a new Member ID card
- Reporting a lost ID card
- Selecting or changing your PCP
- Help we have for members who don't speak or read English well
- How we can help members understand information due to vision or hearing problems
- Filing a complaint, grievance or appeal

For faster service, please have your Member ID number on your Humana Member ID card handy.

We want to hear what you think of us. If you have ideas about how we can improve or ways we can serve you better, please let us know. Your feedback is important. We want you to be happy and healthy. You can provide feedback by calling Member Services.

Managed Care Organization

The state contracts with Managed Care Organizations (MCOs) like Humana, or other Medicaid Health Plans, to provide health coverage to Medicaid and LaCHIP Members. MCOs work with providers across the state including hospitals, doctors, nurse practitioners, therapists and others. You can get your health care from this network of providers. Humana Healthy Horizons® in Louisiana offers incentive plans for providers to improve the quality of services provided to you. More information is available to you upon request, including information on the structure and operation of the MCO, physician incentive plans, service utilization policies, etc.

Utilization Management

We keep track of the services you get from healthcare providers. We talk about some services with your providers before you get them. This is to make sure they are appropriate and necessary. Some services may require permission, or prior authorization, before you receive them so that Humana Healthy Horizons in Louisiana will pay for the care and to ensure you receive the care that is right for you. For example, we review surgeries or stays at a hospital (unless they are emergencies). This is called utilization management (UM). We make sure you get the right amount of care you need when you need it. 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.

All UM requests are reviewed carefully by our review team of nurses and doctors. Doctors decide if a service cannot be covered. We check the work of our reviewers regularly. We tell your doctor in writing of the decision and the reason for it. If we are not able to cover the service, we also tell you in writing. The letter includes our phone number in case you want to call us for more information. If you are not happy with the determination, you can appeal it by calling or writing to us. Your case will be re-reviewed by a different doctor from an appropriate specialty area. You will be notified of the determination in writing. See Grievance and Appeals section.

Louisiana Medicaid may decide that a new treatment not currently covered by Medicaid will be a covered benefit. This might be new:

- Healthcare services
- Medical devices

- Therapies
- Treatment options

This information is reviewed by a committee of healthcare professionals who will make a decision about coverage based on:

- Updated Medicaid and Medicare rules
- External technology assessment guidelines
- Food and Drug Administration (FDA) approval
- Medical literature recommendations

Member Rights and Responsibilities

Your rights shall include, but are not limited to:

1. Receive information in accordance with 42 CFR §438.10
2. Receive information about the Plan, its services, its practitioners and providers and member rights and responsibilities.
3. Be treated with courtesy and respect.
4. Always have dignity and privacy considered and respected.
5. Participate in making decisions with your provider unless it is not in your best interest.
6. Receive 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 and presented in manner appropriate to your condition and ability to understand.
7. Participate in treatment decisions with your provider, including the right to:
    a. refuse treatment;
    b. complete information about your condition and treatment options including, but not limited to the right to receive services in a home or community setting or in an institutional setting if desired;
    c. get second opinions;
    d. information about available experimental treatments and clinical trials and how such research can be accessed; and
    e. assistance with care coordination from the PCP's office.
8. Be free from any form of seclusion in effort to retaliate or discipline.
9. To appeal a Plan's decision about your services.
10. Make a compliant about the plan or the care it provides.
11. Make recommendations to our member rights and responsibilities policy.
12. Receive a copy of your medical records, including, if the HIPAA privacy rule applies, the right to request that the records be amended or corrected as allowed in federal regulations.
13. Be given the health care services in federal regulations governing access standards.

14. Complete an advance directive, or a written instruction, such as a living will or durable power of attorney for health care, legally sound when the individual is incapacitated, as required in federal regulations:
    a. Give you written information on advance directives. State law must be given. We must give you written information as soon as possible and not later than 90 days after the change starts.

- To file a grievance for the advance directive if we are not meeting compliance about the following:
    a. Choose your provider.
    b. Receive health care services.
    c. More information on Advance Directives.

15. Be able to use these rights without any effect on your treatment.

Your responsibilities shall include, but are not limited to:

1. Inform the MCO of the loss or theft of your MCO identification card;
2. Present your Member ID card when using health care services;
3. Protecting your enrolling ID card and misuse of the card, including loaning, selling or giving it to others could result in loss of your Medicaid eligibility and/or legal action;
4. Be familiar with the MCO's policies and procedures to the best of your abilities;
5. Contact Humana, by telephone or in writing (formal letter or electronically, including email), to obtain information and have questions clarified;
6. Provide Humana and its participating network providers with accurate and complete medical information;
7. Living healthy lifestyles and avoiding behaviors known to be detrimental to their health;
8. Following the Grievance system established by the Contractor if they have a disagreement with a provider;
9. Understand your health problems and participate in developing mutually agreed-upon treatment goals with your provider;
10. Make every effort to keep any agreed upon appointments and follow-up appointments and contacting the provider in advance if you are unable to do so;
11. To make and keep your doctors appointments;
12. Asking your doctor questions to understand risks, benefits and costs;
13. Follow plans and instructions for care that you have agreed to with your provider.
14. Let us know right away if you have a:
    a. Workers' Compensation claim;
    b. injury;
    c. medical malpractice lawsuit; and
    d. have been involved in a car accident.

15. Report any changes to your family size, living arrangements, parish of residence, phone number or mailing address to:

    Phone Number: 1-888-342-6207
    Website: myMedicaid.la.gov

    You can also visit your local office to report changes above:
    Website: www.ldh.la.gov/MedicaidOffices

Primary Care Provider

The Role of Your PCP

Your Primary Care Provider or PCP is the main health care person who takes care of you on a regular basis. Your PCP gets to know your medical history. A PCP may be a physician, nurse practitioner, or physician assistant. He or she may be trained in family medicine, internal medicine, or pediatrics Your PCP is your medical home and will quickly learn what is normal for you and what is not. When you need medical care, you will see your PCP first. He or she will treat you for most of your routine health care needs. You should see your PCP at least once a year, even if you are feeling well.

If needed, your PCP will send you to other doctors (specialists) or admit you to the hospital. Your PCP will work with you on all your health-related concerns.

You can reach your PCP by calling the PCP's office. Your PCP's name and phone number are on your Member ID card. It is important to see your PCP as soon as you can. This will help your PCP get to know you and understand your health care needs. If you are seeing a new doctor, make sure to take all your past medical records with you or ask that they be sent to your new doctor.

How to Choose A PCP

If you are new to Humana and want to change or update your PCP, just call Member Services **1-800-448-3810 (TTY: 711)**. We can help you get the care you need and set you up with a PCP.

If you would prefer to have a PCP that has the same cultural, ethnic or racial background as you, please call Member Services to ask if there's someone in the network.

There may be a reason that a specialist will be your PCP, for example if you are pregnant. If you think you need a specialist to be your PCP, please call Member Services.

Special Cases

- If you receive Medicare and Medicaid (dual eligible), you do not have to choose a PCP.
- If your plan covers behavioral health services only, you do not have to choose a PCP.
- If you have recently had a baby, you have two (2) weeks to choose a PCP for your baby. If you do not choose a PCP one will be assigned for your baby.

Changing Your PCP

Choosing a PCP will help you take care of your health care needs. If you would prefer, you can choose a PCP that has the same cultural, ethnic, or racial background as you. You may choose a PCP from Humana's Provider Directory. You can start seeing that PCP on the first day you are signed up. The Directory will give you important information about our providers such as address, telephone number, specialty, and other qualifications. If there is any information that is not included in the directory such as the provider's residency or the medical school they attended, please contact the

provider office to ask. To view our directory, please visit Findcare.humana.com or call our Member Services at **1-800-448-3810 (TTY: 711)** Monday through Friday from 7a.m. - 7p.m.

We hope you are happy with your PCP. If you want to change your PCP for any reason, please login to your Humana .com account or call Member Services to let us know. We will make your change on the date you call. We will send you a new Member ID card with your new PCP on it.

Sometimes PCPs tell us that they are moving away, retiring, or leaving our network. This is called a voluntary termination. If this happens with your PCP, we will let you know by mail within 15 days. We will also help you find a new doctor.

Freedom of Choice

You have the right to choose from our network providers who will provide care for you. You can change to another provider within Humana's network anytime you want. If you decide to change your PCP we will send you a new Member ID card with the name of the new PCP.

To change your PCP, choose from one of the three options below:

- Update your PCP information in your MyHumana account
- Call Member Services at **1-800-448-3810 (TTY: 711)**, Monday – Friday, 7 a.m. – 7 p.m., and let us know you want to change your PCP and who you want as your PCP
- Complete and return the PCP Change Request Form

Doctor Visits

Once you officially have your PCP, this will be your personal doctor. You can see your PCP to get Well care and routine checkups.

Well care includes:	Routine care includes:
Regular checkups/exams	Cold/flu symptoms
Immunizations	Earache
Tests and screenings, when needed	Rash
Counseling to support healthy living and self-management of chronic disease	Sore throat

You should visit your PCP within 90 days of joining Humana. Here are some things to know before going to the doctor:

- Always take your State Medicaid ID card and Humana Member ID card
- Take your prescriptions. It's good for your doctor to know what medicines you take. Make a list of questions for your doctor ahead of time so you don't forget anything
- Your doctor is someone you can trust and rely on
- Ask about any concerns you may have

It is important that you start to build a good relationship with your PCP as soon as you can. Please call their office to schedule a visit. Take any past medical records to your first visit or ask that they be sent before your appointment. Your assigned or chosen PCP will want to get to know you and understand your health care needs.

Routine Medical Care

We want to make sure you get the right care from the right healthcare provider when you need it. Use the following information to help you decide where you should go for medical care.

See your PCP for all routine visits. Below are some examples of general conditions that can be treated by your PCP:

Dizziness	High/low blood pressure
Swelling of the legs and feet	High/low blood sugar
Persistent cough	Loss of appetite
Restlessness	Joint pain
Colds/flu	Headache
Earache	Backache
Constipation	Rash
Sore throat	Taking out stitches
Vaginal discharge	Pregnancy tests
Pain management	Depression or anxiety

Well Care Medical Care

See your PCP for well care. This means going to your doctor at least once a year, even if you do not feel sick. Regular checkups, tests, and health screenings can help your doctor find and treat problems early before they become serious.

Well care includes things such as immunizations, diabetes screening, obesity screening and routine physical exams for members of all ages. Well Care also includes screening for common chronic and Infectious diseases and cancers, clinical and behavioral interventions to manage chronic disease and reduce associated risks, and counseling to support healthy living and self- management of chronic disease.

Getting Care

Family/Caregiver/Legal Guardian Role

Humana can help you find providers for health care services. You can also have a family member, caregiver or legal guardian help you. You should always talk to your PCP first when you have a health care need to get their advice unless it is an emergency situation. You can name an Authorized Representative to act for you. An Authorized Representative is a person or organization chosen by you, the member, or authorized under State Law to act responsibly. If you have any questions or need help you can call Member Services at **1-800-448-3810** or **TTY 711**.

Guardianship

What is a Guardian?
A guardian is an adult chosen by a court to be legally in charge of another person. Any adult can seek to have a guardian appointed for another person. Usually, guardianship is requested by a family member.

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

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 clerk of court for information.

Should 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.

Finding a Provider

We have an easy to use Find a Provider tool. This tool can help you find any healthcare provider within our network, such as a Hospital, Specialists, Medical Supply Companies, Pharmacies, etc. Our website includes simple instructions to help you find exactly what you need. Just go to Findcare.humana.com.

You can also call Humana at **1-800-448-3810 (TTY: 711)** Monday through Friday 7a.m. - 7p.m. to help you find a provider.

Making, Changing, Cancelling Doctor Appointments

It is important to keep your scheduled visits with doctors. Sometimes things happen that keep you from going to the doctor. If you have to change or cancel your appointment, please call the doctor's office at least 24 hours before your appointment or as soon as you can. It is always best to let your doctor's office know if you can't be there. Call Member Services if you need help.

Appointment Timeframes

When you need to make an appointment with any provider, please call the provider's office directly to schedule. The provider's office will schedule appointments in a timely manner to make sure your care is provided as quickly as possible. If you have trouble scheduling an appointment you can call Member Services for help.

Your Health is Important

Here are some ways that you can maintain or improve your health:

- Establish a relationship with your PCP
- Make sure you and your family have regular checkups with your PCP
- Make sure if you have a chronic condition (such as asthma or diabetes) that you see your doctor regularly. You also need to follow the treatment that your doctor has given you. Make sure that you take the medications that they have asked you to take.

Remember, the 24-Hour Nurse Advice Line **1-800-448-3810 (TTY:711)** is available to help you. You can call the number on your Member ID card 24 hours a day, 7 days a week, 365 days a year.

Humana has programs that can help you maintain or improve your health. Call us for more information about these programs: **1-800-448-3810 (TTY: 711)**.

After Hours Care

If you need after hours care:

- Check our online provider directory for providers offering after hours services and our Urgent Care Center partners at https://findcare.humana.com/
- Check with your PCP

In case of an emergency call 911 or go to the nearest emergency room.

24-Hour Nurse Advice Line

You can call any time to talk with a caring, experienced registered nurse at **1-800-448-3810**. This is a free call. You can call 24 hours a day, 7 days a week, 365 days a year. Our nurses can help you:

- Decide if you need to go to the doctor or the emergency room
- Learn about a medical condition or recent diagnosis
- Make a list of questions for doctor visits
- Find out more about prescriptions or over-the-counter medicines
- Find out about medical tests or surgery
- Learn about nutrition and wellness

Louisiana Crisis Hub Line

If you are in crisis and not sure if the problem is an emergency, call the Crisis Line at **1-855-242-2735**. This is a free call. Crisis intervention services are available 24 hours a day, 7 days a week, 365 days a year. These trained behavioral health specialists can help you:

- If you feel you are a danger to yourself or others
- If you are unable to carry out activities of daily living due to your stress, depression, anxiety, problems with emotions or substance use

Urgent Care Center

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 **1-800-448-3810 (TTY: 711)**. You may also find the closest Urgent Care center to you by going to our website at Findcare.humana.com to view the provider directory or by calling Member Services at **1-800-448-3810 (TTY: 711)**.

