Humana Healthy Horizons in Oklahoma Member Handbook

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Health Care Authority

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SoonerSelect

MEMBER HANDBOOK

Humana Healthy Horizons in Oklahoma

April 2024

Auxiliary aids and services, free of charge, are available to you. **855-223-9868 (TTY: 711)**, Monday through Friday, from 8:00 a.m. to 5:00 p.m., Central time.

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

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

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

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。

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

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

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

မြန်မာနိုင်ငံ (Burmese) အခမဲ့ ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ ရယူရန် အထက်ပါ ဖုန်းနံပါတ်ကို ခေါ်ဆိုပါ။

Hmoob (Hmong) Hu rau tus xov tooj saum toj sauv kom tau txais kev pab txhais lus dawb.

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

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

ພາສາລາວ (Lao): ໂທຫາເບີໂທລະສັບຂ້າງເທິງ ເພື່ອຮັບບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ.

ภาษาไทย (Thai): โทรไปที่หมายเลขด้านบนเพื่อรับบริการช่วยเหลือด้านภาษาฟรี

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

tsalagi gawonihisdi (Cherokee) ᏫᏴᏝᏏ ᎾᏍᎩ ᎦᏗᏔᏗᏟ ᏗᏎᏍᏔᏅ ᎾᎢ ᎠᏎᏍᏓ ᎦᏬᏂᎯᏍᏗ ᎤᎾᏓᏅᏒᎦᏘ ᎢᏳᎾᏓᏛᏁᏗᎢ.

فارسی (Farsi) .دیریگب سامت قوف هر امش اب ناگیار ت ر وصب ینابز تلایهست تفایرد ی ارب

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

Humana Healthy Horizons in Oklahoma is a Medicaid product of Humana Wisconsin Health Organization Insurance Corporation.

OKHM43XEN

Your Humana Healthy Horizons in Oklahoma

Quick Reference Guide

I WANT TO:	I CAN CONTACT:
Find a doctor, specialist or health care service	My primary care provider (PCP) is the primary doctor providing care to me. For help with choosing my PCP, I can call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.
Get the information in this handbook in another format or language	Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.
Keep better track of my appointments and health services	My PCP or Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.
Get help with getting to and from my doctor's appointments	Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST. You can also find more information on Transportation Services in this handbook.
Get help to deal with my stress, or anxiety or depression	The Oklahoma Mental Health Lifeline at 988 is open twenty-four (24) hours a day, seven (7) days a week. If you are in danger or need immediate medical attention, call 911.
Get answers to basic questions or concerns about my health, symptoms or medicines	Call the Nurse Line toll-free at 800-854-6619 TTY:711 at any time, 24 hours a day, 7 days a week, or talk with your PCP.
Understand a letter or notice I got in the mail from my health plan File a complaint about my health plan Get help with a recent change or denial of my health care services	Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.
Update my address or personal information	Call the SoonerCare Helpline toll-free at 800-987-7767 or visit www.MySoonerCare.org.

Find my plan's provider directory or other general information about my plan	Visit my plan's website at Humana.com/healthyOklahoma or call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.

Key Words Used in This Handbook

As you read this handbook, you may see some new words. Here is what we mean when we use them.

Abuse: Provider or member practices that result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary.

Advance Directive: A set of directions you give about the medical and behavioral health care you want if you ever lose the ability to make decisions for yourself. This may include a living will, the appointment of a health care proxy or both.

Adverse Benefit Determination: A decision your plan can make to reduce, stop or restrict your health care services.

American Indian/Alaska Native (AI/AN): An individual who is a member of a federally recognized American Indian tribe; an individual who resides in an urban center and qualifies as a member of an American Indian tribe, Alaska Native, or is considered to be an American Indian under federal regulations; an individual considered by the federal government to be an American Indian for any purpose. AI/AN may be used to refer to this population.

Appeal: A request to your health plan to review a decision the plan made about reducing, stopping or restricting your health care services.

Behavioral Health Emergency: A situation in which there is a high risk of behaving in a way that could result in serious harm or death to yourself or others.

Behavioral Health Services: Mental health (emotional, psychological and social well-being) and substance use (alcohol and drugs) disorder diagnostic, treatment, and rehabilitation services.

Benefits: Medical and behavioral health care services covered by your health plan.

Care Manager: A specially trained health professional who works with you and your doctors to make sure you get the right care when and where you need it.

Copay: A fee you pay when you get certain health care services or a prescription.

Durable Medical Equipment: Certain items (such as a walker or a wheelchair) your doctor can order for you to use if you have an illness or an injury.

Emergency Medical Condition: A situation in which your life could be threatened or you could be hurt permanently if you don't get care right away (such as a heart attack or broken bones).

Emergency Medical Transportation: Ambulance transportation to the nearest hospital or medical facility for an emergency medical condition.

Emergency Room Care: Care you receive in a hospital if you are experiencing an emergency medical condition.

Emergency Services: Services you receive to evaluate, treat or stabilize your emergency medical condition.

Excluded Benefits: Services or benefits that are not covered by the health plan.

Expansion Adult: An individual who is aged 19-64, with income at or below 138% of the federal poverty level, and who is determined eligible for Medicaid.

Expedited (faster) Appeal: If your health plan made a decision about reducing, stopping or restricting your health care services and you think waiting 30 days for an appeal decision will harm your health, this is a request to review the decision within 72 hours.

Fraud: Intentional deception or misrepresentation made by a person resulting in some unauthorized benefit to themselves or another person.

Grievance: A complaint you can file if you have a problem with your health plan, provider, care or services.

Habilitation Services and Devices: Health care services that help you keep, learn or improve skills and functioning for daily living.

Health Insurance: A type of insurance coverage that pays for your health and medical costs. Your Medicaid coverage is a type of insurance.

Home Health Care: Certain services you receive outside a hospital or a nursing home to help with daily activities of life, such as home health aide services or skilled nursing.

Hospice Services: Special services for patients and their families during the final stages of illness. Hospice services include certain physical, psychological

and social services that support terminally ill individuals and their families or caregivers.

Hospital Outpatient Care: Care you receive at a hospital or medical facility without being admitted or for a stay of less than 24 hours (even if this stay occurs overnight).

Hospitalization: Admission to a hospital for treatment that lasts more than 24 hours.

Indian Health Care Provider (IHCP): A health care program operated by Indian Health Services or by an American Indian tribe, tribal organization, or Urban Indian Organization. IHCP may be used to refer to this kind of provider. Any individual who is an American Indian or Alaska Native (AI/AN) may choose an IHCP as their primary care provider.

Medicaid: A health plan that helps some individuals pay for health care. For example, the SoonerSelect program is a Medicaid health program that pays for health coverage.

Medically Necessary: Medical services or treatments that you need to get and stay healthy. Services must follow standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability.

Member: A person enrolled in and covered by a health plan.

Network (or Provider Network): A group of doctors, hospitals, pharmacies and other health care professionals who have a contract with your health plan to provide health care services for its members.

Non-Emergency Medical Transportation: Humana can arrange to help you get to and from your appointments, including personal vehicles, taxis, vans, mini-buses and public transportation.

Non-Expansion Adult: An adult who qualifies for Oklahoma's Medicaid program and meets eligibility requirements such as pregnant women and parents/caretakers of dependents under age 19 who meet income limits.

Non-Participating Provider/Out-of-Network Provider: A physician or other provider who has not contracted with or is not employed by the health plan to deliver services under the SoonerSelect program.

Notice of Adverse Resolution: Written information the plan sends you if your appeal is denied.

Notice of Resolution: Written information the plan sends you if your appeal is granted.

Oklahoma Health Care Authority (OHCA): The state agency for Medicaid in Oklahoma, and the agency that oversees the SoonerSelect program.

Out-of-Network Referral: If your health plan does not have the specialist you need in its provider network, they may find one for you to visit who is outside your health plan.

Participating Provider: A physician or other provider, including a pharmacy, who is contracted with or employed by the health plan to deliver services under the SoonerSelect program.

Physician Services: The services provided by an individual licensed under state law to practice medicine or osteopathy, but not services offered by doctors while you are admitted in the hospital.

Plan (or Health Plan): The company providing you with health insurance coverage. Your health plan is Humana Healthy Horizons in Oklahoma.

Premium: A monthly payment made for health insurance coverage. You do not have a premium in SoonerSelect.

Prescription Drugs: A drug that, by law, requires a prescription by a doctor.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Primary care provider (general): A medical doctor who is trained to prevent, diagnose and treat a broad array of illnesses and injuries in the general population.

Primary Care Provider (PCP) (specific to you): The medical provider who takes care of and coordinates all your health needs, including referrals and prior authorizations. Your PCP is often the first person you should contact if you need care. Your PCP can be a physician, including an OB/GYN, a nurse practitioner, a physician assistant, or a certified nurse midwife. If you are an individual who is American Indian or Alaska Native (AI/AN), you may choose an Indian Health Care Provider as your PCP.

Prior Authorization (PA) (or Preauthorization): The approval needed from your plan before you can get certain health care services or medicines.

Provider: A health care professional or a facility that delivers health care services, such as a doctor, hospital or pharmacy.

Rehabilitation Services and Devices: Health care services and equipment that help you regain skills, abilities or knowledge that may have been lost or compromised because of an illness, accident, injury or surgery. These services can include physical or speech therapy or behavioral rehabilitation services.

Skilled Nursing Care: Care that requires the skill of a licensed nurse.

Specialist: A doctor who is trained and practices in a specific area of medicine.

Specialty Care: Advanced medically necessary care that focuses on specific health conditions or are provided by a specialist.

Standard Appeal: A request to your health plan to review a decision the plan made about reducing, stopping or restricting your health care services. Your plan will make a decision on your appeal within 30 days.

State Fair Hearing: If you are unhappy with the final decision your health plan made on your appeal, you may request a hearing to make your case before an administrative law judge.

Substance Use: A condition that includes the misuse or addiction to alcohol and/or legal or illegal drugs.

Urgent Care: Care for a health condition that needs prompt medical attention but is not an emergency medical condition. You can get urgent care in a walk-in clinic for a non-life-threatening illness or injury (such as the flu or sprained ankle).

Waste: The overuse or misuse of health care services that increases Medicaid costs.

Welcome to Humana Healthy Horizons in Oklahoma

SoonerSelect

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Welcome to Humana Healthy Horizons in Oklahoma's SoonerSelect Program

This handbook will be your guide to the full range of Medicaid health care services available to you. If you have questions about the information in your welcome packet, this handbook, or your new health plan, call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST or visit our website at Humana.com/HealthyOklahoma. We can also help you make an appointment with your doctor and tell you more about the services you can get with your new health plan.

How SoonerSelect Works

The Plan, Our Providers and You

Many people get their health benefits through programs like SoonerSelect, which works like a central home for your health. SoonerSelect helps coordinate and manage all your health care needs.

Humana Healthy Horizons in Oklahoma (Humana) has a contract with the Oklahoma Health Care Authority (OHCA) to meet the health care needs of people with Oklahoma Medicaid. In turn, we partner with a group of health care providers to help us meet your needs. These providers (doctors, therapists, specialists, hospitals, home care providers and other health care facilities) make up our provider network. You will find a list of participating providers in our provider directory. You can visit our website at Humana.com/HealthyOklahoma to find the provider directory online. The directory includes important information such as provider address, phone number, specialty, and other qualifications. If there is any information that is not included in the directory such as the residency of the provider or the medical school they attended, please contact the provider office directly to ask. You can also call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST to get a free copy of the provider directory. Humana and SoonerSelect are one in the same.

