Humana Healthy Horizons in Louisiana Member Handbook

Plan year 2024

Contents

Welcome!

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

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

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

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

We look forward to helping you achieve your best health.

Lori Dunne
Market President
Humana Healthy Horizons® in Louisiana

How to Reach Us

Member Services Humana Healthy Horizons® in LA One Galleria Blvd., Suite 1000 Metairie, LA 70001 humana.com/healthylouisiana You can chat with us via MyHumana	1-800-448-3810 (TTY:711) M-F 7a.m. - 7p.m. Fax:1-888-251-1793 Email: LA_Medicaid_Member_Services@humana.com
24-Hour Nurse Line	1-800-448-3810 (TTY:711)
24-Hour Behavioral Health Crisis Line	1-844-461-2848 (TTY:711)
MCNA (dental services for members under age 21 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 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
Member Pharmacy Help Desk	1-800-424-1664 (TTY: 711), 24 hours a day, 7 days a week, 365 days a year
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.

Hours of Service

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

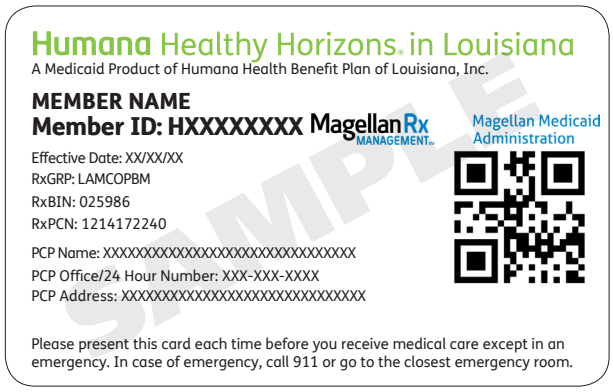
- Choose an option from our phone menu that meets your needs
- Access your records through MyHumana website at Humana.com/logon
- Leave a voice message when our office is closed and a representative will contact you on the next business day
- Email the specific department using the email addresses above

State Medicaid ID Card

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

Humana Member ID Card

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



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

If you have Medicare as well, your Medicaid benefits may be limited to only certain benefits. For dual eligible Members, your ID card will list your PCP as “Medicaid Secondary”.

Tools for Easy Access

MyHumana App

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

- Review your latest health summary including status, summary and detailed information
- Access your Humana Member ID card instantly with a single tap
- Find a provider by specialty or location. *The MyHumana app can even use your current location to locate the closest in-network provider no matter where you are

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

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

MyHumana Account

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

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

Always Keep Your Member ID Card

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

- See your doctor

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

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

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

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

Member Services

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

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

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

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

Managed Care Organization

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

Utilization Management

We keep track of the services you get from health care providers. We talk about some services with your providers before you get them. This is to make sure they are appropriate and necessary. Some services may require permission or prior authorization before you receive them so that Humana Healthy Horizons in Louisiana will pay for the care and to ensure you receive the care that is right for you. For example, we review surgeries or stays at a hospital (unless they are emergencies). This is called utilization management (UM). It makes sure you get the right amount of care you need when you need it. We do not reward providers or our own associates for denying coverage or services. We do not offer financial rewards to our associates that affects their decisions. We do not deny or limit the amount, length of time or scope of the service only because of the diagnosis or type of illness or condition. Any financial incentives for decision makers do not encourage decisions that result in under use of services.

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

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

- Healthcare services
- Medical devices
- Therapies
- Treatment options

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

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

Member Rights and Responsibilities

Your rights shall include, but are not limited to:

1. Receive information about the Plan, its services, its practitioners and providers and member rights and responsibilities
2. Be treated with courtesy and respect
3. Always have dignity and privacy considered and respected
4. Participate in making decisions with your provider unless it is not in your best interest
5. 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
6. 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;
7. Be free from any form of seclusion in effort to retaliate or discipline
8. To appeal a Plan's decision about your services
9. Make a compliant about the plan or the care it provides
10. Make recommendations to our member rights and responsibilities policy
11. 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;
12. Be given the health care services in federal regulations governing access standards;
13. 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.

*The above are according to federal regulations.

14. 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. Let us know right away if you have a
    a. Workers' Compensation claim
    b. injury
    c. medical malpractice lawsuit
    d. have been involved in a car accident.
14. Report any changes to your family size, living arrangements, parish of residence, phone number or mailing address to:

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

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

Primary Care Provider

The Role of Your PCP

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

health care needs.

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

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

How to Choose A PCP

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

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

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

Special Cases

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

Doctor Visits

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

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

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

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

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

Routine Medical Care

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

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

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

Well Care Medical Care

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

Well care includes things such as immunizations, diabetes screening, obesity screening and routine physicals for children, adolescents, and young adults. Well Care also includes screening for common chronic and Infectious diseases and cancers, clinical and behavioral interventions to manage chronic disease and reduce associated risks, and counseling to support healthy living and self-management of chronic disease.

Getting Care

Family/Caregiver/Legal Guardian Role

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

Guardianship

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

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.

How do I get a Guardianship?
Any adult can seek to have guardian appointed for another person. Usually guardianship is requested by a family Member.

Who appoints a Guardian?
Only a court can choose a guardian. The court that chooses a guardian is your local court. This could differ based on where you live. Call your local clerk of court for information.

