Humana Healthy Horizons in Ohio Member Handbook

Plan year 2023

Ohio Medicaid Managed Care

Issuance Date: May 1, 2023

ATTENTION: If you do not speak English, language services, free of charge, are available to you. Call toll-free 877-856-5702 (TTY: 711), Monday – Friday, from 7 a.m. – 8 p.m., Eastern time.

Call If You Need Us

If you have questions or need help reading or understanding this document, call us at **877-856-5702 (TTY: 711)**. We are available Monday through Friday, from 7 a.m. to 8 p.m., Eastern time. We can help you at no cost to you. We can explain the document in English or in your first language. We can also help you if you need help seeing or hearing. Please refer to your Member Handbook regarding your rights.

Important!
At Humana, it is important you are treated fairly.

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

Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **877-856-5702** or if you use a **TTY**, call **711.**

- You can also file a civil rights complaint with the
  Ohio Department of Medicaid (ODM), Office of Civil Rights by emailing
  ODM_EEO_EmployeeRelations@medicaid.ohio.gov, faxing **614-644-1434,**
  or sending by mail to The Ohio Department of Medicaid, Office of Human Resources, Employee Relations, P.O. Box 182709, Columbus, Ohio 43218-2709.

  U.S. Department of Health and Human Services, Office for Civil Rights
  electronically through their Complaint Portal, available at
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at **U.S. Department of Health and Human Services,** 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019, 800-537-7697 (TDD).** Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html.**

Auxiliary aids and services are available to you free of charge.
877-856-5702 (TTY: 711)

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

Humana Healthy Horizons in Ohio is a Medicaid Product of Humana Health Plan of Ohio, Inc.

Language assistance services, free of charge, are available to you.
877-856-5702 (TTY: 711)

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

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

नेपाली (Nepali): नि:शुल्क भाषासम्बन्धी सहयोग सेवाहरू प्राप्त गर्नका लागि माथिको नम्बरमा फोन गर्नुहोस्।

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

Soomaali (Somali): Wac lambarka kore si aad u hesho adeegyada caawimaada luuqada oo bilaash ah.

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

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

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

Kiswahili (Swahili): Piga simu kwa nambari iliyo hapo juu ili upate huduma za usaidizi wa lugha bila malipo.

Українська (Ukrainian): Зателефонуйте за вказаним вище номером для отримання безкоштовної мовної підтримки.

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

Ikinyarwanda (Kinyarwanda): Hamagara nomero iri haruguru uhabwe serivisi z’ubufasha bw’ururimi ku buntu.

简体中文 (Simplified Chinese): 您可以拨打上面的电话号码以获得免费的语言协助服务。

دری (Dari): برای دریافت خدمات رایگان کمک زبانی با شماره بالا تماس بگیرید.

پشتو (Pashto): د وړیا ژبې ملاتړ ترلاسه کولو لپاره پورته شمیرې ته زنګ ووهئ.

አማርኛ (Amharic): ነፃ የቋንቋ ድጋፍ አገልግሎቶችን ለማግኘት ከላይ ባለው ስልክ ቁጥር ይደውሉ።

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.

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Welcome to Humana Healthy Horizons in Ohio!

Welcome to Humana Healthy Horizons in Ohio by Humana. You are now a member of a health care plan, also known as a managed care organization (MCO). Humana Healthy Horizons in Ohio provides health care services to Ohio residents who are eligible, including individuals with low income, individuals who are pregnant, infants, children, older adults, and individuals with disabilities.

This handbook will answer many of your questions. Please take time to read it, and then keep it in a safe place, in case you need to look something up later. If you have questions about the information in your member handbook:

- Go to Humana.com/HealthyOhio
- Call Member Services at 877-856-5702 (TTY: 711), Monday – Friday, from 7 a.m. – 8 p.m., Eastern time

Key Contact Information

Below are different ways to reach us if you have any questions.

Member Services	877-856-5702 (TTY: 711) Monday – Friday, 7 a.m. – 8 p.m., Eastern time
24-hour Medical Advice Line	866-376-4827 (TTY: 711) 24 hours a day, 7 days a week, 365 days a year
Behavioral Health Crisis Line	800-720-9616 (TTY: 711) open 24/7
Online	Humana.com/HealthyOhio
Transportation	Access2Care 855-739-5986 (TTY 866-288-3133)
Mail	P.O. Box 14601 Lexington, KY 40512
Concierge Services for Accessibility (available for alternative formats, interpreter, hearing impaired)	877-320-2233

Hours of Service

Member Services is open Monday – Friday, from 7 a.m. – 8 p.m., Eastern time. 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 Medical Advice Line at 866-376-4827 (TTY: 711).

Humana is closed in observation of the following major holidays:

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

*Note: We are closed on Friday if a holiday falls on Saturday and closed Monday if holiday falls on Sunday.

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 by calling member services at 877-856-5702 (TTY:711). Your feedback is important. We want you to be a happy and healthy member.

Additional Information

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

Quick Reference Guide

I WANT TO:	I CAN CONTACT:
Find a doctor, specialist, or healthcare service	My Primary Care Provider (PCP). If you need help finding and choosing a PCP, go to Humana.com/FindADoctor or call Member Services at 877-856-5702 (TTY: 711)
Get the information in this handbook in another format or language	Member Services at 877-856-5702 (TTY: 711)
Keep better track of my appointments and health services	My PCP, or Member Services at 877-856-5702 (TTY: 711)
Get help with getting to and from my doctor's appointments	Member Services at 877-856-5702 (TTY: 711). You also will find more information on Transportation Services in this handbook.
Get help to deal with my stress or anxiety	Call 911 if you are in danger or need immediate medical attention. Behavioral Health Crisis Hotline at any time, 24 hours a day, 7 days a week. 800-720-9616 (TTY: 711).
Get answers to basic questions or concerns about my health, symptoms or medicines	My PCP, or Humana's 24-Hour-Medical Advice Line at 866-376-4827 (TTY: 711).
• Understand a letter or notice I got in the mail from my health plan • File a grievance about my health plan • Get help with a recent change or denial of my healthcare services	Member Services at 877-856-5702 (TTY: 711).
Update my address	Medicaid Consumer Hotline office at 800-324-8680 to report an address change.
Find my Humana Healthy Horizons in Ohio provider directory or other general information about my plan	Humana.com/OhioDocuments

New Member Information

If you have health care services already approved or scheduled, it is important that you call Member Services immediately. In certain situations, and for a specified time period after you enroll, you may be allowed to receive care from a provider that is not a Humana Healthy Horizons in Ohio network provider. You must call Humana Healthy Horizons in Ohio before

you receive the care. If you do not call us, you may not be able to receive the care and/or the claim may not be paid. For example, you need to call Member Services if you have the following services already approved or scheduled:

- Organ, bone marrow, or hematopoietic stem cell transplant
- Third trimester prenatal (pregnancy) care, including delivery
- Inpatient/outpatient surgery
- Appointment with a primary care or specialty provider
- Chemotherapy or radiation treatments
- Treatment following discharge from the hospital in the last 30 days
- Non-routine dental or vision services (for example braces or surgery)
- Medical equipment
- Services you receive at home, including home health, therapies, and nursing

New member welcome kits

Each new member receives a new member welcome kit and postcard.

The new member kit contains:

- Basic plan benefit information and a short list of things to get you started on your way to your best health
- Information on how to get a copy of the Humana Healthy Horizons in Ohio Provider Directory
- Information about accessing this Member Handbook, which includes information about plan benefits and services
- A health assessment survey, called a Health Risk Assessment (or HRA for short)
- Other preventive health education materials and information

We also send each new member a member ID card. We send the ID card separately from the new member kit.

Identification (ID) Cards

You should have received a Humana Healthy Horizons in Ohio member ID card. This one card is for all members of your family who have joined Humana Healthy Horizons in Ohio. This card is good for as long as you are a member of Humana Healthy Horizons in Ohio.

Your Humana Healthy Horizons in Ohio ID Card will replace your monthly Medicaid card. Your ID Card will be issued at the start of your plan. You can call and request a new ID Card at any point if you lose or misplace it.

If you are pregnant, you need to let Humana Healthy Horizons in Ohio know. You must also call when your baby is born so we can send you a new ID card for your baby OR a new ID card that includes your baby.

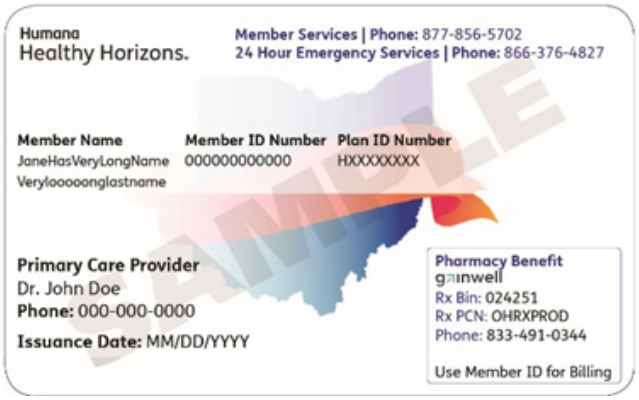
Call your Humana Healthy Horizons in Ohio Member Services as soon as possible at 877-856-5702 (TTY: 711) if:

- you have not received your card(s) yet
- any of the information on the card(s) is wrong
- you lose your card(s)
- you have a baby

Always Keep Your ID Card(s) With You

You will need your ID card each time you get medical services. This means that you need your Humana Healthy Horizons in Ohio ID card when you:

- see your primary care provider (PCP)
- see a specialist or other provider
- go to an emergency room
- go to an urgent care facility
- go to a hospital for any reason
- get medical supplies
- get a prescription
- have medical tests
- schedule transportation



Definitions

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Actuary means an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this part, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

Appeal means a member's request for the OhioRISE Plan to review an adverse benefit determination

Capitation payment means a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the beneficiary receives services during the period covered by the payment.

Choice counseling means the provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among managed care plans and primary care providers. Choice counseling does not include making recommendations for or against enrollment into a specific MCO, PIHP, or PAHP.

Comprehensive risk contract means a risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

(1) Outpatient hospital services.

(2) Rural health clinic services.

(3) Federally Qualified Health Center (FQHC) services.

(4) Other laboratory and X-ray services.

(5) Nursing facility (NF) services.

(6) Early and periodic screening, diagnostic, and treatment (EPSDT) services.

(7) Family planning services.

(8) Physician services.

(9) Home health services.

Co-Payment means a fixed amount a member pays for a covered healthcare service.

Durable Medical Equipment means equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury and is appropriate for use in the home.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Medical Transportation means transportation, by ambulance, of sick, injured or otherwise incapacitated persons who require emergency medical care.

Emergency Room Care means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care treatment or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

Excluded Services means health services that the OhioRISE plan does not pay for or cover.

Emergency services means covered inpatient services, outpatient services, or medical transportation services that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition. As used in this chapter, providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with an MCO.

Enrollee means a Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in each managed care program.

Enrollee encounter data means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a MCO, PIHP, or PAHP that is subject to the requirements of §§ 438.242 and 438.818.

Federally qualified HMO means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Grievance means a member's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness

of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by an MCE to make an authorization decision

Habilitation Services and Devices means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Health Insurance means a contract that requires your OhioRISE Plan to pay some or all of your healthcare costs in exchange for a premium.

Health insuring organization (HIO) means a county operated entity, that in exchange for capitation payments, covers services for beneficiaries -

(1) Through payments to, or arrangements with, providers.

(2) Under a comprehensive risk contract with the State; and

(3) Meets the following criteria -

(i) First became operational prior to January 1, 1986; or

(ii) Is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990 and section 205 of the Medicare Improvements for Patients and Providers Act of 2008).

Home Healthcare means services that include home health nursing, home health aide services and skilled therapies.

Hospice Services means a public agency, a private organization, or a subdivision of either, subject to the conditions of participation pursuant to 42 C.F.R. Part 418 (October 1, 2017), that is licensed in the state of Ohio and approved by the ODM to engaged in providing care to terminally ill individuals. (5160-56-01(V)).

Hospitalization means care in a hospital that requires admission as an inpatient.

Hospital Outpatient Care means diagnostic, therapeutic, rehabilitative, or palliative treatment or services furnished by or under the direction of a practitioner of physician services which are furnished to a patient by a hospital.

Long-term services and supports (LTSS) means services and support provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is -

(1) A Federally qualified HMO that meets the advance directives requirements of; or

(2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:

(i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

(ii) Meets the solvency standards of § 438.116.

Managed care program means a managed care delivery system operated by a State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act.

Material adjustment means an adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.

Medically Necessary means criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.

Network means the OhioRISE plan's contracted providers available to the OhioRISE Plans's members.

Non-Participating Provider means any provider with an ODM provider agreement who does not contract with an OhioRISE plan but delivers healthcare services to an OhioRISE plan's members.

Non-risk contract means a contract between the State and a PIHP or PAHP under which the contractor -

(1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in § 447.362 of this chapter; and

(2) May be reimbursed by the State at the end of the contract period based on the incurred costs, subject to the specified limits.

Overpayment means any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a State to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act.

Participating Provider means any provider, group of providers, or entity that has a network provider contract with the OhioRISE plan in accordance with rule 5160-26-05 of the Administrative Code and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the OhioRISE Plan's provider agreement or contract with ODM.

Physician Services (L) "Practitioner of physician services": are physicians, podiatrists, dentists, clinical nurse specialists, certified nurse-midwives, certified nurse practitioners or physician assistants. (5160-2-02(L)).

Plan (S) "Managed care organization (MCO)" or "managed care plan (MCP)" means a health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM. (5160-26-01(S)).

Post-stabilization care services mean covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 C.F.R. 422.113 (October 1, 2019) to improve or resolve the member's condition.

Potential enrollee means a Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in each MCO, PIHP, PAHP, PCCM or PCCM entity, but is not yet an enrollee of a specific MCO, PIHP, PAHP, PCCM, or PCCM entity.

Preauthorization *(also known as Prior Authorization)* sometimes participating providers contact us about the care they want you to get. This is done before you get the care to make sure it is the best care for your needs. They also make sure that it will be covered. It is needed for some services that are not routine, such as home health care or some scheduled surgeries.

Premium means the monthly payment amount per member to which the MCO is entitled as compensation for performing its obligations in accordance with Chapter 5160-26 of the Administrative Code and/or the provider agreement with ODM. (516026-01(NN))

Prepaid ambulatory health plan (PAHP) means an entity that -

(1) Provides services to enrollees under contract with the State, and based on capitation payments, or other payment arrangements that do not use State plan payment rates.

(2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and

(3) Does not have a comprehensive risk contract.

Prepaid inpatient health plan (PIHP) means an entity that -

(1) Provides services to enrollees under contract with the State, and based on capitation payments, or other payment arrangements that do not use State plan payment rates.

(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and

(3) Does not have a comprehensive risk contract.

Prescription Drug Coverage means drugs covered by the Single Pharmacy Benefit Manager (SPBM) that are dispensed to members for the use in a patient's resident, including a nursing facility or intermediate care facility for individuals with intellectual disabilities.

Prescription Drugs means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law; dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

Primary care means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary care case management means a system under which:

(1) A primary care case manager (PCCM) contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries; or

(2) A PCCM entity contracts with the State to provide a defined set of functions.

Primary care case management entity (PCCM entity) means an organization that provides any of the following functions, in addition to primary care case management services, for the State:

(1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.

(2) Development of enrollee care plans.