When you join Humana, our providers are here to support you. Most of the time, that person will be your primary care provider (PCP). The PCP is the medical provider who takes care of and coordinates all your health needs, including referrals and prior authorizations. If you need to have a test, see a specialist or go into the hospital, your PCP can help arrange it.

If you need to speak to your PCP after hours or weekends, call and leave a message with information on how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can go to certain doctors for some services without checking with your PCP.

How to Use This Handbook

This handbook will tell you how Humana Healthy Horizons in Oklahoma will work. This handbook is your guide to health and wellness services. It tells you the steps to take to make the plan work for you.

The first several pages will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time.

When you have a question, check this handbook, ask your PCP or call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST. You can also visit our website at Humana.com/HealthyOklahoma.

Help from Member Services

There is someone to help you at Member Services. Just call Member Services available free of charge/at no cost at 855-223-9868 TTY: 711 8am-5pm CST.

For help with non-emergency issues and questions, call Member Services M-F 8 a.m. – 5 p.m. CST. If you need help after hours you can call your PCP. Your PCP will have a system in place if you need care after hours or weekends. If you call and must leave a message, include information about how to reach you. Your PCP will get back to you as soon as possible. You can also call the 24-hour nurse line toll-free at 800-854-6619 TTY: 711.

In case of a medical emergency, call 911.

You can call Member Services to get help when you have a question. You may call us to choose or change your PCP, to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report the birth of a new baby, or to ask about any change that might affect you or your family's benefit.

If you are pregnant or become pregnant, your child will become part of Humana on the day your child is born. If you become pregnant, call your plan to choose a doctor for both you and your baby before your baby is born.

If English is not your first language (or if you are reading this on behalf of someone who doesn't read English), we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk with you in your own language. We have a group of people who can help (bilingual staff or interpreters), that are available free of charge.

Other Ways We Can Help

- If you have basic questions or concerns about your health, you can call our Nurse Line toll-free at 800-854-6619 TTY:711 at any time, 24 hours a day, 7 days a week. You can get advice on when to go to your PCP or ask questions about symptoms or medications.
- If you are experiencing emotional or mental distress, call the Oklahoma Mental Health Lifeline at 988 any time, twenty-four (24) hours a day, seven (7) days a week, to speak with someone who will listen and help. We are here to help you with problems like stress, depression or anxiety. We can connect you to the support you need to feel better. **If you are in danger or need immediate medical attention, call 911.**

For people with disabilities: If you use a wheelchair or have trouble hearing or understanding, call us if you need extra help. If you are reading this on behalf of someone who is blind, deaf-blind, or has difficulty seeing, we can also help. We can tell you if a doctor's office is wheelchair accessible or is equipped with special communications devices. Also, we have services available free of charge/at no cost like:

- TTY machine. Our TTY phone number is 711.
- Information in large print.
- Help in making or getting to appointments.
- Names and addresses of providers who specialize in your condition.

Hours of Service

Member Services is open M-F 8a.m. – 5p.m. CST. If you call when we are closed, please leave a message if prompted to do so. We will call you back the next business day. If you have a health-related question, our nurses are available to help you via our 24-Hour Nurse Advice Line toll-free at 800-854-6619 TTY:711.

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

Humana is closed in observation of the following major holidays:

- New Year's Day
- Martin Luther King Jr. Day
- Memorial Day

- Independence Day
- Juneteenth
- Labor Day
- Thanksgiving Day
- The day after Thanksgiving
- Christmas Eve
- Christmas Day

Auxiliary Aids and Services

If you have a hearing, vision or speech impairment, you have the right to receive information about your health plan, care and services in a format that you can understand and access. Humana Healthy Horizons in Oklahoma provides free aids and services to help people communicate effectively with us, available free of charge/at no cost like:

- A TTY machine. Our TTY phone number is 711.
- Qualified American Sign Language interpreters.
- Closed captioning.
- Written information in other formats (like braille, large print, audio, accessible electronic format, and other formats).
- Video remote interpretation.

These services are available to members for free. To ask for aids or services, call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.

Humana Healthy Horizons in Oklahoma complies with federal civil rights laws and does not leave out or treat people differently because of race, color, national origin, age, sex, sexual orientation, gender identity or disability. Humana Healthy Horizons in Oklahoma will not discriminate against anyone on the basis of frequent or high-cost care, health status, need for health care services, or due to an adverse change in enrollment, disenrollment, or re-enrollment with Humana Healthy Horizons in Oklahoma. If you believe that Humana Healthy Horizons in Oklahoma failed to provide these services, you can file a grievance or appeal. To file a grievance or appeal, or to learn more, call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST. You may also file a complaint about your plan with the Oklahoma Insurance Department.

How You Become a Member of the SoonerSelect Program

As an (AI/ American Indian/Alaskan Native AN) individual, you may disenroll from the SoonerSelect program for any reason. As an AI/AN individual, if you choose not to enroll or later decide to disenroll from the SoonerSelect program, you will be able to opt in again during the next open enrollment period. Open enrollment periods happen about every 12 months.

All other individuals who are determined eligible for SoonerCare and the SoonerSelect program will be enrolled in the SoonerSelect program by SoonerCare. You may not disenroll from the SoonerSelect program, but you may change health plans as discussed below.

How You Become a Member of Humana

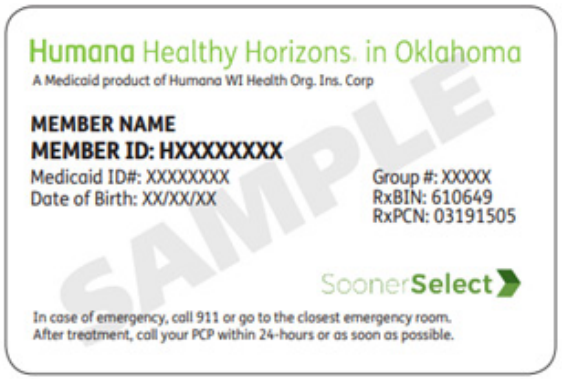
As an AI/AN individual, if you choose to opt in to the SoonerSelect program, you will have the option to choose your health plan when first enrolled and during open enrollment periods. If you opt in to the SoonerSelect program and don't choose a health plan, SoonerCare will assign one to you. You can disenroll from your assigned health plan and choose a different health plan any time within the first 90 days after your health plan benefits begin. You can also change plans during the yearly open enrollment period.

All other individuals who are enrolled in the SoonerSelect program will have the option to choose a health plan when first enrolled and during the yearly open enrollment period. If you don't choose a health plan, SoonerCare will assign one to you. You can disenroll from your assigned health plan and choose a different health plan any time within the first 90 days after your health plan benefits begin or during an open enrollment period.

Your Health Plan ID Card

Your Humana ID card is mailed to you within 7 days after you enroll in your health plan. We use the mailing address on file at Oklahoma Health Care Authority. You may also access a digital copy of your ID Card by going to Humana.com. It will have your Medicaid identification number and information on how you can contact us if you have any questions. Your ID card will have Humana Healthy Horizons in Oklahoma's claims information for providers to use. If anything is wrong on your Humana ID card, call us right away. If you lose your card, we can help; call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST. Carry your ID card always and show it each time you go for care.

If you have not received your ID card yet, call Member Services. If you need to get care they can help to find a doctor and we can give you all the information you need to give to receive services.


Humana Healthy Horizons in Oklahoma
A Medicaid product of Humana WI Health Org. Ins. Corp
MEMBER NAME
MEMBER ID: HXXXXXXXX
Medicaid ID#: XXXXXXXX
Date of Birth: XX/XX/XX
Group #: XXXXX
RxBIN: 610649
RxPCN: 03191505
SoonerSelect
In case of emergency, call 911 or go to the closest emergency room.
After treatment, call your PCP within 24-hours or as soon as possible.
SAMPLE


Member/Provider Services: 855-223-9868 (TTY: 711)
24-Hour Nurse Advice Line: 800-854-6619
24/7 Behavioral Health Crisis HotLine: 888-445-8742
Pharmacy Rx Inquiries: 855-223-9868
Please visit us at: Humana.com/HealthyOklahoma
For online provider services, go to Availity.com
Please mail all claims to:
Humana Medical
P.O. Box 14359
Lexington, KY 40512-4359
SAMPLE

PART I: First Things You Should Know

How to Choose Your PCP

Your primary care provider (PCP) is a doctor, nurse practitioner, physician assistant, or another type of provider who will care for your health, coordinate your needs, and help you get referrals for specialized services if you need them. There are lots of types of health care providers. Yours may be a general practitioner or family medicine, internal medicine, pediatrics, or Indian Health Care Provider. When you enroll in Humana you will have an opportunity to choose your own PCP. To choose your PCP, call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST. If you do not select a PCP within 30 days of your enrollment, we will choose one for you. If we choose a provider for you, we will try to choose a provider you have seen before. We will also choose based on any care needs and conditions you may have. Any provider we choose for you will be close to your home. (See "How to Change Your PCP" to learn how you can change your PCP.)

When deciding on a PCP, you may want to find a PCP who:

- You have seen before;
- Understands your health needs;
- Is taking new patients;
- Can serve you in your language;
- Is easy to get to.

Each family member enrolled in Humana Healthy Horizons in Oklahoma can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children from birth through 18. Family practice doctors treat the whole family. Internal medicine doctors treat adults ages 19 and older. Call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST to get help with choosing a PCP who is right for you and your family.

You can find the list of all the doctors, clinics, hospitals, labs and others who partner with SoonerSelect in our provider directory. You can visit our website at services to look at the provider directory online or get a copy of the provider directory.

Women can choose an OB/GYN to serve as their PCP, but do not have to. Women do not need a PCP referral to see an OB/GYN doctor or another provider who offers women's health care services. Women can get routine check-ups, follow-up care if needed, and regular care during pregnancy.

If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP. If you need help choosing

your PCP call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.

If your provider leaves Humana we will tell you within 30 days from when we know about this. If the provider who leaves Humana Healthy Horizons in Oklahoma is your PCP, we will contact you to help you choose another PCP. If a provider you are getting care from is no longer in network, we will send you a letter letting you know. Details about continued care will be in the letter we will send you. If you would like to find a new provider you can call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST or visit Humana.com/findadoctor.

If you are an American Indian/Alaska Native individual, you may choose an Indian Health Care Provider as your PCP, but you don't have to.

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.

How to Change Your PCP

When you enroll in Humana, you can select a primary care provider (PCP) from our network within the first 30 days after your benefits with Humana Healthy Horizons in Oklahoma begin. After that, we will choose one for you. Whether you choose a PCP for yourself or Humana Healthy Horizons in Oklahoma chooses a PCP for you, you can change your PCP within the first month and that change will become effective the next business day. After that, you can change your PCP any time and the change will become effective the first of the following month from date change. You do not have to give us a reason for the change. If you'd like to change your PCP, you can do so by calling Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST or 24/7 through your MyHumana account at Humana.com/HealthyOklahoma.

How to Get Regular Health Care

Regular health care means exams, regular check-ups, shots or other treatments to keep you well, advice when you need it, and referrals to the hospital or specialists when you need them. It means you and your primary care provider (PCP) work together to keep you well or to see that you get the care you need.

Day or night, your PCP is only a phone call away. Be sure to call your PCP if you have a medical question or concern. If you call after hours or on weekends, leave a message and information on how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how your health plan works.

Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If you cannot keep an appointment, it is important to call to let your PCP know as soon as you know.

Making your first regular health care appointment. As soon as you choose or are assigned a PCP, call to make a first appointment. There are several things you can do to help your PCP get to know you and your health care needs. Your PCP will need to know as much about your medical history as possible. Make a list of your medical history, any problems you have now, and the questions you want to ask your PCP. Bring any medications and supplements you are taking with you to the visit. In most cases, your first visit should be within three (3) months of you joining Humana Healthy Horizons in Oklahoma.

