Indiana PathWays for Aging Member Handbook

Plan year 2024

Medicaid Managed Care

Issuance Date: 07/01/24

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Welcome to Indiana PathWays for Aging

The Indiana Family and Social Services Administration (FSSA) offers Medicaid services for individuals aged 60 and older to eligible Hoosiers through Indiana PathWays for Aging (PathWays). The Indiana PathWays for Aging program helps make sure Hoosiers can choose to age at home and easily get Home and Community-Based Services (HCBS), instead of staying in long-term nursing facilities if they choose, improve quality outcomes and consistency of care across the delivery systems, use data to make wise healthy choices, and promote caregiver support. This manual will provide you information on how your Humana Healthy Horizons in Indiana plan works and important resources.

Contact Us

Mailing Address:	Humana Healthy Horizons in Indiana 201 North Illinois Street Suite 1200 Indianapolis, IN 46204
Online:	Humana.com/HealthyIndiana
Phone Number:	866-274-5888 8 a.m. to 8 p.m. ET Monday – Friday (you can call this number anytime, but there will be different staff working after normal business hours)
TTD/TTY:	711

Hours of Operation

Humana Healthy Horizons in Indiana® is open for business Monday- Friday 8 a.m. to 8 p.m. ET (excluding holidays). After business hours, or when our office is closed, such as major holidays, you can:

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

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 Eve
- Christmas Day

Working With Your Humana Healthy Horizons in Indiana

Service Area	Phone number	Information
24/7 Nurse line	800-449-9039 or TTD/TTY: 711	A nurse is available 24 hours a day/ 7 days a week.

Service Area	Phone number	Information
Behavioral Health Crisis line	855-254-1758 or TTD/TTY: 711	Speak to a behavioral health professional if you are experiencing emotional distress, a mental health or substance use crisis. You can call at any time, 24 hours a day, 7 days a week.
Dental: DentaQuest	866-274-5888 or TTD/TTY: 711	Find a dentist in your area or learn more about changes like phone, address, and income.
Vision: EyeMed	844-961-2057	Call to set up an appointment for your vision needs.
Indiana Family and Social Services Administration (FSSA)	1-800-403-0864	Call this number to report any information changes (your telephone number, family size, address, or income).
Indiana Tobacco Quitline	1-800-QUIT-NOW	Free phone-based service to help smokers quit.
Member Services	866-274-5888 or TTD/TTY: 711	Hours: 8a.m. - 8p.m. M-F ET Call for questions about anything health related.
Relay Indiana	1-800-743-3333 or TTD/TTY: 711	For members with hearing or speech loss, a trained person will help them speak to someone using a standard phone.
State Ombudsman Program	Information/complaint line: 800-622-4484 or 317-232-7134 Fax number: 317-972-3285 Email: LongTermCareOmbudsman@ombudsman.IN.gov	These contact methods can be used if you think or feel that you may be at risk of abuse, self-neglect and/or exploitation, have issues, and/or in need of adult protective services (APS).
Transportation Services: LCP Transportation	800-936-2794 or TTD/TTY: 711	For calls to set up transportation to your doctor appointments.
Utilization Management (UM)	866-274-5888 or TTD/TTY: 711	The prior authorization is requested by your doctor. UM customer service can answer general questions regarding your authorization.
Vision: Eye Med	888-581-3648 or TTD/TTY: 711	Member Services is available to help you find information about your vision benefits and how to find a provider in your area.

Language Assistance

If English is not your main language, we can provide you with an interpreter at no cost to you. To request assistance, please call Member Services.

If you are deaf or hard of hearing, we can provide you with an American Sign Language Interpreter at no cost to you. To request assistance, please call Member Services. You can get help in your language or sign language when you go to the doctor.

We can give you reading materials in your preferred language and/or format. If you need your member handbook and other health plan information in other ways let us know. For example, if you need the information in another language, large print, Braille or in audio format, call Member Services. We will answer your questions in your language.

We can help you talk to your health care provider, or read materials to you in any language, if needed. Interpreters can also help you with a grievance or an appeal when you are not happy with a decision. Interpreters can help over the phone or in person. Please call Member Services to ask for interpreter services 24 hours before the scheduled appointment.