(3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.

(4) Provision of payments to FFS providers on behalf of the State.

(5) Provision of enrollee outreach and education activities.

(6) Operation of a customer service call center.

(7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.

(8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.

(9) Coordination with behavioral health systems/providers.

(10) Coordination with long-term services and supports systems/providers.

Primary care case manager (PCCM) means a physician, a physician group practice or, at State option, any of the following:

(1) A physician assistant.

(2) A nurse practitioner.

(3) A certified nurse-midwife.

Provider means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.

Rate cell means a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the contract.

Rating period means a period of 12 months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by § 438.7(a).

Referrals when your PCP sends you to another healthcare provider.

Rehabilitation Services and Devices means specific tasks that must, in accordance with Title 47 of the Ohio Revised Code, be provided directly by a licensed or other appropriately certified technical or professional healthcare personnel.

Risk contract means a contract between the State an MCO, PIHP or PAHP under which the contractor -

(1) Assumes risk for the cost of the services covered under the contract; and

(2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Skilled Nursing Care means a specific task that must, in accordance with Chapter 4723. of the Ohio Revised Code, be provided by a licensed practical nurse (LPN) at the direction of a registered nurse or by a registered nurse directly.

Specialist means a physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

State means the Single State agency.

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

Subcontractor means an individual or entity that has a contract with an MCO, PIHP, PAHP,

or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP.

How to Use This Handbook

This handbook:

- Includes information you should know as a Humana Healthy Horizons in Ohio member
- Is your guide to the health and wellness services you may be eligible to get
- Tells you the steps to take to make the Plan work for you

The first few pages will tell you what you need to know right away. Use it for reference or check it out a bit at a time.

If you have a question:

- Check this handbook
- Go to Humana.com/HealthyOhio
- Ask your PCP, if the question is about health and wellness
- Call Member Services at 877-856-5702 (TTY: 711), Monday – Friday, from 7 a.m. – 8 p.m., Eastern time

How Managed Care Works

The Plan, Our Providers and You

- Many people get their health benefits through managed care, which works like a central home for your health. Managed care helps coordinate and manage all your healthcare needs.
- Humana Healthy Horizons in Ohio has a contract with the Ohio Department of Medicaid (ODM) to meet the healthcare needs of people with Ohio. In turn, Humana Healthy Horizons in Ohio partners with a group of healthcare providers to help us meet your needs. These providers (e.g., doctors, therapists, specialists, hospitals, home care providers, and other healthcare facilities) make up our provider network.
- The Humana Healthy Horizons in Ohio network of providers is there to support you. Most of the time, the provider you see most for your healthcare is your PCP. Your PCP can help if you need to schedule a test, see a specialist, or go into the hospital.

- 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. Even though your PCP is your main source for healthcare, in some cases, you can go to other doctors for some services without checking with your PCP.
- Building a good relationship with your PCP as soon as you can is important. Your assigned or chosen PCP will want to get to know you and understand your healthcare needs. During the first few days of your enrollment in Humana Healthy Horizons in Ohio:
    - Call your PCP's office to schedule a visit
    - Take your medical records to your first visit or ask your previous doctor to send your records to your new doctor before your appointment

Provider Directory

The Provider Directory lists all our network providers you can use to receive services.

You can ask for a printed Provider Directory by calling Member Services or by returning the postcard you received with your new member materials which includes your member identification (ID) card. You can also visit our website at humana.com/ohioproviderdirectories to view up to date provider network information or call Member Services at 877-856-5702 (TTY: 711) Monday – Friday from 7am-8pm EST for help.

Physician Finder (Find a doctor)

Our online Find a doctor service has information about care options in your area, including:

- In-network providers
- Other healthcare facilities
- Pharmacies
- Retail clinics
- Specialists
- Urgent care centers

You can access our online Find a doctor service at Humana.com/FindADoctor.

Telehealth

Telehealth is the direct delivery of health care using audio and/or video. Instead of coming into the office for your appointment, you stay at your home or office and use your smartphone, tablet or computer to see and talk to your medical and behavioral health professionals. There is no cost to use telehealth and telehealth removes the stress of needing transportation services.

You can see medical and behavioral health professionals via telehealth for many illnesses

and injuries, common health conditions, follow-up appointments and screenings as well as for prescribing medication(s).

Check with your providers to see if they offer telehealth.

Member Services

In case of a medical emergency, call 911. For most non-emergency concerns or questions, we can help.

Our Member Services team is here for you Monday – Friday, from 7 a.m. – 8 p.m., Eastern time, and can:

- Answer questions about benefits, referrals, and services
- Request a new member ID card be sent to you in the mail
- Tell you if a service your doctor wants you to have needs preauthorization
- Update your records, if you want to see a different PCP than the PCP you were assigned

If you are or become pregnant, your child will become part of Humana Healthy Horizons in Ohio on the day your child is born. Our Member Services team and/or your local Ohio State Department of Health can help you find a doctor to take care of you and your baby before your baby is born.

You can reach Member Services at 877-856-5702 (TTY: 711). For faster service, please have your member ID number available. Your member ID number is on your member ID card.

If English is not your first language (or if you are reading this for someone who doesn't read English), we can help. We have a group of people who can share information about your health coverage and benefits in your preferred language.

If you use a wheelchair or have trouble hearing or understanding, and/or if you are reading this for someone who is blind, deafblind, or has difficulty seeing, we can help. We can tell you if a doctor's office is wheelchair accessible or is equipped with special communications devices.

Also, we have services like:

- TTY Machine – Our TTY phone number is 711
- Information in large print
- Help you make or arrange transportation to healthcare appointments
- Names and addresses of providers who specialize in treating people with your condition(s)

We make answers to frequently asked questions available at Humana.com/HealthyOhio. There you can find information about:

- Benefits or eligibility

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

Let Us Know If Your Information Changes

We want to make sure we are always able to connect with you about your care. We don't want to lose you as a member, so it is important to let us know if information from your application changes. You must report any changes to the Ohio Department of Medicaid (ODM). Failure to report changes may result in loss of medical benefits. Examples of changes you must report include:

- Change of physical/mailing address or change in contact information
- Household income changes (e.g., increase or decrease in work hours, increase in pay rate, change in self-employment, beginning a new job, leaving a job, etc.)
- Household size or relationship changes (e.g., someone moves into or out of your household, marries or divorces, becomes pregnant, has a child, etc.)
- You or other members qualifying for other health coverage (e.g., health insurance from an employer, Medicare, Tricare, etc.)
- Changes in immigration status
- Being in jail or prison
- You start or stop filing a federal income tax return
- Changes to your federal income tax return (e.g., a change in dependents or a change to the adjustments to taxable income on page one of the income tax form)

Contact Member Services for any of the above at 877-856-5702 (TTY: 711).

Loss of Insurance Notice

Anytime you lose health insurance, you should receive a notice, known as a certificate of creditable coverage, from your old insurance company. This notice says you no longer have insurance. Keep a copy of this notice for your records because you might be asked to provide a copy.

Other Health Insurance (Coordination of Benefits - COB)

If you or anyone in your family has health insurance with another company, it is very

important that you call Member Services and your county caseworker about the insurance. For example, if you work and have health insurance or if your children have health insurance through their other parent, you need to call Member Services. It is also important to tell Member Services and your county caseworker if you have lost health insurance that you previously reported. Not giving us this information can cause problems with getting care and with payment of medical bills.

Automatic Renewal of MCO Membership

If you lose your Medicaid eligibility but it is started again within 90 days, you will automatically become a Humana Healthy Horizons in Ohio member again.

Interpreter Services

Is there a Humana Healthy Horizons in Ohio member in your family who:

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

If so, we can help. Humana Healthy Horizons in Ohio offers sign and language interpreters (e.g., in-person, video remote interpretation, or over the phone) at no cost at all Humana touchpoints. Oral interpretation is available in more than 200 languages.

If you require assistance with speaking with us or a healthcare provider, we can help you. Please contact Member Services. Interpreter services are available at all Humana touchpoints, and you can use these services to assist with grievances and/or appeals. See grievance and appeal sections within the handbook for more information about grievances and appeals.

Printed materials are available in English and Spanish. Materials can be read over the phone in more than 200 languages and are available in alternative formats in print (braille, large print, accessible PDF, and Daisy) and audio at no cost to you. Just call us at 877-856-5702 (TTY: 711) or the Concierge Service for Accessibility at 877-320-2233 to request alternative formats or interpreter services (in-person, video remote interpretation, or over the phone).

Auxiliary Aids and Services

If you have a hearing, vision, or speech disability, you have the right to receive information about your health plan, care, and services in a format that you can understand and access. We provide free aids and services to help people communicate effectively with us, like:

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

These services are available to members with disabilities for free. To ask for aids or services,

call Member Services at 877-856-5702 (TTY: 711), Monday – Friday, from 7 a.m. – 8 p.m., Eastern time.

Humana Healthy Horizons in Ohio complies with federal civil rights laws and does not leave out or treat people differently because of race, color, national origin, age, disability, religion or sex. If you believe that Humana Healthy Horizons in Ohio failed to provide these services, you can file a grievance.

Important Phone Numbers

Member Services (this includes prescriber and provider as well)	877-856-5702 (TTY: 711)
24-Hour Medical Advice Line	866-376-4827
Behavioral Health Crisis Line	800-720-9616 (TTY: 711) open 24/7
Case Management	877-856-5702 (TTY: 711)
Concierge Services for Accessibility	877-320-2233
Dental	877-856-5702 (TTY: 711)
Ohio Department of Health and Human Services	888-549-0820 (TTY: 888-842-3620)
Disease Management	877-856-5702 (TTY: 711)
Vision	877-856-5702 (TTY: 711)
To report Fraud, Waste and/or Abuse	800-372-2970
To request a Medicaid State Fair Hearing	800-635-2570
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	877-597-2331
To get information about domestic violence	800-799-7233 TTY: 800-787-3224
Transportation	Access2Care 855-739-5986 (TTY 866-288-3133)

Part I: First Things You Should Know

Choosing a Primary Care Provider (PCP)

You must choose a primary care provider (PCP) from Humana Healthy Horizons in Ohio provider directory. Your PCP is an individual provider or provider group practice trained in family medicine (general practice), internal medicine, or pediatrics.

Your PCP will work with you to direct your health care. Your PCP will do your check-ups, shots and treat you for most of your routine health care needs. If needed, your PCP will send you to providers, specialists or admit you to the hospital.

You can reach your PCP by calling the PCP's office. Your PCP's name and telephone number are printed on your Humana Healthy Horizons in Ohio ID card.

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

Changing your PCP

You can change your PCP at any time. If you change your PCP, it will go into effect the first of the following month from date change.

Ways you can change your PCP:

- 24/7 through your MyHumana account
- By calling Member Services at 877-856-5702 (TTY: 711)

Humana Healthy Horizons in Ohio will send you an updated ID card to let you know that your PCP has been changed and the date you can start seeing the new PCP.

For the names of the PCPs in Humana Health Horizons in Ohio, you may look in your provider directory if you requested a printed copy, on our website at humana.com/ohioproviderdirectories, or you can call the Humana Healthy Horizons in Ohio Member Services at 877-856-5702 (TTY: 711) for help. You can also visit our online Find a doctor service at Humana.com/FindADoctor to see doctors in your area who offer PCP services and who may be right for you.

We will:

- Update your records to reflect this new PCP
- Send you a new member ID card that has your new PCP's information

You can see this new PCP as of the day you notify us of the change and we update your records, which we usually can do during the same phone call.

We may contact you if we see that you get PCP services from a PCP that is not listed on your member ID card. Humana wants to ensure that you get PCP services from the PCP we have in your records.

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

Humana Healthy Horizons in Ohio may notify you to change your PCP if your provider says that he or she no longer can be your doctor.

Special Cases

- If you receive Medicare and Medicaid (dual-eligible) meaning you have Medicare coverage (through Humana or another health plan) and coverage through Humana Healthy Horizons in Ohio, you do not have to choose a Humana PCP.
- If you are deemed presumptively eligible, you do not have to choose a PCP. Please note: We will assign presumptively eligible members a PCP, but these members are not required to see the PCP we assign.

When You Don't Pick a PCP

All members are assigned a PCP at the time of their enrollment. If you don't want to pick

a different PCP, do nothing. You can see the PCP we assigned you. You can find your PCP's name and contact information on your member ID card. You can see your PCP starting on the first day you are enrolled with Humana Healthy Horizons in Ohio.

Getting Regular Healthcare

We know you can get sick or hurt without warning. See your PCP for preventive care. This means making regular visits to your doctor even if you do not feel sick. Regular checkups, tests, and health screenings can help your doctor find and treat problems early before they become serious.

For most issues, your PCP:

- Can give you advice about your health and health goals
- Can give you the care you need (e.g., exams, regular checkups, vaccines or other treatments to keep you well)
- Can direct you to the hospital or a specialist when needed
- Can see you when you're well and when you're sick
- May be able to offer you a virtual care (telehealth) visit

Examples of preventive care include:

- Diabetes screenings
- Immunizations
- Obesity screening
- Routine physicals for children, adolescents, and young adults, from birth to age 21

See your PCP if you need care for:

Backache	Pain management
Cold/flu	Persistent cough
Constipation	Possible pregnancy
Dizziness	Rash
Earache	Restlessness
Headache	Sore throat
High/low blood pressure	Swelling of the legs and feet
High/low blood sugar	Taking out stitches
Joint pain	Vaginal discharge
Loss of appetite	

You should visit your PCP within 90 days of joining Humana Healthy Horizons in Ohio. When you visit your doctor:

- Always take your Humana Healthy Horizons in Ohio member ID card, and a photo ID
- Talk to your doctor about any healthcare concerns you have

- Talk to your doctor about the medicine you take
- Prepare in advance any questions you have for your doctor

You and your PCP will work together to make sure you stay well and get the care you need.

Remember, your PCP knows you and how your health plan works.

Your PCP will take care of most of your healthcare needs, but you must have an appointment to see your PCP. If you cannot keep an appointment, call to let your PCP know.

It is important 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 may have to wait to be seen.

APPOINTMENT GUIDE	
IF YOU CALL FOR THIS TYPE OF SERVICE:	**YOUR APPOINTMENT SHOULD TAKE PLACE:**
Adult preventive care (services like routine health check-ups or immunizations)	Within 30 days
Urgent care services (care for problems like sprains, flu symptoms, or minor cuts and wounds)	Within 48 hours
Emergency or urgent care requested after normal business office hours	Immediately (available 24 hours a day, 7 days a week, 365 days a year) at an urgent care clinic (for urgent care) or emergency room (for emergency care)
Mental Health	
Routine services	Within 10 business days
Urgent care services	Within 48 hours
Emergency services (services to treat a life-threatening condition)	Immediately (available 24 hours a day, 7 days a week, 365 days a year)
Mobile crisis management services	Within 30 minutes
Substance Use Disorders	
Routine services	Within 4-12 weeks
Urgent care services	Within 48 hours
Emergency services (services to treat a life-threatening condition)	Immediately (available 24 hours a day, 7 days a week, 365 days a year)

If you have trouble getting the care you need within the time limits described above, call Member Services 877-856-5702 (TTY: 711). If you make an appointment but feel you need to see the doctor even sooner, call your PCP's office to see if you can get an earlier appointment. You may be asked to explain what you want to talk to your doctor about.