If you need care before your first appointment, call your PCP's office to explain your concern. Your PCP will give you an earlier appointment. You should still keep the first appointment to talk about your medical history and ask questions.

If you need care before you choose or are assigned a PCP, call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST for help.

It is important to Humana that you can visit a doctor within a reasonable amount of time, depending on what the appointment is for. When you call for an appointment, use the appointment guide below to know how long you can expect to wait to be seen.

APPOINTMENT GUIDE	
IF YOU CALL FOR THIS TYPE OF SERVICE:	**YOUR APPOINTMENT SHOULD TAKE PLACE:**
PCP (services like routine health check-ups or immunizations)	Within thirty (30) days from date of request for a routine appointment. Within seventy-two (72) hours for non-urgent sick visits. Within twenty-four (24) hours for urgent care.

APPOINTMENT GUIDE	
IF YOU CALL FOR THIS TYPE OF SERVICE:	**YOUR APPOINTMENT SHOULD TAKE PLACE:**
OB/GYN	Within thirty (30) days from date of request for a routine appointment. Maternity care: First trimester – within fourteen (14) calendar days. Second trimester – within seven (7) calendar days. Third trimester – within three (3) business days.
Specialty	Within sixty (60) days from date of request for a routine appointment. Within twenty-four (24) hours for urgent care.
Mental Health	
Adult and Pediatric Mental health	Within thirty (30) days from date of request for a routine appointment. Within seven (7) days of residential care and hospitalization. Within twenty-four (24) hours for urgent care. For mental health emergencies, please call the Oklahoma Mental Health Lifeline at 988
Substance Use Disorders	

APPOINTMENT GUIDE	
IF YOU CALL FOR THIS TYPE OF SERVICE:	**YOUR APPOINTMENT SHOULD TAKE PLACE:**
Adult and Pediatric Substance use	Within thirty (30) days from date of request for a routine appointment. Within seven (7) days of residential care and hospitalization. Within twenty-four (24) hours for urgent care. For substance use emergencies, please call the Oklahoma Mental Health Lifeline at 988.

If you are having trouble getting the care you need within the time limits described above, call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.

Telehealth

As a Humana Healthy Horizons in Oklahoma member, you can meet with your doctor by audio or video if they offer this type of service. Many doctors offer audio and video visits if you are well or sick. This is called telehealth. During an audio and video doctor visit, you can:

- Discuss your health concerns
- Discuss your medications
- And more!

If your doctor does not offer audio and video visits, we can help you find a doctor who does by calling toll-free at 855-223-9868 TTY: 711.

Out-of-Network Providers

A participating provider is a physician or other provider who is contracted with or employed by Humana Healthy Horizons in Oklahoma to deliver services under the SoonerSelect program. A non-participating provider is a physician or other provider who has not contracted with or is not employed by Humana Healthy Horizons in Oklahoma to deliver services under the SoonerSelect program. If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan, or an out-of-network provider. For help and more information about getting services from an out-of-network provider, talk to your primary care provider (PCP) or call Member Services toll-free at 855-223-

9868 TTY: 711 8am-5pm CST.

*Note: You will need a referral to receive care from an out-of-network specialist. Please call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.

You can receive family planning services (birth control) from a doctor who is not a Humana doctor. You do not have to get a referral from your PCP, but you must visit an Oklahoma Medicaid provider. If you are AI/AN, you may receive services from any Indian Health Care Provider (IHCP), even if the IHCP is out of network.

Get These Services Without a Referral

You do not need a referral to get these services:

- Primary care
- Behavioral health services
- Substance use disorder treatment
- Vision services
- Emergency services
- Well-child checkups/EPSDT
- Family planning services and supplies
- Prenatal care
- Department of health providers, including mobile clinics
- Services provided by IHCPs to AI/AN health plan members
- In-network Specialists

Emergencies

If you believe you have an emergency, call 911 or go to the nearest emergency room. If you believe you are having a behavioral health emergency, including mental health and substance use, call the Oklahoma Mental Health Lifeline at 988.

You do not need approval from your plan or your primary care provider (PCP) before getting emergency care, and you are not required to use our hospitals or doctors.

If you're not sure, call your PCP at any time, day or night. Tell the person you speak with what is happening. Your PCP's team will:

- Tell you what to do at home;
- Tell you to come to the PCP's office; or
- Tell you to go to the nearest urgent care clinic or emergency room.

If you are out of the area when you have an emergency, go to the nearest emergency room.

Remember: Use the emergency room only if you have an emergency. If you have questions, call your PCP or Humana Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.

You are always covered for emergencies. An emergency medical condition is a situation in which your life could be threatened, or you could be hurt permanently if you don't get care right away. Some examples of an emergency are:

- A heart attack or severe chest pain
- Bleeding that won't stop
- A bad burn
- Broken bones
- Trouble breathing, convulsions or loss of consciousness
- When you feel you might hurt yourself or others
- If you are pregnant and have signs like pain, bleeding, fever or vomiting
- Drug overdose

Some examples of non-emergencies are colds, upset stomach or minor cuts and bruises. Non-emergencies may also be family issues or a break-up. These may feel like an emergency, but they are not a reason to go to the emergency room unless you are in immediate danger of harm.

Urgent Care

You may have an injury or an illness that is not an emergency but still needs prompt care and attention. This could be:

- A child with an earache who wakes up in the middle of the night and won't stop crying
- Flu symptoms
- If you need stitches
- A sprained ankle

- A bad splinter you cannot remove

You can walk into an urgent care clinic to get care the same day or make an appointment for the next day. Whether you are at home or away, call your primary care provider (PCP) any time, day or night. If you cannot reach your PCP, call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST. Tell the person who answers what is happening. They will tell you what to do.

Care Outside Oklahoma

In some cases, Humana may pay for health care services you get from a provider located just beyond the Oklahoma border or in another state. Your PCP and Humana can give you more information about which providers and services are covered outside of Oklahoma by your health plan, and how you can get them if needed. If you need medically necessary emergency care while traveling anywhere within the United States and its territories, SoonerSelect will pay for your care.

Your health plan will not pay for care received outside of the United States and its territories.

If you have any questions about getting care outside of Oklahoma or the United States, talk with your PCP or call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.

PART II: Your Benefits

The rest of this handbook is for your information when you need it. It lists covered and non-covered services. If you are having problems with your health plan, the handbook tells you what to do. The handbook has other information you may find useful. Keep it handy for when you need it.

How You Know if You are an Expansion Adult or a Non-Expansion Adult

Non-expansion adults are individuals who qualify for Oklahoma's Medicaid program and meet eligibility requirements such as those who are eligible for Medicare, pregnant women, or needy caretakers of dependents under age 19 who meet the income requirements listed at https://oklahoma.gov/ohca/individuals/mysoonercare/apply-for-soonercare-online/eligibility/income-guidelines.html.

Expansion adults are individuals who meet income requirements, are ages 19 to 64, and determined eligible for Medicaid; but do not meet requirements for aged, blind or disabled, breast and cervical cancer, or Medicare. Eligible income means someone earns at or below 138% of the federal poverty level. See the income guidelines at https://oklahoma.gov/ohca/individuals/mysoonercare/apply-for-soonercare-online/eligibility/income-guidelines.html.

Benefits

SoonerSelect provides benefits or health care services covered by your plan.

Humana will provide or arrange for most health services that you will need. Your health benefits can help you stay as healthy as possible if you:

- Are pregnant;
- Are sick or injured;
- Experience a substance use disorder or have other behavioral health care needs;
- Need help getting to the doctor's office; or
- Need medications.

The section below describes the specific services covered by Humana. Ask your primary care provider (PCP) or call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST if you have any questions about your benefits.

You can get some services without going through your PCP. These include primary care, emergency care, women's health services, family planning services, children's screening services, services provided at local health

departments, school-based services, and some behavioral health services.

Dental Services

You will receive all SoonerSelect dental benefits from a separate dental plan that you choose. Your choices are DentaQuest toll-free at 833-479-0687 and LIBERTY Dental toll-free at 888-700-1093. Humana will provide transportation to your dental appointments. For more details about transportation, please refer to the Transportation section within this handbook.

Services Covered by Humana's Network

In most situations, you must get the services below from the providers who are in Humana's network. Services must be medically necessary and provided, coordinated or referred by your primary care provider (PCP). Talk with your PCP or call Member Services toll-free at **855-223-9868 (TTY: 711)**, Monday through Friday, from 8 a.m. to 5 p.m., Central time if you have any questions or need help with any health services.

As a value-added benefit to those who enroll with Humana, all members are exempt from copays for medical and behavioral health services. Copays for pharmacy may still apply for members 21 and older. Members under 21 are always exempt from copays.

Service	Children (under 21)	Non-expansion adults (21 and over)	Expansion adults (21 and over)
Advanced Practice Registered Nurse (APRN)	Covered	Covered: • 4 outpatient visits per month	Covered: • 4 outpatient visits per month Limit can be exceeded based on medical necessity.
Allergy testing	Covered	Covered: • Limited to 60 tests every 3 years	Covered: • Limited to 60 tests every 3 years Limit can be exceeded based on medical necessity.

Service	Children (under 21)	Non-expansion adults (21 and over)	Expansion adults (21 and over)
Alternative treatment for pain management	Covered	Physical therapy when provided in a non-hospital-based setting: a. Initial evaluation covered without prior authorization (PA) b. 12 hours per year requires PA Chiropractic services: a. Initial evaluation covered without PA b. 12 visits per year requires PA. Limits can be exceeded based on medical necessity.	
Ambulance or emergency transportation	Covered		
Ambulatory surgical center	Covered		
Bariatric surgery	Covered, upon meeting pre-surgical evaluation and weight-loss requirements. Requires PA	Covered, upon meeting pre-surgical evaluation and weight-loss requirements. Not covered for treatment of obesity alone. Requires PA	
Certified registered nurse anesthetist and anesthesiologist assistants	Covered		
Chemotherapy	Covered		
Clinic services	Covered Some services may require a PA		

Service	Children (under 21)	Non-expansion adults (21 and over)	Expansion adults (21 and over)
Diabetes education	Covered, 10 hours per first year; 2 hours per subsequent year Limits can be exceeded based on medical necessity and under Early and Periodic Screening, Diagnostic and Treatment (EPSDT).	Covered, 10 hours per first year; 2 hours per subsequent year	Covered, 10 hours per first year; 2 hours per subsequent year Limits can be exceeded based on medical necessity.
Diagnostic testing entities	Covered. Some services may require a PA		
Donor human breast milk	Covered during the first year of life Requires PA	Not covered	
Durable medical equipment supplies and appliances	Covered Requires a prescription by a medical provider Some services may require a PA		
EPSDT and early intervention services, including health and immunization history; physical exams, various health assessments and counseling; lab and screening tests; necessary follow-up care; and applied behavioral analysis (ABA) services	Covered Some services may require PA	Not covered	
Emergency room/ department	Covered		

Service	Children (under 21)	Non-expansion adults (21 and over)	Expansion adults (21 and over)
Eye care to treat a medical or surgical condition	Covered		
Family planning services	Covered		
Federally Qualified Health Center and rural health clinic services	Covered		
Genetic counseling and testing	Covered for pregnant members and members meeting medical necessity criteria. May require a PA		
Hearing services	Covered May require PA	Covered As a value-added benefit, members 21 and older can receive the following: • 1 assessment for hearing aids every 3 years • 1 hearing aid per ear and dispensing fee every 3 years • 2 hearing aid fitting/checking visits every 3 years • 48 batteries per hearing aid per year	
Home health care services	Covered		
Hospice (non-hospital based)	Covered for members with a life expectancy of 6 months or less	Covered for members with a life expectancy of 6 months or less	Covered for members with a life expectancy of 6 months or less
Immunizations	Covered		
Infusion therapy	Covered	Covered when medically necessary and not considered a compensable part of the procedure.	