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

Finding a Provider

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

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

Making, Changing, Cancelling Doctor Appointments

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

Appointment Timeframes

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

Your Health is Important

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

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

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

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

After Hours Care

If you need after hours care:

- Check our online provider directory at humana.com/healthylouisiana
- Check with your PCP

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

24-Hour Nurse Advice Line

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

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

24-Hour Behavioral Health Crisis Line

If you are in crisis and not sure if the problem is an emergency, call our Crisis Line at 1-844-461-2848. This is a free call. Crisis intervention services are available 24 hours a day, 7 days a week, 365 days a year. Our trained behavioral health staff 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 Humana.com/FindADoctor 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 it must be treated right away by a doctor. Humana may cover emergency transportation, too. We cover care for emergencies both in and out of our service area.

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?

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 an approval before you get emergency services. If you are not sure what to do, call your PCP for help, or you can call our 24-hour nurse advice line at 1-800-448-3810.

Remember, if you have an emergency:

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

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

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

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

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

Care after an Emergency

Care after an emergency helps to improve or clear up your health issue, or stop it from getting worse. It does not matter whether you get the emergency care in or outside of our network. We will cover services medically necessary after an emergency. You should get care until your condition is stable.

PCP Services

Early Periodic Screening, Diagnostic and Treatment (EPSDT)

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

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

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

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

EPSDT eligible Members with special health care needs can get Care Management services.

EPSDT well care exams and health screens include:

- Medical/physical exams
- Complete health and development history
- Height and weight checks with nutrition counseling when needed
- Hearing tests
    - Hearing tests start when your child is a newborn
    - Hearing tests and risk assessments happen at each EPSDT visit
- Eye exams (vision)
    - Eye exams start when your child is a newborn
    - Eye exams and risk assessments happen at each EPSDT visit
- Dental visits
    - During EPSDT visits, oral health assessments are provided at recommended ages and referrals made to a dentist when needed
    - Recommendations to dentists by 12 months or earlier if an issue is identified or a tooth erupts
- Referrals to specialists when needed and recommended regardless of child's age
- Developmental and Behavioral Health Screening, Exams, and Assessment

- Lab tests, including blood tests, lead level tests, tuberculosis risk assessments/tests and urine tests
- Immunizations (shots)
- Health and safety education
- Guidelines to measure and improve the health and well-being of the families' preventive health needs (counseling, evaluations or screenings)
- Intervention and/or referral needs for identified risk behaviors
- Car seat safety, seat belts,
- Alcohol/substance use, sexual activity, mental health
- Developmental delays

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

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

Humana will cover services that are medically necessary and approved by a prior approval even when they are not covered in the Louisiana Medicaid Program. Call Member Services if you have a question about coverage or services that require prior approval.

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

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

Specialty Care

Sometimes, you may need to see a provider other than your PCP for medical problems like special issues, injuries, or illnesses. A specialist is a provider who works in one specific health care area. You

do not need to talk to your PCP first, and you do not need a referral from your PCP to see a specialist.

Second Opinions

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

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

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

Right to Refuse Treatment

You have the right:

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

Changing Your PCP

Choosing a PCP will help you take care of your health care needs. You may choose a PCP from Humana's Provider Directory. You can start seeing that PCP on the first day you are signed up. To view our directory, please visit humana.com/healthylouisiana or call our Member Services at 1-800-448-3810 (TTY: 711) Monday through Friday from 7a.m. - 7p.m.

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

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

Freedom of Choice

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

To change your PCP:

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

Transportation

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

- Health care appointments
- Vision and dental appointments

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

For emergency transportation please call 911.

Interpretation/Translation Services

Is there a Humana Member in your family who:

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

If so, we can help. Humana offers sign and language interpreters at no cost for the Member or provider. Oral interpretation is provided for all languages.

We can help Members talk with us or their health care provider or read materials to you in any language, if needed. Interpreters can also help you with a grievance or an appeal when you are not happy with a decision. We can help over the phone or in person. Please call Member Services to ask for sign language services five (5) business days before the scheduled appointment.

Please call Member Services to ask for interpreter services 24 hours before the scheduled appointment.

We can also get printed translated materials in Spanish and each common non-English language as well as the top 15 non-English languages as released by the U.S. Department of Health and Human Services, Office for Civil Rights, in other languages or alternative formats, like large print and Braille, and other auxiliary aids and services. Just call us at 1-800-448-3810 (TTY: 711) to arrange for an

interpreter service.

Pharmacy

Your drug benefit is provided by the Magellan Medicaid Administration Pharmacy Benefits Management Program.

Their member service team is available by calling 1-800-424-1664 (TTY: 711), 24 hours a day, 7 days a week. Your Member ID card has important information for your pharmacy. If you do not have your new Member ID card you can still go to the pharmacy. Tell them you have Medicaid and the pharmacist can call 1-800-424-1664 (TTY: 711), 24 hours a day, 7 days a week to get the needed information. Before you go, make sure the pharmacy accepts Louisiana Medicaid. To find a pharmacy or see what is covered, go to our website, humana.com/healthylouisiana.

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

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

Copayments do not apply to the following:

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

Pharmacy-related Grievances

If you need assistance or want to file a complaint or grievance related to pharmacy services, you may reach Magellan by phone, fax, mail or through the Contact Us feature on the Magellan web portal.