It is important to keep your scheduled visits with providers. Sometimes things happen that prevent you from keeping your appointment. If you must change or cancel your appointment, please call the provider's office at least 24 hours before your appointment or as soon as you can. It is always best to let your provider's office know if you can't be there.

If you call your PCP's office and are prompted to leave a message, be sure to leave your

name and any other information you are prompted to leave (e.g., callback number, birthdate, etc.). Someone from your PCP's office will call you back as soon as possible.

Referrals are Not Required

Your PCP is your medical home and should coordinate your care. However, you may see any provider in our network, including specialists and inpatient hospitals. As a Humana Healthy Horizons in Ohio member, you do not need a referral from your PCP to see a specialist or women's routine and preventative health care services provided by a women's health specialist in our network – if you have not reached the benefit limit for the service.

If you see a doctor who is not your PCP, and your PCP did not tell you to see the other doctor, tell your PCP about the doctor visit.

You may go to out-of-network providers, without an authorization, for:

- Emergency care
- Family-planning services provided at qualified family-planning providers (e.g., Planned Parenthood)

All other out-of-network providers are required to have preauthorization from Humana Healthy Horizons in Ohio. For Humana Healthy Horizons in Ohio to pay for an out-of-network provider, we must approve the preauthorization request.

Out-of-Network

It is important to remember that you must receive services covered by Humana Healthy Horizons in Ohio from facilities and providers in Humana Healthy Horizons in Ohio's network. Providers in the Humana Healthy Horizons in Ohio's network agree to work with your health plan to give you needed care.

The only time you can use providers that are not in Humana Healthy Horizons in Ohio's network is for:

- emergency services,
- federally qualified health centers (FQHC)/rural health clinics (RHC),
- certified nurse midwives or certified nurse practitioners,
- qualified family planning providers,
- an out of network provider that Humana Healthy Horizons in Ohio has approved you to see

Member Emergencies

Emergency Services

Emergency services are for a medical problem that must be treated right away by a provider. We cover care for emergencies both in and out of the county where you live. Some examples of when emergency services are needed include miscarriage/pregnancy with

vaginal bleeding, rape, broken bones, drug overdose, severe chest pain, severe vomiting, shortness of breath or uncontrolled bleeding. You do not have to contact Humana Healthy Horizons in Ohio before you get emergency services. If you have an emergency, call 911 or go to the NEAREST emergency room (ER) or other appropriate care setting. You do not need prior authorization for emergency services. You have the right to use any hospital of your choosing for emergency services.

If you are not sure if you need to go to the ER, call your primary care provider (PCP). Your PCP or the Medical Advice line at 866-376-4827 (TTY:711) can talk to you about your medical problem and give you advice on what you should do.

Remember, if you need emergency services:

- Go to the nearest hospital emergency room or other appropriate setting. Tell them that you are a member of Humana Healthy Horizons in Ohio and show them your Humana Healthy Horizons in Ohio member ID card.
- If the provider treats your emergency, thinks you need other medical care to treat the problem that caused your emergency, the provider must call Humana Healthy Horizons in Ohio.
- Make sure you call your PCP or Member Services to let them know you went to the Emergency Room so they can help you coordinate any follow-up services.
- If the hospital has you stay, make sure that Humana Healthy Horizons in Ohio is called within 24 hours.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient services, outpatient services, or medical transportation services that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition. As used in this chapter, providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with an MCO.

Post-Stabilization Care

Post-stabilization care services mean covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 C.F.R. 422.113 (October 1, 2019) to improve or resolve the member's condition.

Post-stabilization care is care you get after you receive emergency medical services and is available 24/7. This care helps to improve or clear up your health issue or stop it from getting worse. It does not matter whether you get the emergency care in or out of our network. We will cover services medically necessary after an emergency. You should get care until your

condition is stable.

Urgent Care

You may have an injury or an illness that is not an emergency but still needs prompt care and attention. Urgent care centers are:

- Convenient – Most open early, close late, and have weekend hours
- Quick – No appointment needed
- Staffed by trained professionals – Get treatment for a range of issues, including urgent flu-like symptoms, moderate stomach pain, small cuts, minor injuries, ongoing diarrhea, a child with an earache who wakes up in the middle of the night and won't stop crying, and wheezing

You can walk into an urgent care clinic to get care the same day or make an appointment for the next day. Whether at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call Member Services. Tell the person who answers what is happening. She or he will tell you what you can do.

Accidental Injury or Illness (Subrogation)

If you must see a doctor for an injury or illness that was caused by another person or business, you must call Member Services to let us know. For example, if you are hurt in a car wreck, by a dog bite, or if you fall and are hurt in a store, another insurance company may have to pay for the care or services you received. When you call us give the name of the person at fault, their insurance company and the name(s) of any attorney(s) involved.

All Other Services

If you are unable to locate and in-network provider, an out-of-network provider of your choice can submit and out-of-network authorization to Humana Healthy Horizons in Ohio for review.

Second Opinions

You have the right to a second opinion about your treatment, including surgical procedures and treatment of complex or chronic conditions. A second opinion means talking to a different doctor about an issue to get his or her point of view. This may help you decide if certain services or treatments are right for you. Let your PCP know if you want to get a second opinion.

You may choose any doctor in or out of our network to give you a second opinion at no cost. If you cannot find a doctor in our network, we will help you find a doctor. If you need to see a doctor that is not in the Humana Healthy Horizons in Ohio network for a second opinion, the treating provider can submit preauthorization for review.

Any tests for a second opinion should be given by a doctor in our network. Tests requested by the doctor giving you the second opinion must have the prior approval of Humana Healthy Horizons in Ohio. Your PCP will look at the second opinion and help you decide the best treatment.

Care Outside of Ohio

In some cases, we may pay for healthcare services you get from a provider located along the Ohio border or in another state. Humana Healthy Horizons in Ohio and your PCP can give you more information about which providers and services are covered outside of Ohio, and how you can access them if needed.

- If you need medically necessary emergency care while traveling anywhere within the United States, we will pay for your care.
- We will not pay for care received outside of the United States.

If you have any questions about getting care outside of Ohio or the United States, talk with your PCP or call Member Services at 877-856-5702 (TTY: 711).

Part II: Your Benefits: What Is Covered for Humana Healthy Horizons in Ohio Members

Services Covered by Humana Healthy Horizons in Ohio

As a Humana Healthy Horizons in Ohio member, you will receive all medically necessary Medicaid-covered services at no cost to you. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition. Talk with your PCP or call Member Services if you have any questions or need help with any health services.

Humana Healthy Horizons in Ohio provides covered services through a provider agreement with Ohio Department of Medicaid (ODM). If you have questions, contact Ohio Department of Medicaid (ODM) at 800-324-8680 (TTY: 800-292-3572) or member services at 877-856-5702.

All medically necessary health care services must be obtained through Humana Healthy Horizons in Ohio provider network except for emergency care. See Emergency Services section for more information.

- Acupuncture – to treat certain conditions
- Allergy services
- Ambulance and wheelchair van transportation
- Behavioral Health Services (including mental health and substance use disorder treatment)
- Certified nurse midwife services
- Certified nurse practitioner services
- Chemotherapy services
- Chiropractic (back) services

- Dental services
- Developmental therapy services for children aged birth to six years
- Diagnostic services (x-ray, lab)
- Durable Medical Equipment **(breast pump, breast milk storage bags, walking aid, blood pressure)**
- Emergency services
- Family planning services and supplies
- Free-standing birth center services at a free-standing birth center plans should include in the explanation that members should call to see if there are any qualified centers in Ohio or name the specific center(s)
- Federally Qualified Health Center (FQHC) or Rural Health Clinic services (RHC)
- Gynecological Services (OBGYN)
- Home health services
- Hospice care
- Inpatient hospital services
- Medical nutrition therapy (MNT) services
- Nursing facility services (We will cover your stay in a nursing facility as long as you haven't been moved to fee-for-service Medicaid under the Ohio Department of Medicaid. If you need nursing services, please call member services for information on available providers.)
- Maternity care - prenatal and postpartum including at risk pregnancy services
- Outpatient hospital services
- Pharmacist services (under the medical benefit)
- Physician services
- Physical and occupational therapy
- Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source
- Podiatry (foot) services
- Prescription drugs, including certain prescribed over-the-counter drugs
- Preventative mammogram breast cancer and cervical cancer screenings
- Primary care provider services
- Renal dialysis (kidney disease) services

- Respite services (for members under age 21 that have long-term care or behavioral health needs)
- Screening and counseling for obesity
- Services for children with medical handicaps (Title V)
- Shots (immunizations)
- Specialist services (Plans may add)
- Speech and hearing services, including hearing aids
- Telehealth services (Some examples of services available through telehealth are new or established patient doctor visits, mental health and substance use disorder services, medical nutrition services, and tobacco cessation counseling. For more information, please contact Member Services.)
- Tobacco cessation services, including tobacco cessation counseling and FDA approved medications for tobacco cessation. (Please call 1-800-QUIT-NOW for more information or to enroll.)
- Vision (optical) services, including eyeglasses
- Well-child (Healthchek) exams for children under the age of 21
- Yearly well-adult exams

Transportation

If you must travel 30 miles or more from your home to receive covered health care services, Humana Healthy Horizons in Ohio will provide transportation to and from the provider's office. Please call 855-739-5986 (TTY 866-288-3133) for help.

In addition to the transportation assistance that Humana Healthy Horizons in Ohio provides, you can get transportation for certain services through the local county department of job and family services Non-Emergency Transportation (NET) program. Call your county department of job and family services for questions or assistance with NET services.

Members can obtain transportation to Medicaid covered services through Humana Healthy Horizons' Non-Emergent Medical Transportation vendor by calling 855-739-5986. Routine appointments should be called in a minimum of 48 business hours (2 full business days). Reservations are accepted Monday through Friday 7:00 am to 8:00 pm EST.

Members under 21 may have additional transportation options, please reach out to Member Services at 877-856-5702 (TTY: 711), Monday – Friday, from 7 a.m. – 8 p.m., Eastern time.

Prescription Drugs

MCO members will use Gainwell to process prescription claims and will need to refer to the Gainwell member handbook for assistance SPBM Member Handbook.pdf (ohio.gov).

Coordinated Services Program (CSP)

You may see different prescribers for different medical care needs. Each prescriber may

prescribe different medications and using one pharmacy can help ensure you are getting the best possible care.

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

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

- Phone: 855-330-8054, 8 a.m. – 5:30 p.m., Eastern time. After hours, please leave a voicemail with the member's name, Humana member ID number, case number, contact phone number, and a detailed description of your request.
- Fax: 502-996-8184
- Email: CPORM@humana.com

Services Not Covered By Humana Healthy Horizons in Ohio

Humana Healthy Horizons in Ohio will not pay for services or supplies received that are not covered by Medicaid:

- All services or supplies that are not medically necessary
- Paternity testing
- Services to find cause of death (autopsy) or services related to forensic studies

Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual.

If you have a question about whether a service is covered, please call Member Services at 877-856-5702 (TTY: 711), Monday – Friday, from 7 a.m. – 8 p.m., Eastern time.

Services not covered by Humana Healthy Horizons in Ohio unless medically necessary

Humana Healthy Horizons in Ohio regulations and conduct a medical necessity review if needed.

Humana Healthy Horizons in Ohio will not pay for the following services that are not covered by Medicaid **unless determined medically necessary:**

- Abortions except in the case of a reported rape, incest or save the life of the mother
- Biofeedback services
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid and not in accordance with customary standards of practice
- Infertility services for males or females, including reversal of voluntary sterilizations
- Inpatient treatment to stop using drugs and/or alcohol (in-patient detoxification

services in a general hospital are covered)

- Plastic or cosmetic surgery
- Services for the treatment of obesity
- Services determined by Medicare or another third-party payer
- Sexual or marriage counseling
- Voluntary sterilization if under 21 years of age or cannot legally consent to the procedure

Frequency Limitations

Your managed care organization will review all requests for services from your provider. If you have a question about whether a service is covered, please call Member Services at 877-856-5702 (TTY: 711), Monday – Friday, from 7 a.m. – 8 p.m., Eastern time.

Co-Pays

Copayments (co-pays) are not required for any covered service.

Care Management Services

Humana Healthy Horizons in Ohio offers care management services.

Children and adults can benefit from care management. We offer care management services to all members who can benefit from this service regardless of age and based on your individual needs. Members can self-refer, too. We have registered nurses, social workers, and other outreach workers who can work with you one-on-one to help coordinate your health care. 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 Management 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 PCP, Urgent Care, or ER

We will work with a variety of partners including your doctors, and other supports in the community to make sure you have everything you need to improve your health and wellbeing. We will ask about your specific current health and past health as well as your environment to develop a plan we can follow to keep you on a healthy journey.

If you have any questions or need help, call member services at 877-856-5702 (TTY: 771).

There are several Care Management programs available including:

Complex Care Management

Humana Healthy Horizons in Ohio members may be eligible to get Complex Care Management services if they experience multiple hospitalizations or have complex medical needs that require frequent and ongoing assistance. Complex Care Management provides support to members with complex clinical, behavioral, functional, and/or social needs, who have the highest risk factors, such as multiple conditions, or who take multiple medications, served within multiple systems, and often have the highest costs. A team of healthcare providers, nurses, social workers, and community service partners are available to make sure your needs are met, and efforts are made to improve and optimize your overall health and well-being. The Complex care management program is voluntary. To get additional information about our Complex Care Management Program, self-refer into any of our Care Management Programs, or opt out of any of our Care Management Programs, contact our Member Services team at 877-856-5702 (TTY: 711).

HumanaBeginnings Program

Our HumanaBeginnings program helps our pregnant members during and after pregnancy. We tailor this program to each of our pregnant members, to make sure they get the care they need, like extra support from a nurse, pregnancy and family-planning resources, and connects members with additional plan benefits such as gift cards. Call member services at 877-856-5702 (TTY: 711) to learn more and to enroll into HumanaBeginnings program.

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 drugs your doctor gives you
- Help arrange your doctor visits
- Help set up support for when you get home
- Assist you if you transition between health insurance plans

If you or your family member needs help when you get out of the hospital, or if you need help transitioning back to your home from other places where you were treated, please let us know. You can reach member services at 877-856-5702 (TTY: 711).

Chronic Condition Management

Humana Healthy Horizons in Ohio provides members with chronic conditions care support that includes educational information, goal setting, and coordination support for doctor visits. These care services help members to address potential complications, avoid complications, and maintain their health. We can help you learn about your condition and how you can better take care of your health. We have programs for:

- Asthma
- Bipolar Disorder
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Heart Disease
- HIV/AIDS
- Hypertension
- Schizophrenia

We can:

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

To get additional information about our Care Management Program, self-refer into any of our Care Management Program, or opt out of any of our Care Management Programs, contact our Member Services team at 877-856-5702 (TTY: 711).

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 Healthy Horizons in Ohio can connect you to resources in your community to help you manage issues beyond your medical care. This includes concerns such as:

- Worry about your housing or living conditions
- Have trouble getting enough food to feed you or your family
- Find it hard to get to appointments, work, or school because of transportation issues
- Feel unsafe or are experiencing domestic violence (call 911, if you are in immediate danger)

If you need assistance with these issues contact our member services team at 877-856-5702 (TTY: 711).

Other Programs to Help You Stay Healthy

Tobacco Cessation program

If you are 12 years old or older and smoke or use other tobacco products, Humana Healthy Horizons in Ohio can help you quit. Quitting tobacco is one of the most important things you can do to improve your health and the health of your loved ones. You don't have to do it alone! We will provide you with a coach. Your coach will support you in your commitment to stop smoking.