Language Help Phone Number

Member Services at 866-274-5888, TTD/TTY: 711

Hearing and Speech Assistance

If you need hearing and speech help, you can also call the Indiana Relay Service at 1-800-743-3333 or TTD/TTY 711 for TDD/TTD/TTY service. This number can be used anywhere in Indiana. Ask the operator to connect you to Member Services.

Eligibility

The PathWays program is for those individuals that are 60 years and older, blind, or disabled and have limited income and resources.

American Indian/Alaska Native

Process to opt out of Managed Care

Individuals who are American Indian/Alaska Native, as verified by FSSA's Department of Family Resources (DFR), will also be given the option to opt-in to managed care when they become eligible for the PathWays program.

AI/AN members can opt-in at any time. To opt-in, please call Indiana PathWays for Aging at 877-284-9294 TTD/TTY: 711.

Indiana PathWays for Aging: 800-403-0864

DFR Fax: 888-436-9199

Access to Indian Healthcare Providers

Indian health care provider means a health care program operated by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization. American Indian/Alaska Native members who are eligible to receive services from a participating Native American healthcare provider can choose to receive covered services from a Native American healthcare provider. If the provider participates in the network as a PMP, you can choose that provider as your PMP, if the provider has the capacity to provide the services.

To verify if the Native American healthcare provider is a PMP or if they have capacity to provide services, access the provider directory on Humana.com/findadoctor or call Member Services at 866-274-5888 TTD/TTY:711.

Changing Plans

Once you are enrolled in Humana Healthy Horizons in Indiana plan or the state enrolls you in a Managed Care Entity (MCE) Plan, you will have 90 days from the date of your first enrollment to try the MCE. During the first 90 days, you can change MCE's for any reason. You may submit the change over the phone or in writing. Call Indiana PathWays for Aging at 877-284-9294 TTD/TTY: 711. After the 90 days, if you are still eligible for Medicaid, you will be enrolled in the plan until the next Open Enrollment Period. This is called "lock-in." You can also change your plan at any time you have one company for your Medicare benefits and a different one for your Medicaid benefits. For any other reason, you are allowed to change your plans only once per calendar year.

Open Enrollment

If you are a Member that has been assigned to Humana because you have Humana for your Medicare benefits, you have the right to choose another health plan within your Open Enrollment Period. Call Indiana PathWays for Aging at 877-284-9294 TTD/TTY: 711, to choose another plan. If you choose another plan, you will be locked into this plan until the next open enrollment period.

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

Plan Selection Period/Changing Health Plans

With Indiana PathWays for Aging, you must remain in your chosen health plan for a one-year period if you remain eligible. You may only change plans during certain times of the year or for certain reasons outlined below.

Plan Selection Periods:

Plan selection can be made on the application or by calling the enrollment broker within sixty (60) calendar days of coverage start. If you do not select a plan, there will be an assignment process in place directed by the State. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered such as the residential provider of the member (if applicable).

Individuals will have the chance to change a health plan:

1) within sixty (60) days of starting coverage,
2) at any time, your Medicare and Medicaid plans become separated (see definition below) (e.g., member disenrolls from one MA plan to another during quarterly Special Enrollment Period (SEP),
3) once per calendar year for any reason,
4) at any time when:
    - You receive poor quality of care, and the Enrollment Broker and the State agrees with you after they have looked at your medical records
    - You cannot get the services you need through our plan, but you can get the services you need through another plan
    - Your services were delayed without a good reason
    - You do not have access to Providers in your area, or your primary medical provider enrolls in another plan.
    - Failure of the Contractor to comply with established standards of medical care administration;
    - Significant language or cultural barriers;
    - Corrective action levied against the Contractor by the office;

- Limited access to a primary care clinic or other health services within reasonable proximity to your residence;
- A determination that another MCE's formulary is more consistent with a new member's existing health care needs;
- Lack of access to medically necessary services covered under the Contractor's contract with the State;
- A service is not covered by the Contractor for moral or religious objections
- Related services are required to be performed at the same time and not all related services are available within the Contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;
- Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

5) Additionally, during a plan selection period which will be at the same time as the Medicare open enrollment window (mid-October to mid-December) to be effective the following calendar year.

