Humana Healthy Horizons in Louisiana Member handbook for behavioral health

Humana Healthy Horizons® in Louisiana

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Welcome to Humana Healthy Horizons in Louisiana

Humana is happy to have you as a member and is here help you learn about your benefits. Humana is a managed care organization that the state contracts with to provide health coverage to Medicaid and LACHIP members. This handbook will help you learn all about using your benefits. If you would like this handbook printed and mailed to you call **1-800-448-3810 (TTY: 711)**, Monday through Friday, from 7:00 a.m. to 7:00 p.m.

Your plan covers behavioral health (mental health and substance use disorder) services. That includes:

- Basic behavioral health services
- Crisis response services:
  - Mobile crisis response
  - Behavioral health crisis care
  - Community grief crisis support
  - Crisis stabilization
- Evidence-based practices: assertive community treatment, functional family therapy, homebuilders and multi-systemic therapy
- Individual placement support to help you find employment
- Inpatient hospitalization (mental health and substance use disorder treatment)
- Licensed mental health professionals who can provide support through counseling
- Medication-assisted treatment (MAT) and assisted therapy for methadone and opiate withdrawal
- Mental health rehabilitation services
- Personal care services
  - MyChoice Program Eligibility required
- Peer support services
- Psychiatric residential treatment facilities
- Psychiatrists who can help manage your medications
- Therapeutic group homes
- Outpatient substance use disorder treatment services
- Residential substance use disorder treatment services

For more behavioral health information go to Humana.com/LouisianaBH. If you would like a printed copy of the updated Behavioral Health Member Handbook call Member Services at **1-800-448-3810 (TTY: 711)** and we will send it to you for free.

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
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.

Personal Information

My Member ID Number:

My Providers Phone Number:

My Behavioral Health Provider:

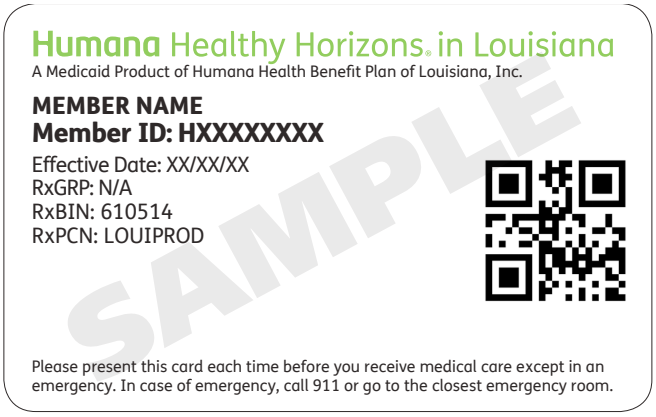
Your ID Cards

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.

Behavioral health services

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).	

Service/Benefit	Service Details	Limit
Crisis Services Continued	BHCC Centers are designed to offer recovery oriented and time limited 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.	

Service/Benefit	Service Details	Limit
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.
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.

Service/Benefit	Service Details	Limit
Inpatient Hospitalization	Mental Health services provided in an inpatient hospital setting.	
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.

Service/Benefit	Service Details	Limit
Psychosocial Rehabilitation (PSR)	Support in the home and Community to learn about behavioral conditions and help with learning coping skills and personal growth.	
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.

Privacy of substance use treatment services

There are laws about who can see your behavioral health information with or without your permission. Some information cannot be shared with others without your written permission. This includes:

- Substance use treatment
- Communicable disease information (such as HIV/AIDS)

To help arrange and pay for your care, there are times when your information is shared without first getting your written permission. These times could include the sharing of information with:

- Physicians and other agencies providing health, social, or welfare services
- Your medical primary care provider
- Certain state agencies and schools following the law, involved in your care and treatment, as needed
- Members of the clinical team involved in your care

At other times, it may be helpful to share your behavioral health information with other agencies, such as schools. Your written permission may be required before your information is shared.

There may be times that you want to share your behavioral health information with other agencies or certain individuals who may be assisting you. In these cases you can sign a Consent for Release of Medical Information. This form states that your medical records, or certain limited sections of your medical records, may be released to the individuals or agencies that you name on the form. You can find this form at Humana.com/LouisianaDocuments.