Should I go to the Emergency Room?

Emergency services are for a medical or a behavioral problem that you think is so serious that your life or your ability to function is at risk and it must be treated right away by a doctor. Humana may cover emergency transportation, too. You may see any emergency room provider or hospital that provides emergency services. We cover care for emergencies both in and out of our service area. We will not refuse to pay for your emergency care because the hospital or doctor did not tell your primary care provider, Humana, or LDH within ten (10) days of treating you.

To decide whether to go to an emergency room (ER) ask yourself these questions:

- Is it safe to wait and call my doctor first?
- Could I die or suffer a serious injury if I don't get medical help right away?
- Do I want to hurt myself or others?
- Am I unable to control my thoughts and feelings?

You do not have to call us for approval before you get emergency services. Humana Healthy Horizons® in Louisiana does not limit emergency services based on diagnoses or symptoms. If you are not sure if your illness or injury is an emergency, call your doctor or our 24-hour nurse advice line. Call **1-800-448-3810** to talk to a nurse.

Here are some examples of when emergency services are needed:

Miscarriage/pregnancy with vaginal bleeding	Uncontrolled bleeding
Severe chest pain	Severe vomiting
Shortness of breath	Rape
Loss of consciousness	Major burns
Seizures/convulsions	Severe stomach pain
Thought of hurting yourself or others	Severe diarrhea
Overdose	Severe injuries

If you have an emergency, call 911 or go to the nearest ER. You do not have to call us for approval before you get emergency services. If you are not sure what to do, call your PCP for help, or you can call our 24-hour nurse advice line at **1-800-448-3810**.

Remember, if you have an emergency:

- Call 911 or go to the nearest ER. Be sure to tell them that you are a Humana Member. Show them your Member ID card.
- If the provider that takes care of your emergency thinks that you need other medical care to treat the problem that caused it, the provider must call Humana.
- If you are able, call your PCP as soon as you can or have someone call for you. Let him or her know that you have a medical emergency.
- Schedule any follow-up care with your PCP as soon as you can after the emergency.

If the hospital has you stay overnight, please make sure that Humana is called within 24 hours.

Sometimes you get sick or injured while you are traveling. Here are some tips for what to do if this happens.

- If it's an emergency, call 911 or go to the nearest emergency room.
- If it's not an emergency, call your PCP for help and advice.
- If you're not sure if it's an emergency, call your PCP or our 24-hour nurse advice line **1-800-448- 3810**. We can help you decide what to do.

If you go to an urgent care center, call your PCP as soon as you can. Let him or her know of your visit.

Care after an Emergency

Care after an emergency helps to improve or clear up your health issue, or stop it from getting worse. It does not matter whether you get the emergency care in or outside of our network. We will cover services medically necessary after an emergency. Services that require inpatient admission after an emergency are called post-stabilization services. You should get care until your condition is stable. We will cover post-stabilization services to make sure you are stable after an emergency. There are no copay requirements for post-stabilization services.

PCP Services

Early Periodic Screening, Diagnostic and Treatment (EPSDT)

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are preventive (well care) exams and age recommended health screenings for members under the age of 21. Humana covers EPSDT services at no cost to you.

Humana Healthy Horizons® in Louisiana follows the recommendations of the American Academy of Pediatrics (AAP) and the Bright Futures initiative around the timing of EPSDT visits.

EPSDT Special Services (other necessary health care, further diagnosis, and treatment) are available to your child to correct a physical, developmental, mental health, substance use issue or other condition and to make sure your child's individual needs are met through better care so they can live healthy lives.

Well care is the key to making sure children, adolescents, and older youth stay healthy. Taking your child for regular exams and screenings will help you and the provider identify and prevent illness or disease early, so your child can get care quickly.

EPSDT eligible members with special health care needs can get Care Management services to help coordinate care. If you are interested in Care Management services for yourself or someone you are helping to care for, please call Member Services at **1-800-448-3810 (TTY:711)** M-F 7a.m. - 7p.m. and ask to speak to a Care Manager.

EPSDT well care exams and health screens include:

- Autism screenings
- Maternal depression screenings
- Medical/physical exams
- Complete health and development history
- Height and weight checks with nutrition counseling when needed

- Hearing tests
  - Hearing tests start when your child is a newborn
  - Hearing tests and risk assessments happen at each EPSDT visit
- Eye exams (vision)
  - Eye exams start when your child is a newborn
  - Eye exams and risk assessments happen at each EPSDT visit
- Dental visits
  - During EPSDT visits, oral health assessments are provided at recommended ages and referrals made to a dentist when needed
  - Recommendations to dentists by 12 months or earlier if an issue is identified or a tooth erupts
- Referrals to specialists when needed and recommended regardless of child's age
- Developmental and Behavioral Health Screening, Exams, and Assessment
- Lab tests, including blood tests, lead level tests, tuberculosis risk assessments/tests and urine tests
- Immunizations (shots)
- Health and safety education
- Guidelines to measure and improve the health and well-being of the families' preventive health needs (counseling, evaluations, or screenings)
- Intervention and/or referral needs for identified risk behaviors
- Car seat safety, seat belts
- Alcohol/substance use, sexual activity, mental health
- Developmental delays

Call your child's PCP to schedule an EPSDT well care visit (well-care exam and age recommended health screenings). Take your child's shot record with you to the visit so the PCP will have a complete health record. It is important to schedule EPSDT exams for all eligible family members regularly so you, your child and PCP can work as a team to keep your family healthy. EPSDT well care child visits are different from a visit to the PCP when your child is sick. Humana recommends scheduling the first EPSDT well care exam within 90 days of becoming a member.

You or your child's PCP may suspect a problem that needs more than well care. This may include other health care (special services), diagnostic services and medically necessary treatment including rehabilitative services, physician and hospital care, home health care, medical equipment and supplies, vision, hearing and dental services, additional lab tests, etc.

Humana will cover services that are medically necessary and approved through our prior authorization process, even when they are not covered in the Louisiana Medicaid Program. Call Member Services at **1-800-448-3810 (TTY:711)** M-F 7a.m. - 7p.m. if you have a question about coverage or services that require prior approval.

EPSDT Preventive Visits (well care) are recommended at these ages:

Infancy Newborn 3-5 days 1 month 2 months 4 months 6 months 9 months	***Early Childhood*** 12 months 15 months 18 months 24 months 30 months 3 years * for ages 3 and above, EPSDT visits are once a year
Middle Childhood 3 through 10 years Every year	***Adolescence and Young Adults*** 11 through < 21 years Every year

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 Medicaid decides 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.

Specialty Care

Sometimes, you may need to see a provider other than your PCP for medical problems like special issues, injuries, or illnesses. A specialist is a provider who works in one specific health care area. You do not need to talk to your PCP first, and Humana does not require that you get a referral from your PCP to see a specialist.

Second Opinions

You have the right to a second opinion about your treatment at no cost to you. This includes surgical procedures and treatment of complex or chronic conditions. This means talking to a different doctor about an issue to get his or her point of view. This may help you decide if certain services or treatments are right for you. Let your PCP know if you want to get a second opinion.

You may choose any doctor in or out of our network to give you a second opinion. If you can't find a doctor in our network, we will help you find a doctor. If you need to see a doctor that is not in the Humana network for a second opinion, you must get prior approval from us.

- If you are wanting a second opinion of any tests, these should be given by a doctor in our network. Tests requested by the doctor giving you the second opinion must have the prior approval of Humana. Your PCP will look at the second opinion and help you decide the best treatment.

Right to Refuse Treatment

You have the right:

- To receive information about your health. It may also be given to your Authorized Representative, or it may be given to someone you said should be reached in an emergency when it is not in the best interest of your health to give it to you.

- To ask questions and get complete information about your health and treatment options in a way that you can follow. This includes specialty care.
- To have a candid discussion of any appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- To take an active part in decisions about your health care unless it is not in your best interest.
- To say yes or no to treatment or therapy. If you say no, the doctor or Humana must talk to you about what could happen. They will put a note in your medical record.
- To refuse to go through with any medical service, or treatment, or accept any health services if you don't want to or agree based on religious grounds (this is also for a child if the parent or guardian feels this way).

Transportation

For members who need a ride, Humana provides non-emergency medical transportation both ways for Medicaid covered services:

- Health care appointments
- Vision and dental appointments

This could be on a bus, a handicap-accessible van, or other kinds of vehicles. Transportation services are available in all parts of the state, including rural and urban areas. Transportation to out-of-state appointments can be made but requires prior approval from Humana. Urgent transportation can be scheduled when absolutely necessary. Members under 17 years old must be accompanied by an adult. Call MediTrans at **1-844-613-1638** M-F 7a.m. - 7p.m. to schedule or check the status of a ride. Be sure to call at least 48 hours before the appointment to schedule a ride.

For emergency transportation please call 911.

Interpretation

Is there a Humana Member in your family who:

- Does not speak English?
- Has hearing or visual problems?
- Has trouble reading or speaking English?

If so, we can help. Humana offers sign and language interpreters at no cost for the member. Oral interpretation is provided over the phone and is available in 200 most common languages.

Members can request to be read member materials in the most common languages. If you are filing a grievance or appeal, you can request an interpreter for assistance in filling them out. Please call Member Services to ask for sign language services. In-person Sign language interpretation is provided free of charge when available please provide 72 hours or more to ensure better availability of in-person interpreters. Video remote Interpretation (VRI) is provided when in-person interpreters are not available for an appointment. VRI can be provided with as little as 24 hour notice.

Call us at **1-800-448-3810 (TTY: 711)** to arrange for interpretation, alternative formats, like large print and Braille, Audio CD, and Screen reader PDF.

Translation Services

We can also get printed translated materials in Spanish and the top 15 non-English languages as released by the US Department of Health and Human Services, Office for Civil Rights. Just call us at **1-800-448-3810 (TTY: 711)** to arrange for written translation of a document.

Pharmacy

Managing your medication is important. We want you to feel comfortable knowing what medicines and over-the-counter (OTC) medicines Humana covers when both prescribed by a provider and filled at a pharmacy in our network.

As a Humana Healthy Horizons in Louisiana member, you can access a full range of safe and effective medication. There are many medications that are covered. You can find a short list of these medicines on the Louisiana Medicaid Preferred Drug List (PDL). If you do not see your medication on this list, contact Member Services for more information.

Your Member ID card has important information for your pharmacy. If you do not have your new Member ID card you can still go to the pharmacy. Tell them you have Medicaid and the pharmacist can call **1-800-448-3810 (TTY: 711)**, M-F 7a.m. - 7p.m. to get the needed information.

Before you go, make sure the pharmacy accepts Louisiana Medicaid. To find a pharmacy or see what is covered, go to our website, https://findcare.humana.com/.

Louisiana Medicaid Preferred Drug List (PDL)

Your provider will use the PDL to choose the best medicine to treat you and your condition. Occasionally, your provider may need to get our approval if he or she wants you to use a medicine that is Non-preferred on the PDL. Your provider also will need to get approval if covered medicines have a limit such as:

- Age limit: covered for certain age group
- Quantity limits: a limit on the number of drugs you can get at one time
- Prior authorization: requires approval before it can be covered

The PDL may change from time to time. New drugs are added or removed as needed. We will notify you if your medicine is removed from the PDL. You can find the most up to date PDL at https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf or call Member Services at **1-800-448-3810 (TTY: 711)** for help.

To view current medical and pharmacy coverage policies, please visit https://mcp.humana.com/tad/tad_new/home.aspx?type=provide.

Prior Authorization For Medications

Some medications may require prior authorization before they are covered by Humana. Your provider can tell you if a medication needs prior authorization. You can also call Member Services at **1-800-448-3810 (TTY: 711)** to see if a medication needs prior authorization.

If prior authorization is needed, your provider will give Humana information about why you need the medication. Humana will base its decision on the Louisiana Medicaid Preferred Drug List and the information provided by your doctor. Humana will let your provider know if the medication is approved or denied. After we get your request, most Prior Authorization for Medications determinations are made within 24 hours.

If you or your provider are not happy with the decision, you can request a second review from Humana. This is called an appeal. See the Appeals section.

Copay

Some adult members (21 years of age or older) may be subject to a sliding copay per prescription. The total amount paid for medications can't be more than 5% of the family's monthly income each month. Once the 5% of the family's monthly income is spent on co-payments, members will not have any co-payments for the rest of the month. The following table shows the co-payment amounts:

- $0.00 for drugs costing $5.00 or less
- $0.50 for drugs costing $5.01 to $10.00
- $1.00 for drugs costing $10.01 to $25.00
- $2.00 for drugs costing $25.01 to $50.00
- $3.00 for drugs costing $50.01 or more

Copayments do not apply to the following:

- Family planning services and supplies
- Emergency services
- US Preventive Services Task Force (USPSTF) A and B recommendations
- Services given to:
    - Members younger than 21
    - Pregnant women
    - Members who are inpatient in long-term care facilities or other institutions
    - Native Americans
    - Alaskan Eskimos
    - Members in a Home and Community Based Waiver
    - Members in the Breast or Cervical Cancer Program
    - Members getting hospice services

Participating Pharmacies

You can fill your prescription at any pharmacy that accepts Humana Healthy Horizons in Louisiana. Use our online Find a Pharmacy service at Humana.com/FindaPharmacy to find an in-network pharmacy near you. Make sure to bring your member ID card with you to the pharmacy.

Medication Therapy Management (MTM)

At Humana, we understand the impact that proper medication use can have on your health.

That’s why we have a Medication Therapy Management (MTM) Program for our qualified members. This Program is geared towards helping you learn about your medications, prevent, or address medication-related problems, decrease costs, and stick to your treatment plan.

This Program is available from many local pharmacists. In most cases, a pharmacist will ask if you are interested in learning more about your medications. They are asking because they want to help you. The pharmacist may ask to schedule time with you to go over all of your medications, which includes any pills, creams, eye drops, herbals, or over-the-counter items.

Through the Program, your pharmacist will get alerts and information about your medications and decide if you need extra attention . They offer ways to help you with your medications and how to take them the right way . They will also work with your doctor and others to address your needs and improve how you use your medications .