Your coach will listen to you, help you understand your habits, and work with you to act. Your doctor also may recommend you try medicines. To reach a coach who can help you quit, call the coaching enrollment team at 800-955-0783 and press 1 for Tobacco Cessation coaching.

Weight Management program

Our weight management program offers one on one time with a coach to help you reach your goals. This is available to any Medicaid member 12 years old or older. To find out more information, call 800-955-0783 and press 2 for weight management coaching.

Refer to the Go365 for Humana Healthy Horizons™ chart for more information.

24/7 Medical Advice Line

If you are needing information or guidance regarding a health condition you can contact our 24/7 Medical Advice Line. This line will connect you with a Registered Nurse who can work with you regarding your question and provide guidance.

The 24/7 Medical Advice line number is 866-376-4827.

Our nurses can help you:

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

Behavioral Health Services

Mental health and substance use disorder treatment services are available. These services include:

- Diagnostic Evaluation and Assessment
- Psychological Testing
- Psychotherapy and Counseling

- Crisis Intervention
- Mental Health Services including Therapeutic Behavioral Service, Psychosocial Rehabilitation, Community Psychiatric Supportive Treatment, Assertive Community Treatment for Adults, and Intensive Home-Based Treatment for Children/ Adolescents
- Substance Use Disorder Treatment Services including Case Management, Peer Recovery Support, Intensive Outpatient, Partial Hospitalization, Residential Treatment, and Withdrawal Management
- Medication-Assisted Treatment for Addiction
- Opioid Treatment Program Services
- Medical Services
- Behavioral Health Nursing Services

If you need mental health and/or substance, use disorder treatment services, Humana Healthy Horizons in Ohio is dedicated to providing the individual services needed. Your PCP may refer you or you may refer yourself for mental health and/or substance abuse treatment.

When needed, our provider directory is available upon request. This directory is a list of all the doctors and providers you can use to get the services you need in your area. You can access this information on our website humana.com/ohioproviderdirectories, or by calling member services at 877-856-5702.

Behavioral Health Crisis Support

For members in need of emotional support including those experiencing a mental health or substance use crisis, the Ohio Department of Mental Health and Addiction Services offers the Ohio CareLine. Behavioral health professionals staff the CareLine 24 hours a day, 7 days a week. They offer confidential support in times of personal or family crisis when individuals may be struggling to cope with challenges in their lives. When callers need additional services, they will receive assistance and connection to local providers. Once a member is directed to the most appropriate resource, Humana will work with those providers to authorize services and ensure continuity of care for the member.

The number to contact the Ohio Care Line is 800-720-9616.

Mental health or substance use crises include:

- Those that create a danger to the member or others
- Those that render the member unable to carry out actions of daily life due to functional harm
- Those resulting in serious bodily harm that may cause death

OhioRISE

Ohio resilience through integrated systems and excellence (OhioRISE) program is a

managed care program for youth with behavioral health needs. OhioRISE aims to expand access to in-home and community-based services to ensure OhioRISE members and families have the tools they need to direct their interactions with multiple systems such as juvenile justice, child protection, developmental disabilities, mental health and addiction, education, and others. An individual who is enrolled in the OhioRISE program will also keep their managed care enrollment for the physical health benefit.

OhioRISE Eligibility:

- Enrolled in Ohio Medicaid
- Under the age of 21
- Meet a functional needs threshold for behavioral health care, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment

OhioRISE Services:

In addition to the behavioral health services already available through Medicaid, OhioRISE offers the following services:

- Care Coordination determined by the CANS assessment
- Your managed care organization will also be included in your care management.
- Intensive Home-Based Treatment (IHBT)
- Mobile Response and Stabilization Service (MRSS)
- Behavioral Health Respite
- Wraparound supports
- Psychiatric Residential Treatment Facility (PRTF): Available January 2023

For more information on OhioRISE services please contact Aetna Better Health of Ohio member services at (833) 711-0773. If you are enrolled in OhioRISE it will display on your ID Card.

Healthchek

Healthchek is Ohio's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Healthchek covers medical exams, immunizations (shots), health education, and laboratory tests for members under the age of 21. These exams make sure that children are healthy and are developing physically and mentally. Mothers should have prenatal exams and children should have exams at birth, 3-5 days of age and at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months of age. After that, children should have at least one exam per year.

Healthchek covers medical, vision, dental, hearing, nutritional, developmental, behavioral health exams, and other care to treat physical, behavioral, or other problems or conditions found by an exam. Some of the tests and treatment services may require prior authorization.

Healthchek is available at no cost to members and include:

- Preventive check-ups for newborns, infants, children, teens, and young adults under the age of 21
- Healthchek screenings:
    - Medical exams (physical and development screenings)
    - Vision exams
    - Dental exams
    - Hearing exams
    - Nutrition checks
    - Developmental exams
    - Lead testing
- Laboratory tests (age and gender appropriate exams)
- Immunizations
- Medically necessary follow-up care to treat health problems or issues found during a screening. This could include, but is not limited to:
    - visits with a primary care provider, specialist, dentist, optometrist and other Humana Healthy Horizons in Ohio providers to diagnose and treat problems or issues
    - inpatient or outpatient hospital care
    - clinic visits
    - prescription drugs
- Health education

It is very important to get preventive checkups and screenings so your providers can find any health problems early. That way your provider can treat them, or make a referral to a specialist for treatment, before the problem gets more serious. Remember: Some services may require a referral from your PCP or prior authorization by Humana Healthy Horizons in Ohio. For some EPSDT items or services, your provider may ask for prior authorization for Humana Healthy Horizons in Ohio to cover things that have limits or are not covered for members over the age of 20. Please see page 49 to see what services require a referral and/or prior authorization.

As a part of Healthchek, care management services are available to all members under the age of 21 who have special health care needs. Please see page 39 to learn more about the care management services offered by Humana Healthy Horizons in Ohio.

You can get your Healthchek services by:

- Calling your PCP and/or Dentist to make appointments for regular check-ups (make sure to ask for a Healthchek exam when calling your PCP)

- Call Member Services if you have questions or need help with:
    - Getting care
    - Finding a provider
    - Making an appointment
    - What services are covered
    - Transportation
    - Prior authorizations
    - Referrals for women, infants, children (WIC)
    - Help me grow
    - Bureau for children with medical handicaps (BCMH)
    - Headstart
    - Community services such as: food, heating assistance, etc...

COVID Testing and Vaccinations

Humana Healthy Horizons in Ohio will cover all Medicaid-covered COVID-19 testing, treatment, and vaccinations at no cost to you.

COVID testing locations can be found online at: https://coronavirus.ohio.gov/wps/portal/gov/covid-19/dashboards/other-resources/testing-ch-centers.

The Ohio Department of Health (ODH) has developed a search tool for Ohioans to use to find a vaccine provider. The directory is searchable by county and ZIP code and displays providers currently receiving shipments of COVID vaccines. You can get information and vaccination locations at https://vaccine.coronavirus.ohio.gov/ or by calling the Ohio Department of Health toll free at 833-427-5634.

Humana Healthy Horizons in Ohio can assist you in finding a testing or vaccination location in your community. They also can help with scheduling and transportation to the appointment. Contact your plan at humana.com/healthyohio or by phone at 877-856-5702 (TTY:711) or the Medical Advice Line at 866-376-4827 (TTY: 711).

The Ohio Department of Health provides regular vaccination updates on the eligibility phases at: https://coronavirus.ohio.gov/wps/portal/gov/covid-19/covid-19-vaccination-program.

Other Programs to Help You Stay Healthy

Tobacco Free program

If you smoke or use other tobacco products, the state of Ohio 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! You can enroll in the Tobacco

Cessation program and earn rewards for both enrolling in and completing the program.

To enroll in the program, call Member Services at 877-856-5702 (TTY: 711) for more information.

Added Benefits

Humana Healthy Horizons in Ohio also offers extra services and/or benefits to their members. Please see the insert included with your member handbook that explains these extra services.

Value-added Benefits	Description
Smartphone Services	1 Free smartphone through the Federal Lifeline Program, per household. Members who are under 18 will need a parent or guardian to sign up. This benefit covers per lifetime: 1 phone, 1 charger, 1 set of instructions, unlimited Talk, text and high-speed data, training for you and your caregiver at the first case manager orientation visit if you are enrolled in care management. Members must make 1 phone call or send 1 text message every month to keep benefit. Members may qualify for enhanced benefits through the Affordable Connectivity Program (ACP) that provides unlimited minutes, 10 GB hotspot and unlimited data. You can opt into this benefit by contacting SafeLink at 1-800-SAFELINK or online at www.safelink.com/en/ACP11. Benefits are subject to change by the FCC under the Lifeline program.
Childcare Assistance	Up to $50 per quarter, up to four times per year, for reimbursement for childcare expenses for caretakers who are seeking employment. Member must participate in some sort of Workforce program in order to be eligible.
Dental Services – Adult (Age 21 and older)	1 additional cleaning per year.
Employment Physical Exam (Age 18 and older)	1 employment physical per year.
GEDWorks (Age 16 and older)	GED test preparation assistance, including a bilingual advisor, access to guidance and study materials, and unlimited use of practice tests. Test preparation assistance is provided virtually to allow maximum flexibility for member. Also includes test pass guarantee to provide member multiple attempts at passing the test. Note: For those members who are 16 or 17 years of age must submit a consent form signed by either the parent, guardian or court official. Additionally, they must be officially withdrawn from school.

Value-added Benefits	Description

Member Assistance Program (MAP)	**Childcare support includes:**
	• Support to identify childcare options, including childcare centers, family day care homes, nanny agencies, babysitter search tools, back-up/on-demand childcare.
	• Special needs support information: support groups, advocates, childcare for special needs children, socialization groups, and special needs services (i.e. ABA therapy).
	Counseling and Caregiving support includes:
	• Behavioral health counseling and support for Caregivers of a Humana member (up to three sessions).
	• Authorization is required.
	Legal and financial support includes:
	• Support for do-it-yourself document preparation:
	  • Wills/living wills
	• Consultations with attorneys, mediators, CPAs and financial professionals:
	  • Under the legal/financial piece of the MAP program, members have access to free 30-minute consultations with attorneys/financial consultants, depending on the issue they are seeking support for.
	  • Members can also get support for budget preparation through this service, and if members need to retain an attorney or financial consultant, the program (and pricing) includes a 25% discount on the legal services.

Portable Crib (Pregnant Females)	Member must consent to participate in the HumanaBeginnings Care Manager program, complete the comprehensive assessment, and complete 1 additional follow up call within 56 days, or 8 weeks, of enrollment or identification of a pregnancy indicator. 1 crib, per pregnancy, per child.
Post-Discharge Meals	Up to 10 home-delivered meals following discharge from an inpatient or residential facility, limit 40 meals per year (up to 4 discharges).
Social Services Support (Age 18 and older)	Up to $500 allowance toward assistance with utility, bills, eviction diversion, etc. Once per lifetime. At the Care Management staff discretion.

Value-added Benefits	Description

Transportation
(21 and older)
	All members receive 30 one-way (15 round) trips that are less than 30 miles per calendar year (Case Manager Approval Not Required)
	• **Trips falling under this category could include:**
	  • Doctor, Dental, and Vision Appointments
	  • Grocery Store Food Banks
	  • WIC Appointments
	  • SNAP Appointments
	  • CDJFS Redetermination Appointments
	  • Social Support (support group, wellness classes)
	  • Redetermination Appointment
	  • Job Interviews and GED Classes
	  • Maternity Childbirth Classes / Baby Showers
	• **Additional transportation may be available for members enrolled in Humana case management programs:**
	  • BH/SUD: Must be actively engaged in following courses of treatment:
	  • Outpatient and residential BH services
	  • Intensive outpatient treatment (IOP)
	  • Coverage for parents to visit their child in the NICU and parents to visit their child in a residential or inpatient BH facility
	  • Postpartum: Limited to 12 weeks, for trips <30 miles
	• **Unlimited Chronic Conditions Requiring In-Person Treatment (Care Manager Not Necessary):**
	  • Dialysis
	  • Radiation Chemotherapy
	  • Diabetes Management
	  • Hospital Discharge
	  • Urgent Care
	  • Organ Transplant

Activity	Reward Details
	• Wound Care • Prenatal Care • Postpartum Trips up to 12 months to Doctors Appointment
Vision Services – Adult (Ages 21 - 64)	• 1 eye exam per year • Up to $200 allowance for 1 set of glasses (frames and lenses) or contacts, not both during the plan year • Member pays any cost over $200

Go365 for Humana Healthy Horizons

All our enrollees can participate in Go365 for Humana Healthy Horizons™, a wellness program that offers an opportunity to earn rewards for taking eligible healthy actions.

To earn rewards, you must:

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

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

Go365

Activity	Reward Details
Completion of Health Risk Assessment (HRA)	• $25 in rewards for all members who complete their health risk assessment (HRA) within 90 days of enrollment with Humana, one reward per lifetime.
Prenatal Visit, Postpartum Visit	• Up to $105 in rewards per pregnancy for pregnant females who complete a prenatal visit. Members are eligible for $15 in rewards per visit, with a 7-visit limit. • $50 in rewards for all postpartum females who complete 1 postpartum visit within 7 - 84 days after delivery once per pregnancy.
Well-Child Visits (0-15 Months)	• Up to $90 in rewards – Members ages 0-15 months who complete a well-child visit are eligible for $15 in rewards per visit, with a 6-visit limit.

Activity	Reward Details
Well-Child Visits (16-30 Months)	• Up to $30 in rewards – Members ages 16-30 months who complete a well-child visit are eligible for $15 per visit, with a 2-visit limit.
Well-Child Visits (3 to 20 years)	• $50 reward for members who complete 1 annual wellness visit.
Annual Wellness Visits (Age 21 and older)	• $25 in rewards for members who complete 1 annual wellness visit.
Annual Flu Vaccine (Age 13 and older	• $25 in rewards for members who receive an annual flu vaccine from their provider, pharmacy, or self-reporting if they received a vaccine from another source.
Breast Cancer Screening (Age 40 and older)	• $50 in rewards for female members who obtain a mammogram once per year.
Cervical Cancer Screening (Age 21 and older)	• $50 in rewards for female members who obtain a pap smear once per year.
Colorectal Cancer Screening (Age 45 and older)	• $25 in rewards for members who obtain a colorectal cancer screening as recommended by their primary care provider once per year.
Diabetic Retinal Eye Exam (Age 21 and older)	• $25 in rewards for diabetic members who complete a retinal eye exam once per year.
Diabetic Screening (Age 21 and older)	• Up to $50 in rewards for diabetic members who complete an annual screening with their PCP for HbA1c and kidney once per year. • HbA1c Screening - $25.00 • Kidney screening - $25.00
COVID-19 Vaccine (Age 12 and older)	• $25 in rewards for members who upload a picture/file of their completed COVID-19 vaccine card. • 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.

Activity	Reward Details

Tobacco Cessation Program (Age 12 and older)	• For all members Age 12 and older, up to 8 health coaching/cessation support calls within 12 months from enrollment date.
	• For members Age 18 and older, nicotine replacement therapy upon request.
	• This program will have two opportunities where members can earn rewards:
	  • $25 in rewards for members who complete 2 calls within the first 45 days of enrollment in the coaching program, 1 per year.
	  • $25 in rewards for members who complete 6 additional Wellness Coaching calls (total 8) within 12 months of the first coaching session, 1 per year.