Service	Children (under 21)	Non-expansion adults (21 and over)	Expansion adults (21 and over)
Inpatient hospital services	Covered	Covered: a. Inpatient hospital services (inpatient stay): no limit b. Inpatient physician services: covered c. Inpatient surgical services: no limit d. Inpatient rehabilitation hospital services: 90 days per individual per state fiscal year (SFY)	Covered: a. Inpatient hospital services (inpatient stay): no limit b. Inpatient physician services: covered c. Inpatient surgical services: no limit d. Inpatient rehabilitation hospital services: 90 days per individual per SFY Amount limits can be exceeded based on medical necessity.
Laboratory, X-ray, diagnostic imaging and imaging (CT/ PET scans and MRIs)	Covered Some services may require a PA		
Lactation consultant (help with breastfeeding)	Covered for pregnant and postpartum members		
Lodging and meals for the health plan member and/ or one approved medical escort	Covered Services require PA		
Long-term care hospital for children	Covered	Not covered	
Mammograms	Covered		

Service	Children (under 21)	Non-expansion adults (21 and over)	Expansion adults (21 and over)
Maternal and infant licensed clinical social worker services	Covered for pregnant and postpartum members		
Non-emergency medical transportation (NEMT)	Covered As a value-added benefit: All members can receive 1 in-state round trip (2 in-state one-way trips) per day for a parent and/or guardian to visit their child during a NICU or inpatient hospital stay. Members using non-emergency medical transportation may be allowed to bring up to 3 children when childcare is not available. • Total number of passengers, including the driver, cannot exceed more than 5 • Each child must be younger than 13 • Each child must be the member's by birth, marriage, legal adoption, foster child or legal guardianship • Each child must have his/her own car seat provided by the member if required by OK state law		
Nurse midwives	Covered under EPSDT	Covered	
Nursing facility and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)	Covered for up to 60 days pending the level of care determination		

Service	Children (under 21)	Non-expansion adults (21 and over)	Expansion adults (21 and over)
Nutrition services (dietitian)	Covered	Covered up to 6 hours per year Nutritional services for treatment of obesity are not covered. Services must be for diagnosing, treating or preventing, or minimizing effects of illness.	Covered up to 6 hours per year Nutritional services for treatment of obesity are not covered. Services must be for diagnosing, treating or preventing, or minimizing effects of illness. Limits can be exceeded based on medical necessity.
Orthotics	Covered	Not covered	Covered without limitations when medically necessary.
Outpatient hospital and surgery services	Covered		
Parenteral/enteral nutrition (IV and tube-feeding)	Covered Some services may require a PA		
Personal care	Covered		
Physician and physician assistant services	Covered	Covered Limit 4 visits per month	Covered Limit 4 visits per month Limit can be exceeded based on medical necessity.
Podiatry	Covered		
Post-stabilization care services	Covered		

Service	Children (under 21)	Non-expansion adults (21 and over)	Expansion adults (21 and over)
Pregnancy and maternity services including prenatal, delivery and postpartum	Covered		
Prescription drugs	Covered	Covered: As a value-added benefit, the monthly prescription limit is waived for members 21 and older. All prescriptions are subject to state and federal requirements for Drug Utilization Review, safety edits, quantity limits, and PA.	
Preventive care and screening	Refer to EPSDT coverage	Covered for outpatient hospital services, other laboratory and X-ray services, diagnosis and treatment of conditions found, clinic services, screening services and rehabilitative services. There is not a stand-alone preventive services benefit package for adults providing coverage for all services.	
Private duty nursing	Covered up to 16 hours per day. Additional hours available for 30 days following a stay in the hospital or when regular caregiver is not available.	Not covered	This service is substituted with skilled nursing under the home health services benefit.
Prosthetic devices	Covered when prior authorized	Only breast prosthesis and support accessories and prosthetic devices are covered when part of surgery. Limited coverage with required PA	Covered without limitations when medically necessary.

Service	Children (under 21)	Non-expansion adults (21 and over)	Expansion adults (21 and over)
Public health clinic services	Covered	Covered: 4 visits per month	Covered: 4 visits per month Limit can be exceeded based on medical necessity
Radiation	Covered		
Reconstructive surgery	Covered May require PA	Covered Non-cosmetic breast reconstruction/ implantation/removal is covered only when it is a direct result of a mastectomy which is medically necessary. May require PA	
Renal dialysis facility services	Covered		
Routine patient cost in qualifying clinical trials	Covered to the extent that the provision of the service would otherwise be covered outside of the participation in the clinical trial.		
School-based health related services	Covered	Not covered	
Telehealth	Covered		
Therapy services: physical therapy (PT), occupational therapy (OT), and speech therapy (ST)	OT and PT: a. Initial evaluation covered without PA b. Treatment requires PA ST: a. Evaluation and treatment require PA	Rehabilitative services: a. 15 visits per year for each OT, PT and ST (cumulative total: 45 visits)	Habilitative services: a. 15 visits per year for each OT, PT and ST (cumulative total: 45 visits) Rehabilitative Services: a. 15 visits per year for each OT, PT and ST (cumulative total: 45 visits)

Service	Children (under 21)	Non-expansion adults (21 and over)	Expansion adults (21 and over)
Tobacco Cessation Services	Nicotine replacement therapy (NRT) products (including patches, gum, lozenges, inhalers, and nasal spray) and Zyban®/ Bupropion to include combination therapy of these products are covered. Chantix®/Varenicline is covered up to 180 days per 12 months. Tobacco cessation products are covered without duration limits, PA, or co-payment. 8 tobacco cessation counseling sessions per year		
Transplant Services	Covered with a PA Cornea and kidney transplants do not need a PA.		
Urgent care centers or facilities	Covered	Up to 4 outpatient visits per month	Up to 4 outpatient visits per month Limit can be exceeded based on medical necessity
Vision services	Covered under EPSDT with a limit of 2 eyeglass frames per year	Covered As a value-added benefit, members 21 and older receive an annual eye exam. In addition, members can choose one of the following every 2 years: • Eyeglasses include non-high index polycarbonate lenses and a $100 allowance for the frame, or • $100 allowance for the cost of contact lenses, members are responsible for any cost over the allowance.	

Pharmacy

Talk with your pharmacist or call Member Services toll-free at **855-223-9868 (TTY: 711)**, Monday through Friday, from 8 a.m. to 5 p.m., Central time if you have any questions or need help with your pharmacy services. To view current pharmacy coverage policies, please visit Humana pharmacy coverage policies.

Humana Document and Forms provides enrollees access to documents including the Preferred Drug List (PDL), Over the Counter (OTC) Drug List, Prior Authorization (PA) Criteria, and Diabetic Supplies Preferred Drug List among other important information about your pharmacy benefit. You can

also quickly check drug coverage and find a pharmacy in your area that accepts your benefit.

Copay

Prescriptions are subject to a copay of four dollars ($4) if applicable.

Service	Children (under 21)	Non-expansion adults (21 and over)	Expansion adults (21 and over)
Prescription drugs	Covered	Covered As a value-added benefit, the monthly prescription limit is waived for members 21 and older. All prescriptions are subject to state and federal requirements for Drug Utilization Review, safety edits, quantity limits and PA.	
Medication-assisted treatment services (MAT)	Covered Includes: • Generic buprenorphine/naloxone sublingual tablets • Vivitrol • Methadone		
Tobacco cessation products (to help you quit using tobacco)	NRT products (including patches, gum, lozenges, inhalers and nasal spray) and Zyban®/Bupropion to include combination therapy of these products are covered. Chantix®/Varenicline is covered up to 180 days per 12 months. Tobacco cessation products are covered without duration limits, PA or co-payment.		
Diabetic supplies (insulin, syringes, test strips, lancets and pen needles)	Covered		
Family planning supplies	Covered		

Behavioral Health Services and Mental Health and Substance Use Disorder Services

Behavioral health care includes mental health (your emotional, psychological and social well-being) and substance use (alcohol and drugs) disorder treatment and rehabilitation services. All members have access to services to help with mental health issues like depression or anxiety, or to help with

alcohol or other substance use disorders. These services can include:

- Medication-assisted therapy (MAT)
- Tobacco cessation (to help you quit using tobacco)
- Behavioral health crisis services

If you believe you need access to more intensive behavioral health services that your plan does not provide, talk with your PCP or call Member Services toll-free at **855-223-9868 (TTY: 711)**, Monday through Friday, from 8 a.m. to 5 p.m., Central time.

As a value-added benefit to those who enroll with Humana, all members are exempt from copays for medical and behavioral health services. Copays for pharmacy may still apply for members 21 and older. Members under 21 are always exempt from copays.

Service	Children (under 21)	Non-expansion adults (21 and over)	Expansion adults (21 and over)
Applied behavioral analysis	Covered Requires PA	Not covered	
Certified Community Behavioral Health Centers (CCBHC) services	Covered		
Day treatment services	Covered for a minimum of 3 hours per day for 4 days per week Requires PA	Not covered	
Inpatient hospital – freestanding psychiatric	Covered Requires PA	Ages 21-64: • Covered for a maximum of 60 days per episode. Requires PA Ages 65 and older: • Covered for a maximum of 60 days per episode. Requires PA	
Inpatient hospital – general acute	Covered Requires PA		

Service	Children (under 21)	Non-expansion adults (21 and over)	Expansion adults (21 and over)
Licensed behavioral health provider (who can bill independently)	Covered Requires PA	Not covered	
Medication assisted treatment (MAT)	Covered Includes: • Generic buprenorphine/naloxone sublingual tablets • Vivitrol • Methadone		
Opioid treatment programs	Covered Requires PA		
Outpatient behavioral health agency services	Covered Requires PA		
Partial hospitalization	Covered for a minimum of 3 hours per day for 5 days per week Requires PA		
Peer recovery support services	Covered for ages 16-21 Requires PA	Covered Requires PA	
Program for Assertive Community Treatment services (PACT)	Covered for ages 18-21	Covered	
Psychiatric residential treatment facility	Covered Requires PA	Not covered	
Psychiatrist	Covered		
Psychologist (who can bill independently)	Covered Requires PA		
Substance abuse treatment (outpatient, inpatient, and residential)	Outpatient substance abuse treatment: Covered, requires PA Residential substance abuse treatment: Covered		

Service	Children (under 21)	Non-expansion adults (21 and over)	Expansion adults (21 and over)
Targeted case management	Covered for targeted populations Requires PA		
Therapeutic behavioral services, family support and training	Covered for children with Serious Emotional Disturbance in a systems of care wraparound team	Not covered	
Therapeutic foster care	Covered Requires PA	Not covered	

Other Covered Services

- Post-stabilization care services (provided after you have had an emergency medical condition to keep you safe)
- School-based health related services
- Public health clinic services
- Federally Qualified Health Center (FQHC) services
- Services provided at your local health department
- Value-added benefits

Additional Value-Added Benefits		
Benefit name	**Age limit**	**Description**
Breast pumps	All	Female members can receive 1 non-hospital grade breast pump every 2 years, or 1 rental of a hospital-grade breast pump if your baby has an inpatient stay in a neonatal intensive care unit (NICU).