This service, and the pharmacist's help and information, are part of being a Humana Member and are available at no cost to you . MTM services:

- Improve safe use of medications
- Improve coordination with all your doctors and other caregivers
- Increase knowledge of your medications and how to use them correctly
- Improve overall health

You can call Member Pharmacy Help Desk at **1-800-448-3810 (TTY: 711)** to ask about our list of covered medications and those that need prior approval.

Lock-in Program

You may see different prescribers for different medical care needs. Each prescriber may prescribe you different medications and using one pharmacy can help ensure you are getting the best possible care and use your medications in a healthier way.

If you are eligible for this program, we will work with you and your provider to have your prescriptions transferred to one pharmacy to make filling your prescriptions as easy as possible.

One pharmacy location will help provide better coordination of health care to assure you are getting the right medicines to stay healthy. If you have any questions, please contact us by:

- Phone: **1-833-410-2496**, 7 a.m. – 4:30 p.m. After hours, please leave a voicemail with your name, Humana member ID number, case number, contact phone number, and a detailed description of your request.
- Fax: 1-502-996-8184

Over-the-Counter (OTC) Health and Wellness

As part of your expanded pharmacy benefit, you have a $75 per quarter allowance to spend on OTC health and wellness items. These medicines will be sent by UPS or the U. S. Postal Service within 10–14 working days after the order is made. There is no charge to you for shipping. Go to Humana.com/LouisianaPharmacy to see the list of health and wellness items available as well as an OTC order form. Keep in mind that some OTC medicines are covered on your pharmacy benefit and available only with a prescription.

If you have questions about this mail-order service, call: CenterWell Pharmacy **1-855-211-8370 (TTY: 711)**, Monday - Friday, 7 a.m. - 10 p.m., and Saturday, 7 a.m. to 5:30 p.m.

Prior Authorization for Services

Services that need prior approval are services Humana Healthy Horizons® in Louisiana needs to approve before you get them. Your provider will ask for a prior authorization from us and should schedule these services for you. Humana Healthy Horizons® in Louisiana will not pay for these services if they are done without prior authorization. Covered services that need a prior authorization are marked in the benefits details section.

You can request prior authorization for a service by:

- Completing prior authorization form located at Humana.com/LouisianaDocuments and mailing it to:
  P.O. Box 14822
  Lexington, KY 40512-4822
- Calling Member Services at **1-800-448-3810 (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.

Note: This section does not apply to pharmacy. Pharmacy service is for drugs that are prescribed to you by a doctor or other healthcare provider. Your healthcare provider will help coordinate request for prior authorization for medications. See Prior Authorization for Medications section.

Prior Authorization for Services Timeframes

After we get your request, we will review it under either a standard or an expedited (faster) process. Your doctor can ask for an expedited review if it is believed that a delay will cause serious harm to your health.

We will review your request for Prior Authorization within the following timeframes:

- Standard review: We will decide about your request within seven (7) Calendar Days of receiving the request.
- Expedited (faster) review: We will decide about your request within seventy-two (72) hours of receiving the request.
- Retrospective (post service) review: We will decide about your request within 30 days.

Note: Both timeframes for standard and expedited reviews can be extended up to 7 calendar days if, the member, or the provider requests an extension, or if the Humana Healthy Horizons® in Louisiana justifies a need for additional information and the extension is in the member's best interest. If we approve a service and you have started to receive that service, we will not reduce, stop, or restrict the service during the time it has been approved unless we determine the approval was based on information that was known to be false or wrong.

If we deny a service, we will send a notice to you and your provider.

Note: This does not apply to pharmacy. Most Prior Authorization for Medications determinations are made within 24 hours. See Prior Authorization for Medications section.

Services that Do Not Require Prior Approval

The following services do not require prior approval:

- Emergency Services or post-stabilization services, whether provided by an in-network or out-of-network provider;
- Non-emergency inpatient hospital admissions for normal newborn deliveries; and
- EPSDT screening services.

Advance Directives

Advance Directives are forms you fill out in case you become seriously ill or not able to make your own health care decisions. Doctor's offices and hospitals may have these forms available. If you haven't thought about this, now is a good time to start. You may want to talk to your family, too. However, Advance Directives are always voluntary. You must be over 18 years old to have an Advance Directive. You can find the forms you need on our website Humana.com/LouisianaDocuments.

Advance Directives can give you peace of mind knowing your choices about your medical treatment will be voiced and followed. They let your doctors and others know how you want to be treated or who you want making health care decisions for you if you get very sick.

You sign them while you are still healthy and able to make these decisions. They are only used when you are too ill or not able to communicate. They allow you to express if you would like things done to keep you alive or name someone to make health care decisions for you. You have the right to cancel your advance directives at any time as long as you're able. If you have questions related to your advance directives contact Member Services at **1-800-448-3810**.

If a provider or anyone else refuses to honor your advance directive you can file a complaint with LDH Health Standards Section, Louisiana's Survey and Certification Agency at **1-225-342-0138**.

If you do not have an Advance Directive and you are not able to make health care decisions, Louisiana law still lets others make decisions for you. Other people may be a:

- Guardian
- Attorney
- Spouse
- Adult child
- Parent
- Next-of-kin

If you have any questions regarding Advance Directives, you should always consult a qualified legal professional such as LA.FreeLegalAnswers.org. This information is provided for general information purposes and is not intended to be legal advice.

Mental Health Advance Directive

You may also state your specific preferences regarding the mental health treatment you may or may not wish to receive in the event you become unable to make your own decisions regarding mental health treatment. For example, you may not want certain types of medication or treatment.

Mental Health Advance Directives must be in writing. They must be signed and dated by you and witnessed by two adults or one notary.

For more information on how you can state your preferences on the mental health treatment you wish to receive, please visit humana.com/healthylouisiana.

Living Will

A Living Will allows you to leave instructions in these important areas. You can:

- Name a Health Care Surrogate (this is someone who is legally responsible for making healthcare decisions when the person cannot make decisions for themselves)
- Refuse or request life prolonging treatment (This is a treatment taken to sustain life of a critically ill person to save their life)
- Refuse or request artificial feeding or hydrations (feeding tube or hydration IVs)
- Express your wishes regarding organ donation (Donation of organs)

When you name a Health Care Surrogate, you allow one or more persons, such as a family member or close friend, to make health care decisions for you if you lose the ability to decide for yourself When choosing a Health Care Surrogate, remember that the person you name will have the power to make important treatment decisions. Even if other people close to you might want a different decision.

Choose the person best qualified to be your Health Care Surrogate. Also, consider picking a back-up person, in case your first choice isn't available when needed. Be sure to tell the person that you have named them as a Health Care Surrogate and make sure that the person understands what's most important to you. Your wishes should be laid out specifically in the Living Will.

A Living Will allows you to make your wishes known regarding life-prolonging treatment and artificial feeding or hydrations so your Health Care Surrogate or doctor will know what you want them to do. You can also decide whether to donate any of your organs in the event of your death. If you decide to make a Living Will, be sure to talk about it with your family and your doctor.

Living Wills must be in writing. They must be signed and dated by you and witnessed by two adults or one notary.

Continuation of Care You Are Receiving

If you move from one MCO to another, or an MCO's contract ends, you have the right to continue care you are currently receiving for up to 90 days.

If you are pregnant, and are in your second or third trimester, you can continue to see your prenatal care provider for up to 60 days after your delivery.

Member Satisfaction

Right to Fair Treatment

Discrimination is Against the Law

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.

Humana Inc. and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Service at **1-800-448-3810 (TTY 711)**.

If you believe that Humana Inc. or its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512 – 4618
1-800-448-3810 or if you use a TTY, call 711.

You can file a grievance by mail or phone. If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TTY)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Grievances and Appeals

We hope you will be happy with Humana and the service we provide. Please let us know if you are unhappy with anything. We want you to contact us so we can help you.

Grievances and appeals are not the same thing. You can use the appeal or grievance process, depending on what type of issue you are experiencing. An appeal is a request for Humana to review an adverse benefit determination (benefit denial). A grievance is any other dissatisfaction that does not involve an adverse benefit determination. At any time during the appeal or state fair hearing process you can request copies of the documents pertaining to your case free of charge by contacting Member Services at **1-800-448-3810 (TTY: 711)**.

Grievances (Complaints)

If you are unhappy with Humana or one of our providers, this is called a grievance. You, or someone you have chosen to represent you, can call us. You can file a grievance at any time orally or in writing. If you ever want information about grievances please ask us. Call Member Services at **1-800-448-3810 (TTY: 711)**. If needed, we can help you file a grievance. You can also get help from

others. People who can help you are:

- Someone you choose to act for you with your written consent
- Your legal guardian
- A provider you choose to act for you with your written consent
- Interpreters that we will provide to you, if needed

You can let us know about your grievance by doing one of the following:

- Calling Member Services at **1-800-448-3810 (TTY: 711)**
- Writing us a letter
    - Be sure to put your first and last name, the member number from the front of your Humana Member ID card, and your address and phone number in the letter. This will allow us to contact you if we need to. You can also send any information that helps explain the problem
- Submitting a request online at humana.com
- Faxing your grievance to 1-800-949-2961
- Mail the form or letter to:

    Humana
    Grievance and Appeals Department
    P.O. Box 14546
    Lexington, KY 40512-4546

We will send you a letter within five (5) business days from the day we receive your grievance to let you know we received it.

We will then review it and send you a letter within 90 calendar days to let you know our decision. Negative actions will not be taken against:

- A member who files a grievance
- A provider that supports a member's grievance or files a grievance on behalf of a member with written consent

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 by calling or writing to us.

If needed, we can help you file an appeal. You can also get help from others. People who can help you are:

- Someone you choose to act for you, with your written consent
- Your legal guardian
- A provider you choose to act for you, with your written consent
- Interpreters that we will provide to you, if needed

You can file an appeal by:

- Calling Member Services at **1-800-448-3810 (TTY: 711)**
- Writing us a letter
    - Be sure to put your first and last name, the member number from the front of your Humana ID card, and your address and phone number in the letter. This will allow us to contact you if we need to. You can also send any information that helps explain your appeal.
- Submitting a request online at Humana.com/LouisianaGrievance
- Faxing your appeal to 1-800-949-2961
- Mail the form or letter to:

    Humana
    Grievance and Appeals Department
    P.O. Box 14546
    Lexington, KY 40512-4546

We will send you a letter within five (5) business days from the receipt of your appeal request to let you know we received it.

After we complete the review of your appeal, we will send you a letter within 30 calendar days to let you know our decision. You or someone you choose to act for you may:

- Review all of the information used to make the decision
- Provide more information throughout the appeal review process
- Examine the member's case file before and during the appeals process
    - This includes medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by us, or at our direction, in connection with the appeal
    - This information will be provided, upon request, free of charge and sufficiently in advance of the resolution timeframe

If you feel waiting for the 30-day timeframe to resolve an appeal could seriously harm your health, you can request that we make a decision faster or expedite the appeal. In order for your appeal to be expedited, it must meet the following requirements:

- A delay could seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function.

We make decisions on expedited appeals within 72 hours or as fast as needed based on your health. Negative actions will not be taken against:

- A member or provider who files an appeal
- A provider that supports a member's appeal or files an appeal on behalf of a member with written consent

If you or your authorized representative request an expedited appeal and the appeal does not meet the requirements for expedited processing, we will process the appeal within the standard 30 calendar days. We will make reasonable efforts to give you prompt oral notice that your request does not meet the requirements for expedited processing. We will also give you written notice within two (2) calendar days.

The timeframe for your appeal or expedited appeal can be extended up to 14 calendar days. We will make reasonable efforts to give you prompt oral notice of the delay. We will also give you written notice within two (2) calendar days of the reason for the decision to extend the timeframe. If we need more information to make either a standard or expedited decision about your appeal, we will:

- Write you and tell you what information is needed. For expedited appeals, we will call you right away and send a written notice later.
- Explain why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.
- We also will inform you of the right to file a grievance if you disagree with the decision to extend the timeframe.

You can present additional evidence (such as medical records, supporting statements from a provider, etc.) over the phone, in person or in writing. You can include the information with your appeal request or submit it at any time during the appeal process. For a standard appeal, we have to receive this information within 30 calendar days of us receiving your appeal request. For an expedited appeal, we must receive any supporting information within 72 hours of your appeal request.

Continuation of Benefits during the Appeal Process

For some adverse benefit determinations, you can ask to continue receiving services during the appeal and Medicaid Fair Hearing process. You can request that services be continued if:

- You already are receiving the services that are being reduced, suspended or terminated.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not yet ended.

You have to request that your services continue within ten (10) days from the date on our Notice of Adverse Benefit Determination letter, or, on or before the date we told you the service would be reduced, suspended or terminated, whichever is later.Your benefits will continue until one of the following occurs:

- Until the original authorization period for your services has ended
- You withdraw your appeal
- You do not request an appeal or State Fair Hearing with continuation of benefits within ten (10) days from the date on Humana Healthy Horizons' decision letter
- Following a Medicaid Fair Hearing, the Administrative Law Judge issues a decision that is not in your favor

If the appeal was denied and you request a Louisiana State Medicaid Fair Hearing with continuation of services within ten (10) days of the date on the appeal resolution letter, your services will continue during the Medicaid Fair Hearing. (See the Medicaid Fair Hearing section.)

However, if the Administrative Law Judge agrees with our first decision to deny your service, you may be required to pay for these services.

Medicaid State Fair Hearings

You have the right to ask for a Medicaid State Fair Hearing from the Division of Administrative Law after you have completed the Humana appeal process. You also have the right to ask for a Medicaid State Fair Hearing if Humana does not give you a decision about your appeal within 30 calendar days for a standard appeal or 72 hours for an expedited appeal. You can do so in writing, by mail or fax. Your request may also be submitted online. You, your authorized representative, or a provider acting on your behalf, with your written permission, may file for a Medicaid State Fair Hearing within 120 days from the date on our appeal decision letter.

Write:
Division of Administrative Law – Louisiana Department of Health Section
P.O. Box 4189
Baton Rouge, LA 70821-4189

Fax: 1-225-219-9823

Call: 1-225-342-5800 or **1-225-342-0443**

Online: https://www.adminlaw.la.gov

You can have someone else represent you during the Medicaid state fair hearing if you choose. That person can be a friend, relative, attorney or other person, with your written consent.