Weight Management Program (Age 12 and older)	• Enrollment in Weight Management Program, completion of a well-being check-up and form with their primary care provider, completion of 6 total wellness coaching calls within 12 months of enrollment date or return of the PCP form and a final well-being check-up and form with their PCP.
	• This program will have two opportunities where members can earn rewards.
	  • $10 in rewards - Enrollment in the weight Management Program:
	  • Completion of Wellbeing checkup with primary care provider
	  • Submission of PCP form
	  • $20 in rewards - Completion of the program:
	  • 6 wellness coaching calls within 12 months of the first coaching session

Program Disclaimer

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

Go365 for Humana Healthy Horizons™ is available to all members who meet the requirements of the program. Rewards are not used to direct the member to select a certain provider. 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.

If You Get a Bill

If you get a bill for a treatment or service you do not think you should pay for, do not ignore it. Call Member Services at 877-856-5702 (TTY: 711) right away. We can help you understand why you may have gotten a bill. If you are not responsible for payment, we will contact the provider and help fix the problem for you.

You have the right to ask for an appeal if you think you are being asked to pay for something we should cover. An appeal allows you or your representative to make your case before an administrative law judge. See the appeals section in this handbook for more information. If you have any questions, call Member Services.

Tools for Easy Access

MyHumana Account

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

MyHumana App

- Use your Humana plan on the go with the free MyHumana mobile app. The app safely allows you to use your mobile device to:
    - Review your latest health summary including status, summary, and detailed information

- Access your member ID card instantly with a single tap
- Find a provider by specialty or location. *The MyHumana app even can use your current location to locate the closest in-network provider no matter where you are

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

May require location sharing enabled on your phone.

Note: If under 18 years old you will need to call member services to register for access.

Part III: Plan Procedures

Preauthorization

Certain covered services need preauthorization. These are services Humana Healthy Horizons in Ohio needs to approve before you get them. Your provider will ask for preauthorization from us and should schedule these services for you. Humana Healthy Horizons in Ohio will not pay for these services if they are done without prior approval. To find out if a service needs preauthorization, call Member Services at 877-856-5702 (TTY: 711).

Preauthorization 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, Diagnosis and Treatment (EPSDT) services. To learn more about EPSDT services visit our website at Humana.com/OhioKids.

What Happens After We Get Your Preauthorization Request

Humana Healthy Horizons in Ohio Utilization Management (UM) makes sure you get the right amount of care you need when you need it. This is to make sure they are appropriate and necessary. UM requests are reviewed carefully by our review team, which includes nurses, licensed behavioral health providers, and doctors. Their job is to be sure that the treatment or service you asked for or need is covered by Humana Healthy Horizons in Ohio and is medically necessary.

Any decision to deny a preauthorization request or to approve it for an amount that is less than requested is called an **adverse action**. These decisions will be made by a doctor. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for adverse actions related to medical necessity.

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 you or your doctor think that 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 in the next section of this handbook.

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

Any decisions we make with your healthcare providers about the medical necessity of your healthcare are based only on how appropriate the care setting or services are.

We do not reward providers or our own staff for denying coverage or services. We do not offer financial rewards to our staff that affect 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.

We may decide that a new treatment not currently covered by Ohio's Medicaid Plan 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:

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

You can call Member Services to learn more about any topic in this handbook, including:

- Benefits, eligibility, claims, or participating providers
- How many members leave our plan
- How we pay our providers
- How we work with other health plans, if you have other insurance
- Our structure and operation
- Results of member surveys

If you want to tell us about things you think we should change, please call Member Services at 877-856-5702 (TTY: 711).

Preauthorization and Timeframes

We will review your request for a preauthorization within the following timeframes:

Standard review: Non-Urgent Preservice/Standard Authorization(s) Review:

For non-urgent pre-service standard requests, initial requests should be submitted by providers no later than seventy-two (72) hours before service start date. Providers should request the authorizations for continued service needs no later than 14 days from the date of start of service or the current authorization expiration date.

For non-urgent preservice/standard authorization decisions, Humana Healthy Horizons in Ohio will provide notice to you and your provider as expeditiously as your health condition requires but no later than ten (10) calendar days following receipt of the request for service. If requested by you, your provider, or Humana Healthy Horizons in Ohio, standard authorization decisions may be extended up to fourteen (14) additional calendar days. Pursuant to 42 C.F.R. § 438.404, the service authorization decision may be extended up to fourteen (14) calendar days if one of the following conditions is met:

- You, your provider on behalf of you, or authorized representative requests the extension; or
- Humana Healthy Horizons in Ohio justifies (to ODM upon prior-approval request) a need for and including documentation and additional information as to how the extension is in your best interest.

If ODM approves Humana Healthy Horizons in Ohio extension request, and in accordance with 42 C.F.R. § 438.404(c)(4), Humana Healthy Horizons in Ohio will give you written notice of the reason for the decision to extend the time frame and inform you of the right to file a grievance if you disagree with that decision. Humana Healthy Horizons in Ohio will carry out its determination as expeditiously as your health condition requires and no later than the date the extension expires. (OAC 5160-26-03.1 (B)(3)(e)).

- **Inpatient Behavioral Health review:** Humana Healthy Horizons in Ohio will make concurrent review determinations when you are already inpatient, within three (3) calendar days of obtaining the appropriate medical information that may be required. These determinations shall not exceed three (3) calendar days from the date of the receipt of request.

Expedited (fast track) review:

In accordance with 42 CFR § 438.210(d)(2) & 438.404(c)(6) and in the event a provider indicates, or Humana Healthy Horizons in Ohio determines, that following the standard service authorization timeframe could seriously jeopardize your life, health, or ability to attain, or regain maximum function, Humana Healthy Horizons in Ohio will make an expedited authorization decision and provide notice as expeditiously as the your health condition requires, but no later than forty-eight (48) hours after the receipt of the request for service. (OAC 5160-26-03.1 (B)(3)(f))

If requested by you, your provider, or Humana Healthy Horizons in Ohio, urgent/expedited authorization decisions may be extended up to fourteen (14) additional calendar days. Pursuant to 42 C.F.R. § 438.404, the service authorization decision may be extended up to

fourteen (14) calendar days if one of the following conditions is met:

- You, your provider on behalf of you, or authorized representative requests the extension; or
- Humana Healthy Horizons in Ohio justifies (to ODM upon prior-approval request) a need for and including documentation and additional information as to how the extension is in your best interest.

Humana Healthy Horizons in Ohio will not request an extension for lack of clinical information without making a minimum of one (1) attempt to obtain the information necessary for the medical necessity determination.

If ODM approves Humana Healthy Horizons in Ohio extension request, and in accordance with 42 C.F.R. § 438.404(c)(4), Humana Healthy Horizons in Ohio will give you written notice of the reason for the decision to extend the time frame and inform you of the right to file a grievance if you disagree with that decision. Humana Healthy Horizons in Ohio will carry out its determination as expeditiously as your health condition requires and no later than the date the extension expires. (OAC 5160-26-03.1 (B)(3)(f))

Once we decide based on medical necessity, you will be notified. **If we approve a service and you have started to receive that service, we will not reduce, stop, or restrict the service during the time it has been approved, unless we determine the approval was based on information that was known to be false or wrong.**

If we deny a service, we will send a notice to you and your provider the day the service is denied. These notices are not bills. **You will not have to pay for any care you received that was covered by Humana Healthy Horizons in Ohio, even if Humana Healthy Horizons in Ohio later denies payment to the provider.**

How You Can Help with Health 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 at Humana Healthy Horizons in Ohio, like:

Technical Advisory Committees (TAC) - TACs act as advisors to the Advisory Council for Medical Assistance. Each TAC represents a specific provider type or are individuals representing Medicaid beneficiaries.

Call Member Services at 877-856-5702 (TTY: 711) to learn more about how you can help.

Appeals and Grievances

“If you are unhappy with Humana Healthy Horizons in Ohio or our providers, or do not agree with a decision we made, contact us as soon as possible. You, or someone you want to speak for you, can contact us. If you want someone to speak for you, you will need to let us know. Humana Healthy Horizons in Ohio wants to help.”

To contact us, you can:

- Contact Member Services Department at 877-856-5702

- Fill out the form in your member handbook
- Call Member Services Department to ask for a printed copy
- Visit our website at www.Humana.com/HealthyOhio
- Write a letter telling us what you are unhappy about. Please include your first and last name, the number from the front of your Humana Healthy Horizons in Ohio member ID card, your address and your telephone number. You should also send any information that helps explain your problem. You can submit facts and supporting documentation about your case to Humana Healthy Horizons in Ohio until the grievance or appeal due date.

Mail the form or your letter to:

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

Fax the form or letter to 800-949-2961

Submit and track your Grievance or Appeal online at www.Humana.com/HealthyOhio

Humana Healthy Horizons in Ohio will send you something in writing if we decide to:

- deny a request to cover a service for you.
- reduce, suspend, or stop services before you receive all the services that were approved; or
- deny payment for a service you received that is not covered by Humana Healthy Horizons in Ohio

We will also send you something in writing if we did not:

- decide on whether to cover a service requested for you, or
- give you an answer to something you told us you were unhappy about.

Appeals

If you do not agree with the decision or action listed in the letter, you can contact us **within 60 calendar days** to ask that we change our decision or action. This is called an **appeal**. The 60-calendar day period begins on the day after the mailing date on the letter. If we have decided to reduce, suspend, or stop services before you receive all the services that were approved, your letter will tell you how you can keep receiving the services if you choose and when you may have to pay for the services.

Unless we tell you a different date, we must give you an answer to your appeal in writing within 15 calendar days from the date you contacted us. If we do not change our decision or action because of your appeal, we will notify you of your right to request a state hearing. **You may only request a state hearing after you have gone through** Humana Healthy Horizons in Ohio **appeal process.**

Grievance

If you contact us because you are unhappy with Humana Healthy Horizons in Ohio or our providers, this is called a **grievance**. Humana Healthy Horizons in Ohio will give you an answer to your grievance by phone, or by mail if we can't reach you by phone. We will give you an answer within the following time frames:

- 2 working days for grievances about not being able to get medical care
- 30 calendar days for all other grievances except grievances about getting a bill for care you have received
- 60 calendar days for grievances about getting a bill for care you have received

If we need more time to decide for either an appeal or a grievance, we will send you a letter telling you that we need to take up to 14 more calendar days. That letter will also explain why we need more time. If you think we need more time to decide on your appeal or grievance, you can also ask us to take up to 14 calendar days.

You can review grievance and appeal case files at any time – free of charge. This includes any documents, records, clinical criteria or other information related to the appeal or grievance.

You also have the right to file a complaint **at any time** by contacting the:

Ohio Department of Medicaid
Bureau of Managed Care Compliance and Oversight
P.O. Box 182709
Columbus, Ohio 43218-2709
800-605-3040 or 800-324-8680
TTY: 800-292-3572

Ohio Department of Insurance
50 W. Town Street
3rd Floor – Suite 300
Columbus, Ohio 43215
800-686-1526

Evidence for Appeals

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

State Hearings

A state hearing is a meeting with you or someone you want to speak on your behalf, someone from the County Department of Job and Family Services, someone from Humana Healthy Horizons in Ohio, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). In this meeting, you will explain why

you think Humana Healthy Horizons in Ohio did not make the right decision and Humana Healthy Horizons in Ohio will explain the reasons for making our decision. The hearing officer will listen and then decide who is right based on the rules and the information given.

Humana Healthy Horizons in Ohio will notify you of your right to request a state hearing if:

- we do not change our decision or action because of your appeal
- a decision is made to propose enrollment or continue enrollment in the Humana Healthy Horizons in Ohio's Coordinated Services Program
- a decision is made to deny your request to change your Humana Healthy Horizons in Ohio's Coordinated Services Program provider

You may only request a state hearing after you have gone through Humana Healthy Horizons in Ohio's **appeal process.**

If you want a state hearing, you, or someone you want to speak on your behalf, must request a hearing **within 90 calendar days.** The 90-calendar day period begins on the day after the mailing date on the hearing form. If your appeal was about a decision to reduce, suspend, or stop services before all the approved services are received, your letter will tell you how you can keep receiving the services if you choose to and when you may have to pay for the services. If we propose to enroll you in the Humana Healthy Horizons in Ohio's Coordinated Services Program and you request the hearing within 15 calendar days from the mailing date on the form, we will not enroll you in the program until the hearing decision.

To request a hearing:

- you can sign and return the state hearing form to the address or fax number listed on the form,
- call the Bureau of State Hearings at 866-635-3748,
- submit your request via e-mail at bsh@jfs.ohio.gov.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association at 800-589-5888.

State hearing decisions are usually issued no later than 70 calendar days after the request is received. However, if MCO or the Bureau of State Hearings may decide that the health condition meets the criteria for an expedited decision. An expedited decision will be issued as quickly as needed but no later than three working days after the request is received. Expedited decisions are for situations when making the decision within the standard time frame could seriously jeopardize your life, your health or your ability to attain, maintain, or regain maximum function.

Continuation of Benefits

For some adverse benefit determinations, you may request to continue services during the appeal and State Fair Hearing process. Services that can be continued must be services that we previously approved and you already are receiving as ordered by an authorized provider, including services that we are reducing or terminating.

If you request continuation of services within 10 calendar days from our notice of adverse benefit determination letter, or before the date we told you they would be reducing, suspending, or terminating, whichever is later, your benefits will continue until one of the following occurs:

- 10 days after we mail the appeal decision
- You withdraw your appeal
- Following a State Fair Hearing, the administrative law judge issues a decision that is not in your favor

If the appeal was denied and you request a State Fair Hearing with continuation of services within 10 calendar days of the date on the appeal resolution letter, your services will continue during the State Fair Hearing process. See the State Fair Hearing section for more information.

However, if the outcome of the appeal remains the same as the first decision to deny your service, you may be required to pay for these services.

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

- If you choose to leave Humana Healthy Horizons in Ohio, 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 plan. After that, we will help you find a provider in our network to get any additional services, if you need them.
- In almost all cases, your doctors will be Humana Healthy Horizons in Ohio providers. There are some instances when you can still see another provider that you had before you joined Humana Healthy Horizons in Ohio. You can continue to see your doctor if:
    - At the time you join Humana Healthy Horizons in Ohio, you have an ongoing course of treatment or an ongoing special health condition. In that case, you can ask to keep your provider for up to 90 days.
    - If you are pregnant, you can continue to see your provider until you can find another provider that is in our network or for up to 6 weeks after your delivery. We will work with you to help you find a new provider if you need help.
    - You are pregnant when you join Humana Healthy Horizons in Ohio, and you receive services from a behavioral health treatment provider. In that case, you can keep your provider until after your delivery.

If your provider leaves our network, we will notify you within 15 days of receipt or issuance of the termination notice or no less than 30 days prior to the provider termination date. We also will tell you how you can select a new PCP or specialty provider, and we will work to assist you in finding a provider if you need help.

If you have any questions, call Member Services at 877-856-5702 (TTY: 711).