Additional Value-Added Benefits		
Benefit name	**Age limit**	**Description**
Convertible car seat or portable crib	All	Pregnant members who enroll and actively participate in our HumanaBeginnings® Care Management Program and complete a comprehensive assessment and at least 1 follow-up call with a HumanaBeginnings Care Manager can select 1 convertible car seat or portable crib per infant, per pregnancy.
Criminal expungement services	18 and older	Member can receive reimbursement of up to $150 for criminal record ex-pungement, as allowed per **https://osbi.ok.gov/criminal-history/expungement**, per lifetime.
Disaster preparedness meals	All	1 box of 14 shelf-stable meals before or after a natural disaster once per year. Member must not live in a residential facility. The Governor must declare the disaster for the member to be eligible for the meals.
Disaster preparedness/ relief kit	18 and older	1 disaster relief kit per year before or after a natural disaster Kit includes: a backpack with food bars, emergency water, hygiene pack, first aid kit, flashlight, rain poncho, disaster guide, whistle, blanket and disposable mask
Employment physical	18 and older	1 employment physical per year
Financial literacy coaching	16 and older	Up to 6 life coaching sessions for money management and budgeting
Fresh produce box	18 and older	Up to 4 boxes of in-season nutritious fresh fruits and vegetables annually for members identified as food insecure Plan approval required

Additional Value-Added Benefits		
Benefit name	**Age limit**	**Description**
GED testing	16 and older	GED test preparation assistance, including a bilingual advisor, access to guidance and study materials, and unlimited use of practice tests. Test preparation assistance, including tutoring, is provided virtually to allow maximum flexibility for members. Also includes test pass guarantee to provide members multiple attempts at passing the test.
Hearing Services	21 and older	• 1 assessment for hearing aids every 3 years • 1 hearing aid per ear and dispensing fee every 3 years • 2 hearing aid fitting/checking visits every 3 years 48 batteries per hearing aid per year
Home-based interventions for asthma	All	Asthmatic members in our Care Management or Disease Management Programs can receive an allowance up to $350 per year for allergen free bedding, an air purifier and/or carpet cleaning. Care Manager approval required

Additional Value-Added Benefits		
Benefit name	**Age limit**	**Description**
Housing assistance	18 and older	Up to $350 per member per year (unused allowance does not roll over to the next year) to assist with the following housing expenses: • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water, gas or internet (late payment notice required) • Trailer park and lot rent if this is your permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority • 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
Maternal and infant virtual care	All	Pregnant members and members with a child up to 1 year of age, unlimited access to a smartphone application that provides 24 hour a day, 7 days a week access to a proprietary, video-enabled call routing system that allows members to connect with a lactation consultant or a physician extender for on-demand assistance.

Additional Value-Added Benefits		
Benefit name	**Age limit**	**Description**
Native American traditional medicine	All	Reimbursement of up to $300 per calendar year for Native American members to help cover costs for Native American Traditional and/or Ceremonial Services. Member is required to provide a signed verification form
Newborn care kit	0-6 months	1 newborn kit per birth Kit includes: diaper bag, diapers, wipes, diaper rash cream, baby blanket, thermometer and bulb syringe
Non-medical transportation (NMT)	21 and older	Up to 15 round trips (or 30 one-way trips) up to 45 miles for NMT per year to locations such as social support groups, wellness classes, WIC and SNAP appointments, and food banks. This benefit also offers transportation to locations providing social benefits and community integration for members such as community and neighborhood centers, parks, recreation areas and churches.

Additional Value-Added Benefits		
Benefit name	**Age limit**	**Description**
Non-Emergency Medical Transportation (NEMT)	All	One in-state round trip (2 in-state one-way trips) per day for a parent and/or guardian to visit their child during a NICU or inpatient hospital stay. Member's using non-emergency medical transportation may be allowed to bring up to 3 children when childcare is not available. • Total number of passengers, including the driver, cannot exceed more than 5 • Each child must be younger than 13 • Each child must be the member's by birth, marriage, legal adoption, foster child or legal guardianship • Each child must have his/her own car seat provided by the member if required by OK state law
Over-the-counter (OTC) pharmacy allowance	All	Up to $30 per household per quarter allowance enables households to purchase products that support common occurring conditions such as: • Pain relivers • Diaper rash cream • Cough and cold relief medicine • First aid equipment that do not require prescriptions Unused amounts do not roll over to the next quarter
Parent-guardian self-care allowance	All	Reimbursement up to $40 per quarter for members that are a legal parent or guardian of children up to 12 months old to help cover the costs of childcare and enable our new parents/ guardians to spend time doing activities independently and relieve stress.

Additional Value-Added Benefits		
Benefit name	**Age limit**	**Description**
Pest control	All	Up to $200 allowance per household per year per for pest control. If member resides with caregiver, they must show proof. Member can provide lease that they reside with caregiver. Plan approval required.
Post discharge meal	All	14 refrigerated home-delivered meals following discharge from an inpatient or residential facility
Prescription limit waived for adults	21 and older	The 6 prescription per month limit for adult members is waived All prescriptions are still subject to state and federal requirements for drug utilization review, safety edits, quantity limits and prior authorizations.
Self-monitoring devices – blood pressure monitoring kit	21 and older	Members under care management may receive 1 digital blood pressure kit once every 3 years. Kit includes the cuff and monitor. Care Manager approval required
Self-monitoring devices – weight scale	21 and older	Members under care management may receive 1 weight scale every 3 years Care Manager approval required
Smartphone services	All	Smartphones can provide easy access to health-related information and enable members to stay connected to their care team and health plan. Humana members that qualify for the Federal Lifeline program are eligible to receive a free smartphone with monthly talk minutes, text and data.
Sports physical	6-18 years	1 sports physical per year

Additional Value-Added Benefits		
Benefit name	**Age limit**	**Description**
Tobacco & Vaping Cessation Coaching	13 and older	Tobacco Cessation Program is focused on tobacco and vaping cessation coaching for members aged 13 and older. The program is designed as a 6-month engagement for a total of 8 coaching calls, but enrollees have 12 months to complete the program if needed. Humana's tobacco and vaping cessation health coaching program offers support for both over the counter (OTC) and prescription nicotine replacement therapy (NRT) for members ages 18 and older.
Vision Services	21 and older	1 annual eye exam Members can choose one of the following every 2 years: • Eyeglasses include non-high index polycarbonate lenses and a $100 allowance for the frame, or • $100 allowance for the cost of contact lenses, members are responsible for any cost over the allowance.
Waived copays	21 and older	Waive copays for medical and behavioral health services
Weight Management Coaching	12 and older	Weight Management Coaching Program delivers weight management intervention for members who are 12 and older. Upon receiving physician clearance, member can complete 6 weight management coaching sessions with health coach; approximately one call per month for a period of 6 months.
Youth academic support	Grades K-12	Members in grades K-12 access to online tutoring services up to 2 hours per week as well as ACT/SAT test preparation.

Additional Value-Added Benefits		
Benefit name	**Age limit**	**Description**
Youth development and recreation	4-18 years	Member can receive reimbursement of up to $200 annually for participation in activities such as: • YMCA • Boys and Girls Club programming • Swim lessons • Computer coding classes • Music lessons

If you have any questions about any of the benefits above, talk to your PCP or call Member Services toll-free at **855-223-9868 (TTY: 711)**, Monday through Friday, from 8 a.m. to 5 p.m., Central time.

Transportation Services

Emergency Transportation: If you need emergency transportation (an ambulance), call 911.

Non-emergency Transportation: Humana can arrange and pay for your transportation to help you get to and from your appointments for Medicaid-covered care. This service is free to you. If you need an attendant to go with you to your doctor's appointment, or if your child (18 years old or younger) is a member of the plan, the transportation is also covered for the attendant or parent or guardian. Non-emergency transportation includes personal vehicles, taxis, vans, ambulatory vehicles, and public transportation.

How to get non-emergency transportation: Humana partners with ModivCare to meet your transportation needs. You can call ModivCare toll-free at 877-718-4213 TTY: 866-288-3133 up to 72 hours before your appointment, excluding weekends and state holidays, to arrange transportation to and from your appointment. If you need to cancel your trip, please cancel within 24hrs.

ModivCare can help with:

- Public transportation
- Gas mileage reimbursement
- Getting a ride in a:
    - o sedan
    - o van

- o taxi
- o rideshare
- o wheelchair lift equipped vehicle (including bariatric)
- o stretcher vehicles

You can schedule reservations by calling toll-free at 877-718-4213 TTY: 866-288-3133 or online at ModivCare.com.

If we deny you transportation services, you have the right to appeal our decision. See the Appeals Section of this handbook for more information on appeals. If you have questions about transportation, call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.

Extra Support to Manage Your Health

Managing your health care alone can be hard, especially if you are dealing with many health problems at the same time. If you need extra support to get and stay healthy, we can help. As a member of Humana you may have a care manager on your health care team. A care manager is a specially trained health professional who works with you and your doctors to make sure you get the right care when and where you need it.

Your care manager can:

- Coordinate your appointments and help arrange for transportation to and from your doctor;
- Support you in reaching your goals to better manage your ongoing health conditions;
- Answer questions about what your medicines do and how to take them;
- Follow up with your doctors or specialists about your care;
- Connect you to helpful resources in your community; and
- Help you continue to receive the care you need if you switch health plans or doctors.

Humana can also connect you to a care manager who specializes in supporting a healthy lifestyle and any treatment plan your doctor has ordered for any condition you may have such as Asthma, Diabetes, Depression and others.

To learn more about how you can get extra support to manage your health, talk to your PCP or call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.

Help With Problems Beyond Medical Care

It can be hard to focus on your health if you have problems with your housing or worry about having enough food to feed your family. Humana can connect you to resources in your community to help you manage issues beyond your medical care.

- Call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST if you need help paying for your medicines
- need help paying your housing related bills (water and electricity)
- paying for food
- looking for assistance with childcare and after school activities
- need more medicine

Care Management and Outreach Services

Children and adults with special healthcare needs often can benefit from care management. We offer care management services to all members who can benefit from these services. Members can self-refer, too.

We have:

- registered nurses
- social workers
- other outreach workers

These healthcare workers can help you coordinate your healthcare. This coordination 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
- Our staff feels this service may be helpful to you or your family

Care Manager Services can:

- Coordinate your appointments and help arrange for transportation to and from your doctor
- Support you in reaching your goals to better manage your ongoing health conditions
- Answer questions about what your medicines do and how to take them

- Follow up with your doctors or specialists about your care
- Connect you to helpful resources in your community
- Help you continue to receive the care you need if you switch health plans or doctors
- Help you figure out when to get medical care from your PCMH, Urgent Care, or ER

There are several Care Management programs available including:

Complex Care Management

Humana Healthy Horizons in Oklahoma members may be eligible to get Complex Care Management services if they are hospitalized multiple times or have special needs. A team of healthcare providers are ready to help make sure your needs are met.

These members have the highest risk factors such as:

- Multiple conditions
- Take multiple medications
- Have multiple clinical providers

To get more information about the Complex Care Management Program, self-refer into, or opt out of the Complex Care Management Program call Care Management Support Services toll-free at 855-223-9868 TTY: 711 M-F 8a.m. - 5p.m. CST. This program is optional.

Care Transitions

If you are hospitalized, our care managers can help you before you leave the hospital. We can:

- Answer any questions you may have about getting out of the hospital
- Answer questions about the medicine your doctor gives you
- Help arrange your doctor visits
- Help set up support for when you get home

If you need help after leaving the hospital and going back home please let us know. Call Member Services toll-free at 855-223-9868 8am-5pm CST.