If you request a Medicaid State Fair Hearing and want your Humana benefits to continue, you must file a request with us (Humana) within ten (10) days from the date on our decision letter.

The decision will be made within 90 days from the date the Division of Administrative Law receives the request.

If the hearing officer approves a request for authorization of services, Humana will authorize those services as quickly as your health condition requires, but no later than 72 hours from the date we receive the decision.

If the Medicaid State Fair Hearing finds that our decision was right, you may have to pay the cost of the services provided for the benefits that were continued during the Medicaid State Fair Hearing.

In a State Fair Hearing, the Division of Administrative Law will make the recommendation to the Secretary of the LDH who has final authority to determine whether services will be provided.

Bills for Covered Services

Humana pays for certain services; Refer to the “What we pay for” section. You should not have to pay out of pocket for these covered services. If you receive a bill or a statement from a provider requesting payment for an approved covered service:

- Contact the provider to clarify if the statement is a bill or just a receipt.
- Contact Humana’s Member Services at **1-800-448-3810, (TTY: 711)**

Report Fraud, Waste and Abuse

We have a comprehensive fraud, waste and abuse program in our Special Investigations Unit (SIU). It is designed to handle cases of managed care fraud. Help us by reporting questionable situations.

Fraud can be committed by providers, pharmacies, or Members. We monitor and take action on all provider, pharmacy, or Member fraud, waste, and abuse.

Examples of provider fraud, waste, and abuse include doctors or other healthcare providers who:

- Prescribe drugs, equipment or services that are not medically necessary
- Fail to provide patients with medically necessary services due to lower reimbursement rates
- Bill for tests or services not provided
- Use wrong medical coding on purpose to get more money
- Schedule more frequent return visits than are medically necessary
- Bill for more expensive services than provided
- Prevent Members from getting covered services resulting in underutilization of services offered

Examples of pharmacy fraud, waste and abuse include:

- Not dispensing medicines as written
- Submitting claims for a more expensive brand name drug that costs more when you actually receive a generic drug that costs less
- Dispensing less than the prescribed quantity and then not letting the Member know to get the rest of the drug

Examples of Member fraud, waste and abuse include:

- Inappropriately using services such as selling prescribed narcotics or trying to get controlled substances from more than one provider or pharmacy
- Changing or forging prescriptions
- Using pain medications you do not need
- Sharing your Member ID card with another person
- Not disclosing that you have other health insurance coverage
- Getting unnecessary equipment and supplies
- Receiving services or picking up medicines under another person's ID (identity theft)
- Giving wrong symptoms and other information to providers to get treatment, drugs, etc.
- Too many ER visits for problems that are not emergencies
- Misrepresenting eligibility for Medicaid

Members who are proven to have abused or misused their covered benefits may:

- Be required to pay back money that we paid for services that were determined to be a misuse of benefits
- Be prosecuted for a crime and go to jail
- Lose Medicaid benefits
- Be locked in to one PCP, one controlled substance prescriber, one pharmacy and/or one hospital for non-emergency services.

Report Fraud

If you think a doctor, pharmacy or Member is committing fraud, waste, or abuse, you must inform us. Report it to us in one of these ways:

- Call 1-800-614-4126 (TTY: 711), 24 hours a day, 7 days a week
- Select the menu option for reporting fraud
- Complete the Fraud, Waste, and Abuse Reporting form online at, humana.com/legal/si-referral-form
- You can write a letter and mail it to us at:

  Humana
  Attn: Special Investigations Unit
  1100 Employers Blvd.
  Green Bay, WI 54344

You do not have to give us your name when you write or call. There are other ways you may contact us that are not anonymous. If you are not concerned about giving your name, you may also use one of the following ways to contact us:

- Send an email* to siureferrals@humana.com or ethics@humana.com
- Fax us at 1-920-339-3613

When you report fraud, waste, or abuse, please give us as many details as you can. Include names and phone numbers. You may remain anonymous. If you do, we will not be able to call you back for more information. Your report will be kept confidential to the extent permitted by law.

*Most email systems are not protected from third parties. This means people may access your email without you knowing or saying it's okay. Please do not use email to tell us information that you think is confidential, like your Member ID number, social security number, or health information. Instead, please use the form or phone number above.

This can help protect your privacy.

If you would like to report fraud directly to LDH, you can:

- Report provider fraud: Online at https://ldh.la.gov/form/22 or call **1-800-488-2917 TTY: 1-800-220-5404**
- Report Member fraud: Online at https://ldh.la.gov/form/23 or call **1-833-920-1773 TTY: 1-800-220-5404**

Member Advisory Committee

Humana is excited to offer you the chance to improve your health plan. We invite you to join your Member Advisory Council. As a Council member, you can share with us how we can better serve you.

Attending offers you the chance to meet other Plan Members in your community. You can bring a family member, caregiver or close friend. Humana wants to hear how we can improve your health plan. If you can't attend in person, you can join us by phone. A $25 gift card will be distributed to all Humana Healthy Horizons members after the session.

If you would like to attend a Member Advisory Council meeting or would like more information, please contact Member Services at **1-800-448-3810** or email la_medicaid_member_services@humana.com.

CALL: 1-800-448-3810
TTY: 711
WEBSITE: Humana.com/HealthyLouisiana

Quality Improvement

Program Purpose

The goals and objectives of the Humana Quality Improvement (QI) Program are:

- Coordinate care
- Promote quality
- Ensure performance and efficiency on an ongoing basis
- Improve the quality and safety of clinical care and services provided to Humana Members

The quality program is developed with Humana's purpose in mind to help people achieve their best health.

We align with the Institutes for Healthcare Improvement's Triple Aim:
Better Care, Healthy People/Healthy Communities, and Affordable Care.

Your care means a lot to us. The purpose of the Humana Quality Improvement Program is to continue to improve the quality of health care services provided to you. We work to:

- Obtain accreditation compliance with NCQA Accreditation standards
- Receive a high level of HEDIS® performance
- Receive a high level of CAHPS® performance

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Program Scope

The Humana Quality Improvement Program governs the quality assessment and improvement activities for Humana Healthy Horizons® in Louisiana. This includes:

- Meeting the quality requirements of the Centers for Medicare and Medicaid Services (CMS)
- Establishing safe clinical practices throughout the network of providers
- Providing quality oversight of all clinical services
- Compliance with NCQA accreditation standards
- HEDIS® compliance audit and performance measurement
- Monitoring and evaluation of Member and provider satisfaction
- Managing quality of care and quality service complaints
- Ensuring the Humana QI Program is effectively serving Members with culturally and linguistically diverse needs

- Ensuring the Humana QI Program is effectively serving Members with complex health needs
- Assessing the traits and needs of the Member population
- Assessing the geographic availability and accessibility of primary and specialty care providers

On an annual basis, Humana makes information available about its Quality Program to Members and providers on the Humana website. To get a printed copy of the Humana Quality Improvement (QI) Program please call Member Services.

Humana gathers and uses provider performance data to improve quality of services.

Quality Measures

Humana continually assesses and analyzes the quality of care and services offered to our Members.

Humana uses HEDIS® to measure the quality of care delivered to Members. HEDIS® is one of the most widely used means of health care measurement in the United States. HEDIS® is developed and maintained by the National Committee for Quality Assurance (NCQA).

The HEDIS® tool is used by America's health plans to measure important dimensions of care and service. It allows for comparisons across health plans to meet state and federal performance measures and national HEDIS® benchmarks.

HEDIS® measures are based on evidence-based care and address the most pressing areas of care. Potential quality measures for Humana are:

- Preventive screenings (cervical cancer, colorectal cancer, etc.)
- Well-child care
- Chronic care management
- Comprehensive diabetes care
- Controlling high blood pressure
- Behavioral health
- Follow-up after hospitalization for mental illness
- Follow-up for children prescribed ADHD medication
- Safety

Humana uses the CAHPS® survey to capture Member perspectives on health care quality. CAHPS® is a program overseen by the United States Department of Health and Human Services – Agency for Healthcare Research and Quality (AHRQ).

Potential CAHPS® measures for the plan are:

- Member service
- Getting care quickly
- Getting needed care
- How well doctors communicate
- Ratings of all health care, health plan, personal doctor, specialist

What We Pay For

Benefit Details: What is covered under your Humana Healthy Horizons® in Louisiana Medicaid Plan

If Humana Healthy Horizons is unable to provide a necessary and covered service in our network, we will cover these services out of network. We will do this for as long as we cannot provide the service in network. If you are approved to go out of network, this is your right as a member. There is no cost to you.

We cover all medically necessary services, as shown on the list below, at no cost to you. There may be some copays for medications. Some services may require a prior approval and will be noted on the chart below. Our goal is to help you maintain lifelong well-being.

Covered Services

Services covered by Humana Healthy Horizons in Louisiana include but are not limited to the below listing. The following list of covered services does not apply to members who have behavioral health only benefits. Some limitations and prior approval requirements may apply. Call Member Services to learn more about these benefits at **1-800-448-3810**.

Service/Benefit	Description	Limit
Advanced Practice Registered Nurses (APRN)	A nurse licensed as an APRN includes a: • Clinical Nurse Specialist (CNS) • Certified Nurse Practitioner (CNP) • Certified Nurse Midwife (CNM)	
Allergy testing and allergen immunotherapy	Testing and treatment for allergies to things like food, animals, pollen and dust mites	
Ambulatory surgical services	Outpatient surgical center for procedures that do not require an inpatient hospital stay	
Anesthesia	Anesthesia services are covered when provided by an anesthesiologist or certified registered nurse anesthetist (CRNA)	
Bariatric surgery	Open or laparoscopic procedures that revise the gastrointestinal anatomy to restrict the size of the stomach, reduce absorption of nutrients, or both, for weight loss; covered when determined to be medically necessary	
Breast surgery	Mastectomy, breast reconstruction, reduction mammoplasty and removal of breast implants when determined to be medically necessary	
Cardiovascular Services	Elective Invasive Coronary Angiography (ICA) and Percutaneous Coronary Intervention (PCI) are covered as treatment for cardiovascular conditions under specific circumstances	Covered for members 18 and older

Service/Benefit	Description	Limit
Chiropractic services	Chiropractic services to diagnose and treat neuromusculoskeletal conditions associated with the functional integrity of the spine	Covered for members age 0–20 under EPSDT Covered for members age 21 and older as an in lieu of service
Cochlear implant	Includes: • Preoperative evaluation • Implants, equipment, repairs, and replacements • Implantation procedure, postoperative rehabilitative costs, and subsequent therapy • Postoperative programming	Covered for members age 0–20
Dental services—emergency	Services to restore a natural tooth, as best as possible, due to accidental injury	
Dental services – Preventative and Routine	Dental Covers: • EPSDT • Adult Waiver • Adult ICF/IID Programs Covered Service categories include: • Services to maintain oral health, such as preventative services, x rays, and restorative services. • Diagnostic; • Preventive; • Restorative; • Endodontic; • Periodontal; • Removable Prosthodontics; • Maxillofacial Prosthetics; • Fixed Prosthodontics; • Oral and Maxillofacial Surgery; • Orthodontic; and • Adjunctive General Services.	Covered for members aged 0–20 as an EPSDT service through member's dental benefits management company: MCNA or DentaQuest. Comprehensive dental services are available for Adults Waiver beneficiaries (21 and over) who are enrolled in the New Opportunities Waiver, Residential Options Waiver or the Supports Waiver. Comprehensive Dental services are also provided to adults 21 years of age and older with developmental or intellectual disabilities who reside in an Intermediate Care Facilities for Individuals with Intellectual Disabilities.
Diabetic Supplies	Diabetic supplies such as glucose meters, test strips, transmitters and sensors, insulin pumps, control solution, ketone test strips, lancets and devices, pen needles, insulin pens, syringes	Certain supplies covered with a prescription when filled at an in-network pharmacy

Service/Benefit	Description	Limit
Diabetes self-management training (DSMT)	Training to teach members how to cope with and manage diabetes includes: • Instructions for blood glucose self-monitoring • Education regarding diet and exercise • Individualized insulin treatment plan (for insulin-dependent members) • Encouragement and support for use of self-management skills Parents or legal guardians can participate in DSMT rendered to their child.	A maximum of 10 hours of initial training (1 hour of individual and 9 hours of group sessions) are allowed during the first 12-month period beginning with the initial training date. A maximum of 2 hours of individual sessions are allowed for each subsequent year.
Doula services	Doulas offer physical, emotional, and educational support to supplement pregnancy and postpartum health care services and support pregnant enrollees to receive healthy, safe, and equitable prenatal and postnatal care.	Prenatal visits: 5 visits for up to 90-minute sessions Support and assistance during labor and childbirth: 1 visit Postpartum visits: 3 visits for up to 90-minute sessions
Durable medical equipment, prosthetics, orthotics and certain supplies	Medical equipment, supplies, or devices primarily and customarily used for medical purposes and not generally useful in the absence of illness or injury	Prior authorization may be required. Refer to the Humana Healthy Horizons Prior Authorization List (PAL) for services requiring prior authorization.
Early Periodic Screening Diagnosis and Treatment (EPSDT) services	• Complete health and developmental history • Unclothed physical exam • Laboratory tests (including lead screening) • Immunizations (shots) • Screenings (including mental health, depression, substance use, development, hearing, vision, lead, other) • Dental screenings and referrals to dental providers • Nutrition • Health education and guidance • Referrals for further diagnosis (testing) and treatment when needed • Vision services • Dental services • Hearing (Audiology) services	Covered for members age 0–20

Service/Benefit	Description	Limit
Emergency and post-stabilization services	• Emergency service and care • Post-stabilization care after an emergency	Emergency services and post-stabilization care covered for out-of-state or out-of-network providers until safe discharge or transfer to an in-state facility is medically appropriate.
End-stage renal disease services	Services include: • Renal dialysis treatments (hemodialysis and peritoneal dialysis) • Routine laboratory services • Nonroutine laboratory services • Medically necessary injections	
Eye care and vision services	Members 0 through 20: • Examinations and treatment of eye conditions, including examinations for vision correction, refraction error • Regular eyeglasses when they meet a certain minimum strength requirement. Medically necessary specialty eyewear and contact lenses with prior authorization. Contact lenses are covered if they are the only means for restoring vision Members 21 and over: • Examinations and treatment of eye conditions, such as infections, cataracts, etc. • If the recipient has both Medicare and Medicaid, some vision related services may be covered. The recipient should contact Medicare for more information since Medicare would be the primary payer • Contact lenses are covered if they are the only means for restoring vision	
Family planning services	• Evaluation and management • Diagnostic services o Contraceptive services o Implantable contraceptive capsules o Diaphragm o Intrauterine contraceptives o Contraceptive supplies o Injectable contraceptives o Oral contraceptives	Covered for members age 10–59