Member Rights and Responsibilities

Your Membership Rights

As a member of Humana Healthy Horizons in Ohio you have the following rights:

- To receive all information and services that Humana Healthy Horizons in Ohio must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally approved to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To discuss medically necessary treatment options for your condition(s), no matter the cost or benefit coverage.
- To participate with providers in making decisions relating to your health care.
- To be able to take part in decisions about your health care as long as the decisions are in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To say “yes” or “no” to having any information about you given out unless Humana Healthy Horizons in Ohio must by law.
- To say no to treatment or therapy. If you say no, the provider or Humana Healthy Horizons in Ohio must talk to you about what could happen, and they must put a note in your medical record about it.
- To file an appeal, a grievance (complaint) or state hearing.
- To get help free of charge from Humana Healthy Horizons in Ohio and its providers if you do not speak English or need help in understanding information.
- To get all written member information from the Humana Healthy Horizons in Ohio:
    - at no cost to you.
    - in the prevalent non-English languages of members in the Humana Healthy Horizons in Ohio: service area.

- in other ways, to help with the special needs of members who may have trouble reading the information for any reason.

- To get help with sign language if you are hearing impaired.
- To be told if the health care provider is a student and to be able to refuse their care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will).
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your primary care provider (PCP) to another PCP in the Humana Healthy Horizons in Ohio's network at least monthly. Humana Healthy Horizons in Ohio must send you something in writing that says who the new PCP is by the date of the change.
- To be free to carry out your rights and know that the Humana Healthy Horizons in Ohio, the Humana Healthy Horizons in Ohio providers or the Ohio Department of Medicaid will not hold this against you.
- To know that the Humana Healthy Horizons in Ohio must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- If you are a female, to be able to go to a woman's health provider in the Humana Healthy Horizons in Ohio network for covered woman's health services.
- To get a second opinion from a qualified provider in the Humana Healthy Horizons in Ohio's network. If a qualified provider is not able to see you, Humana Healthy Horizons in Ohio must set up a visit with a provider not in our network.
- To get information about Humana Healthy Horizons in Ohio from us.
- To contact the Ohio Department of Medicaid and/or the United States Department of Health and Human Services Office of Civil Rights at the addresses below with any complaint of discrimination based on race, ethnicity, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

The Ohio Department of Medicaid
Office of Human Resources, Employee Relations
P.O. Box 182709
Columbus, Ohio 43218-2709

E-mail: ODM_EmployeeRelations@medicaid.ohio.gov
Fax: (614)644-1434

Office for Civil Rights
United States Department of Health and Human Services

233 N. Michigan Ave. – Suite 240
Chicago, Illinois 60601
Ph: (312) 886-2359 TTY (312) 353-5693

Your Responsibilities

As a member of Humana Healthy Horizons in Ohio, you agree to:

- Work with your PCP to protect and improve your health
- Find out how your health plan coverage works
- Listen to your PCP's advice and ask questions when you are in doubt
- Call or go back to your PCP if you do not get better or ask to see another provider
- Treat healthcare staff with the respect you expect yourself
- Tell us if you have problems with any healthcare staff by calling Member Services at 877-856-5702 (TTY: 711)
- Keep your appointments and calling as soon as you can if you must cancel
- Use the emergency department only for real emergencies
- Call your PCP when you need medical care, even if it is after-hours

As a member of Humana Healthy Horizons in Ohio, you must be sure to:

- Know your rights
- Follow Humana Healthy Horizons in Ohio policies and procedures
- Know about your service and treatment options
- Take an active part in decisions about your personal health and care and lead a healthy lifestyle
- Understand as much as you can about your health issues
- Take part in reaching goals that you and your healthcare provider agree upon
- Let us know if you are unhappy with us or one of our providers
- Use only approved providers
- Report suspected fraud, waste, or abuse
- Keep scheduled doctor visits (e.g., be on time, and, if you must cancel, call at least 24 hours in advance to cancel)
- Follow the advice and instructions for care you have agreed upon with your doctors and other healthcare providers
- Always carry and show your member ID card when receiving services

- Never let anyone else use your member ID card
- Let us know of a name, address, or phone number change, or a change in the size of your family (e.g., birth, death, etc.)
- We want to make sure we always can connect with you about your care. We don't want to lose you as a member, so letting us know is important. It is also a good idea to tell your local Ohio Department of Medicaid (ODM).
- Call your PCP after going to an urgent care center, a medical emergency, or getting medical care outside of the Humana Healthy Horizons in Ohio service area
- Let Humana Healthy Horizons in Ohio know if you have other health insurance coverage
- Provide the information that Humana Healthy Horizons in Ohio and your healthcare providers need in order to care for you
- Notify us immediately of any worker's compensation claim, a pending personal injury or medical malpractice lawsuit, or if you are in an auto accident

We will tell you about changes to our member rights and responsibilities on our website at Humana.com/HealthyOhio.

Ending Your Humana Healthy Horizons in Ohio Membership

As a member of a managed care organization (MCO), you have the right to choose to end your membership at certain times during the year. You can choose to end your membership during the first three months of your membership or during the annual open enrollment month. The Ohio Department of Medicaid will send you something in the mail to tell you when your annual open enrollment month will be. If you live in a mandatory enrollment area, you will have to choose another managed care organization to cover your health care services.

If you want to end your membership during the first three months of your membership or during the annual open enrollment month, you can call the Medicaid Hotline at 800-324-8680; (TTY 800-292-3572). You can also submit a request online to the Medicaid Hotline website at www.ohiomh.com. If you call before the last 10 days of the month, your membership will end the first day of the next month. If you call after this time, your membership will not end until the first day of the following month. If you chose another managed care organization, your new managed care organization will send you information in the mail before your membership start date.

Just Cause Membership Terminations

Sometimes there may be a special reason that you need to end your membership with a plan. This is called a "just cause" membership termination. To ask for a just cause membership termination, you may first call Humana Healthy Horizons in Ohio and give us a chance to resolve the issue. If we cannot resolve the issue, you can ask for a just cause termination if you have one of the following reasons:

1. You move and your current MCO is not available where you now live, and you need non-

emergency medical care in your new area before your MCO membership ends.

2. Your current MCO does not, for moral or religious objections, cover a medical service that you need.
3. Your doctor has said that some of the medical services you need must be received at the same time and the services are not all in the MCO's network.
4. You have concerns that you are not receiving quality care and the services you need are not available from another provider in the Humana Healthy Horizons in Ohio's network.
5. You do have access to medically necessary Medicaid-covered services or do not have access to providers that are experienced in dealing with your special health care needs.
6. The PCP that you chose is no longer on your in the Humana Healthy Horizons in Ohio's network and that was the only in-network PCP who spoke your language and was located within a reasonable distance from you; or another plan has a PCP in their network that speaks your language that is located within a reasonable distance from you and will accept you as a patient.
7. If you think staying as a member in your current managed care plan is harmful to you and not in your best interest.
8. If the child is getting Title IV-E federal foster care maintenance or is in foster care or other out of home placement. The change must be initiated by the local public children's services agency (PCSA) or the local Title IV-E juvenile court.

You may ask to end your membership for just cause by calling the Medicaid Hotline at 800-324-8680; (TTY 800-292-3572). The Ohio Department of Medicaid will review your request and decide if you meet a just cause reason. You will receive a letter in the mail to tell you if the Ohio Department of Medicaid will end your membership and the date your membership ends. If you live in a mandatory enrollment area, you will have to choose another plan unless the Ohio Department of Medicaid tells you differently. If your just cause request is denied, the Ohio Department of Medicaid will send you information that explains your state hearing right for appealing the decision.

Things to keep in mind if you end your membership

If you have followed any of the above steps to end your membership, remember:

- Continue to use Humana Healthy Horizons in Ohio doctors and other providers until the day you are a member of your new health plan or back on regular Medicaid.
- If you chose a new MCP and have not received a member ID card before the first day of the month when you are a member of the new plan, call the Humana Healthy Horizons in Ohio Member Services Department. If they are unable to help you, call the Medicaid Hotline at 800-324-8680; TTY 800 292-3572.
- If you were allowed to return to the regular Medicaid card and you have not received a new Medicaid card, call your county caseworker.

- If you have chosen a new MCO and have any medical visits scheduled, call your new plan to be sure that these providers are in the new plan's provider network and that any needed paperwork is done. Some examples of when you should call your new plan include *when you have an appointment to see a new doctor, a surgery, blood test or x-ray scheduled and especially if you are pregnant.*
- If you were allowed to return to regular Medicaid and have any medical visits scheduled, please call the providers to be sure that they will take the regular Medicaid card.

Optional Membership Terminations

You have the option not to be a member of a managed care organization (MCO) if:

- You are a member of a federally recognized Indian tribe, regardless of your age.
- You are an individual who receives home- and community- based waiver services through the Ohio Department of Developmental Disabilities.

If you believe that you or your child meet any of the above criteria and do not want to be a member of a managed care organization, you can call the Medicaid Hotline at 800-324-8680 (TTY 800-292-3572). If you meet the above criteria and does not want to be an MCO member, your MCO membership will be ended.

Exclusions – Individuals that are not permitted to join a Medicaid MCO:

You may not be allowed to join a Medicaid managed care organization (MCO) if you are:

- Dually eligible under both the Medicaid and Medicare programs:
- Institutionalized (in a nursing home and are not eligible under the Adult Extension category, long-term care facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or some other kind of institution); or
- Receiving Medicaid Waiver services and are not eligible under the Adult Extension category.

** If you are eligible for Medicaid under the Adult Extension category, you will receive your nursing home services through the Managed Care Organization. Additionally, Adult Extension members approved for waiver services will remain in the Managed Care Organization.*

If you believe that you meet any of the above criteria and should not be a member of a Managed Care Organization, you must call the Medicaid Hotline at 800-324-8680 (TTY 800-292-3572). If you meet the above criteria, your MCO membership will be ended.

Can Humana Healthy Horizons in Ohio End My Membership?

Humana Healthy Horizons in Ohio may ask the Ohio Department of Medicaid to end your membership for certain reasons. The Ohio Department of Medicaid must okay the request before your membership can be ended.

The reasons that Humana Healthy Horizons in Ohio can ask to end your membership are:

- For fraud or for misuse of your Humana Healthy Horizons in Ohio ID card

- For disruptive or uncooperative behavior to the extent that it affects the MCO's ability to provide services to you or other members

Humana Healthy Horizons in Ohio provides services to our members because of a contract that Humana Healthy Horizons in Ohio has with the Ohio Department of Medicaid. If you want to contact the Ohio Department of Medicaid, you can call or write to:

Ohio Department of Medicaid
Office of Managed Care
Bureau of Managed Care Compliance and Oversight
P.O. Box 182709
Columbus, Ohio 43218-2709

Phone: 800-324-8680
TTY: 800-292-3572
You can also visit the Ohio Department of Medicaid on the web at www.medicaid.ohio.gov.

You can contact Humana Healthy Horizons in Ohio to get any other information you want including the structure and operation of Humana Healthy Horizons in Ohio and how we pay our providers. If you want to tell us about things you think we should change, call Member Services at 877-856-5702 (TTY: 711).

Choosing A New Plan

If you are thinking about ending your membership to change to another managed care organization (MCO), you should learn about your choices. Especially if you want to keep your current provider(s). Remember, each MCO has its own list of doctors and hospitals that are in the network. Each MCO also has written information which explains the benefits it offers and the rules that it has. If you would like written information about a managed care organization you are thinking of joining or if you simply have questions about the MCO, you may either call the plan or call the Medicaid Hotline at 800-324-8680; TTY 800-292-3572. You can also find information about the MCOs in your area by visiting the Medicaid Hotline website at www.ohiomh.com.

You Could Become Ineligible for Medicaid Managed Care

You will be disenrolled from Humana Healthy Horizons in Ohio if you:

- Stay in a nursing home for more than 30 days in a row
- Become eligible for Medicare
- Abuse or harm health plan members, providers, or staff
- Do not fill out forms honestly or do not give true information (commit fraud)

Loss of Medicaid Eligibility

It is important that you keep your appointments with the County Department of Job and Family Services. If you miss a visit or don't give them the information they ask for, you can lose your Medicaid eligibility. If this happened, Humana Healthy Horizons in Ohio would be told to stop your membership as a Medicaid member and you would no longer be covered by Humana Healthy Horizons in Ohio.

Advance Directives

Advance directives are forms you fill out in case you become seriously ill or cannot make your own healthcare decisions. Doctor's offices and hospitals may have these forms available. If you haven't thought about this, now is a good time to start. You may want to talk to your family, too. However, advance directives are always voluntary. You must be older than 18 years old to have an advance directive.

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

You sign them while you are still healthy and able to make these decisions. They are only used when you are too ill or not able to communicate. They allow you to express if you would like things done to keep you alive or name someone to make healthcare decisions for you. You have the right to cancel your advance directives at any time if you're able.

You can change your advance directives when you want. You should keep a copy of your advance directives in your personal files, and give copies to:

- Your provider and/or healthcare facility to put into your medical record
- A trusted family member or friend

Ohio law requires us, your family, doctor, and other healthcare providers to honor your valid advance directives unless the law provides an exception.

Federal law gives you the right to file a grievance with Humana Healthy Horizons in Ohio or the State Survey and Certification Agency if you are not happy.

Advance Directives in Ohio

In Ohio, there are different types of advance directives. Advance directives may include:

- Living Wills
- Healthcare Power of Attorney
- Mental Health Treatment Directives

We will notify you, your PCP, and our Member Services team within ninety (90) days of changes in rules and regulations for these advance directives.

You can request a printed advanced directive by contacting Member Services at 877-856-5702 (TTY: 711), Monday – Friday, from 7 a.m. – 8 p.m., Eastern time.

Living Will

A living will allow you to leave instructions in these important areas. You can:

- Name a Healthcare Surrogate
- Refuse or request life-prolonging treatment
- Refuse or request artificial feeding or hydrations

- Express your wishes regarding organ donation

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

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

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

Living wills must be:

- In writing
- Signed and dated by you
- Witnessed by two adults or one notary

Estate Recovery

If you are permanently institutionalized or age 55 or older when you receive Medicaid benefits, the Estate Recovery Program may recover payments for the cost of your care paid by Medicaid from your estate. The cost of your care may include the capitation payment that Medicaid pays to your managed care plan, even if the capitation payment is greater than the cost of the services you received. **Estate Recovery only happens after the death of the Medicaid recipient.**

Mental Health Treatment Directive

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

Mental Health Treatment Directives must be:

- In writing
- Signed and dated by you
- Witnessed by two adults or one notary

For more information on how you can state your preferences on the mental health treatment you want to receive, please visit Humana.com.

Others Who May Make Healthcare Decisions for You

If you do not have an advance directive and you are not able to make healthcare decisions, Ohio law still lets others make decisions for you. Other people may be a(n):

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

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

Healthcare Power of Attorney

A healthcare power of attorney is a legal document in which you can name one or more people as your healthcare agents to make medical and behavioral health decisions for you as you become unable to decide for yourself. You can always say what medical or behavioral health treatments you would want and not want. You should choose an adult you trust to be your healthcare agent. Discuss your wishes with the person/people you want as your Healthcare Power of Attorney before you put them in writing.

Again, it is always helpful to discuss your wishes with your family, friends, and your doctor. A healthcare power of attorney will go into effect when a doctor states in writing that you are not able to make or to communicate your healthcare 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.

Fraud, Waste and Abuse

We have a comprehensive fraud, waste, and abuse program in our Special Investigations Department. We designed this program to handle cases of managed care fraud. Help us by reporting questionable situations.

Fraud can be committed by providers, pharmacies, or members. We monitor and act on all provider, pharmacy, or member fraud, waste, and abuse.