Magellan Medicaid Administration

Call Center (24/7/365)

Phone Number: 1-800-424-1664

Fax Number: 1-800-424-7402

Address:
Magellan Medicaid Administration, LLC
Attn: GV – 4301
P.O. Box 64811
St. Paul, MN 55164-0811

Web portal Contact Us: https://www.lamcopbmpharmacy.com

Prior Authorization

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

You can request prior authorization for a service by:

- Completing prior authorization form located at humana.com/healthylouisiana 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.

Note: This does not apply to pharmacy

Prior Authorization 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 fourteen (14) Calendar Days of receiving the request.
- Expedited (faster) review: We will decide about your request within seventy-two (72) hours of receiving the request.

Note: Both timeframes for standard and expedited reviews can be extended up to 14 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 deny a service, we will send a notice to you and your provider.

Note: This does not apply to pharmacy

Services that Do Not Require Prior Approval

The following services do not require prior approval:

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

Medication Therapy Management (MTM)

At Humana, we understand the impact that proper medication use can have on your health. That's why we have a Medication Therapy Management (MTM) Program for our qualified Members. This Program is geared towards helping you learn about your medications, prevent, or address medication-related problems, decrease costs, and stick to your treatment plan.

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

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

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

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

You can call Member Pharmacy Help Desk at 1-800-424-1664 (TTY: 711) to ask about our list of covered medications and those that need prior approval.

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/healthylouisiana.

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

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

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

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

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

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

Mental Health Advance Directive

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

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

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

Living Will

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

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

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

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

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

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

Continuation of Care You Are Receiving

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

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

Member Satisfaction

Right to Fair Treatment

Discrimination is Against the Law

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws.

Humana Inc. and its subsidiaries:

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

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

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

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

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

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

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

Grievances and Appeals

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

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

Grievances (Complaints)

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

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

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

- Calling Member Services at 1-800-448-3810 (TTY: 711)
- Filling out the form in the back of this Member Handbook
- 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 should also send any information that helps explain your problem
- Submitting a request online on 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 an Member's grievance or files a grievance on behalf of an 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 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)
- Filling out the form in the back of this handbook and sending it to us at the address below
- 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 should also send any information that helps explain your appeal.
- Submitting a request online at Humana.com
- 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, clinical 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 shall 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: expedite the appeal. In order for your appeal to be expedited, it must meet the following criteria:

- 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 an Member's appeal or files an appeal on behalf of an Member with written consent

If we extend the timeframe for your appeal or decide expedited criteria is not met (we are requesting it, not you) we will make reasonable efforts to give you prompt oral notice of the delay, and 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 an 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.

You can present, in person or in writing, evidence (such as medical records, supporting statements from a provider, etc.) to include with your appeal submission prior to the end of the appeal resolution timeframe. For a standard appeal, we must receive this information within 30 calendar days of us receiving your appeal. For an expedited appeal, we must receive any supporting information within 72 hours of receipt.

Continuation of Benefits during the Appeal Process

For some adverse benefit determinations, you may request to continue services during the appeal and Medicaid Fair Hearing process. Services that can be continued must be services that you are already receiving, including services that are being reduced or terminated. We will continue services if you request an appeal within ten (10) days from our Notice of Adverse Benefit Determination letter, or before the date we told you they would be reduced 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

- Ten (10) days after we mail the appeal decision
- You withdraw your appeal
- 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 we decide that we agree with our first decision to deny your service, you may be required to pay for these services.

Medicaid State Fair Hearings

You also 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 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 – Health and Hospitals 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: http://www.adminlaw.state.la.us/HH.htm

You can have someone else represent your situation if you choose. That person can be a friend, relative, attorney or other spokesperson.

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 you receive our appeal decision.

The decision will be made within 90 days from the date the division of Administrative law received the request.

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 shall make the recommendation to the Secretary of the LDH who has final authority to determine whether services shall 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)

Any limitations involving the provision of information for adult persons who do not want

information shared with family members, including age(s) of consent for behavioral health treatment as per 42 C.F.R. Part 2.

Report Fraud, Waste and Abuse

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

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

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

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

Examples of pharmacy fraud, waste and abuse include:

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

Examples of Member fraud, waste and abuse include:

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

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

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

Report Fraud

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

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

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

- You can go to our website, humana.com/healthylouisiana and fill out the form

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 www.ldh.la.gov/ReportProviderFraud or call 1-800-488-2917 TTY: 1-800-220-5404
- Report Member fraud: Online at www.ldh.la.gov/ReportRecipientFraud or call 1-833-920-1773 TTY: 1-800-220-5404

Member Advisory Committee

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

Attending offers you the chance to meet other Plan Members in your community. You can bring a family member, caregiver or close friend. Humana wants to hear how we can improve your health plan. If you can't attend in person, you can join us by phone.

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

CALL: 1-800-448-3810
TTY: 711
WEBSITE: humana.com/healthylouisiana

Quality Improvement

Program Purpose

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

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

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

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

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

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

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

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

Program Scope

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

- Meeting the quality requirements of the Centers for Medicare and Medicaid Services (CMS)
- Establishing safe clinical practices throughout the network of providers
- Providing quality oversight of all clinical services

- Compliance with NCQA accreditation standards
- HEDIS® compliance audit and performance measurement
- Monitoring and evaluation of Member and provider satisfaction
- Managing quality of care and quality service complaints
- Ensuring the Humana QI Program is effectively serving Members with culturally and linguistically diverse needs
- Ensuring the Humana QI Program is effectively serving Members with complex health needs
- Assessing the traits and needs of the Member population
- Assessing the geographic availability and accessibility of primary and specialty care providers

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

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

Quality Measures

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

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

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

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

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

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

Potential CAHPS® measures for the plan are:

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

What We Pay For

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

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

Covered Services

Physical Health Services

Physical health services include, but are not limited to, the below listing. Some limitations and prior approval requirements may apply.