Exceptions

There are times when we cannot keep information confidential. The following information is not protected by the law:

- If you commit a crime or threaten to commit a crime at the program or against any person who works at the program, we must call the police.
- If you are going to hurt another person, we must let that person know that he or she can protect himself or herself. We must also call the police.
- We must report suspected child abuse to local authorities.
- If there is a danger that you might hurt yourself, we must try to protect you. If this happens, we may need to talk to other people inf your life or other service providers such as hospitals and other counselors to protect you.
- Only necessary information to keep you safe is shared.

The role of your PCP

Your primary care physician (PCP) takes care of your general health and can coordinate your care with specialists when needed. You do not need a referral from your primary care physician (PCP) for behavioral health services offered by an in-network provider. In case of a behavioral health emergency, you can contact our behavioral health crisis line anytime at **1-855-242-2735 (TTY: 711)** or visit www.louisianacrisisconnect.org. They can help you get the care you need.

Be sure to call your provider to schedule an appointment within the first 90 days of your plan year. For a routine checkup, you should be able to get an appointment within 30 days. For an urgent visit, expect to be seen within 48 hours. To make a change or to cancel, please call at least 24 hours before the appointment.

How to Choose and Change 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. Because you already have other primary care insurance, we will not assign you a primary care provider (PCP) from our network. Ask your primary insurance provider for a PCP or to change your PCP if you don't already have one. See your PCP for all of your routine healthcare needs and checkups.

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.

Freedom of Choice

You have the right to choose from our behavioral health network providers who will provide mental health and substance use services for you. You can change to another provider within Humana's network anytime you want.

To change your PCP, choose, please contact your primary insurance provider.

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 behavioral health 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.

Family/Caregiver/Legal Guardian Role

Humana can help you find providers for behavioral 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.

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 behavioral health 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.

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:

- Mental Health
- Substance Abuse
- Members with special health care needs
    - o ADHD
    - o Depression and PTSD
    - o Substance use disorder, including opioid use disorder

We can:

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

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.

Early Periodic Screening, Diagnostic 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
- Referrals to specialists when needed and recommended regardless of child's age
- Developmental and behavioral Health Screening, Exams and Assessment
- 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
- Alcohol/substance use, sexual activity, mental health
- Developmental delays

Transportation services

Humana Healthy Horizons in Louisiana members can set up nonemergency transportation to and/or from a medical appointment through MediTrans.

To schedule a ride, call MediTrans at **1-844-613-1638** Monday – Friday, from 7 a.m. – 7 p.m.

If you have to cancel your ride, please do so at least 48 hours in advance.

After-hours care

If you need medical care when your doctor's office is closed, call our 24-hour nurse advice line at **1-800-448-3810 (TTY: 711)**, or go to an urgent care facility.

In case of emergency

Emergencies are serious medical or behavioral problems that must be treated right away by a doctor. 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 (TTY: 711)** to talk to a nurse.

If you have an emergency, call 911 or go to the nearest emergency department.

Be sure to call Member Services at **1-800-448-3810 (TTY: 711**) when you are able and let us know about your situation.

Important contact information for Humana members

Member Services
1-800-448-3810 (TTY: 711)
Monday – Friday, 7 a.m. – 7 p.m.

24-hour nurse advice line
1-800-448-3810 (TTY: 711)

Louisiana Crisis Hub Line
1-855-242-2735 (TTY: 711)

Member pharmacy help desk
1-800-437-9101 (TTY: 711)
Monday – Friday, 8 a.m. – 4:30 p.m.

MediTrans transportation services
1-844-613-1638 (TTY: 711)
Monday – Friday, 7 a.m. – 7 p.m.

Mailing address
P.O. Box 14601
Lexington, KY 40512

Website **Humana.com/LouisianaBH**

Reporting contact information/address changes, visit **ldh.la.gov/UpdateMyInfo**, call **1-888-342-6207 (TTY: 1-800-220-5404)**, Monday – Friday, 8 a.m. – 4:30 p.m. or visit in person. You can find your local Medicaid office at www.ldh.la.gov/MedicaidOffices.