Humana Care Beginnings Maternity Services

Humana members who are expecting or who have recently given birth can get services and support for mom and baby including:

- Arranging doctor visits
- Answering questions about pregnancy, delivery, postpartum, and newborn care
- Provide lactation support
- Provide newborn supplies
- Provide support during the post-partum period

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit

Plan members under age 21 can get any treatment or health service that is medically necessary to treat, prevent or improve a health problem. This special set of benefits are called Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Members who need EPSDT benefits:

- Can get EPSDT services through their health plan;
- Do not have to pay any copays for EPSDT services; and
- Can get help with scheduling appointments and arranging for free transportation to and from the appointments.

Some EPSDT services may require a prior authorization (PA). EPSDT includes services that can help treat, prevent or improve a member's health issue, including, but not limited to:

- Health and immunization history;
- Physical exams;
- Various health assessments and counseling;
- Lab and screening tests;
- Necessary follow-up care; and/or
- Applied behavioral analysis (ABA) services.

If you have questions about EPSDT services, talk with your child's primary care provider (PCP). You can also find more information on EPSDT services online by visiting our website at Humana.com/HealthyOklahoma or by visiting the SoonerCare EPSDT web page at https://oklahoma.gov/ohca/providers/types/child-health-epsdt.html

Child Health Visits Schedule

We recommend regular child health appointments. This table shows when your child should have appointments.

Infancy:

Younger than 1 month	2 months	4 months
6 months	9 months	12 months

Early childhood:

15 months	18 months	24 months
30 months	3 years	4 years

Middle childhood:

5 years	6 years	7 years
8 years	9 years	10 years

Adolescence and young adults:

11 years	12 years	13 years
14 years	15 years	16 years
17 years	18 years	19 years
20 years	21 years (through the end of the enrollee's 21st birth month)	

Services Not Covered

These are examples of some of the services that are not available from Humana. If you get any of these services, you may have to pay the bill:

- Acupuncture
- Cosmetic surgery
- Infertility treatment
- Weight loss programs
- Services from a provider who is not part of Humana unless it is a provider you are allowed to see as described elsewhere in this handbook or Humana, or your primary care provider (PCP) sent you to that provider
- Services for which you need a referral (approval) in advance, and you did not get it

- Services for which you need prior authorization (PA) in advance, and you did not get it
- Medical services provided out of the country
- Tattoo removal

Other Services not covered:

Dental services, except for Dental Related Emergency Services in the inpatient, outpatient, and ambulatory surgery center settings, will be reimbursed by OHCA outside of Humana's capitation and delivered through the SoonerSelect Dental program. Additionally, Humana will not be financially responsible for services rendered by IHCPs that are eligible for one hundred percent (100%) federal funding.

This list does not include all the services that are not covered. To determine if a service is not covered, call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.

You may have to pay for any service that your PCP or Humana does not approve. This includes:

Services not covered (including those listed above).

- Unauthorized services.
- Services provided by providers who are not part of Humana.

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

If You Get a Bill

In most cases, you do not have to pay for SoonerSelect services and should not get a bill from a provider. You may have to pay if you agreed in writing to pay for services not paid for by Humana Healthy Horizons in Oklahoma. If you get a bill for a treatment or service you do not think you should pay for, do not ignore it. Call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST right away. We can help you understand why you may have gotten a bill. If you are not responsible for payment, Humana will contact the provider and help fix the problem for you.

You have the right to file an appeal if you think you are being asked to pay for something Humana should cover. See the grievance and appeals section in this handbook for more information. If you have any questions, call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.

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 decide about coverage based on:

- Updated Medicaid and Medicare rules
- External technology assessment guidelines
- Food and Drug Administration (FDA) approval
- Medical literature recommendations[KD1]

PART III: Plan Procedures

Pharmacy Lock-in Program

To protect the health of our members, Humana Healthy Horizons in Oklahoma has a pharmacy lock-in program. This is for members who abuse or misuse prescription drugs. Members are assigned to one pharmacy and one doctor. You may change your doctor or pharmacy one time a year unless you have a special situation like moving. If you are placed in the program, you may be enrolled for a minimum of two years. We will review your enrollment at least every year. You can appeal being placed in the lock-in program. See the grievance and appeals section in this handbook for more information.

Prior Authorization and Actions

Humana Healthy Horizons in Oklahoma will need to approve some treatments and services before you receive them. Asking for approval of a treatment is called a prior authorization. For a list of services that require a prior authorization, please see the chart in the "Services Covered by Humana Healthy Horizons in Oklahoma's Network" section of this handbook. Typically, your primary care provider (PCP) will submit the prior authorization to Humana Healthy Horizons in Oklahoma for you through the provider portal.

- Typically, your primary care provider (PCP) will submit the prior authorization to Humana Healthy Horizons in Oklahoma for you through the provider portal. Asking for approval of a treatment or service is called a prior authorization request.

For help or more information, you or your doctor may call Humana Clinical Pharmacy Review toll-free at 1-800-555-2546 TTY: 711 or send your request in writing to P.O. Box 14601 Lexington, KY 40512. Your doctor may also submit requests.

Prior Authorization Requests for Children Under Age 21

Special rules apply to decisions to approve medical services for children under age 21 receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. To learn more about EPSDT services call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST or visit our website at Humana.com/HealthyOklahoma.

What Happens After We Get Your Prior Authorization Request?

The health plan has a review team to be sure you get the services we promise and that you need. Qualified health care professionals (such as doctors and nurses) are on the review team. Their job is to be sure that the treatment or service you asked for is covered by your plan and that it will help with your medical condition. They do this by checking your treatment plan against

medically acceptable standards.

After we get your request, we will review it under either a standard or an expedited (faster) process. You or your doctor can ask for an expedited review if a delay will cause serious harm to your health. If your request for an expedited review is denied, we will tell you and your case will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so but no later than described timeframes noted within the next section of this handbook.

We will tell your provider in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options you will have for an appeal when you don't agree with our decision.

Any decision to deny a prior authorization (PA) request or to approve it for an amount that is less than requested is called an adverse benefit determination. These decisions will be made by a health care professional. You can request the specific medical standards, called clinical review criteria, used to make the decision for adverse benefit determinations related to medical necessity. We do not reward providers or our own staff for denying coverage or services. We do not offer financial rewards to our staff 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.

Prior Authorization and Timeframes

We will review your request for a prior authorization (PA) within the following timeframes:

Standard review: We will make a decision about your request within 72 hours after we receive it.

Expedited (faster) review: We will decide about your request, and you will hear from us within 24 hours.

Inpatient Behavioral Health: We will make a decision about your request within 24 hours.

Post Service review: We will send a response to your provider within 14 days of your request.

For both standard and expedited decisions may have an extension to the time frame up to fourteen (14) additional calendar days if the enrollee or the provider request the extension or need for additional information and how the extension is in the enrollee's interest.

In most cases, if you are receiving a service and a new request is made to

keep receiving a service, we must tell you at least 10 days before we change the service if we decide to reduce, stop or restrict the service.

If we approve a service and you have started to receive that service, we will not reduce, stop or restrict the service during the approval period unless we determine the approval was based on information that was known to be false or wrong.

If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills.

How You Can Help with Plan Policies

We value your ideas. You can help us develop policies that best serve our members. Maybe you would like to work with one of the member committees in our health plan or with OHCA, like:

- Humana Advisory Board; and/or
- Humana Behavioral Health Advisory Board (BHAB).

Call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST to learn more about how you can help.

Appeals

If you are not satisfied with our decision about your care or received an adverse benefit determination, you have the right to file an appeal.

To file an appeal, write to:

Attn: Grievance and Appeals Department

P.O. Box 14163

Lexington, KY 40512-4163

Fax: 800-949-2961

To file an appeal by phone, call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.

If you are not satisfied with an action we took or what we decided about your prior authorization (PA) request, you can file an appeal within 60 calendar days from the date on the denial letter. An appeal is a request for us to review the decision.

You can do this yourself or, with your written consent, your authorized representative or your provider can call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST or visit our website at Humana if you need help filing an appeal.

The appeal can be made by phone or in writing. You don't have to use any specific or legal terms as long as you clearly state that you are dissatisfied with the decision we made. We can help you complete the appeal form. If needed, auxiliary aids and services will be provided to you upon request and free of charge.

If your appeal needs to be reviewed more quickly than the standard timeframe because you have an immediate need for health services, you may request an expedited (faster) appeal.

- **Standard appeals:** If we have all the information we need, we will tell you our decision in writing within 30 days after your appeal is received.
- **Expedited (faster) appeals:** If we have all the information we need, we will call you and send you a written notice of our decision within 72 hours from when we receive your appeal.

You may file a grievance your request for an expedited (fast tracked) appeal is denied.

We will not treat you any differently or act badly toward you because you file an appeal.

Before and during the appeal, you or your representative can see your case file, including medical records and any other documents and records being used to decide your case.

You can ask questions and give any information (including new medical documents from your providers) that you think will help us to approve your request. You may do that in person, in writing or by phone.

If you need assistance with the appeals process, have questions, or want to check the status of your appeal, you can call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST.

More Information for Appeals

If we need more information to make either a standard or an expedited (faster) decision about your appeal, we may extend the time to resolve your appeal. If so, 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.

If you need more time to gather your documents and information, just ask.

You, your provider, or someone you trust may ask us to delay your case by up to 14 days. We want to make the decision that supports your health best. You can request more time by calling Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST or writing to:

Attn: Grievance and Appeals Department

P.O. Box 14163

Lexington, KY 40512-4163

Our Decision on Your Appeal

If we agree with you that we should not have reduced or stopped services you were already receiving, we will send you a notice of resolution of the appeal telling you that we granted your appeal. If we still disagree with you and believe we were right to have reduced or stopped services you were already receiving, we will send you a notice of adverse resolution of the appeal telling you that we denied your appeal. If you disagree with the adverse resolution of the appeal, you have the right to request a State Fair Hearing. See the next section for important details about timing and filing your request.

Your Care While You Wait for a Decision on Your Appeal

- When the health plan's decision reduces or stops a service you were already receiving, you can ask to continue the services your provider had already ordered while we are making a decision on your appeal. You can also ask an authorized representative to make that request for you. Providers are not allowed to ask for your services to continue for you.
- While you are waiting for us to make a decision on your appeal, if you want to continue services you were already receiving, be sure to ask us to continue those services at the time you file your appeal.
- You can request services be continued if the time period included in the original service request from your provider has not expired.
- Your request to continue services must be made within 10 days of the date on the denial letter or before the date we told you the services would be reduced or terminated, whichever date is later.
- If we continue the services that you were already receiving, we will pay for those services if your appeal is decided in your favor. **Your appeal might not change the decision the health plan made about your services.**
- When your appeal doesn't change the health plan's decision, the health plan may require you to pay for the services you received while waiting for a decision.

If you are unhappy with the result of your appeal, you can ask for a State Fair Hearing (see next section in this handbook).

State Fair Hearings

After you receive a notice of adverse resolution (denial) to your appeal and you still don't agree with the decision that we made that reduced, stopped, or restricted your services, you can ask for a State Fair Hearing. A State Fair Hearing is your opportunity to give more information and ask questions about the decision in front of an administrative law judge. The judge in your State Fair Hearing is not a part of your health plan in any way.

If you want to continue benefits while you wait for the administrative law judge's decision about your State Fair Hearing, you should say so at the time you request a State Fair Hearing.

If you need help with understanding the State Fair Hearing process, you can call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST. You don't have to use any special legal or formal language to request a State Fair Hearing as long as you clearly state that you are dissatisfied with the decision we made.

Your Care While You Wait for a Decision on your State Fair Hearing

If you requested and received continued services during your appeal, we must continue providing those services until you do one of the following:

- You withdraw your appeal or your request for State Fair Hearing, or
- A State Fair Hearing officer issues a hearing decision that disagrees with you.

You can also ask a trusted representative to make that request for you.