- Advanced Practice Registered Nurses
- After Hours Care on Evenings, Weekends, and Holidays
- Allergy Testing and Allergen Immunotherapy
- Ambulatory Surgical Services
  - o Ambulatory Surgical Centers (Non-Hospital)
  - o Outpatient Hospital Ambulatory Surgery
- Anesthesia
- Applied Behavior Analysis Therapy (age 0-20)
- Assistant Surgeon/Assistant at Surgery
- Audiology Services
- Bariatric Surgery
- Breast Surgery
- Cardiovascular Services
- Chiropractic Services (age 0-20)
- Cochlear Implant (age 0-20)
- Community Health Workers
- Concurrent Care – Inpatient
- Diabetes Self-Management Training
- Durable Medical Equipment, Prosthetics, Orthotics and Certain Supplies
- Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (age 0-20)
- Emergency Services
- End Stage Renal Disease Services
- Eye Care and Vision Services
- Family Planning Services
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Services
- Genetic Counseling and Testing
- Glasses, Contacts, and Eye-Wear
- Gynecology
- Home Health-Extended Services (age 0-20)
- Home Health Services
- Hospice Services
- Hospital Services
  - o Inpatient Hospital Services

- Outpatient Hospital Services
- Hyperbaric Oxygen Therapy
- Immunizations
- Intrathecal Baclofen Therapy
- Laboratory Services
- Limited Abortion Services
- Medical Transportation Services
- Newborn Care and Discharge
- Obstetrics
- Organ Transplants
- Pediatric Day Healthcare Services (age 0-20)
- Personal Care Services (age 0-20)
- Pharmacy Services
- Physician Administered Medication
- Physician Assistants
- Physician/Professional Services
- Podiatry Services
- Portable X-Ray Services
- Preventive Services for Adults (age 21 and older)
- Radiology Services
- Routine Care Provided to Enrollees Participating in Clinical Trials
- Sinus Procedures
- Skin Substitutes for Chronic Diabetic Lower Extremity Ulcers
- Sterilization
- Telemedicine/Telehealth
- Therapy Services
- Tobacco Cessation Services
- Vagus Nerve Stimulators

Behavioral Health

Mental health and substance use services are covered services for Humana Members. 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.

Behavioral Health Only Plan

Some members are only 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)

This handbook covers information for members who are eligible for specialized behavioral health services.

There may be a time where you need support and need to speak with someone right away. You can call our 24-Hour Behavioral Health Crisis Line at 1-844-461-2848 (TTY:711) and get help.

Humana provides a comprehensive range of behavioral health services including:

Note: Some of the services listed below may need a prior authorization. Please call member services

for more information at 1-800-448-3810 or TTY: 711.

Activity	Service Details
Assisted therapy for methadone and opiate withdrawal	Covered services include: • Outpatient services. • Assistance with withdrawal from opiates. Available to members of all ages. • Medication-assisted treatment (MAT) including Methadone treatment in Opioid Treatment Programs (OTPs)
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.
Crisis Services	• Mobile Crisis Response (21-64 years old) A service that will help in a crisis, where help comes to the member. • Behavioral Health Crisis Care (21-64 years old) A program that gives short-term help after a crisis. • Community Brief Crisis Support (21-64 years old) An in person crisis response, to help with stabilization and support in the community after help from the first time. • Crisis Stabilization (0-20 years old) Short-term support resources for the youth and his/her family out of home. • Adult Crisis Stabilization (Ages 21 and older) To provide treatment via the least restrictive level of care, allowing an alternative to inpatient hospitalization.
Crisis Stabilization Units for Adults Age 21 and Older	Provides treatment via the least restrictive level of care, allowing an alternative to inpatient hospitalization.
Evidence Based Practices (EBPs)	• Assertive Community Treatment (age 18 and older) 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. • Functional Family Therapy (FFT) and Functional Family Therapy-Child Welfare (FFT-CW) (ages 0-20) These are programs that help youth who are between the ages of 10 and 18 (0 to 18 for FFT-CW) and are showing serious behavioral issues. • Homebuilders® (age 0-18) This is a home program for children (birth to 18 years) at risk of out-of-home placement, or in coming together again from placement. Homebuilders is provided through the Institute for Family Development (IFD). • Multi-Systemic Therapy (MST) (ages 0-20) This is a home and family and community therapy for youth who are at risk for being removed for the home or who are returning home from placement.
Individual Placement Support (IPS)	Supported employment for members with behavioral health needs. 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.