Visit **Humana.com/LouisianaBH** to find detailed information about covered benefits, programs and services offered through Humana Healthy Horizons.

Here you can also find, review and print copies of your:

- Member Handbook
- Provider directory

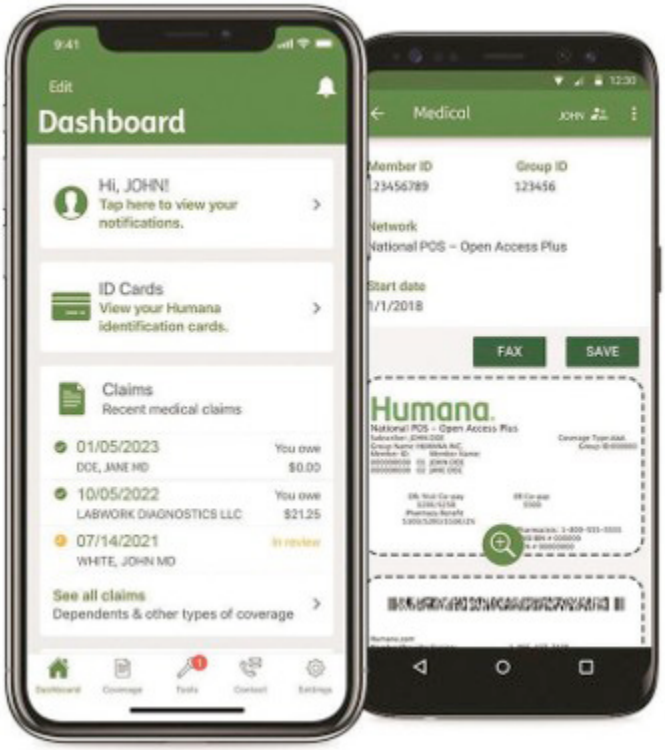
Create your MyHumana account

MyHumana is your secure online portal where you can change your doctor, view claims and plan details, and update your account information with us. To get started:

1. **Download** the MyHumana app from your mobile phone's app store (Apple App Store® or Google Play®).
2. Activate your MyHumana account

   → Select "Activate online account" and follow the prompts.

   → If you already have an account and need help with your username or password, click "Forgot username" or "Forgot password."
3. **Log in to MyHumana** from the MyHumana app or **MyHumana.com**



We can help you quit smoking

We want to help you lead your healthiest life, so you have access to our tobacco and vaping cessation program via the wellness coaching team.

- Up to eight health coaching/cessation support calls within 12 months of the first coaching session for members age 12 and older

- Nicotine replacement therapy upon request for members age 18 and older

For more information, go to **Humana.com/LouisianaQuits**.

Need to control your gambling?

If you need help with a gambling problem, go to Humana.com/LouisianaGamblingResources.You can also call the Louisiana Problem Gamblers Helpline at **1-877-770-STOP (7867)**. All calls are confidential and treatment is free to Louisiana residents.

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

How to access your pharmacy benefits

Pharmacy

Members who only receive behavioral health services through Humana Healthy Horizons in Louisiana will receive their pharmacy benefits through Louisiana Medicaid Pharmacy Fee-For-Service Program.

If you have questions, call 1-800-437-9101 for more information. You can also send an email to healthy@la.gov or go online to ldh.louisiana.gov → Medicaid → Get More Information → Medicaid Services → Pharmacy Services.

Pharmacy Fee-For-Service Program covers prescription drugs, except:

- Cosmetic drugs (Except Accutane);
- Cough & cold preparations;
- Anorexics (Except for Xenical);
- Fertility drugs when used for fertility treatment;
- Experimental drugs;

- Compounded prescriptions;
- Drug Efficacy Study Implementation (DESI) drugs;
- Erectile Dysfunction (ED) Medications
- Over the counter (OTC) drugs, with some exceptions;

Prescription limits: 4 per calendar month (The physician can approve an override for this limit when medically necessary). Limits do not apply to recipients under age 21, pregnant women, or those in Long Term Care.