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

- Agent Fraud
- Bill for more expensive services than provided
- Bill for tests or services not provided

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

Examples of pharmacy fraud, waste, and abuse include:

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

Examples of member fraud, waste, and abuse include:

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

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

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

If You Suspect Fraud, Waste, or Abuse

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

- Call 800-614-4126 (TTY: 711) 24 hours a day, 7 days a week
    - Select the menu option for reporting fraud
- Complete the Fraud, Waste, and Abuse Reporting Form at Humana.com/Fraud
- Write a letter and send it to:

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

You can report suspected fraud and abuse by calling the U.S. Office of Inspector General's Fraud Line at 800-HHS-TIPS (800-447-8477).

Visit Humana.com/Fraud for more information.

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

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

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

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

This can help protect your privacy.

Keep Us Informed

Call Member Services at 877-856-5702 (TTY: 711) when these changes happen in your life:

- You give birth
- You have a change in eligibility
- There is a change in coverage for you or your children

Quality Improvement

Program Purpose

The Humana Healthy Horizons in Ohio Quality Improvement Program:

- Includes clinical and nonclinical services
- Is updated as needed to be responsive to member needs, provider feedback, current standards of care, and business needs

Quality Improvement Program goals and objectives include:

- Coordination of care
- Evaluating performance and efficiency of services received, clinical and nonclinical
- Improving the quality and safety of clinical care and services provided to members
- Promoting quality of care

Quality Improvement Program guiding principles include:

- To make a lasting difference in our members' lives by improving their health and well-being
- To transform lives through innovative health and life services

Humana Healthy Horizons in Ohio supports the Institutes for Healthcare Improvement's Triple Aim:

- At the same time improve the health of members, enhancing the experience and outcomes of members, and lowering the cost of care to benefit everyone

The purpose of the Humana Healthy Horizons in Ohio Quality Improvement Program is to ensure that we have the necessary ability to:

- Create a comprehensive Population Health Management Program
- Create a comprehensive Provider Engagement Program
- Obtain Accreditation Compliance with National Committee for Quality Assurance (NCQA) Accreditation standards
- Reach a high level of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) performance
- Reach a high level of Healthcare Effectiveness Data and Information Set (HEDIS®) performance

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

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

Program Scope

The Humana Healthy Horizons in Ohio Quality Improvement Program governs the quality assessment and improvement activities for Humana Healthy Horizons in Ohio. The scope includes:

- Assessing the characteristics and needs of members
- Assessing the geographic availability and accessibility of primary and specialty care providers
- Complying with NCQA accreditation standards
- Ensuring that the Quality Improvement Program is effectively serving members with complex health needs
- Ensuring that the Quality Improvement Program is effectively serving members with culturally and linguistically diverse needs
- Establishing safe clinical practices throughout the network of providers
- Conducting HEDIS compliance audit and performance measurement
- Managing all quality of care and quality service grievances
- Monitoring and evaluating member and provider satisfaction
- Promoting the Institute for Healthcare Improvement's Model for Improvement
- Providing quality oversight of all clinical services

The Humana Healthy Horizons in Ohio Medical Director oversees the Quality Improvement Program. The Quality Improvement Director implements the program. On an annual basis, Humana Healthy Horizons in Ohio makes information available about its Quality Improvement Program to members and providers at Humana.com/HealthyOhio. To get a printed copy of the Humana Quality Improvement Program, please call Member Services.

Humana Healthy Horizons in Ohio gathers and uses provider performance data to improve quality of services.

Quality Measures

Humana Healthy Horizons in Ohio continually assesses and analyzes the quality of care and services offered to our members. We use objective and systematic monitoring and evaluation to improve outcomes.

We use HEDIS and other performance measures to measure the quality of care delivered to members. HEDIS is one of the most widely used means of healthcare measurement in the United States. HEDIS is developed and maintained by the NCQA.

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

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

- Antidepressant medication management
- Behavioral health
- Chronic disease management
- Comprehensive diabetes care
- Controlling high blood pressure
- Follow-up after hospitalization for mental illness
- Follow-up for children prescribed ADHD medication
- Maternal health
- Preventive screenings (e.g., breast cancer, cervical cancer, chlamydia)
- Safety
- Use of imaging studies for low back pain
- Well-childcare
- Wellness and prevention

Humana Healthy Horizons in Ohio uses the annual CAHPS surveys to capture member perspectives on healthcare quality. CAHPS is a program overseen by the United States Department of Health and Human Services – Agency for Healthcare Research and Quality

(AHRQ).

Potential CAHPS measures the plan uses are:

- Customer service
- Getting care quickly
- Getting needed care
- How well doctors communicate
- Ratings of all healthcare, health plan, personal doctors, and specialists

Preventive Guidelines and Clinical Practice Guidelines

Humana Healthy Horizons in Ohio recommends evidence-based nationally accepted standards and guidelines to help inform and guide the clinical care provided to Humana Healthy Horizons in Ohio members. Guidelines are reviewed at least annually, or more often as appropriate, and updated as necessary.

These guidelines:

- Are used to measure how they affect outcomes of care
- Are reviewed by the Humana Clinical Practice Guidelines Committee, which also recommends updates
- Are approved by the Humana Corporate Quality Improvement Committee
- Are presented to the Humana Healthy Horizons in Ohio Quality Improvement Committee

Topics for guidelines are identified through analysis of members. Guidelines may include, but are not limited to:

- Adult health (e.g., hypertension, diabetes)
- Behavioral health (e.g., depression)
- Population health (e.g., obesity, tobacco cessation)

Information about clinical practice guidelines and health information is available to Humana Healthy Horizons in Ohio members via member newsletters, the Humana Healthy Horizons member website (Humana.com/HealthyOhio), or upon request. Preventive guidelines and health links are available to members and providers via the website or hard copy.

Your Health is Important

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

- Establish a relationship with a healthcare provider
- Make sure you and your family have regular checkups with your healthcare provider

- Make sure you see your doctor regularly, follow the treatment that your doctor has given you, and take the medicines that your doctor has asked you to take, if you have a chronic condition (such as asthma or diabetes)

Remember, the 24-Hour Medical Advice Line is available to help you. You can call the number on your member ID card 24 hours a day, 7 days a week, 365 days a year.

Humana Healthy Horizons in Ohio has programs that can help you maintain or improve your health. For more information about these programs, call Member Services at 877-856-5702 (TTY: 711), Monday – Friday, from 7 a.m. - 8 p.m., Eastern time.

Notice of Privacy Practices

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

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

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes 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 personal and health information?

Personal and health information - from now on referred to as "information" - includes medical information and individually identifiable information, like your name, address, telephone number, or Social Security Number. The term "information" in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare. We protect this information in all formats including electronic, written, and oral information.

How do we protect your information?

In keeping with federal and state laws and our own policy, we have a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

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

How do we use and disclose your information?

We must 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
- Where required by law

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 and requests for services
    - Coordinating your care
    - Resolving disputes
    - Conducting medical management
    - Improving quality
    - Reviewing the competence of healthcare professionals
    - Determining premiums for performing underwriting activities

Note: 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 such as to allow your plan sponsor to obtain bids from other health plans
    - We will not share detailed health information to your plan sponsor unless you provide us your permission, or your plan sponsor has certified they agree to maintain the privacy of your information
- To contact you with information about:
    - Health-related benefits and services
    - Appointment reminders
    - Treatment alternatives that may be of interest to you if you have not opted out as described below
- To your family and friends if you are unable to communicate, such as in an

emergency

- To your family and friends or any other person you identify, provided the information is directly relevant to their involvement with your healthcare or payment for that care
    - For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm receipt and payment of the claim
- To provide payment information to the subscriber for Internal Revenue Service (IRS) substantiation
- To public health agencies, if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities, and as otherwise required by law
- To assist in 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
- 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?

In all situations other than described in this notice, we will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission. The following uses and disclosures will require an authorization:

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

What do we do with your information when you are no longer a member, or you do not obtain coverage through us?

Your information may continue to be used for purposes described in this notice when your enrollment is terminated, or 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. The following are your rights with respect to your information:

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- Adverse Underwriting Decision – You have the right to be provided a reason for denial or adverse underwriting decision if we decline your application or insurance.
- Alternate Communications – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life-threatening situation. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for a period of six years at your request. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- Notice – You have the right to receive a written copy of this notice any time you request.
- Restriction – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

What types of communications can I opt out of?

- Appointment reminders
- Fundraising activities
- Treatment alternatives or other health-related benefits or services

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

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

- Calling us at 866-861-2762 (TTY: 711) at any time
- Visiting Humana.com/Legal/Privacy
- Send completed request form to:

  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

What should I do if I believe my privacy has been violated?

If you believe your privacy has been violated in any way, you may file a complaint with us by calling us at 866-861-2762 (TTY: 711) any time.

You also may submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request.

You also have the option to e-mail your complaint to OCRComplaint@hhs.gov.

We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

We follow all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, we follow the law, rule, or regulation that provides greater member protection.

We are required by law to abide by the terms of this notice currently in effect.

What will happen if my classified information is used or disclosed inappropriately?

You have a right to receive a notice that a breach has resulted in your unsecured private information being inappropriately used or disclosed. We will notify you in a timely manner if such a breach occurs.

The following affiliates and subsidiaries also adhere to our privacy policies and procedures:

Arcadian Health Plan, Inc.

CarePlus Health Plans, Inc.

Cariten Health Plan Inc.

CHA HMO, Inc.

CompBenefits Company

CompBenefits Dental, Inc.

CompBenefits Insurance Company

Corphealth Provider Link, Inc.

DentiCare, Inc.

Emphesys Insurance Company

HumanaDental Insurance Company

Humana Benefit Plan of Illinois, Inc.

Humana Employers Health Plan of Georgia, Inc.

Humana Health Benefit Plan of Louisiana, Inc.

Humana Health Company of New York, Inc.

Humana Health Insurance Company of Florida, Inc.

Humana Health Plan of California, Inc.

Humana Health Plan of Ohio, Inc.

Humana Health Plan of Texas, Inc.

Humana Health Plan, Inc.

Humana Health Plans of Puerto Rico, Inc.

Humana Insurance Company

Humana Insurance Company of Kentucky

Humana Insurance Company of Ohio

Humana Insurance Company of New York

Humana Insurance of Puerto Rico, Inc.

Humana Medical Plan, Inc.

Humana Medical Plan of Michigan, Inc.

Humana Medical Plan of Pennsylvania, Inc.

Humana Medical Plan of Utah, Inc.

Humana Regional Health Plan, Inc.

Humana Wisconsin Health Organization Insurance

Managed Care Indemnity, Inc.

The Dental Concern, Inc.

Appeal/Grievance Request Form

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

Member name:	
Member ID number:	Date of birth:
Authorized representative*:	
Phone number:	
Address: _____ _____ _____	

Service or claim number:
Provider name:
Date of service:

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

_____
Relationship to member (if representative)

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

Humana Healthy Horizons in Ohio
Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax: 800-949-2961

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:** _____

_____

_____

Ohio Department of Medicaid (ODM)

Member Handbook

Ohio Single Pharmacy Benefit Manager **(SPBM)**

Version 0.1

Table of Contents

1 Member Handbook Contents

1.1 Corporate Identity

Gainwell Technologies is a company with over 50 years of proven experience, and a reputation for service excellence and unparalleled expertise. Gainwell does not operate under any other trade names or DBA. At Gainwell, everything we do focuses on people.

The mission at Gainwell is to empower clients through innovative technologies and solutions to deliver great health and human services outcomes.

You are now a member of our Single Pharmacy Benefit Manager (SPBM). Here at Gainwell, we believe you deserve quality pharmacy services and should receive the most up-to-date services that we can provide.

Online: https://spbm.medicaid.ohio.gov

Email: OH_MCD_PBM@gainwelltechnologies.com

If you suspect provider or consumer fraud, please contact our Fraud, Waste, and Abuse toll free tip line at **1-833-491-0344 (TTY 1-833-655-2437)** and select the option to report Fraud, Waste, and Abuse concerns.

1.2 Available Services

Gainwell covers all Medicaid-covered, medically necessary prescription and over-the-counter (OTC) medications. We use a preferred drug list (PDL) which is a list of drugs we prefer your provider prescribe. We may require your prescriber to submit a prior authorization request, which is where your prescriber would provide us additional information explaining why a specific medication and/or a certain dose or quantity of a medication may be required.

The below services are available to you to support any additional needs you may have:

- Oral interpretation.
- Translation services.
- Auxiliary aids and services.
- Written information in alternative formats including, braille and large print.

1.2.1 Preferred Drug List

Gainwell uses a PDL which is a list of drugs we prefer your provider prescribes. You can find a copy of the PDL in the following locations:

- Under the Medicaid Information tab at: https://spbm.medicaid.ohio.gov
- Logging in to your Gainwell Member Portal at https://spbm.medicaid.ohio.gov
- The Ohio Department of Medicaid pharmacy website at: https://pharmacy.medicaid.ohio.gov/unified-pdl
- A paper copy can be requested by calling Member Services at **1-833-491-0344 (TTY 1-833-655-2437)**

1.2.2 Prior Authorizations

Your prescriber may be required to submit a prior authorization request for certain medications. These requests will be sent by your prescriber through many different routes (phone, fax, mail, or web portal) to ensure a quick and efficient review of your medication. In these circumstances, your provider will send an authorization request to the Gainwell Pharmacy Services team, where they will complete a clinical review of the medication your prescriber is requesting. Gainwell Pharmacy Services team will work closely with your prescriber to provide the best clinical decision. You will receive a letter in the mail with the outcome of the decision made.

If you do not agree with the decision that is made by Gainwell, you will be sent detailed information on how you can appeal our decision.

You have the option to call Member Services toll free at **1-833-491-0344 (TTY 1-833-655-2437)** to obtain information regarding the PDL, medications that may require prior authorization, or to ask any medication related questions you may have. The PDL and a list of medications that require prior authorization are available for you to access online at: https://spbm.medicaid.ohio.gov. It is important that you and/or your prescriber reference the PDL and/or the list of medications that require prior authorizations each time you have questions, as these are documents that can change.

1.2.3 Pharmacy Utilization Management Strategies

The PDL will be used with each prior authorization review that is completed by the Gainwell Pharmacy Services team. When a prior authorization is required, Gainwell must approve the prescriber's request before you will be able to fill your medication at your preferred, in-network pharmacy. A prior authorization may be required if:

- A generic or pharmacy alternative drug is available
- The requested drug can be misused/abused
- Other medications must be tried first
- Quantity limits for the requested medication have been exceeded
- The medication your provider has prescribed is not included on the PDL

The PDL usually includes multiple medication options for treating a particular condition. These different drugs are referred to as "alternative" drugs and are just as effective as other drugs with no additional side effects or health problems.

Specific reasons your prescriber may be required to submit a prior authorization request include:

Step Therapy - In some cases, our plan requires you first try certain drugs to treat your medical condition.

Generic Substitution - This is where a pharmacy will be required to provide a generic drug in place of a brand-name drug when available. Generic drugs are just as safe and effective as brand name drugs and should be prescribed first.

Therapeutic Interchange - This is where you are unable to take a medication for reasons like an allergy, intolerance, etc., a medication might not work for you and your prescriber may write a prescription for a medication that is not on the approved drug list.

Specialty Medications - This is a review of a medication that is considered more complex for a specific disease and requires specific attention and handling during the prior authorization review process. For these medications, you may have to get them through a specialty pharmacy. Your prescriber will work with Gainwell Pharmacy Services to make sure you can obtain the medication you need as quickly as possible.