Activity	Service Details
Doctor Specializing in Behavioral Health	Psychiatrists (Medical Doctor that can help with Behavioral Health diagnosis, medications and talk therapy
Licensed Mental Health Professionals That Can Provide Support	• Licensed Psychologists • Medical Psychologists • Professional Counselors • Clinical Social Workers • Addiction Counselors • Marriage and Family Therapists • Advanced Practice Registered Nurses (psychiatric specialists The services include individual, family and group therapy, evaluations, and assessments.
Mental Health Rehabilitation Services	• Community Psychiatric Support and Treatment (CPST) Support in the home and community to build skills and help with functional development. • Psychosocial Rehabilitation (PSR) Support in the home and Community to learn about behavioral conditions and help with learning coping skills and personal growth. • Crisis intervention and Crisis Stabilization Services
Personal Care Services (PCS)	Must be at least 21 years or older and have moved from a nursing home through the My Choice Louisiana program.
Peer Support Specialist (PSS) (Must be at least 21 years or older)	Help members with setting and completing goals during the recovery process.
Therapeutic Group Homes (TGH) (age 0-20)	Community-based 24-hour services where the youth lives in a homelike setting with other youth to receive mental health services.
Psychiatric Residential Treatment Facilities (PRTF) (age 0-20)	Long-term care in a 24-hour group living facility. A residential setting that provides inpatient psychiatric services.
Inpatient Hospitalization	Mental Health Services provided in an Inpatient Hospital setting.
Rehabilitation Substance Use Disorder	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 leaning coping skills and managing substance use behaviors.
Medication Assisted Treatment	The use of medication and therapy for treatment of substance use disorder.

Services Covered by the State Plan, but not Humana

Long-Term Care

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

Coordinated System of Care (CSoC)

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

Adult Denture Services

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

To find a provider, contact your Medicaid dental plan:

https://dentaquest.com/state-plans/regions/louisiana/ DentaQuest: 1-800-685-0143 (TTY: 1-800-466-7566), Monday – Friday, 7 a.m. to 7 p.m.

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

Dual Eligible and Waiver Population

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

Services MCO does not cover due to moral or religious objections

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

Go365 for Humana Healthy Horizons®

Go365 for Humana Healthy Horizons® is a wellness program that offers Members the opportunity to earn rewards for taking healthy actions. It's easy to participate in healthy activities and earn rewards through our Go365 for Humana Healthy Horizons® wellness program.

To earn rewards, you must:

- Download the Go365 for Humana Healthy Horizons® App from iTunes/Apple Shop or Google Play on a mobile device
- Create an account to access and engage in the program
  - Members who are 18 and older can register to create a Go365 for Humana Healthy Horizons® account
  - Parents or guardians of Members under age 18 can create an account on behalf of the minor
  - You must have your Member ID number

For each eligible Go365 activity completed, you can earn rewards and then redeem the rewards for gift cards in the Go365 for Humana Healthy Horizons® in-app mall.

Activity	Reward Details
Breast Cancer Screening (Ages 40 and older)	• Annual $25 reward for female Members who obtain a mammogram

Activity	Reward Details
Cervical Cancer Screening (Age 21 and older)	• Annual $25 reward for female members who obtain a pap smear
Chlamydia Screening	• Annual $25 reward for female members who obtain a chlamydia screening when sexually active and as recommended by their healthcare provider
Colorectal Cancer Screening (Age 45 and older)	• Annual $25 reward for members who obtain a colorectal cancer screening as recommended by their PCP
Covid-19 Vaccination Vaccine (56 months and older)	• Annual $20 in rewards for members who upload a picture/ file of their completed COVID-19 vaccine card, 1 per year • Members who were vaccinated prior to enrollment in Humana plan may upload vaccination card within 90 days of enrollment to receive the reward • New members that were not vaccinated prior to enrollment in Humana, have 90 days from completion of vaccination and upload the vaccination card to receive the reward
Diabetic Retinal Eye Exam (Ages 18 and older)	• Annual $25 reward for diabetic members who complete a retinal eye exam
Diabetic Screening (Ages 18 and older)	• Annual $20 reward for diabetic members who complete an annual screening with their PCP for HbA1c and blood pressure
Digital Onboarding	• One-time $25 reward for downloading Humana's mobile Go365 application and completing the registration
Flu Vaccine	• Annual $20 reward for members who receive an annual flu vaccine from their provider, pharmacy, or self-reporting if they received a vaccine from another source
Follow up After High-Intensity Care for Substance Use Disorder	• $25 reward for members who received follow-up care within 30 days of an inpatient hospital discharge, residential treatment or detoxification visit for a diagnosis of substance use disorder
Follow up After Hospitalization Illness for Mental	• $25 reward for members who received follow-up care within 30 days after a hospital discharge for a diagnosis of select mental illness or intentional self-harm
Health Needs Assessment Completion	• One-time $30 reward for completing the Health Needs Assessment. Must be completed within 90 days of enrollment
HPV Vaccine (Ages 9-13)	• One-time $50 reward for members who receive 2 doses of the HPV vaccine between their 9th and 13th birthday
Level of Care Video (Ages 19 and older)	• Annual $10 reward upon watching a short educational video about when to access the emergency room
Notification of Pregnancy (NOP)	• $25 reward when pregnant members notify Humana of pregnancy prior to delivery once per pregnancy
Postpartum Visit	• $25 reward for all postpartum females who complete 1postpartum visit within 7-84 days after delivery once per pregnancy
Prenatal Visits	• Pregnant members can earn $10 per prenatal visit, up to 10 prenatal visits, for a total of up to $100 once per pregnancy