An aligned member is someone who has the same plan for both their Medicare and Medicaid benefits. For example, if you have Humana for your Medicare plan as well as your Medicaid benefits.

An unaligned member is someone who has one Plan for their Medicare benefits, and a different plan for their Medicaid benefits. For example, if you have Traditional Medicare and Humana for your Medicaid benefits.

If you have any questions about whether you can change your plan, call Indiana PathWays for Aging at 877-284-9294 TTD/TTY: 711.

Medicare Election:

- To enroll, a prospective member who is eligible for Medicare must:
  - Enroll in and remain enrolled in all parts of Medicare for which the prospective member is eligible (Medicare Part A, Part B, and/or Part D); or
  - Obtain all Medicare Part A, Part B, and Part D benefits, if eligible, from the MCE's Special Needs Plan.
- If you become Medicare-eligible after enrollment, the member must enroll in all parts of Medicare for which the member is eligible.

Moving to Medicare

If you become eligible for a Medicare program, you must apply to the program. This includes if you are over 65 years old or have a disability. Medicare will help you apply as you get closer to your 65th birthday. If you become disabled, there is also Medicaid Disability. Your current health plan will help you apply for Medicaid Disability coverage.

When you move from your current health plan to a disability or Medicare program, your start date may be in the past. When your coverage changes you may receive different benefits. Plan selection can be made by calling the enrollment broker within sixty (60) calendar days of the start of coverage. We are here to help make sure you get help for both your Medicare and Medicaid benefits, without having to call anyone. We will be your Medicare Plan if you are already in our Medicaid Plan.

When you enroll in Medicaid with Humana Healthy Horizons in Indiana and you become eligible for a Medicare Dual Special Needs Plan (D-SNP), you can automatically be enrolled in Humana Medicare for your D-SNP.

If you have questions about your Medicare options call SHIP at for help at (800) 452-4800 TTY/TTD: 711. SHIP is the State Health Insurance Assistance Program (SHIP). It is a free and impartial counseling program to help with decisions on health insurance options related to Medicare.

Coordination of Medicare and Medicaid Services

Humana Healthy Horizons in Indiana will take care of all your Medicare and Medicaid services. This includes traditional Medicare, unaligned Medicare Advantage plans, Chronic Conditions Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs).

Humana Healthy Horizons in Indiana is responsible for providing medically necessary Medicaid covered services to you. If the service is not covered by Medicare, you may have coverage through Medicaid benefits. Humana will engage with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits you receive. They coordinate with relevant State and social service agencies and community-based organizations (CBOs) as needed to better identify and address both your medical and social needs.

How to Change Health Plans

At certain times each year, you can choose to change your health plan. You can stay with your current health plan, or you can switch to a different one. You can only switch health plans during your plan selection time-period. Right Choices Program members are not eligible to change plans.

PathWays members have plan selection for the first 60 calendar days they are eligible for coverage. Look out for a notice for your PathWays plan selection time.

Member Services

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

- Medical benefits, eligibility, claims, or participating providers
- Pharmacy benefits, coverage, or participating pharmacies
- If prior approval is necessary before getting a service
- What services are covered and how to use them
- How to get a new Member ID card
- Reporting a lost ID card
- Selecting or changing your Primary Medical Provider (PMP)
- Updating your demographic information such as mailing address, phone number and email address
- Filing a complaint, grievance or appeal
- How we work with other health plans if you have other insurance
- Our structure and operation

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

Member Identification Card

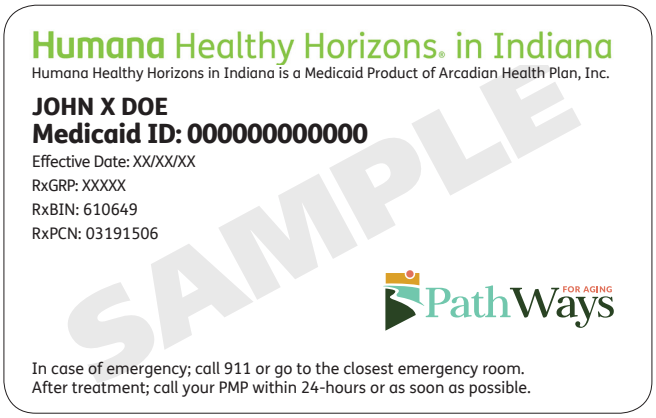
Humana Member Card

Humana will send you a member ID card. Your member ID card is very important. You must have one to use your benefits. You must give your ID card to the medical staff before you use any service or see your doctor.