Service/Benefit	Description	Limit
FQHC/RHC services	• Physician services • Services and supplies incident to a physician's professional services • Physician assistant services • Nurse practitioner and nurse midwife services • Services and supplies incident to provider assistant, nurse practitioner and nurse midwife services • Visiting nurse services to the homebound • Clinical psychologist • Clinical social worker services • Services and supplies incident to the services of clinical psychologists and clinical social workers • Other ambulatory services • Diabetes self-management training • Fluoride varnish applications	
Genetic counseling and testing	• Genetic Counseling • Breast and ovarian cancer • Familial adenomatous polyposis • Lynch syndrome	
Gynecology	Area of medicine involving the treatment of women's diseases, especially those of the reproductive organs includes: • Hysterectomies • Long-acting reversible contraceptives • Mammograms • Pap tests • Pelvic examinations • Saline infusion sonohysterography or hysterosalpingography	
Home health services	• Skilled nursing services • Home health aide services • Physical therapy • Occupational therapy • Speech-language pathology services • Intermittent skilled nursing • Extended home health (EHH) services (private duty nursing) • Extended skilled nursing services	Members aged birth through age 20: no annual service limits Members aged 21 and older: 1 visit per profession per day

Service/Benefit	Description	Limit
Hospice services	Comfort care for patients who are terminally ill, provided in their home or in a hospice facility when the member has elected hospice care.	
Hospital-based Care Coordination of Pregnant and Postpartum Individuals with Substance Use Disorder (SUD) and Their Newborns	Coverage for a comprehensive pregnancy medical home model of care to Humana Healthy Horizons in Louisiana members with SUD, who are 18 years of age and older, and pregnant or up to 12 months postpartum.	Offered by Humana Healthy Horizons as an in-lieu of service for members aged 18 and older: pregnant and postpartum members up to 12-months. Prior authorization is not required
Hospital Services – Inpatient	Care needed for the treatment of an illness or injury that can only be provided safely and adequately in a hospital setting and includes those basic services a hospital is expected to provide	Authorization is required.
Hospital Services – Outpatient	Care provided in an outpatient hospital setting for less than 24 hours	
Hyperbaric oxygen therapy	Treatments administered in a hyperbaric oxygen therapy chamber if deemed medically necessary	
Immunizations	Vaccines for members age 0–18 are covered when recommended by the Advisory Committee on Immunization Practices (ACIP). These vaccines are provided free of charge through the Louisiana Immunization Program/ Vaccines for Children Program. For members age 19 and older, all ACIP-recommended vaccines and vaccine administration are covered according to ACIP recommendations.	Limitations apply depending on member's age.
Intrathecal Baclofen Therapy	This therapy is used to help relax certain muscles in the body, relieving the spasms, cramping and tightness caused by medical issues such as multiple sclerosis, cerebral palsy or certain injuries to the spine	Covered for members aged 4 and older.
Laboratory services	Most diagnostic testing and radiological services ordered by the attending or consulting physicians are covered. Portable (mobile) x-rays are covered only for recipients who are unable to leave their place of residence without special transportation or assistance to obtain physician ordered x-rays.	
Medical Transportation Services	Transportation to and from Medicaid-covered services appointments	Managed by MediTrans, **1-844-613-1638**, Monday – Friday, 7 a.m. – 7 p.m.

Service/Benefit	Description	Limit
Newborn Care and Discharge	Educating new parents and caregivers on newborn care and safety. Includes: • Discharge services • Newborn screenings for genetic disorders • Screening of all newborns for early detection of cytomegalovirus (CMV) infection	
Obstetrics	Field of study concentrated on pregnancy, childbirth and the postpartum period Includes but not limited to: • Initial prenatal visit(s) • Follow-up prenatal visits • Postpartum care visit • Prenatal laboratory and ultrasound services	
Organ Transplants	Medically necessary organ transplants are covered when performed in a hospital that is a Medicaid approved transplant center for that procedure	
Outpatient Lactation Support	Coverage of outpatient lactation support services for members who are breastfeeding or exclusively pumping	Offered by Humana Healthy Horizons as an in-lieu of service including 6 total treatment sessions that occur during pregnancy or while less than 24 months post-partum Individual sessions: 60-minute minimum session length Group sessions: Up to a max of 8 participants in a group session with a 60-minute minimum session length

Service/Benefit	Description	Limit
Pediatric Day Healthcare Services	Services include: • Nursing care • Respiratory care • Physical therapy • Speech-language therapy • Occupational therapy • Social services • Personal care services (activities of daily living [ADL]) • Transportation to and from the Pediatric Day Healthcare facility, paid in a separate per diem	Covered for members age 0–20 when medically necessary Prior authorization is required.
Personal Care Services – EPSDT	Provision of medically necessary assistance, in the home or in the community, with ADL and age-appropriate instrumental ADL (IADL) to enable members to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability Services may include: • Basic personal-care toileting and grooming activities • Assistance with bladder and/or bowel requirements or problems • Assistance with eating and food preparation • Performance of incidental household chores, only for the recipient • Accompanying, not transporting, recipient to medical appointments	Covered for members aged 0 to 20 when medically necessary. Prior authorization is required.
Pharmacy Services	Medicine used to promote healing. This service is for drugs that are prescribed to you by a doctor or other healthcare provider	Prior authorization may be required. Some members may have copays. Some medicine may only be covered for certain age groups
Physician Administered Medication	Outpatient drug other than a vaccine that is typically administered by a healthcare provider in a physician's office or other outpatient clinical setting	

Service/Benefit	Description	Limit
Physician/ Professional Services	Professional services are provided by, but are not limited to: • Physician services • Nurse midwife • Nurse practitioner • Clinical nurse specialists • Physician assistant • Certain family planning services are covered when provided in a physician's office • Telemedicine/Telehealth	
Podiatry Services	Medical care and treatment of the foot • Office visits • Certain radiology & lab procedures and other diagnostic procedures	
Portable X-Ray Services	Portable x-rays for member's who are unable to travel to a physician's office or outpatient hospital's radiology facility. Covered radiographs are limited to: • Skeletal films of a member's limbs, pelvis, vertebral column or skull • Chest films which do not involve the use of contrast media; and • Abdominal films which do not involve the use of contrast media.	
Preventive Services for Adults	Screenings, check-ups, vaccinations and member counseling, from primary care providers or specialists, to prevent illness, disease, or other health problems	Covered for members 21 and older
Routine Care Provided for Members Participating in Clinical Trials	Cover any item or service provided to a member participating in a qualifying clinical trial to the extent that the item or service would otherwise be covered for the member when not participating in the qualifying clinical trial, including any item or service provided to prevent, diagnose, monitor or treat complications resulting from participation	

Service/Benefit	Description	Limit
Radiology Services	Radiology includes but not limited to: • X-ray (with or without contrast) • MRI (with or without dye) • CT/CAT scan • Magnetic angiography and imaging • Radiographic exams • Ultrasound (endoscopic, echography, breast, abdominal, kidney, uterus, elastography)	
Sinus Procedures	Balloon ostial dilation and functional endoscopic sinus surgery are considered medically necessary for the treatment of chronic rhinosinusitis when the member meets the necessary criteria	
Skilled Nursing Facility	Nursing facilities services, with the exception of post-acute rehabilitation care.	Offered by Humana Healthy Horizons as an in lieu of service Prior Authorization is required.
Skin Substitutes for Chronic Diabetic Lower Extremity Ulcers	Skin substitutes are covered and considered to be medically necessary for the treatment of partial and full-thickness diabetic lower extremity ulcers when the member meets the necessary criteria	
Sterilization	Medically necessary procedure to permanently render a member incapable of reproducing	Covered for members aged 21 and older
Therapy Services	Therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments • Audiological Services (Available in rehabilitation Clinic and Hospital-Outpatient settings only.) • Occupational Therapy • Physical Therapy • Speech & Language Therapy	

Service/Benefit	Description	Limit
Tobacco Cessation Services	Smoking cessation treatments and services, including individual counseling, group counseling, nicotine patches, nicotine gum, nicotine lozenges, nicotine nasal spray, nicotine inhaler, bupropion, and varenicline.	Coverage for a minimum of six months Up to 4 tobacco cessation counseling sessions per quit attempt; Up to 2 quit attempts per calendar year; For a max of 8 sessions per calendar year Limits may be exceeded if medically necessary
Vagus Nerve Stimulators (VNS)	Medical treatment that involves delivering electrical impulses to the vagus nerve. It is used as an add-on treatment for certain types of intractable epilepsy and treatment-resistant depression Includes: • Vagus nerve stimulator • Implantation of VNS • Programing of the VNS • Battery replacement	For members age 12 years or older, although case by case consideration may be given to younger children who meet all other criteria and have sufficient body mass to support the implanted system

Behavioral Health

Mental health and substance use services are covered services for Humana Members who have behavioral health benefits. Humana recognizes that behavioral health and physical health function as a part of the whole person, and one can affect the other. Therefore, we use a whole person approach to addressing behavioral health and substance use.

Family members, caregivers, and legal guardians are very important in behavioral health care. They help share helpful information and support you during treatment. They also help you follow your care plan. When families stay involved, it can help you feel supported, stay engaged, and make progress in your recovery.

Some members are eligible for behavioral health services only (mental health, substance use treatment and non-emergency transportation). Call Member Services to learn more about these benefits at **1-800-448-3810 or TTY: 711**.

Some members will only get specialized behavioral health services from a Healthy Louisiana plan. The mandatory populations include:

- Individuals residing in Nursing Facilities (NF)
- Individuals under the age of 21 residing in Intermediate Care Facilities for people with developmental Disabilities (ICF/DD)

There may be a time where you need support and need to speak with someone right away. You can call the Louisiana Crisis Hub Line at **1-855-242-2735 (TTY: 711)** and get help.

Humana provides a comprehensive range of behavioral health services including:

Note: Your plan covers behavioral health (mental health and substance use disorder treatment) services. Some of the services listed below may need prior authorization, have an age restriction and/or be limited to Medicaid waiver and demonstration project eligibility. Call Member Services to learn more about these benefits at **1-800-448-3810 or TTY: 711**.

Service/Benefit	Service Details	Limit
23-hour observation bed services	Inpatient hospital-based intervention designed to allow for the opportunity to hold and assess a member without admission.	Offered by Humana Healthy Horizons as an in-lieu of service for members aged 21 and older. Prior authorization is not required.
Applied behavior analysis therapy (ABA)	Focuses on improving specific behaviors, such as social skills, communication, reading and academics as well as adaptive learning skills, such as fine motor dexterity, hygiene, grooming, domestic capabilities, punctuality and job competence.	Covered for members age 0–20 prior authorization required.
Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT)	This is for members with more serious behavioral health issues. This helps with supporting recovery through improving daily living skills, building strengths and independence and much more.	Covered for members aged 18 years and older.
Assisted therapy for methadone and opioid withdrawal	Covered services include: • Outpatient services • Assistance with withdrawal from opioids • Medication-assisted treatment (MAT) including Methadone treatment in Opioid Treatment Programs (OTPs)	Available to members of all ages.
Basic Behavioral Health Services	Basic Behavioral Health services are mental health and substance use services. Members with emotional, psychological, substance use, psychiatric symptoms and/or disorders get these services by the primary care physician (PCP) as part of primary care service activities.	
Community Psychiatric Support and Treatment (CPST)	Support in the home and community to build skills and help with functional development.	

Service/Benefit	Service Details	Limit
Child Parent Psychotherapy (CPP)	Child Parent Psychotherapy (CPP) is an intervention for children age 0-6 and their parents who have experienced at least one (1) form of trauma including but not limited to maltreatment, sudden traumatic death of someone close, a serious accident, sexual abuse, or exposure to domestic violence.	Covered for members aged 0 – 6 years old that have: 1. Experienced at least one traumatic event; and 2. Are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD) because of experienced trauma.
Crisis Services	Services can include: • Mobile Crisis Response (youth and adults across the lifespan) MCR services are an initial or emergent crisis response intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis in the community. MCR is a face-to-face, time-limited service provided to a member who is experiencing a psychiatric crisis due to mental health or substance use until the member experiences sufficient relief/resolution and the member can remain in the community and return to existing services or be linked to alternative behavioral health services which may include higher levels of treatment like inpatient psychiatric hospitalization. • Behavioral Health Crisis Care (18 years old and above) BHCC services are an initial or emergent psychiatric crisis response intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis for adults. BHCC Centers operate 24 hours a day, seven days a week as a walk-in center providing short-term mental health crisis response, offering a community based voluntary home-like alternative to more restrictive settings, such as the emergency departments, or coercive approaches, such as Physician Emergency Certificates (PECs), law enforcement holds, or Orders of Protective Custody (OPC). BHCC Centers are designed to offer recovery oriented and time limited	

Service/Benefit	Service Details	Limit
Crisis Services Continued	services up to 23 hours per intervention, generally addressing a single episode that enables a member to return home with community-based services for support or be transitioned to a higher LOC as appropriate if the crisis is unable to be resolved. • Community Brief Crisis Support (youth and adults across the lifespan) CBCS services are an ongoing crisis response intended to be rendered for up to 15 days and are designed to provide relief, resolution and intervention through maintaining the member at home/ community, de-escalating behavioral health needs, referring for treatment needs, and coordinating with local providers. CBCS is a face-to-face, time-limited service provided to a member (and for minors, the member's caregiver) who is experiencing a psychiatric crisis until the crisis is resolved and the member can return to existing services or be linked to alternative behavioral health services. As determined by the MCE, CBCS can also be provided to individuals who have experienced a presentation to an emergency department for a reason related to emotional distress.	
Crisis Stabilization Units	Crisis stabilization for adults is a short-term based crisis treatment and support service for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization, including nursing home placement.	Covered for members age21 and older as in lieu of service.
Dialectical Behavioral Therapy (DBT)	DBT is a comprehensive, multi-diagnostic, modularized behavioral intervention designed to treat both adults and children/adolescents with severe mental disorders and uncontrolled cognitive, emotional and behavior patterns, including suicidal and/or self-harming behaviors.	
Doctor Specializing in Behavioral Health	Psychiatrists (Medical Doctor that can help with Behavioral Health diagnosis, medications and talk therapy.	
Eye Movement Desensitization and Reprocessing (EMDR) Therapy	Eye Movement Desensitization and Reprocessing (EMDR) Therapy is an evidence-based psychotherapy that treats trauma-related symptoms.	Covered for members aged 2 throughout adulthood.