Activity	Reward Details
Tobacco Cessation Program (Ages 12 and older)	• For all members age 12 and older, up to 8 health coaching/ cessation support calls within 12 months from enrollment date • For members age 18 and older, nicotine replacement therapy upon request • This program will have two opportunities where members can earn rewards: o $25 in rewards for members who complete 2 calls within the first 45 days of enrollment in the coaching program, 1 per year o $25 in rewards for members who complete 6 additional Wellness Coaching calls (total 8) within 12 months of the first coaching session, 1 per year Members who enroll in the Tobacco Cessation Program will have two opportunities to earn rewards annually: • $25 reward for completing two calls within 45 days of enrollment in the program • $25 reward for completing the full program
Weight Management Program (Ages 12 and older)	Members who enroll in the Weight Management Program will have two opportunities to earn rewards annually: • $30 reward for completing a wellbeing check up • $20 reward for completing the program
Well-Child Visits (0-15 months)	• Up to $120 in rewards for members who complete routine well-child visits. Members can recieve $20 in rewards per visit, with a six-visit limit
Well-Child Visits (16-30 months)	• $30 reward for members who complete routine well-child visits. Members can receive $15 reward per visit with a two-visit limit
Wellness Visits (Ages 3 and older)	• Annual $35 reward for completing an annual wellness visit

Program Disclaimer

Rewards have no cash value. The monetary amounts listed above are reward values, not actual dollars. For some rewards, your doctor has to tell us that you completed the healthy activity. Once we get this information from your doctor, you will see in the app the option to redeem the reward. For any reward you earn during the plan year, we must get confirmation from your doctor by March 15th 2025.

Go365 for Humana Healthy Horizons® is available to all members who meet the eligibility requirements. Rewards may take 90 to 180 days or greater to receive. Rewards are non-transferrable to other MCOs or other programs. Members will lose access to the Go365® in Humana Healthy Horizons® App to the earned incentives and rewards if they voluntarily dis-enroll from the Humana Healthy Horizons or lose Medicaid eligibility for more than one-hundred eighty (180) days. At the end of plan year (December 31st), members with continuous enrollment will have 90 days to

redeem their rewards.

In accordance with the federal requirement of CMS, no amounts on the gift cards shall be used to purchase covered medical supplies or prescription drugs nor are they redeemable for cash. Rewards cannot be used for gambling, alcohol, tobacco or drugs (except for over-the-counter prescriptions). Rewards may be limited to once per year, per activity. See activity description for details.

Value Added Benefits

These are extra services that offered by Humana and approved by LDH. These services or benefits are not otherwise covered or exceeds the limits of the core benefits listed above. All Value Added Benefits are for ages 21 and over unless otherwise stated in the description.

Value Added Benefits	Description
Convertible Car Seat or Portable Crib	Pregnant members who enroll and actively participate in our HumanaBeginnings Care Management program, complete a comprehensive assessment, and at least 1 follow-up call with a HumanaBeginnings Care Manager can select 1 convertible car seat or portable crib per infant, per pregnancy.
Dental (Ages 21 and older)	Up to $500 allowance towards services such as routine dental exams, x-rays, cleanings, fillings and extractions with in network providers.
Disaster Preparedness Meals	One box of 14 shelf- stable meals after a hurricane or tornado twice per year The Governor must declare the tornado or hurricane a disaster for the member to be eligible for the meals
Drowning Prevention Classes (Ages 0 to 21)	Drowning prevention classes are offered with the free YMCA membership . If the member does not reside within 20 miles of a partnering YMCA, the member is eligible for reimbursement of up to $200 annually for swimming lessons for infants and children from a certified swim instructor
GED Testing	GED test preparation assistance, including a bilingual advisor, access to guidance and study materials, and unlimited use of practice tests. Test preparation assistance is provided virtually to allow maximum flexibility for members. Also includes test pass guarantee to provide members multiple attempts at passing the test. 16 - 18 years: must provide additional documentation Underage testers must enroll in the state's official Adult Education Program and take free classes until they are ready to sit for the exam. They will need documentation from the school system that they have officially withdrawn.

Value Added Benefits	Description
Home-Based Asthma Interventions	Up to $200 allowance once per year • Members with asthma can utilize this allowance towards carpet cleaning, allergen-free bedding, and/or air purifier . • Must have asthma diagnosis. • Must be Care Manager approved.
Housing Assistance (Ages 21 and older)	Up to $500 per member per lifetime to assist with the following housing expenses: • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water, gas or internet (late payment notice required) • Trailer Park and lot rent if this is your permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority Plan approval required. • Member must not live in a residential facility or nursing facility • Funds will not be paid directly to the member • If the bill is in the spouse's name, a marriage certificate may be submitted as proof
Newborn Circumcision (Ages 0 to 1)	Up to 12 months of age or as medically necessary. Once per lifetime
Non Medical Transportation (NMT) (Ages 18 and older)	Up to 15 round trips (or 30 one-way trips) up to 30 miles for non-medical transportation per year. Locations include social support groups, wellness classes, WIC and SNAP appointments, food banks, and applicable value-added benefit services offered. This benefit also offers transportation to locations providing social benefits and community integration for members such as community and neighborhood centers, parks, recreation areas, and churches.
Over-the-Counter (OTC) Pharmacy Allowance	Up to $25 per calendar month allowance enables members to purchase products that support common occurring conditions such as: • Pain relievers • Diaper rash cream • Cough and cold relief medicine • First aid equipment that do not require prescriptions Unused amounts do not roll over to the next month
Pain Management Alternatives- Acupuncture (21 and older)	Up to 24 annual acupuncture visits to manage chronic pain