If you ask your health plan to continue services you already receive during your State Fair Hearing case, the health plan will pay for those services if your case is decided in your favor. Your State Fair Hearing might not change the decision the health plan made about your services.

Requesting a State Fair Hearing

You don't have to use any special legal or formal language to request a State Fair Hearing as long as you clearly state that you are dissatisfied with the decision we made.

You must first file an appeal with Humana and receive our decision before requesting a State Fair Hearing. If we don't decide your appeal within 30 days of your appeal request, you can also ask for a State Fair Hearing.

You don't need an attorney for your State Fair Hearing, but you may use one.

You may represent yourself or allow someone else to represent you.

If you allow someone else to represent you, they will have to show proof in writing that you asked for their help.

Without this written proof, your appeal will be rejected.

You can ask for a State Fair Hearing at any time within 120 days from the date on the notice of adverse resolution (denial) letter.

- You can use one of the following ways to request a fair hearing:

  Writing: Grievance Docket Clerk P.O. Drawer 18497

  Oklahoma City, OK 73154-0497

  Fax: 405-530-3444

  Phone: 405-522-7217

  Email: docketclerk@okhca.org

Appeals to the external Medicaid state fair hearing process must be filed within 120 calendar days of the date of the internal appeal decision.

If You Have Problems with Your Health Plan

We hope our health plan serves you well. If you have a problem, talk with your primary care provider (PCP) and call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST or write to our Grievance and Appeals Department:

Attn: Grievance and Appeals Department

P.O. Box 14163

Lexington, KY 40512-4163

Fax: 800-949-2961

Most problems can be solved right away. If you have a problem with your health plan, care, provider, or services, you can file your complaint with Humana Healthy Horizons in Oklahoma. **This kind of complaint is called a grievance.** Problems that are not solved right away over the phone and any grievance that comes in the mail will be handled according to our grievance procedures described below.

You can ask someone you trust (your authorized representative) to file the grievance for you. If you need our help because of a hearing or vision impairment, if you need translation services, or if you need help filling out the forms, we can help you. We will not make things hard for you or take any

action against you for filing a grievance.

You may also file a complaint with the Oklahoma Insurance Department by going to https://www.oid.ok.gov/consumers/file-an-online-complaint/.

If You Are Unhappy with Your Plan: How to File a Grievance

If you are unhappy with your health plan, provider, care or your health services, you can file a grievance (a formal complaint) with Humana. You can file a grievance by phone or in writing at any time. If you need help or have questions please call Member Services toll-free at 855-223-9868 TTY: 711 M-F 8 a.m. – 5 p.m. CST. We will provide an interpreter at no cost to you if needed.

To file by phone, call Member Services toll-free at: 855-223-9868 TTY: 711 Monday-Friday 8 a.m. – 5 p.m. CST

To file in writing, you can write us with your grievance to Attn: Grievance and Appeals Department

P.O. Box 14163

Lexington, KY 40512-4163

Fax: 800-949-2961

What Happens Next?

- We will let you know in writing that we received your grievance.
- We will decide the resolution of a grievance within 30 days after receiving your grievance.
- We will tell you how we resolved it in writing within 3 days after we resolve the grievance.

Your Care When You Change Health Plans or Doctors (Transition of Care)

If you choose to leave Humana we will share your health information with your new plan.

You can finish receiving any services that have already been authorized by your previous health insurance or Humana Healthy Horizons in Oklahoma, even if the provider you are seeing is an out-of-network provider.

Prior authorizations will be honored until the services are used or until ninety (90) days after your new plan benefits begin, whichever comes first. After that, we will help you find a provider in our network to get any additional services if you need them.

If you are pregnant when you join Humana Healthy Horizons in Oklahoma

you can continue the care that you were receiving before you joined our plan. You can continue seeing your doctor even if he or she is an out-of-network provider.

If you are receiving chemotherapy or radiation treatment, dialysis, major organ or tissue transplant services, bariatric surgery, Synagis treatment, medications for hepatitis C treatment or if you are terminally ill, when you change plans you can continue your current treatment plan.

Children receiving private duty nursing services will continue to receive these services. These services will only change if we perform a new assessment and determine your child needs different services.

We will continue to cover your out-of-state services and/or meals and lodging assistance if it is already being received from Humana Healthy Horizons in Oklahoma when you join our plan.

If you are receiving services for hemophilia, those services will continue being provided by your current hemophilia providers for up to ninety (90) days even if the provider is out-of-network. After ninety (90) days, we can help you find a network provider.

If you are on a current treatment plan and receiving behavioral health services, you may keep seeing your current behavioral health treatment provider(s) for up to ninety (90) days, even if the provider is out-of-network. After ninety (90) days, we can help you find a network provider.

If you are waiting for durable medical equipment (DME) or supplies authorized and ordered prior to joining our plan, we will help you to receive these items on time.

If your PCP leaves Humana we will tell you in writing within thirty (30) days from when we know about this. We will tell you how you can choose a new PCP or choose one for you if you do not make a choice within thirty (30) days.

If a provider you are getting care from is no longer in network, we will send you a letter letting you know. Details about continued care will be in the letter we will send you. If you would like to find a new provider you can call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST or visit Humana.com/findadoctor.

If you have any questions, call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST. Interpreter services are available free of charge/at no cost.

Member Rights and Responsibilities

Your Rights

As a member of Humana, you have a right to:

- Receive information on the SoonerSelect program and Humana Healthy Horizons in Oklahoma, its services, providers and member rights and responsibilities.
- Be treated with respect and with due consideration for your dignity and privacy.
- Have a discussion and receive information on available treatment options and alternatives, in a way you understand, regardless of cost or benefit coverage.
- Participate in decisions regarding your health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of your medical records, and to request that they be amended or corrected in accordance with HIPAA Rules and other applicable federal and State laws and regulations.
- Obtain available and health care services covered by Humana Healthy Horizons in Oklahoma.
- Voice complaints or appeals about Humana Healthy Horizons in Oklahoma or the care it provides.
- Make recommendations regarding the member rights and responsibilities policy.

Your Responsibilities

As a member of Humana, you agree to the following responsibilities:

- Check OHCA/Humana information, correct inaccuracies and allow government agencies, employers and providers to release records to OHCA or Humana.
- Notify OHCA or Humana within 10 days if there are changes in income, the number of people living in the home, address or mailbox changes, or health insurance changes.
- Transfer, assign, and authorize to OHCA all claims you may have against health insurance, liability insurance companies or other third parties. This includes payments for medical services made by OHCA for any dependents.
- Respond to requests for assistance from the OHS Office of Child Support Services.

- Allow SoonerCare to collect payments from anyone who is required to pay for medical care.
- Share necessary medical information with any insurance company, person or entity who is responsible for paying the bill.
- Inspect any medical records to see if claims for services can be paid.
- Obtain permission for Oklahoma Human Services or Oklahoma Health Care Authority to make payment or overpayment decisions.
- Keep your identification card and know your Social Security number to receive health care services or prescriptions.
- Confirm that any care received is covered.
- Understand how and when to request non-emergency medical transportation (NEMT) services.
- Cost sharing.
- Ensure all information provided to OHCA or Humana is complete and true upon penalty of fraud or perjury.
- Supply information, to the extent possible, that Humana Healthy Horizons in Oklahoma and its providers need in order to provide care.
- Follow plans and instructions for care that they have agreed to with their provider.
- Understand your health problems and participate in setting agreed-upon goals, to the degree possible.

Disenrollment Options

If You Want to Leave the Plan

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

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

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

- You need related services to be performed at the same time, not all services are available within Humana's network, and getting the services separately would put your health at risk,

- You have a complex medical condition and another health plan can better meet your needs,
- You have filed and won a grievance about poor quality of care, lack of access to services we must provide, lack of access to providers experienced in dealing with your needs, or any other issue that would support disenrollment,
- You were enrolled by mistake, and
- You need services that Humana Healthy Horizons in Oklahoma does not provide for moral or religious reasons.

If you have a good cause reason to disenroll from Humana, you must submit your request using the grievance process. We will review the request within 10 days from when you filed the grievance. If you are unhappy with the disenrollment decision, we will refer the request to the Oklahoma Health Care Authority for the final decision.

Humana Healthy Horizons in Oklahoma does not deny coverage for services or benefits because of moral or religious objections.

You Could Become Ineligible for SoonerSelect

You may have to leave Humana if you:

- Are no longer eligible for Medicaid. If you become ineligible for Medicaid, all your services may stop immediately.
- Begin receiving Medicare.
- Transition to an eligibility group that does not participate in SoonerSelect.
- Become a foster child under state custody.
- Become a juvenile in the justice system under state custody.
- Become an inmate of a public institution.
- Commit fraud or provide fraudulent information.
- Are ordered by a hearing officer or court.

We Can Ask You to Leave Humana

You can also lose your Humana membership if you:

- Abuse or harm to plan members, providers or staff.
- Were enrolled in error.
- Have a complex medical condition and another health plan can better

meet your needs.

- Do not fill out forms honestly or do not give true information. This is considered fraud.

Advance Directives

There may come a time when you become unable to manage your own health care and a family member or other person close to you is making decisions on your behalf. By planning in advance, you can arrange now for your wishes to be carried out. An advance directive is a set of directions you give about the medical and mental health care you want if you ever lose the ability to make decisions for yourself. For example, some people do not want to be put on life-support machines if they go into a coma.

Making an advance directive is your choice. If you become unable to make your own decisions, and you have no advance directive, your doctor or behavioral health provider will consult with someone close to you about your care. Discussing your wishes for medical and behavioral health treatment with your family and friends now is strongly encouraged, as this will help to make sure you get the level of treatment you want if you can no longer tell your doctor or other physical or behavioral health providers what you want. Your advance directives, no matter the type, should be given to your primary care provider (PCP) and your care manager at Humana.

Oklahoma has three ways for you to make a formal advance directive. These include living wills, health care power of attorney, and advance instructions for mental health treatment.

Living Will

In Oklahoma, a living will is a legal document that tells others whether or not you want to die a natural death if you:

- Become incurably sick with an irreversible condition that will result in your death within a short period of time,
- Are unconscious and your doctor determines that it is highly unlikely that you will regain consciousness, or
- Have advanced dementia or a similar condition which results in a substantial cognitive loss, and it is highly unlikely the condition will be reversed.

In a living will, you can direct your doctor not to use certain life-prolonging treatments such as a breathing machine (called a “respirator” or “ventilator”), or to stop giving you food and water through a feeding tube.

A living will go into effect only when your doctor and one other doctor

determine that you meet one of the conditions specified in the living will. Discussing your wishes with family, friends and your doctor now is strongly encouraged so that they can help make sure that you get the level of care you want at the end of your life.

Health Care Power of Attorney

A Health Care Power of Attorney is a legal document in which you can name one or more people as your health care agents to make medical and behavioral health decisions for you as you become unable to decide for yourself, for as long as you choose. You can always say what medical or behavioral health treatments you would want and would not want. You should choose an adult you trust to be your health care agent. Discuss your wishes with the people you want as your agents before you put them in writing. Your chosen Power of Attorney will be able to have access to your medical information and medical records, for as long as that person is so designated, up to your death.

Again, it is always helpful to discuss your wishes with your family, friends and your doctor. A Health Care Power of Attorney will go into effect when a doctor states in writing that you are not able to make or to communicate your health care choices. If, due to moral or religious beliefs, you do not want a doctor to make this determination, the law provides a process for a non-physician to do it.