1.2.4 Excluded Services

Gainwell will not pay for the following categories that are not covered by the Ohio Medicaid pharmacy program:

- Drugs for the treatment of obesity
- Drugs for the treatment of infertility
- Drugs for the treatment of erectile dysfunction
- DESI drugs or drugs that may have been determined to be identical, similar, or related
- Drugs that are eligible to be covered by Medicare Part D
- Over-the-counter drugs that are not listed in accordance with paragraph C of OAC rule 5160-9-03
- Drugs being used for indications not approved by the Food and Drug Administration (FDA) unless supported by compelling clinical evidence

1.2.5 Additional Services

The Gainwell Pharmacy team can also assist you with the below services by calling your member help desk at **1-833-491-0344 (TTY 1-833-655-2437).** You can also access this information on your member portal by logging in at https://spbm.medicaid.ohio.gov.

- Locating a pharmacy to fill the prescription you were given by your provider
- Verifying you have active pharmacy coverage
- Obtaining diabetic supplies covered through your pharmacy benefit
- Obtaining durable medical equipment (DME) covered through your pharmacy benefit

1.3 Request for Appeals, Grievances, or State Hearings

Grievance

If you are unhappy with anything in relation to Gainwell Pharmacy Services or our providers, please contact us as soon as possible. This is called a grievance.

To contact us you can:

- Call member services at **1-833-491-0344 (TTY 1-833-655-2437)** and choose option 1 to speak with a Gainwell Pharmacy Help Desk team member.
- Fill out the Grievance/Appeal form included in this member handbook and mail to Gainwell Pharmacy Services at the address below or online through your member portal.
- Visit our website at https://spbm.medicaid.ohio.gov.
- Write a letter telling us you are unhappy. Please be sure to include your first and last name, your Medicaid ID, your address, and your telephone number so we are able to contact you, if needed. You can submit your form or letter via email or mail.

Email: OH_MCD_PBM@gainwelltechnologies.com
Mail:
Gainwell Pharmacy Services
5475 Rings Rd.
Atrium II North Tower, Suite 125
Dublin, OH 43017-7565

Once you contact Gainwell to submit your grievance, we will follow up with you by telephone, mail delivery, or other appropriate means within the below timeframes:

- Two (2) working days for grievances about not being able to get the medications you need
- Thirty (30) calendar days for all other grievances

Appeal

If you receive a notice from us that you disagree with, you may ask for an appeal within sixty (60) calendar days after the date of the notice. Gainwell will provide you with an answer to your appeal within fifteen (15) calendar days from the date you contacted us. If you believe fifteen (15) calendar days could seriously jeopardize your life, physical or mental health or ability to attain, maintain, or regain maximum function, contact Gainwell Member Services at the number listed below as soon as possible to expedite your review process. To request an appeal, you can:

- Call Member Services at **1-833-491-0344 (TTY 1-833-655-2437)** and choose option 1 to speak with a Gainwell Pharmacy Help Desk team member.
- Fill out the Grievance/Appeal form included in this member handbook and mail to Gainwell Pharmacy Services at the address below, or complete online through your member portal.
- Visit our website at https://spbm.medicaid.ohio.gov.
- Write a letter. Please be sure to include your first and last name, your Medicaid ID, your address, and your telephone number so we are able to contact you, if needed. You can submit your form or letter via email or mail.

  Email: OH_MCD_PBM@gainwelltechnologies.com
  Mail:
  Gainwell Pharmacy Services
  5475 Rings Rd.
  Atrium II North Tower, Suite 125
  Dublin, OH 43017-7565

When submitting an appeal, please include the following information:

- Your name and Medicaid ID number on your card
- Your prescriber's name
- The reason you disagree with the outcome provided by Gainwell
- Any documentation or information to support your request to have your decision overturned

Gainwell must provide you with an answer to your appeal within fifteen (15) calendar days from the date you contacted us. If we do not change our decision, you will be notified in writing and will be provided your right to request a State hearing. You must complete the appeal process before you are able to request a State hearing.

If we need more time to make a decision for either a grievance or appeal, we will send you a letter telling you we need to take up to fourteen (14) more calendar days. That letter will also provide you with information as to why we need more time to complete your request.

State Hearing

You must complete the Gainwell appeal process before you are able to request a State hearing. A State hearing is a meeting with you or your authorized representative, someone from the County Department of Job and Family Services, someone from Gainwell, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). During this meeting, you will explain why you think Gainwell Pharmacy Services did not make the right decisions and Gainwell will explain the reasons for making our decision. A decision will be made by the hearing officer based on rules, regulations, and information provided during the hearing.

You will be notified of your right to request a State hearing if we do not change our decision as a result of your appeal to Gainwell. If you would like to request a State hearing, you or your authorized representative must request a hearing within ninety (90) calendar days of your denied appeal from Gainwell.

To request a hearing, you can sign and return the State hearing form to the address or fax number listed on the form, call the Bureau of State Hearings at **1-866-635-3748 (TTY/TDD 614-728-2985),** or submit your request via email to bsh@jfs.ohio.gov. If you want information on free legal services, you can call the Ohio State Legal Services Association at 1-800-589-5888 for the local number to your local legal aid office.

State hearing decisions are usually issued no later than seventy (70) calendar days after the request is received. If it is determined that the health condition meets the criteria for an expedited decision, the decision will be issued as quickly as needed but no later than three (3) business days after the request is received. Expedited decisions are for situations when the standard review time frame could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function.

1.4 Change Recommendations

As a member of Gainwell Pharmacy Services, you have a membership right to make recommendations regarding rights and responsibilities surrounding your medication coverage.

Recommendations can be emailed to Gainwell Pharmacy Services at **OH_MCD_PBM@gainwelltechnologies.com or call Member Services at 833-491-0344 (TTY/TDD 614-728-2985).**

1.5 Pharmacy Access

Gainwell Pharmacy Services offers a member portal for you to log in and manage your pharmacy needs. To log in to your personal member portal, visit https://spbm.medicaid.ohio.gov and log in with your personal information that you have set up for your account.

To sign up for a provider through the Gainwell Member Portal, you can follow the directions on the website at https://spbm.medicaid.ohio.gov or call your Member Services toll free at 1**-833-491-0344 (TTY 1-833-655-2437)** to speak with a Gainwell Pharmacy Services agent to receive step-by-step assistance to sign up for access.

1.6 Emergency Outpatient Drug

In the event of an emergency situation, you will have the option to receive a 72-hour (3 day) supply of your medically necessary medication. If you have difficulties with this process, please contact Gainwell Pharmacy Services at **1-833-491-0344 (TTY 1-833-655-2437).**

1.7 Non-Discrimination Statement

Gainwell Pharmacy Services follows State and Federal civil rights laws that protect you from discrimination or unfair treatment. We do not treat people unfairly because of a person's age, race, color, national origin, religion, gender, gender identity, sexual orientation, marital status, mental or physical disability, medical history, health status, genetic information, evidence of insurability, military status, veteran status, ancestry, the need for health services to receive any of the covered services or geographic location.

Gainwell has no moral or religious objections to services that we provide for Ohio Department of Medicaid members.

If you are in need of any of the additional services below, please contact Member Services toll free at **1-833-491-0344 (TTY 1-833-655-2437)** to speak to a team member at no additional charge:

- Oral interpretation
- Translation services
- Auxiliary aids and services
- Written information in other languages, including, but not limited to, Spanish, Somali, and Arabic
- Written information in alternative formats including, but not limited to, braille and large print

1.8 Provider Network Statement

Gainwell works with pharmacies to fill prescriptions close to your home for easy access to any of your medication needs. Many of the pharmacies offer services including prescription home delivery, medication management and assistance if you have limited English, hearing or sight difficulties, or a disability needing extra support. Specialty pharmacies also are available to provide medications with specific handling, storage, and distribution requirements to treat high risk, complex, or rare disease(s). If there are any changes to these pharmacies, we will be sure to let you know via the website, Gainwell Member Portal, or mailings as determined by your preferred communication request.

Gainwell does not cover prescription fills at pharmacies that are not signed up (Out of Network) to dispense medications for Ohio Medicaid members, which includes, but is not limited to, pharmacies that are far away from your home, except for emergency situations (if out of the State in an emergency or if an Ohio pharmacy cannot supply the medication).

1.9 Pharmacy Provider Network

You can obtain information on how to locate a pharmacy covered in your network by accessing the Pharmacy Provider Directory online at https://spbm.medicaid.ohio.gov or through logging in to your Gainwell Member Portal at https://spbm.medicaid.ohio.gov. You can request a paper copy of the Pharmacy Provider Directory by calling Member Services toll free at **1-833-491-0344 (TTY 1-833-655-2437).**

English (United States)
To help you understand this notice, language assistance and interpretation services are available upon request at no cost to you. You can request these services by following the below steps:

- Call Gainwell Member Services at 1-833-491-0344
- Select option 8

Spanish
Para ayudarlo a comprender este aviso, puede solicitar previamente los servicios de interpretación y asistencia con el idioma que están disponibles de manera gratuita. Puede solicitar estos servicios siguiendo los siguientes pasos:

- Llame a Servicios para Afiliados de Gainwell al 1-833-491-0344
- Seleccione la opción 8

Arabic

اللغة الإنجليزية (الولايات المتحدة)
لمساعدتكم على فهم هذا الإشعار فإن خدمات المساعدة اللغوية والترجمة الشفوية متاحة لكم عند الطلب دون أي تكلفة. ولكي يتسنى لك طلب هذه الخدمات اتباع الخطوات التالية:

- اتصل بخدمات أعضاء جاينويل Gainwell على رقم الهاتف: 1-833-491-0344
- ثم حدد الخيار رقم 8

Somali
Si ay gacan uga gaystaan inaad fahanto ogaysiiskan, kaalmo luuqadda ah iyo adeegyada tarjumaadda ayaa markaad codsato bilaa lacag ku heli kartaa. Waxaad codsan kartaa adeegyadan adigoo raacaya tallaabooyinka hoose:

- Ka wac Adeegyada Xubinta Gainwell 1-833-491-0344
- Dooro raacaya 8

Nepali
तपाईंलाई यो सूचना बुझ्नमा मद्दत गर्नका लागि, तपाईको अनुरोधमा भाषा सहायता र दोभाषे सेवाहरू तपाईलाई शुल्कबिना उपलब्ध हुन्छन्। तपाईं तलका चरणहरू पालना गरेर यी सेवाहरू अनुरोध गर्न सक्नुहुन्छ:

- Gainwell Member Services लाई 1-833-491-0344 मा फोन गर्नुहोस्
- विकल्प 8 चयन गर्नुहोस्

Kinyarwanda
Mu rwego rwo kugufasha gusobanukirwa neza iri tangazo, hari ubufasha bw'ururimi na serivisi z'ubusemuzi uhabwa igihe ubisabye nta kiguzi uciwe. Ushobora gusaba izi serivisi ukurikiza amabwiriza akurikira:

- Hamagara Gainwell Member Services kuri 1-833-491-0344
- Hitamo uburyo bwa 8

Swahili
Ili kukusaidia kuelewa taarifa hii, usaidizi wa lugha na huduma za ukalimani zinapatikana baada ya ombi bila gharama kwako. Unaweza kuomba huduma hizi kwa kufuata hatua zilizo hapo chini:

- Piga simu kwa Huduma za Mwanachama wa Gainwell (Gainwell Member Services) kwa 1-833-491-0344
- Teua chaguo la 8

French
Pour vous aider à comprendre cet avis, les services d’aide linguistique et d’interprétation sont disponibles à la demande et sans frais. Vous pouvez demander ces services en suivant les étapes ci-dessous :

- Appelez les services aux membres de Gainwell au 1-833-491-0344
- Sélectionnez l’option 8

Amharic
ይህንን ማስታወቂያ እንዲረዱት እርስዎን ለመርዳት የቋንቋ ድጋፍ እና የትርጉም አገልግሎቶች በሚፈለጉበት ጊዜ ለእርስዎ ያለምንም ወጪ ይቀርባሉ። የሚከተሉትን ደረጃዎች በመከተል እነዚህን አገልግሎቶች መጠየቅ ይችላሉ:-

- ለጌይንዌል አባል አገልግሎቶችን (Gainwell Member Services) በ 1-833-491-0344 ይደውሉ
- አማራጭ 8 ን ይምረጡ

Gujarati
આ સૂચનાને સમજવામાં તમારી મદદ કરવા માટે, વિનંતી પર તમારા માટે ભાષા સહાય અને દુભાષિયા સેવાઓ મફતમાં ઉપલબ્ધ છે. તમે નીચે આપેલા પગલાંને અનુસરીને આ સેવાઓ માટે વિનંતી કરી શકો છો:

- ગેઇનવેલ મેમ્બર સર્વિસીસને 1-833-491-0344 ફોન કરીને
- વિકલ્પ 8 પસંદ કરો

Dari (Afghani)
جهت کمک به شما در درک این اعلان، مساعدت لسانی و خدمات ترجمانی شفاهی در صورت درخواست بصورت رایگان برای شما موجود است. شما میتوانید این خدمات را با تعقیب نمودن مراحل ذیل درخواست نمائید:

- با خدمات اعضای Gainwell به نمبر 1-833-491-0344 به تماس شوید
- گزینهٔ 8 را انتخاب کنید

Pashto (Afghani)
پر دغې خبرتیا د پوهېدو په برخه کې ستاسو د مرستې لپاره د ژبې شفاهي ژباړن خدمتونه ستاسو د غوښتنې له مخې په وړیا توګه د لاسرسي وړ دي. تاسو د لاندې پړاوونو په څارلو سره د دغو خدمتونو غوښتنه کولی شئ:

- د Gain Well د غړو خدمتونو ته په دغې شمېرې زنګ ووهئ 1-833-491-0344
- 8 انتخاب غوره کړئ

Russian
Вам по запросу доступны бесплатные услуги языкового сопровождения и устного перевода, чтобы Вы могли понять это уведомление. Вы можете запросить эти услуги следующим способом:

- Позвонить в службу Gainwell Member Services по телефону 1-833-491-0344
- Выбрать вариант 8

Ukrainian
Для того щоб ви змогли зрозуміти це повідомлення, вам доступні послуги мовної допомоги та усного перекладу, якими можна скористатися безкоштовно за запитом. Для замовлення цих послуг виконайте такі кроки:

- Зателефонуйте до центру обслуговування клієнтів Gainwell за номером 1-833-491-0344.
- Оберіть опцію 8.

Vietnamese
Để giúp bạn hiểu thông báo này, các dịch vụ hỗ trợ ngôn ngữ và thông dịch có sẵn theo yêu cầu và được miễn phí. Bạn có thể yêu cầu các dịch vụ này bằng cách làm theo các bước sau:

- Gọi cho bộ phận Dịch vụ Thành viên Gainwell theo số 1-833-491-0344
- Chọn tùy chọn 8

Chinese (Simplified)
为帮助您理解本通知，我们可根据要求，向您免费提供语言协助和传译服务。 您可遵照如下步骤，请求这些服务：

- 致电 1-833-491-0344 联系Gainwell Member Services
- 选择 8

Chinese (Traditional)
為了幫助您了解這份通知，如有需求，我們會提供免費語言協助及翻譯服務。 這項服務可以藉由下列方式申請：

- 撥打Gainwell會員服務電話: 1-833-491-0344
- 按8

Questions?

Call member services
at 877-856-5702 (TTY: 711)

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