Value Added Benefits	Description
Post Discharge Meal	14 refrigerated home-delivered meals following discharge from an inpatient or residential facility. Limited to 4 discharges per year
Respite Care for Homeless Program (Males ages 18 and older)	The Medical Respite Program ensures member recovery and stabilization and successful integration back into his community and avoid unnecessary emergency department visits and hospital admissions.
Smartphone Services	1 Free smartphone through the Federal Lifeline Program, per household. Members who are under 18 will need a parent or guardian to sign up. This benefit covers per lifetime: 1 phone, 1 charger, 1 set of instructions, unlimited talk, text and high-speed data. It also covers training for you and your caregiver at the first case manager orientation visit if you are enrolled in care management. Members must make 1 phone call or send 1 text message every month to keep benefit. Members may qualify for enhanced benefits through the Affordable Connectivity Program (ACP) that provides unlimited minutes, 10 GB hotspot and unlimited data. You can opt into this benefit by contacting SafeLink at 1-800-SAFELINK or online at www.safelink.com/en/ACP11 Benefits are subject to change by the FCC F13 under the Lifeline program
Sports Physical (Ages 6 to 18)	1 sports physical per year
Tobacco & Vaping Cessation Coaching (Ages 12 and older)	Tobacco & Vaping Cessation Coaching is focused on tobacco and vaping cessation coaching for members aged 12 and older. The program is designed as a 6-month engagement for a total of 8 coaching calls, but members have 12 months to complete the program if needed. Humana's tobacco & vaping cessation health coaching offers support for both over the counter (OTC) and prescription nicotine replacement therapy (NRT).
Vision Services (Ages 21 and older)	1 eye exam per year Up to $100 allowance for 1 set of glasses (frames and lenses) and/or contacts Member pays any cost over $100
Weight Management Coaching (Ages 12 and older)	Weight Management Coaching delivers weight management intervention for members who are 12 and older. Upon receiving physician clearance, member can complete six (6) weight management coaching sessions with Health Coach; approximately one call per month for a period of six (6) months.
YMCA Gym Membership	Free one year annual membership at participating YMCA

Pregnancy and Family Planning Services

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

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

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

Before You Are Pregnant

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

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

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

After Your Baby is Born

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

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

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

Services Not Covered

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

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

Helping you be Healthy

Population Health/Chronic Care Management

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

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

We can:

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

Members with these conditions are contacted for enrolling in the Care Management Program. If you would like to enroll or have questions please call our Care Management Support department at 1-800-252-2444 (TTY: 711) or Member Services.

Care Management and Outreach Services

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

- Your doctor asks us to call you.

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

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

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

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

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

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

Complex Care Management

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

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

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

Health Education

Additional Health Support Programs from LDH

Tobacco Cessation

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

Remember, if you are 12 years old or older and smoke or use other tobacco products, Humana

Healthy Horizons® in Louisiana can help you quit. Quitting tobacco is one of the most important things you can do to improve your health and the health of your loved ones. You don't have to do it alone! We will provide you with a coach. Your coach will support you in your commitment to stop smoking.

Your coach will listen to you, help you understand your habits, and work with you to take action. Your doctor also may recommend you try medicines. To reach a coach who can help you quit, call the coaching enrollment team at 1-866-270-4223 and press 1 for Tobacco Cessation coaching.

Problem Gambling

If you are 18 years or older, call Louisiana Problem Gamblers Helpline 24 hours a day, seven days a week to learn more and/or to join the Problem Gamblers Program. This call is toll-free and confidential. You can also get in touch with the Louisiana Problem Gamblers Hotline the following ways:

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

Other Plan Details

Rights and Protections

Notice of Privacy Practices

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

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

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

example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.

- To provide payment information to the subscriber for Internal Revenue Service substantiation.
- To public health agencies, if we believe that there is a serious health or safety threat.
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence.
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For law enforcement purposes, to military authorities and as otherwise required by law.
- To help with disaster relief efforts.
- For compliance programs and health oversight activities.
- To fulfill our obligations under any workers' compensation law or contract.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For research purposes in limited circumstances and provided that they have taken appropriate measures to protect your privacy.
- For procurement, banking, or transplantation of organs, eyes, or tissue.
- To a coroner, medical examiner, or funeral director.

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

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

The following uses and disclosures will require your written permission:

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

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

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

What are my rights concerning my information?

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

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. As required under applicable law, we will make this personal information available to you or to your designated representative.
- Adverse Underwriting Decision – If we decline your application for insurance, you have the right to be provided a reason for the denial.

- Alternate Communications – To avoid a life-threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request correction of any of this personal information through amendment or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion of the information in dispute, or of our refusal to make such correction after further investigation. If we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute.*

  *This right applies only to our Massachusetts residents in accordance with state regulations.
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information.
  This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- Notice – You have the right to request and receive a written copy of this notice any time.
- Restriction – You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.

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

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

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also email your complaint to OCRComplaint@hhs.gov. If you elect to file a complaint, your benefits will not be affected, and we will not punish or retaliate against you in any way.

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

Our Responsibilities

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

We can change the terms of this notice, and the changes will apply to all information we have about you.

The new notice will be available upon request, in our office, and on our web site.