Advance Instruction for Mental Health Treatment

An Advance Instruction for Mental Health Treatment is a legal document that tells doctors and mental health providers what mental health treatments you would want and what treatments you would not want if you later became unable to decide for yourself. It can also be used to nominate a person to serve as guardian if guardianship proceedings are started. Your advance instruction for behavioral health treatment can be a separate document or combined with a Health Care Power of Attorney or a General Power of Attorney. An Advance Instruction for Behavioral Health may be followed by a doctor or behavioral health provider when your doctor or an eligible psychologist determines in writing that you are no longer able to make or communicate behavioral health decisions.

You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself. Talk to your primary care provider (PCP) or call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST if you have any questions about advance directives.

Fraud, Waste and Abuse

If you suspect that someone is committing Medicaid fraud, report it. Some examples of Medicaid fraud include (not limited to):

- An individual does not report all income or other health insurance when applying for Medicaid.
- An individual who does not get Medicaid uses a Medicaid member's card with or without the member's permission.
- A doctor or a clinic bill for services that were not provided or were not medically necessary.

You can report suspected fraud and abuse in any of the following ways:

- Call the Medicaid Fraud, Waste and Program Abuse Tip Line toll-free at 800-614-4126 24/7
- Call the U.S. Office of Inspector General's Fraud Line toll-free at 800-HHS-TIPS (800-447-8477).

Important Phone Numbers

- Member Services toll-free at 855-223-9868 TTY: 711 M-F 8a.m. – 5p.m. CST
    - If you have Prescriber Services questions call Member Services for help
- 24-hour Oklahoma Mental Health Lifeline 988
- 24-hour Nurse Line toll-free at 800-854-6619 TTY: 711
- SoonerCare Helpline toll-free at 800-987-7767
- The plan's Provider Service line toll-free at 855-223-9868 TTY: 711
- Care Management Support Services toll-free at 855-223-9868 TTY: 711 M-F 8a.m. - 5p.m. CST hours of operation
    - Call this phone number for Medical Management questions
- Free Legal Services line toll-free at 405-521-3638
- Advance Health Care Directive Registry phone number toll-free at 855-223-9868 TTY: 711
- OK Medicaid Fraud, Waste and Abuse Tip Line toll-free at 800-614-4126
- State Auditor Waste Line toll-free at 405-521-3495

- U.S. Office of Inspector General Fraud Line toll-free at 800-HHS-TIPS or 800-447-8477

Keep Us Informed

Call Member Services toll-free at 855-223-9868 TTY:711 8am-5pm CST whenever these changes happen in your life:

- You have a change in Medicaid eligibility.
- You become pregnant or give birth.
- There is a change in Medicaid coverage for you or your children.
- Someone in your household goes into state custody.
- You begin receiving Medicare.
- You move.

Additional Information

Please call Member Services if you want information about the structure and operation of Humana Healthy Horizons in Oklahoma, physician incentive plans, and service utilization policies.

PART IV: Health & Wellness Information

Other Programs to Help You Stay Healthy

Humana Healthy Horizons in Oklahoma wants to help you and your family get and stay healthy. If you want to quit smoking or are a new mom who wants to learn more about how to best feed your baby, we can help connect you with the right program for support.

Call Member Services toll-free at 855-223-9868 8am-5pm CST to learn more about:

- Tobacco cessation services (support to help you stop smoking or dipping).
- SoonerStart is Oklahoma's early intervention program is designed to meet the needs of families with infants or toddlers (ages birth to 3 years old) with developmental delays and/or disabilities in accordance with the Individuals with Disabilities Education Act (IDEA). The program builds upon and provides supports and resources to assist family members to enhance infants or toddler's learning and development through everyday learning opportunities.

Maternity program

Our maternity program helps our pregnant members during and after a pregnancy. This program can help with:

- extra support from a nurse
- pregnancy and family-planning resources
- access to a healthy rewards program

Call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST to learn more and to enroll into our maternity program.

Tobacco Free program

If you smoke or use other tobacco products, Humana Healthy Horizons in Oklahoma 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 resources to support you in your commitment to quit.

Counselors will listen to you:

- help you understand your habits
- work with you to take action

Your doctor also may recommend you try medicines. To reach a coach who

can help you quit, call Member Services toll-free at 855-223-9868 TTY: 711 8am-5pm CST. As a member in Oklahoma you have access to the Oklahoma Tobacco Helpline which offers free assistance with many types of tobacco use, for those that use as well as family and friends.

You may call toll-free at 1-800 QUIT NOW (800-784-8669) to receive many resources which include:

- Free information on quitting tobacco
- One-to-one telephone counseling with a Quit Coach to boost your chance for success in quitting
- Referrals on local programs and services in your community to help you quit tobacco

You may also visit https://okhelpline.com/ to register and receive services through the web without any phone calls.

Go365 for Humana Healthy Horizons

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

Participate in healthy activities and earn rewards you can redeem for e-gift cards.

Humana Healthy Horizons in Oklahoma members can participate in Go365 for Humana Healthy Horizons. Participating in eligible healthy activities and earning rewards through our Go365 for Humana Healthy Horizons wellness program is easy.

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 under the age of 18 must have a parent or guardian register on their behalf to participate and engage with the program. The person completing the registration process on behalf of a minor must have the minor's SoonerSelect member ID.
    - Members who are 18 and older can register to create a Go365 account. You must have your SoonerSelect member ID.

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

For each eligible Go365 activity completed, you can earn rewards and then

redeem the rewards for gift cards in the Go365 Mall in the app. Rewards earned through Go365 have no cash value and must be earned and redeemed prior to the reward expiration date.

Call Go365 toll-free at 855-223-9868 TTY: 711 to learn more.

You can qualify to earn rewards by enrolling in Go365 for Humana Healthy Horizons and then completing one or more healthy activities:

Rewards name	Age limit	Description
Breast Cancer Screening	40 and older	Annual $25 reward for female members who obtain a mammogram
Cervical Cancer Screening	21 and older	Annual $25 reward for female members who obtain a pap smear
Chlamydia Screening	All	Annual $25 reward for female member who obtain a chlamydia screening when sexually active and as recommended by their healthcare provider
Colorectal Cancer Screening	45 and older	Annual $25 reward for members who obtain a colorectal cancer screening as recommended by their PCP
COVID-19 Vaccine	5 and older	Annual $40 reward 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 Exam	18 and older	Annual $25 reward for Diabetic members who complete a retinal eye exam

Rewards name	Age limit	Description
Diabetic Screening	18 and older	Annual $50 reward for diabetic members who obtain a screening with their PCP for HbA1c and blood pressure
Digital Onboarding	All	One-time $25 reward for downloading Humana's mobile Go365 application and completing the registration
Flu Vaccine	All	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	All	$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 for Mental Illness	All	$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 Risk Screening (HRS)	All	One-time $50 reward for completing the health risk screening (HRS). Must be completed within 30 days of enrollment
HPV Vaccine	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 Education	19 and older	Annual $10 reward upon watching a short educational video about when to access the emergency room
Notification of Pregnancy (NOP)	All	$25 reward when pregnant members notify Humana of pregnancy prior to delivery once per pregnancy

Rewards name	Age limit	Description
Postpartum Visit	All	$25 reward for all postpartum females who complete 1 postpartum visit within 7 to 84 days after delivery once per pregnancy
Prenatal Visits	All	Pregnant members can earn $10 per prenatal visit, up to 10 prenatal visits, for a total of up to $100 once per pregnancy
Tobacco Cessation Program	13 and older	Members who enroll in the Tobacco & Vaping 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 rewards for completing the full program
Weight Management Program	12 and older	Members who enroll in the Weight Management Program will have two opportunities to earn rewards: • $10 in rewards for completing a wellbeing check up • $20 in rewards for completing the program
Well-Child Visits (0- 15 Months)	0-15 months	Up to $60 reward for members who complete routine well-child visits. Members can receive $10 in reward per visit with a six-visit limit
Well-Child Visits (16-30 Months)	16-30 months	$20 reward for members who complete routine well-child visits. Members can receive $10 reward per visit with a two-visit limit
Wellness Visit	3 and older	Annual $25 reward for completing an annual wellness visit

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.

Go365 for Humana is available to all members who meet the requirements of the program. Rewards are not used to direct the enrollee to select a certain provider. Rewards may take 90 to 180 days or greater to receive. Rewards are non-transferrable to other Managed Care Plans or other programs. Members will lose access to the Go365® 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 (June 30), members with continuous enrollment will have 90 days to redeem their rewards.

In accordance with the federal requirement of the Centers for Medicare & Medicaid Services, 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.

MyHumana Account

Your MyHumana account is a private, personal online account that can help you get the most out of your enrollee experience. Your account includes key coverage information and useful enrollee tools and resources.

You can access your MyHumana account on a mobile device or on a desktop computer by:

- Going to Humana.com/Login
- Entering your username and password

Need to register for MyHumana?

- Go to Humana.com/Registration
- Follow the prompts to create an account, username, and password

Please note: You can use the same username and password for MyHumana and Go365 for Humana Healthy Horizons.

Quality Improvement

Your care means a lot to us. The Plan aims to make a lasting difference in your life by improving your health and well-being through the latest health and life services.

We have a Quality Improvement (QI) Program that aims to:

- Improve the health of all members
- Ensure positive experiences and outcomes of members, and
- Lower the cost of care to benefit everyone

Our QI Program goals and purpose are:

- Organize care
- Promote value
- Ensure ongoing performance and efficiency
- Improve the quality and safety of clinical and nonclinical care and services

We work to:

- Meet national quality standards
- Receive high customer and provider satisfaction, and
- Achieve top enrollee health outcomes

Our QI Program conducts the following activities:

- Assess the unique needs of members
- Assess the availability of providers for members in every region of the state
- Meet national quality standards
- Ensure The Plan is effectively serving members with complex health needs
- Ensure The Plan is effectively serving members with diverse cultural and language needs
- Establish safe clinical practices with all of our providers
- Manage all quality of care and quality service complaints
- Provide quality oversight of all clinical services
- Meet the quality requirements of the Centers for Medicare and Medicaid Services (CMS)
- Monitor and evaluate enrollee and provider satisfaction

For more information on the QI Program, please call Enrollee Services or visit our website.

Insurance ACE
Notice of Privacy Practices

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

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

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

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

What is nonpublic personal or health information?

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

How do we collect information about you?

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

What information do we receive about you?

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

How do we protect your information?

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

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

How do we use and disclose your information?

We use and disclose your information:

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

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care.
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For healthcare operation activities, including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform, plan administration functions such as eligibility, enrollment, and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission, or your plan sponsor must certify they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you. If you have opted out, we will not contact you.
- To your family and friends if you are unavailable to communicate, such as in an emergency.
- To your family and friends, or any other person you identify. This applies if the information is directly relevant to their involvement with your 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

Insurance ACE
Notice of Privacy Practices (continued)

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.*
- 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

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

Insurance ACE
Notice of Privacy Practices (continued)

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

Grievance and Appeal Office
APPOINTMENT OF REPRESENTATIVE FORM

_____ _____

Member Name **Member ID Number**

_____

Reference Number

The Member will complete this section.

I choose _____ to advocate for me.

(The legal guardian or representative name goes here.)

√ My legal guardian or representative can discuss everything about my medical services.

√ My legal guardian or representative can have all the documents directly related to my case.

_____ _____

The Member signs here. **Date**

Address: _____ **Phone Number:** _____

_____

_____

The legal guardian or representative will complete this section.

I am the _____ of _____.

(spouse, child, friend, lawyer, or other) (The Member's name goes here.)

I agree to advocate or represent for _____.

(The Member's name goes here.)

_____ _____

The legal guardian or representative needs to sign here. **Date**

Address: _____ **Phone Number:** _____

_____

_____

Questions?

Call Member Services
at 855-223-9868 (TTY: 711)
8am-5pm CST

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