Service/Benefit	Service Details	Limit
Freestanding Psychiatric Hospitals for Adults	Services received in an Institution for Mental Disease (IMD)	Offered by Humana Healthy Horizons as an in- lieu of service for members age 21 to 64. Prior authorization required.
Functional Family Therapy (FFT) and Functional Family Therapy-Child Welfare (FFT-CW)	Functional Family Therapy (FFT) is an evidence-based treatment model that helps families change their interactions to address youth and young adult behavioral or emotional issues.	FFT is for youth who are between the ages of 10 and 18 and are showing serious behavioral issues. FFT-CW is for youth who are between the ages of 0 to 18 and are showing serious behavioral issues.
Homebuilders®	This is a home program for children at risk of out-of-home placement, or in coming together again from placement. Homebuilders is provided through the Institute for Family Development (IFD).	Covered for members aged 0-18.
Individual Placement Support (IPS)	Individual Placement and Support (IPS) refers to the evidence-based practice of supported employment for members with mental illness. IPS helps members living with mental health conditions work at regular jobs of their choosing that exist in the open labor market and pay the same as others in a similar position, including part-time and full-time jobs. IPS helps people explore the world of work at a pace that is right for the member. Based on member's interests, IPS builds relationships with employers to learn about the employers' needs in order to identify qualified job candidates.	Must be at least 21 years or older and Transitioned from a nursing facility or been diverted from nursing facility level of care through the My Choice Louisiana program.
Injection Services for Adults provided by Licensed Nurses	Coverage for licensed nurses to administer injections instead of Physicians.	Offered by Humana Healthy Horizons as an in- lieu of service for members aged 21 and older. Prior authorization is not required.
Inpatient Hospitalization	Mental Health services provided in an inpatient hospital setting.	

Service/Benefit	Service Details	Limit
Licensed Mental Health Professionals (LMHPs)	Specialized behavioral health services such as individual, family and group therapy, evaluations, and assessments provided by LMHPs. LMHPs can be: • Licensed Psychologists • Medical Psychologists • Professional Counselors • Clinical Social Workers • Professional Counselors • Marriage and Family Therapists • Advanced Practice Registered Nurses (psychiatric specialists)	
Medication Assisted Treatment (MAT)	The use of medication and therapy for treatment of substance use disorder.	
Mental Health Intensive Outpatient Programs (IOP)	Members can receive mental health services including intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education.	Offered by Humana Healthy Horizons as an in- lieu of service for members aged 12 and older. Prior authorization is not required.
Multi-Systemic Therapy (MST)	This is a home and family and community therapy for youth who are at risk of being removed from the home or who are returning home from placement.	Covered for members aged 0-20.
Parent/Child Interaction Therapy (PCIT)	Parent-child interaction therapy (PCIT) is an evidence-based behavior parent training treatment developed by Sheila Eyberg, PhD for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship.	Covered for members aged 2 - 7 years old (can be up to 9 years old based on clinical judgement).
Peer Support Specialists (PSS)	PSS have “lived” experience and can help members with setting and completing care and life goals during the recovery process.	Covered for members aged 21 and older. Services provided through Local Governing Entities (LGEs).

Service/Benefit	Service Details	Limit
Personal Care Services for Behavioral Health (BH-PCS)	PCS services such as help with bathing, dressing, shopping, etc. when recommend by a treating licensed mental health professional (LMHP) or physician with their scope of practice.	Medicaid eligible members who meet medical necessity criteria may receive PCS when recommended by the member's treating licensed mental health professional (LMHP) or physician within their scope of practice. Members must be at least 21 years of age and have transitioned from a nursing facility or been diverted from nursing facility level of care through the My Choice Louisiana program. Members must be medically stable, not enrolled in or eligible for a Medicaid funded program which offers a personal care service or related benefit, including Long Term Personal Care Services (LT-PCS), and whose care needs do not exceed that which can be provided under the scope and/or service limitations of this personal care service.
Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT)	Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT) are cognitive behavioral therapy interventions for posttraumatic stress disorder (PTSD) and trauma-related symptoms.	PPT is covered for members aged 3 – 6 years. YPT is covered for members aged 7 – 18 years.
Psychiatric Residential Treatment Facilities (PRTF)	A long-term residential, 24-hour, group living facility setting that provides inpatient psychiatric services.	Covered for members aged 0 – 20.
Psychosocial Rehabilitation (PSR)	Support in the home and Community to learn about behavioral conditions and help with learning coping skills and personal growth.	

Service/Benefit	Service Details	Limit
Substance Use Disorder (SUD) Rehabilitation	Person-centered outpatient, intensive outpatient, residential, and detox services. Members' treatment needs will be assessed using a focus on rehabilitation and recovery to support the members in learning coping skills and managing substance use behaviors.	
Therapeutic Group Home (TGH)	Community-based, 24-hour, services where the youth lives in a homelike setting with other youth to receive mental health services.	Covered for members aged 0 – 20.
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	TF-CBT is a child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events.	Covered for members aged 3 - 18 and their parents.
Triple P Positive Parenting Program	The Triple P Positive Parenting Program is a parenting and family support system designed to prevent and treat behavioral and emotional problems in children. It aims to prevent problems in the family, school and community before they arise and to create family environments that encourage children to realize their potential.	Covered for parents (members) of children from 0 – 12 years.

Services Covered by the State Plan, but not Humana

Long-Term Care

If you need services at a nursing facility for rehabilitation or long-term care, we will help you. We will talk to your doctor and the facility to make sure you get the care you need. Keep in mind that after 30 days in long-term care you may only be eligible for limited services with us and LDH will cover all other services provided within the nursing facility. If you have questions, please call Member Services at **1-800-448-3810 (TTY: 711)**.

Coordinated System of Care (CSoC)

If you have a child between the ages of 5 and 20 who has major behavioral health challenges and is at risk of out-of-home placement, Humana can help you. We will provide a screening and connect you and your child with a CSoC coordinator or care management services as appropriate.

EPSDT Dental Program

This program provides comprehensive, medically necessary dental care for members under 21, covering preventive services and treatments, ensuring early detection and correcting dental issues to maintain health.

Adult Denture Program

This program covers denture-related services for eligible adults.

Adult Waiver Dental Program

This program offers comprehensive dental coverage for 21 and older members in specific waiver programs for developmental/intellectual disabilities.

Adult ICF/IID Dental Program

This program offers comprehensive dental care for adults in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

Adult Denture Services

Members who need dentures or denture repairs may qualify for coverage through their Medicaid dental plan.

To find a provider, contact your Medicaid dental plan:

https://www.dentaquest.com/: **1-800-685-0143 (TTY: 1-800-466-7566)**, Monday – Friday, 7 a.m. to 7 p.m.

https://www.mcnala.net/members: **1-855-702-6262 (TTY: 1-800-955-8771)**, Monday – Friday, 7 a.m. to 7 p.m.

Dual Eligible and Waiver Population

Even if you receive most of your health care services from the State, when you are enrolled with Humana, you will also be able to receive limited services from us. These services include specialized behavioral health and non-emergency medical transportation. Please call Member Services if you have any questions on what benefits you can get as a part of our Plan.

Services MCO does not cover due to moral or religious objections

Humana has no moral or religious objections for providing any MCO covered services.

Go365 for Humana Healthy Horizons: Download the app and start earning rewards

Go365 for Humana Healthy Horizons® is a wellness program that offers you the opportunity to earn rewards for taking healthy actions.

For each eligible Go365 activity completed, you earn rewards that can be redeemed for e-gift cards in the Go365 Shop. Rewards earned through Go365 have no cash value and must be earned and redeemed in the same plan year.

To earn Go365 rewards:

1. Download the Go365 for Humana Healthy Horizons app from iTunes/App Store® or Google Play® on a mobile device.
2. Create an account. If you have a MyHumana account, you can use the same login information to access Go365 for Humana Healthy Horizons, after you download the app.

If you are the guardian of a minor, follow these steps to register the minor:

a. Register for the Go365 Healthy Horizons app using your adult member/ caregiver account credentials.

b. After signing in, click the button to 'Add a Minor' or go to account settings and select the option to add a dependent/minor and follow the prompts.

   i. Enter the minor's information exactly as shown on Humana records, including the minor's Member ID and demographic details (name, date of birth, address, etc.).

c. Where applicable, upload documents that verify your relationship to the minor. The app will prompt you for required documents and accepted file types. Typical documents that may be requested include:

   i. Birth certificate

   ii. Divorce decree or custody order

   iii. Legal guardianship papers or court order

   iv. Medical support order or related legal documentation

   v. Adoption decree

d. Submit the documents and confirm that uploads were successful.

e. Once approved, upon login, you will have access to all accounts under the same username and password.

3. Complete a healthy activity.

4. Redeem your rewards. Sign in to the Go365 app and access the 'Shop' tab to redeem your rewards for e-gift cards to popular retailers.

Note: Members under the age of 18 must have a parent or guardian register on their behalf to participate and engage with the program. Members 18 and older can register to create their own Go365 account using their Medicaid member ID.

Questions? Call Go365 at **888-225-4669** to learn more.

You can qualify to earn rewards by completing one or more healthy activities in the chart below.

Activity	Reward criteria	Reward amount
Annual Well Visit	Complete an annual wellness visit with a primary care provider (PCP). Available to members 3 and older.	$25 in rewards per year
Behavioral Health Follow-Up Visit	Have a follow-up visit within 30 days after hospital discharge for a behavioral health diagnosis. Available to all members.	$25 in rewards per year

Activity	Reward criteria	Reward amount
Breast Cancer Screening	Get a mammogram. Available to female members 40 and older.	$25 in rewards per year
Cervical Cancer Screening	Get a cervical cancer screening as part of a routine pap smear. Available to female members 21 and older.	$25 in rewards per year
Chlamydia Screening	Get a chlamydia screening when sexually active or as recommended by your healthcare provider. Available to all female members.	$25 in rewards per year
Colorectal Cancer Screening	Get a colorectal cancer screening as recommended by your Primary Care Provider. Available to members 45 and older.	$25 in rewards per year
Comprehensive Diabetic Screening	Get an annual HbA1c and blood pressure screening. Available to diabetic members 18 and older.	$25 in rewards per year
Diabetic Retinal Eye Exam	Get a retinal eye exam. Available to diabetic members 18 and older.	$25 in rewards per year
Digital Onboarding	Download the Go365 for Humana Healthy Horizons app and update communication preferences. Available to all members.	$5 in rewards per lifetime
Flu Shot	Get the flu vaccine. If given by someone other than a physician or at a pharmacy, upload a photo for documentation in the Go365 app. Available to all members.	$20 in rewards per year

Activity	Reward criteria	Reward amount
Health Needs Assessment (HNA)	Must complete within 90 days of enrollment in Humana Healthy Horizons. The HRA can be done in 1 of these 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. Call **1-800-448-3810 (TTY: 711)**, Monday – Friday, 7 a.m. – 7 p.m., or 4. Create a MyHumana account and complete and submit the HNA online (available via desktop only). Available to all members.	$20 in rewards per year
High-Intensity Care of Substance Use Disorder	Have a follow-up visit within 30 days after discharge from inpatient care, residential treatment, or a detoxification visit. Available to all members.	$25 in rewards per year
Human Papillomavirus Vaccine (HPV)	Must complete both doses to receive reward. Available to members ages 9-13.	$20 in rewards per lifetime
Postpartum Visit	Complete one postpartum visit within 7 - 84 days after delivery. Available to pregnant female members.	$25 in rewards per pregnancy
Prenatal Visits	Complete up to 10 prenatal visits. Available to pregnant female members.	$10 in rewards per visit, up to 10 visits, max $100 per pregnancy

Activity	Reward criteria	Reward amount
Tobacco & Vaping Cessation Coaching	Work with a coach over the phone to quit smoking or vaping. • $25 for completing two calls within 45 days of enrolling in coaching. • $25 for completing six more calls (eight total) within 12 months of your first coaching session. Enroll by calling **1-866-270-4223 (TTY: 711)**. When prompted, select option one. Available to members 12 and older.	Up to $50 in rewards per year
Weight Management Coaching	Work with a coach over the phone to reach or keep a healthy weight. • $15 for completing enrollment. • $15 for completing a total of six calls, within 12 months of enrolling. To enroll, call **1-866-270-4223 (TTY: 711)**. When prompted, select option two. Available to members 12 and older.	Up to $30 in rewards per year
Well-Child Visits (0 to 15 months)	Complete up to 6 wellness visits with a pediatrician. Available to members 0 to 15 months.	$10 in rewards per visit, up to six visits, max $60 per year
Well-Child Visits (16-30 months)	Complete up to 2 wellness visits with a pediatrician. Available to members 16 to 30 months.	$10 in rewards per visit, up to two visits, max $20 per year

Questions? Call Go365 at **1-888-225-4669** to learn more.

Go365 for Humana Healthy Horizons is available to all members who meet the requirements of the program. Rewards are not used to direct the member to select a certain provider. Gift cards cannot be used to purchase prescription drugs or medical services that are covered by Medicare; Medicaid; or other federal healthcare programs; alcohol; tobacco; e-cigarettes; or firearms. Gift cards must not be converted to cash. Rewards may be limited to once per year, per activity.

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.

Value Added Benefits

These are extra services that are offered by Humana and approved by LDH. These services or benefits are not otherwise covered or exceed the limits of the core benefits listed above.