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

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

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

Other Insurance/Subrogation

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

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

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

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

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

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

- The person at fault;
- His or her insurance company; and
- Any lawyers involved.

Medical Record Requests

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

- If you would like a copy of your information, please send a written request to the Humana privacy officer.
- Humana will provide one copy of records per 12-month period free of charge.
  - o You may be charged for additional copies.
- Humana will respond to requests within 30 days of receipt.

- Humana may ask for an extra 30 days if necessary. We will let you know if we need the extra time.
- Humana has the right to keep you from having or seeing all or parts of your records for specific reasons related to HIPAA and State law.
- Humana will tell you the reasons in writing.
- Humana will give you information on how to file an appeal if you disagree with our decision.

Changing Plans

Enrollment

If you are a mandatory Member required to enroll in a plan, once you are enrolled in a Humana Healthy Horizons® in Louisiana or the state enrolls you in a Plan, you will have 90 days from the date of your first enrollment to try the MCO. During the first 90 days, you can change MCO's for any reason. Call the Medicaid Enrollment Broker at 1-855-229-6848.

If you use TTY, call 1-855-526-3346, Monday – Friday, 8 a.m. – 5 p.m., to choose another plan. After the 90 days, if you are still eligible for Medicaid, you will be enrolled in the plan until the next Open Enrollment Period. This is called “lock-in.”

Open Enrollment

If you are a mandatory Member, you have the right to choose another health plan within your Open Enrollment Period. Call the Medicaid Enrollment Broker at 1-855-229-6848. If you use TTY, call 1-855-526-3346 Monday – Friday, 8 a.m. – 5 p.m., to choose another plan. Once you choose either Humana Health Plan or another plan, you will be locked into that plan until the next open enrollment period.

If you do not choose a new health plan during open enrollment, you will automatically remain a Member of Humana Healthy Horizons® in Louisiana.

Disenrollment for Cause

If you are a mandatory Member and you want to change plans after you are locked in, you must have one of the following state-approved good-cause reason to change plans:

- 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 by the MCO as determined by LDH;
- Lack of access to MCO covered services as determined by LDH;
- 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.

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
- 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.

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.

Humana will not disenroll you from our Plan unless directed by the state.

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 www.ldh.la.gov/HealthyLaMarketingComplaint or
- Fax a completed Healthy Louisiana Marketing Complaint form (copy of the form can be found in Appendices) to 1-877-523-2987.
- Via email to MMEReview@la.gov

Medicaid Related

Eligibility

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

Sometimes things in your life might change, and these changes can affect whether or not you can still have Medicaid. It is very important to make sure that you have Medicaid before you go to any appointments. Just because you have a State Medicaid ID Card does not mean that you still have Medicaid. Do not worry! If you think your Medicaid has changed or if you have any questions about your Medicaid, call Member Services at 1-800-448-3810 and we can help you check on it.

- If you lose your Medicaid Eligibility
- If you lose your Medicaid and get it back, you should call the Medicaid Enrollment Broker at 1-855-229-6848 and choose Humana Healthy Horizons® in Louisiana.
- If you have Medicare
- If you have Medicare, continue to use your Medicare ID card when you need medical services (like going to the doctor or the hospital), but also give the provider your Member ID card too.
- If you are having a baby

If you have a baby, he or she will be covered by us on the date of birth. Call Member Services to let us know that your baby has arrived and we will help make sure your baby is covered and has Medicaid right away.

It is helpful if you let us know that you are pregnant before your baby is born to make sure that your baby has Medicaid. Call LDH toll free at 1-888-342-6207 while you are pregnant. If you need help talking to LDH, call us. LDH will make sure your baby has Medicaid from the day he or she is born. They will give you a Medicaid number for your baby. Let us know the baby's Medicaid number when you get it.

Demographic Changes

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

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

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

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

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

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

FAQ/Index

What do I do if...

How do I...

Call If You Need Us

If you have questions or need help reading or understanding this document, call us at **1-800-448-3810 (TTY: 711)**. We are available Monday through Friday, from 7 a.m. to 7 p.m. We can help you at no cost to you. We can explain the document in English or in your first language. We can also help you if you need help seeing or hearing. Please refer to your Member Handbook regarding your rights.

Important!

At Humana, it is important you are treated fairly.

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

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-800-448-3810** or if you use a **TTY,** call **711.**
- You can also file a civil rights complaint with the
  U.S. Department of Health and Human Services, Office for Civil Rights
  electronically through their Complaint Portal, available at
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 1-800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html.**

Auxiliary aids and services, free of charge, are available to you.

1-800-448-3810 (TTY: 711)

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

Humana Healthy Horizons® in Louisiana is a Medicaid Product of Humana Benefit Plan of Louisiana, Inc.

Language assistance services, free of charge, are available to you.
1-800-448-3810 (TTY: 711)

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

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

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

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

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

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

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

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

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

ພາສາລາວ (Lao): ໂທຫາເບີໂທລະສັບຂ້າງເທິງ ເພື່ອຮັບບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ.

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 بگیید.

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

¡‘À“‰∏√ (Thai): ‚∏√‰∏∑Ò¬‘√¥â“πμ¢ ª∫ ∫ŸÈ“ ƒ‘ƒ ‡æ√◊ËÕμ¢ ¡‘À“¿ƒ

LAHLDHGEN

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:**

Questions?

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

Humana

Healthy Horizons®
in Louisiana

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