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, the Louisiana Department of Health 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 the Louisiana Medicaid Pharmacy Fee-For-Service Program:

- Phone: **1-800-437-9101**, 8 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

Copay

Some medications are free, but some adult members will need to pay a small copay for their prescriptions based on the calculated state payment. Your cost for this medicine should not be more than $3. Your total copays for the month depend on your family's income each month. If the state shows you have paid 5% of your monthly income on copays, you will not have to pay.

Pharmacy cost	Your copay
$5.00 or less	$0.00
&5.01 to $10.00	$0.50
$10.01 to $25	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

There are no member copays for the following:

- Individuals age 21 and younger
- Pregnant women
- Individuals who are inpatients in long-term care facilities or other institutions

- Family planning services and supplies
- Emergency services
- Native Americans
- Alaskan Inuit
- Women who are receiving services on the basis of breast and cervical cancer
- Members receiving hospice services
- Home and Community Based Waiver
- U.S. Preventative Services Task Force (USPSTF) A and B Recommendations

Prior Authorization 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.

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.

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.

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/LouisianaBH.

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.

Do you need help communicating?

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

Just call Member Services at
1-844-613-1638 (TTY: 711)
Monday – Friday, from 7 a.m. – 7 p.m.

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

Help in making or getting to appointments

Information and materials in large print, audio (sound), and braille

Names and addresses of providers who specialize in your disability

Telecommunications relay service
This helps people who have trouble hearing or talking to make phone calls. Call **711** and give them our Member Services phone number. It is **1-800-448-3810**, Monday – Friday, from 7 a.m. – 7 p.m. They will connect you to us.

What if you get a bill for treatment?

If you get a bill for a treatment or service you do not think you should pay for, do not ignore it. Call Member Services at **1-800-448-3810 (TTY: 711)** right away. We can help you understand why you may have gotten a bill. If you are not responsible for payment, Humana Healthy Horizons will contact the provider and help fix the problem for you.

Know your member rights

As a Humana plan member, you have certain rights and responsibilities when being treated by Humana network providers.

This includes:

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. Request information on provider incentive plans.
16. 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

Grievances

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.

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 and abuse

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.

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**

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

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

How to change plans

If you are unhappy with your behavior health 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 Humana. During the first 90 days, you can change from Humana for any reason.

After the 90 days, you have the right to choose another health plan within the calendar year for any reason. You may make up to two (2) plan changes during the calendar year. After two plan changes have been made, you must remain in your selected plan until the start of the next calendar year.

If you want to change your health plan, you can through any of the following:

- Online at www.myplan.healthy.la.gov/myaccount
- On the Healthy Louisiana mobile app
- By phone at **1-855-229-6848 (TTY: 1-855-526-3346)**, Monday – Friday, 8 a.m. – 5 p.m. (Ask for a transfer form)

If 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

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

You have a right to your medical records

You are entitled to one free copy of your medical records. More copies are available at a cost. You also have a right to ask that your medical records be corrected if needed. Your records will be held for five years or longer as required by federal law. Contact your PCP office directly for a copy of your records.

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.

_____

_____

_____

_____

_____

_____

_____ _____

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

Insurance ACE Notice of Privacy Practices

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

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

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

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

What is nonpublic personal or health information?

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

How do we collect information about you?

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

What information do we receive about you?

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

How do we protect your information?

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

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

How do we use and disclose your information?

We use and disclose your information:

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

We have the right to use and disclose your information:

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

– continued to next page

Insurance ACE Notice of Privacy Practices – continued

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

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

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

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

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

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

The following uses and disclosures will require your written permission:

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

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

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

What are my rights concerning my information?

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

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

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

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Insurance ACE Notice of Privacy Practices – continued

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

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

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

Our Responsibilities

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

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

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

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

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

If you have any questions, please visit **Humana.com** or call the number on the back of your member ID card.

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)**.

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.

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): ໂທຫາເບີໃຫ້ຂ້າງເທິງ 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

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