Value Added Benefits	Description
Baby and Me Meals	Up to two (2) pre-cooked home-delivered meals per day for 10 weeks for pregnant members who are high-risk. This benefit is available exclusively during pregnancy and may be utilized only once per pregnancy. Care manager approval required
Convertible Car Seat or Portable Crib	All Pregnant members who enroll and actively participate in our HumanaBeginnings Care Management program, 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.
Dental (ages 21 and older)	Up to $500 allowance towards services such as routine dental exams, x-rays, cleanings, fillings, and extractions within network providers.
Disaster Preparedness Meals	One (1) box of 14 shelf- stable meals after a hurricane or tornado twice per year The Governor must declare the tornado or hurricane a disaster for the member to be eligible for the meals
GED Testing (ages 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 is provided virtually to allow maximum flexibility for members. Also includes test pass guarantee to provide members multiple attempts at passing the test. 16 - 18 years: must provide additional documentation Underage test-takers. Underage testers must enroll in the state's official Adult Education Program and take free classes until they are ready to sit for the exam. They will need documentation from the school system that they have officially withdrawn. Age Limit: 16 Years and Older
Healthy Food Produce Box	Poor nutrition can worsen existing health conditions and slow recovery, while a healthy diet can prevent and manage disease. If you are living with or at risk of living with chronic conditions, we offer up to four (4) produce boxes a year containing nutritious food that meets medical dietary guidelines, and educational materials that include recipes tailored to your condition. To be eligible for this benefit, you must have a qualifying chronic condition, be able to prepare your own meals and actively participate in Care Management. Age Limit: All ages, but members must have a qualifying chronic condition, be able to prepare their own meals and actively participate in Care Management.

Value Added Benefits	Description
Home-Based Asthma Interventions	Asthmatic Members in our Care/Disease Management programs can receive an allowance of up to $200 per year to alleviate the cost of services such as allergen free bedding, carpet cleaning, and/or an air purifier. Care Manager approval Required
Housing Assistance (ages 18 and older)	Our comprehensive Housing Assistance benefit aims to promote stable housing and reduce related disparities by offering members up to $350 annually for housing-related expenses such as rent, utility payments, and moving expenses. The benefit can be used towards: • Rent or mortgage payment (late payment notice required) • Utility payment for electric, water, or gas (late payment notice required) • Trailer Park and lot rent if this is your permanent residence (late payment notice required)
Newborn Circumcision (ages 0 to 1)	Humana will offer the circumcision procedure for all newborn male members, encouraging circumcision procedures during the delivery stay to ensure timely access.
Non-Emergency Medical Transportation (NEMT) (ages 18 and older)	Rides up to 30 miles to medical appointments with stop at pharmacy for medications.
Non Medical Transportation (NMT) (ages 18 and older)	Up to 15 round trips (or 30 one-way trips) up to 30 miles for non-medical transportation per year to locations such as social support groups, wellness classes, WIC and SNAP appointments, food banks, and applicable value added benefit services offered. 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.
Over the Counter (OTC) Pharmacy Allowance	Up to $75 per quarter allowance enables members to purchase products that support common occurring conditions such as: • Pain relievers • 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
Post Discharge Meal	14 refrigerated home-delivered meals following discharge from an inpatient or residential facility. Limited to four (4) discharges per year.

Value Added Benefits	Description
Produce Box for Maternal Care	To reduce access and cost barriers, Humana provides up to four (4) boxes of in-season, nutritious, fresh food annually to pregnant members from their second trimester to 60 days postpartum, with Care Manager approval. Each box includes an educational pamphlet with recipes and meal ideas tailored to the specific items in the delivery. Participation in HumanaBeginnings is required Age Limit: All Pregnant Members engaged in Care Management
Respite Care for Homeless Program (Males ages 18 and older)	The Medical Respite Program ensures Member recovery and stabilization, successful Member integration back into the community, and reducing unnecessary emergency department visits and hospital admissions. Members may receive up to 89 days of respite care.
Smartphone Services (18 and older)	With a smartphone, you have easy access to health-related information and can stay connected to your care team and health plan. Any member who qualifies for the Federal Lifeline program will be eligible to receive a free cell phone with monthly talk minutes, text, and data
Sports Physical (ages 6 to 18)	1 sports physical per year
Tobacco & Vaping Cessation Coaching (ages 12 and older)	Tobacco & Vaping Cessation Coaching is focused on helping members aged 12 and older with stopping their usage of nicotine products. The program is designed as a monthly engagement for a total of 8 coaching calls, but the member has 12 months to complete the program if needed. The program also offers support for both over the counter (OTC) and prescription nicotine replacement therapy (NRT) for members aged 18 and older.
Vision Services (ages 21 and older)	• 1 eye exam per year • Up to $100 allowance for 1 set of glasses (frames and lenses) and/or contacts • Member pays any cost over $100
Weight Management Coaching (ages 12 and older)	Weight Management Coaching Program delivers weight management intervention for members who are 12 and older. The Member can complete six (6) weight management coaching sessions with a Wellness Coach: approximately one (1) call per month for a period of six months.
YMCA Gym Membership	Free membership at participating YMCA during the plan year

Value Added Benefits	Description
Youth Development and Recreation (ages 4 to 18)	Members ages 4 to 18 can receive reimbursement of up to $250 annually for participation in activities such as: • YMCA • Swim lessons • Computer coding classes • Music lessons

Pregnancy and Family Planning Services

Humana wants you to have access to reproductive health. These services are confidential and private for all Members regardless of age. Here is how you can take advantage of the services and benefits we have to offer.

Humana offers access to family planning services (birth control) and is provided in a way that protects and allows you to choose the method of family planning you want.

You can receive family planning services without a referral. You may see a provider who is not in the Humana network.

Before You Are Pregnant

It is never too early to prepare for a healthy pregnancy. If you are having a baby, you can do some things now to be as healthy as possible before you get pregnant to reduce potential problems during pregnancy:

- Make an appointment to see your doctor for a physical exam
- Talk with your doctor about what makes a healthy diet
- Talk with your doctor about your current medications
- Take folic acid every day
- Don't drink alcohol, smoke, or use illegal drugs

If you are pregnant, make an appointment with an obstetrician (OB). You can find an OB in your Provider Directory. If you need help, go to Humana .com and use the Find Care Tool or call Member Services at **1-800-448-3810 (TTY: 711)**. Be sure to make an appointment as soon as you know you are pregnant.

After Your Baby is Born

Congratulations! Please call LDH to tell them you have had a baby.

You can reach LDH at **1-888-342-6207**. If you are getting Social Security income, you will need to apply with LDH to ensure your baby receives benefits.

It is also important to have a postpartum checkup with your OB. He or she will make sure your body is healing and recovering from giving birth. Call your OB to schedule an appointment for 4 to 6 weeks after your baby is born. If you delivered by C-section or had any problems during delivery, make your appointment within the first or second week after your baby is born.

Services Not Covered

The following services are not covered services and will not be given to Members under this plan.

- Elective abortions and related services, unless otherwise stated
- Experimental/investigational drugs, procedures, or equipment, unless approved by the Secretary of LDH
- Elective Cosmetic surgery
- Assisted reproductive technology for treatment of infertility
- Care received by providers or in facilities located outside of the country.

Helping you be Healthy

Population Health/Chronic Care Management

We offer free Chronic Care Management education and resources. We can help you learn about your condition and how you can better take care of your health to reduce complications from conditions such as:

- Asthma
- Cancer
- Diabetes
- Congestive heart failure
- Hypertension
- HIV+/AIDS
- Mental Health
- Adult/Pediatric asthma
- Substance Abuse
- Members with special health care needs
    - o ADHD
    - o Depression and PTSD
    - o Hepatitis C treatment
    - o HIV/AIDS
    - o Sickle Cell Disease
    - o Substance use disorder, including opioid use disorder

We can:

- Help you understand the importance of controlling the disease
- Give you tips on how to take good care of yourself
- Encourage healthy lifestyle choices

If you would like to enroll in our Case Management program or have questions please call Member Services at **1-800-448-3810 (TTY: 711)** and request to speak to a Care Manager.

Care Management and Outreach Services

We offer Care Management services to all Members who can benefit from them. Care management program participation is optional. Children and adults with special health care needs can often benefit from care management. We have registered nurses, social workers, community health workers and others who can work with you one-on-one to help coordinate your health care needs. This may include helping you find community resources you need. We may contact you if:

- Your doctor asks us to call you.
- You ask us to call you.
- We feel our services may be helpful to you or your family.

We may ask questions to learn more about your health. We will give you information to help you understand how to care for yourself and get services. We can also help you find local resources to help you with many areas if you:

- Do not have enough food;
- Have trouble paying bills;
- Need help for more education; or
- Do not have friends, family, or neighbors to help you.

We will talk to your PCP and other providers to make sure your care is coordinated. You may also have other medical conditions that our Care Managers can help you with.

We can also work with you if you need help figuring out when to get medical care from your PCP, an urgent care center, or the ER.

Please call us if you have questions or feel that you need these services. We are happy to help you. You can reach our Care Management department by calling Member Services at **1-800-448-3810 (TTY: 711)**.

Complex Care Management

We offer Complex Care Management services for Members if they experience multiple hospitalizations or have complex medical needs that require frequent and ongoing assistance. Complex Care Management provides support to Members with complex clinical, behavioral, functional, and/or social needs, who have the highest risk factors, such as multiple conditions, or who take multiple medications, served within multiple systems, and often have the highest costs.

To get additional information about the Complex Care Management Program, self-refer into, or opt out of the Complex Care Management Program, you may contact our Care Management department at **1-800-448-3810 (TTY: 711)**.

Required interventions are more intensive. A team of healthcare providers, social workers, and community service partners are available to make sure your needs are met, and all efforts are made to improve and optimize your overall health and well-being. The Care Management Program is optional.

Health Education

Tobacco Cessation

The Louisiana Tobacco Control Program in the Office of Public Health has assistance available to help Members quit. If you are 18 years or older, call the Louisiana Tobacco Quit Hotline at **1-800-QUIT-NOW** (24 hours a day) to learn more and/or to join the smoking cessation program. This is a resource that offers personalized telephone counseling sessions for Members trying to quit using tobacco products.

Tobacco & Vaping Cessation Coaching offers one-on-one support for members who want to stop using nicotine products. Our National Board-Certified Health & Wellness Coaches are experts in guiding people who want to improve their lives and well-being. Participants complete 8 sessions with a Wellness Coach and have 12 months to complete the program. Available to members 12 and older.

More information is available in the Go365 for Humana Healthy Horizons app. To get started, call **1-866-270-4223** and press 1 for Tobacco & Vaping Cessation Coaching.

The program also offers support for both over the counter (OTC) and prescription nicotine replacement therapy (NRT) for members 18 and older.

Problem Gambling

If you think you or someone you know may have a gambling problem, call the Louisiana Problem Gamblers Helpline 24 hours a day, seven days a week to learn more about free gambling help in Louisiana. This call is toll-free and confidential. You can also get in touch with the Louisiana Problem Gamblers Helpline the following ways:

Phone: **1-877-770-STOP (7867)**
Text: 1-877-770-STOP.
Online: Live chat at www.helpforgambling.org

Other Plan Details

Rights and Protections

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 don’t 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://assets.humana.com/is/content/humana/GCHLYTBENpdf

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.

HIPAA

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 health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation.
- To public health agencies, if we believe that there is a serious health or safety threat.
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence.
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For law enforcement purposes, to military authorities and as otherwise required by law.
- To help with disaster relief efforts.
- For compliance programs and health oversight activities.
- To fulfill our obligations under any workers' compensation law or contract.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For research purposes in limited circumstances 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.

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

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

The following uses and disclosures will require your written permission:

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

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

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

What are my rights concerning my information?

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

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. 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.*

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

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

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

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also 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 **1-866-861-2762**
- Accessing our website at Humana.com and going to the Privacy Practices link
- Send completed request form to:
  Humana Inc. Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

Other Insurance/Subrogation

If you have other medical insurance, please call Member Services at **1-800-448-3810 (TTY: 711)** to let us know. You may have medical insurance through your job, or your children may be insured through their other parent.

You should also call us if you have lost medical insurance that you told us about. Not giving us this information can cause problems with getting care and with your bills.

Providers will send a bill to your primary insurance first. After your primary insurance pays its amount, your provider will bill us. We will pay the remaining amount after the primary insurance has made payment (up to the amount we would have paid as the primary insurance). You should let us know right away if your other insurance changes.

Another insurance company might have to pay the doctor or hospital bill if:

- You are hurt in a car wreck;
- You are bitten by a dog; or
- You fall and are hurt in a store.

The following information will help avoid delays in processing your benefits. You can call Member Services to tell us the name of:

- The person at fault;

- His or her insurance company; and
- Any lawyers involved.

Medical Record Requests

Humana does not keep complete copies of your medical records. If you would like a copy of your medical records, please contact your doctor. Humana designated record set includes enrollment, claims data, and payment records made in your behalf.

- If you would like a copy of your information, please send a written request to the Humana privacy officer.
- Humana will provide one copy of records per 12-month period free of charge.
  - o You may be charged for additional copies.
- Humana will respond to requests within 30 days of receipt.
- Humana may ask for an extra 30 days if necessary. We will let you know if we need the extra time.
- Humana has the right to keep you from having or seeing all or parts of your records for specific reasons related to HIPAA and State law.
- Humana will tell you the reasons in writing.
- Humana will give you information on how to file an appeal if you disagree with our decision.

Changing Plans

Enrollment

If you are a mandatory Member required to enroll in a plan, once you are enrolled in a Humana Healthy Horizons® in Louisiana or the state enrolls you in a Plan, you will have 90 days from the date of your first enrollment to try the MCO. During the first 90 days, you can change MCO's for any reason.

Call the Medicaid Enrollment Broker at **1-855-229-6848** . If you use TTY, call **1-855-526-3346**, Monday – Friday, 8 a .m . – 5 p .m ., to choose another plan. After the 90 days, if you are still eligible for Medicaid you will remain enrolled in the plan.

Annual Enrollment

If you are a mandatory Member, you have the right to choose another health plan within the calendar year. You may make up to two (2) plan changes during a calendar year. After two plan changes have been made, you must remain in your selected plan until the start of the next calendar year. Call the Medicaid Enrollment Broker at **1-855-229-6848**. If you use TTY, call **1-855-526-3346** Monday – Friday, 8 a .m . – 5 p .m ., to choose another plan.

If you do not choose a new health plan, and you are still eligible for Medicaid you will automatically remain a Member of Humana Healthy Horizons® in Louisiana.

Disenrollment for Cause

If you are a mandatory Member and you want to change plans after two plan changes, you must have one of the following state-approved for-cause reason to change plans that include but are not limited to:

- The member moves out of the MCO service area;
- The MCO does not, because of moral or religious objections, cover the service the Member seeks;
- The Member needs related services to be performed at the same time; not all related services are available within the MCO and the Member's PCP or another provider determines that receiving the services separately would subject the Member to unnecessary risk;
- The Contract between the MCO and LDH is terminated;
- Poor quality of care, lack of access to covered services, or lack of access to providers experienced in dealing with member's care needs;
- The Member's active specialized behavioral health provider ceases to contract with the Contractor for reasons other than non-compliance with the provider agreement or this Contract; or
- Any other reason deemed to be valid by LDH and/or its agent.

Disenrollment Requested by Humana Healthy Horizons® in Louisiana

Humana may request disenrollment of a member in the following circumstances:

- When the member ceases to be eligible for medical assistance under the State Plan as determined by the Department;
- Upon termination or expiration of the Contract;
- Death of the member;
- Confinement of the member in a facility or institution when confinement is not a covered service under the Contract; or
- If directed by the state.

LDH can remove you from our Plan (and sometimes Medicaid entirely) for certain reasons. This is called involuntary disenrollment. These reasons include:

- You lose your Medicaid Eligibility
- Death of a member
- You move outside the State of Louisiana
- You knowingly use your Member ID card incorrectly or let someone else use your Member 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
- If LDH is unable to contact you by first class mail and if Humana cannot provide them with your valid address. You may remain disenrolled until either LDH or Humana can locate you and eligibility can be restored.
- Upon termination or expiration of the Contract
- Confinement of the member in a facility or institution when confinement is not a covered service under the Contract

If you need help changing plans call the Medicaid Enrollment Broker at **1-855-229-6848**. If you use TTY, call **1-855-526-3346**, Monday – Friday, 8 a.m. – 5 p.m.

Marketing Violation

The state of Louisiana insists that MCOs follow certain marketing guidelines, such as:

- Not directly marketing to Members of another MCO or potential Members
- Failing to meet time requirements for communication with new Members (distribution of welcome packets, welcome calls)
- Failing to provide interpretation services or make materials available in required languages
- Not communicating negatively about other MCOs

If you suspect that we have not followed these guidelines, you should make a marketing complaint. You can do this one of the following ways:

- Online at https://ldh.la.gov/form/253 or
- Fax a completed Healthy Louisiana Marketing Complaint form (copy of the form can be at the back of the handbook) to **1-877-523-2987**.
- Via email to MMEReview@la.gov

Medicaid Related

Eligibility

In order for you to go to your health care appointments and for Humana Healthy Horizons® in Louisiana to pay for your services, you have to be covered by Medicaid and enrolled in our Plan. This is called having Medicaid eligibility. LDH decides if someone qualifies for Medicaid.

Sometimes things in your life might change, and these changes can affect whether or not 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 State Medicaid ID Card does not mean that 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 at 1-800-448-3810 and we can help you check on it.

- If you lose your Medicaid Eligibility
- If you lose your Medicaid and get it back, you should call the Medicaid Enrollment Broker at **1-855-229-6848** and choose Humana Healthy Horizons® in Louisiana.
- 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 Member 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 that you are pregnant before your baby is born to make sure that your baby has Medicaid. Call LDH toll free at **1-888-342-6207** while you are pregnant. If you need help

talking to LDH, call us. LDH 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.

Demographic Changes

We want to make sure we are always able to connect with you about your care. We don't want to lose you as a Member, so it is really important to let us know if information from your Medicaid application changes. You must report any changes to LDH within 30 days. Failure to report changes within 30 days may result in loss of medical benefits. Examples of changes you must report within 30 days include:

- Change of physical/mailing address or change in contact information
- Household income changes. For example, increase or decrease in work hours, increase in pay rate, change in self-employment, beginning a new job, or leaving a job
- Household size or relationship changes. For example, someone moved into or out of your household, marries or divorces, becomes pregnant, or has a child
- You or other Members qualify for other health coverage such as health insurance from an employer, Medicare, TRICARE, or other types of health coverage
- Changes in immigration status
- Being in jail or prison
- You start or stop filing a federal income tax return
- Changes to your federal income tax return such as a change in dependent or a change to the adjustments to taxable income on page one of the income tax form

Report any demographic changes or other information which may affect eligibility to LDH at:

Phone Number: **1-888-342-6207**
Monday through Friday from 8 a.m. to 4:30 p.m.
Website: myMedicaid.la.gov

You can also visit your local office to report changes above:

Local Offices: www.ldh.la.gov/Medicaidoffices

Managed Care Terms – Standard Definitions

APPEAL: A step you can take to ask Medicaid to change its mind when it decides it will not pay for care you need.

BEHAVIORAL HEALTH SERVICES: Health care for emotional, psychological, substance use and psychiatric problems. It is part of your health plan.

CO-PAYMENT: Money you have to pay out of your pocket before you can see a health care provider.

CONTINUITY OF CARE: If your primary care provider sends you to a specialist, your primary care provider will stay involved and keep up with all your medical/dental treatments.

CARE COORDINATION: Your primary care provider works with you and other providers to make sure that all your providers know about your health problems.

DENTAL PLAN: A group of dentists and other providers who work together to help you get the dental care services you need. They may provide services like x-rays, teeth cleaning and fillings.

DURABLE MEDICAL EQUIPMENT: Equipment ordered by your physician that helps you at home. This includes wheelchairs, hospital beds, canes, crutches, walkers, kidney machines, ventilators, oxygen, monitors, pressure mattresses, lifts, nebulizers, etc.

EMERGENCY MEDICAL CONDITION: A health problem that needs immediate medical/dental attention. An example includes a health problem that can cause you (or your unborn child, if you are pregnant) serious harm.

EMERGENCY DENTAL CONDITION: A health problem that needs immediate dental attention. An example includes a dental problem that can cause you serious harm.

EMERGENCY MEDICAL TRANSPORTATION: Ambulance.

EMERGENCY ROOM CARE: Care for an emergency medical or dental condition that is too serious to be treated in a clinic or urgent care center.

EMERGENCY SERVICES: Inpatient and outpatient medical or dental care by a health care provider to screen, evaluate, and/or stabilize your emergency medical or dental condition.

EXCLUDED SERVICES: Care that is not paid for by Medicaid.

GRIEVANCE: A report that you can make if you are not happy with the quality of care you got or if you think a provider or someone at the clinic was rude or denied you access to the care you needed.

HABILITATION SERVICES AND DEVICES: Health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't 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.

HEALTH INSURANCE: A plan that helps you pay for health care visits, procedures, hospital stays and preventive care. It will pay for the high cost expenses and routine screenings that it says are covered.

HEALTH PLAN: A group of doctors, hospitals and other providers who work together to help you get the health care services you need. They may provide physical health services, like doctor, hospital and emergency room visits; x-rays and prescriptions; and non-emergency medical transportation. They may also provide mental health or substance use disorder services, like psychotherapy or crisis intervention.

HEALTH NEEDS ASSESSMENT: A form you fill out to tell about your health and health behavior. Health providers use the information to figure out whether you are at risk of getting certain diseases or medical or dental conditions.

HOME HEALTH CARE: A wide range of health care given in your home to treat an illness or injury. Examples include care for a wound, patient education, checking your blood pressure and breathing, checking on you after you get out of the hospital.

HOSPICE SERVICES: Hospice is to keep you comfortable and as free as possible from pain and symptoms when you have a terminal illness. Hospice helps you have a good quality of life for time remaining. Most hospice care happens at home or it can be given in hospital or special facility.

Hospice is for patients likely to die within six months if their disease runs its normal course.

HOSPITALIZATION: When you are checked into a hospital for care.

HOSPITAL OUTPATIENT CARE: Care given at a hospital that your doctor does not expect will need an overnight stay. In some cases you may stay overnight without being registered as an in-patient. Examples include same-day surgery and blood transfusions.

MEDICALLY NECESSARY: Medical or dental care or supplies your provider says are needed to prevent, diagnose or treat your illness, injury, or disease. To be medically necessary, the care or supplies must be clinically appropriate and meet accepted standards of medicine. Medicaid does NOT pay for treatments that are experimental, non-FDA approved, investigational, or cosmetic.

NETWORK OR PROVIDER NETWORK: The group of providers linked to your health plan who provide primary and acute health care.

NON-PARTICIPATING PROVIDER: A provider that is not part of your provider network.

PARTICIPATING PROVIDER: A provider who works for your health plan or is linked to your health plan.

PHYSICIAN SERVICES: Care provided by a physician.

PLAN: See Health Plan or Dental Plan.

PREAUTHORIZATION: Getting permission for specific health services before you receive them so that Medicaid will pay for the care.

PREMIUM: The amount of money you must pay for your health care plan.

PRESCRIPTION DRUG COVERAGE: The medicines your plan will pay for that your provider prescribes that have to be filled by a pharmacy.

PRESCRIPTION DRUGS: These are medicines your provider prescribes that have to be filled by a pharmacy.

PRIMARY CARE PHYSICIAN: The doctor who is responsible for your health care. This doctor may also refer you to a specialist, or admit you to a hospital.

PRIMARY CARE DENTIST: The dentist who is responsible for your dental care. This dentist may also refer you to a specialist.

PRIMARY CARE PROVIDER: A physician, nurse practitioner, or physician assistant who manages your health care needs. This includes preventive care and care when you are sick. The primary care provider may treat you, refer you to a specialist, or admit you to a hospital.

PROVIDER: An individual, clinic, hospital or other caregiver approved by Medicaid to provide health care.

REHABILITATION SERVICES AND DEVICES: Care and items that help restore your health and functions. Examples include cardiac rehab (for your heart), pulmonary rehab (to help you breathe better) and physical or speech therapy. These include exercise, education and counseling. These are usually provided in a hospital outpatient setting but can be offered in a skilled nursing facility.

SKILLED NURSING CARE: A high level of nursing care. Nurses help to manage, observe, and evaluate your care.

SPECIALIST: A health professional who is educated and trained to have in-depth knowledge of how to care for certain medical or dental problems. Physician specialist examples include cardiologist (heart doctor), pulmonologist (lung doctor), nephrologist (kidney doctor) and surgeon.

URGENT CARE: Medical care to treat an illness or injury that needs quick attention but that is not a medical emergency. Examples include stomach pain, dizziness that will not go away, or a suspected broken bone. Urgent care requires face-to-face medical attention within 24 hours of noticing the urgent problem.

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LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Marketing Complaint Submission Form

Revision 10/2018

FOR LDH USE ONLY	
STAGE OF REVIEW	**DATE**
☐ Form Received at LDH	
☐ Investigation Begins	
☐ Sanctions Applied	
☐ Response sent to Complainant	
☐ Investigation Closed	
Marketing Complaint Tracking #	

COMPLAINANT CONTACT INFORMATION		
Complainant Name/Title/Organization:		
Address:		
Phone:	**E-mail:**	**Fax:**

COMPLAINT DETAILS
Parties to the Alleged Violation *(violator, witnesses and others)*
Date/Time/Frequency of Alleged Violation:
Location of Alleged Violation: *(facility name including location - address, unit, room, floor)*
Narrative/specifics of alleged violation: *(Please attach any documentation to support this allegation and attach additional pages if more space is needed)*
Why is this alleged violation a violation of the Marketing Policy and Procedures? *(Please include citations to specific policies and procedures)*
What harm has resulted due to this alleged violation? *(such as misrepresentation, unfair advantage gained)*
What is the complainant's expectation/desire for resolution/remedy, if any?

LDH FINDINGS	
LDH Investigator Signature: *(at completion of investigation)*	**Date:**

Grievance/appeal request form

Please complete this form with information about the member whose treatment is the subject of the grievance and/or appeal.

Member name: _____

Member ID number: _____ Date of birth: _____

Authorized Representative*: _____

Phone Number: _____

Address: _____

Service or Claim number: _____

Provider name: _____

Date of service: _____

Humana
Healthy Horizons®
in Louisiana

* We must have an Appointment of Authorized Representative (AOR) form or other legal documentation when a request for a grievance and/or appeal is submitted by someone other than the member. If this form or other legal documentation is not on file, we are unable to continue your appeal or grievance. If you have any questions about this, please contact us at **1-800-448-3810 (TTY: 711).**

Please explain your appeal and your expected resolution. Attach extra pages if you need more space.

_____

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_____ _____

Member (or Representative) signature Date

Relationship to member (if Representative) _____

Important: Return this form to the following address so that we can process your grievance or appeal:

Humana Inc.

Grievance and Appeal Department

P.O. Box 14546

Lexington, KY 40512-4546

Fax: 1-800-949-2961

Auxiliary aids and services, free of charge, are available to you. **1-800-448-3810 (TTY: 711)**, Monday through Friday, from 7:00 a.m. to 7:00 p.m.

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.

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

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

繁體中文 (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。

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

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

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

Português (Portuguese): Ligue para o número acima para receber serviços gratuitos de assistência no idioma.

ພາສາລາວ (Lao): ໂທຫາເບີໂທລະສັບຂ້າງເທິງ ເພື່ອຮັບບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ.

日本語 (Japanese): 無料の言語支援サービスを受けるには、上記の番号までお電話ください。

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

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

فارسی (Farsi): برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

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

ภาษาไทย (Thai): โทรไปที่หมายเลขด้านบนเพื่อรับบริการช่วยเหลือด้านภาษาฟรี

This notice is available at **Humana.com/LouisianaDocuments.**

Humana Healthy Horizons in Louisiana is a Medicaid product of Humana Health Benefit Plan of Louisiana Inc.

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **1-800-448-3810 (TTY: 711)**, Monday through Friday, from 7:00 a.m. to 7:00 p.m. If you believe that Humana, Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail, or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **1-800-448-3810 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**.

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Questions?

Call Member Services
at 1-800-448-3810 (TTY: 711).











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