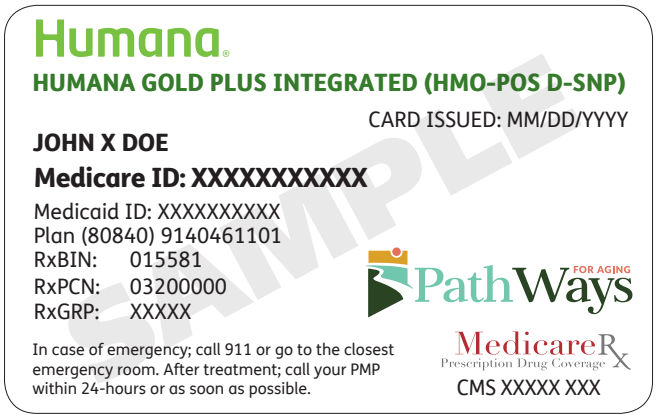
The front side has personal information, and the back side of the card has important phone numbers.

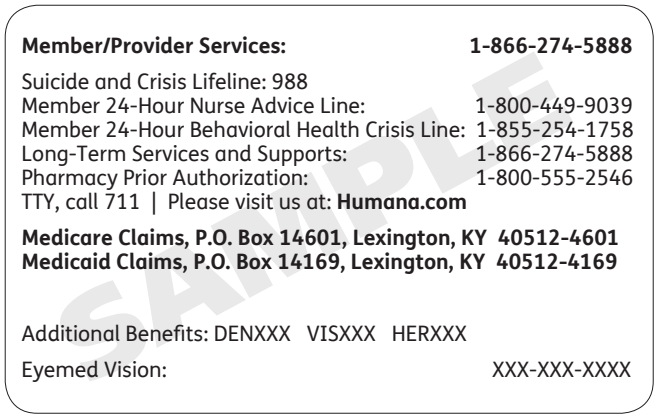
Medicare benefits and Medicaid benefits are different. Sometimes, Medicare may not cover a service, but Medicaid will cover it. For more information, please see the “Coordination of Medicare and Medicaid Services”

section.



Note: Your member ID card will not be available until 2025 if you are an aligned member. An aligned member is someone who has the same plan for both their Medicare and Medicaid benefits. For example, if you have Humana for your Medicare and Medicaid plan. You will be able to receive all of your Medicare and Medicaid benefits through us.





Always Keep Your Member ID Card

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

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

Also, be sure to have a picture ID with you. Your doctor or provider may ask you for your Humana card and a picture ID to validate your identity.

When you call us, please have the Member ID number on your Humana Member ID card available. This will

help us serve you faster. Call Member Services if:

- You have not received your Humana ID card.
- Any of the information on the card is wrong.
- You lose your card.
- You have any questions on how to use your Humana Member ID card.

You can also view and download a copy by going to Humana.com or downloading the Humana App.

Tools for Easy Access

MyHumana Account

You'll need to create a MyHumana account by going to Humana.com/logon and selecting "Register now."

Your MyHumana account is personal and private. You can access your MyHumana account on your mobile device or on your computer. When you sign-in with your username, you will receive access to key coverage information and useful Member tools and resources. You can also call Member Services at 866-274-5888 TTD/TTY:711 if you have questions.

MyHumana App

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

Use your plan on the go with the free mobile app. The app allows you to:

- Review your latest health summary.
- Access your Humana Member ID card with a single tap.
- Find a provider.

*The MyHumana app can even use your current location to locate the closest in-network provider. *This may require location sharing enabled on your phone.

Demographic Changes

We want to make sure we are always able to contact you about your care. We don't want to lose you as a member. It is important to let us know if information from your Medicaid application changes. You must report any changes to Division of Family Resources (DFR), within 10 calendar days. Failure to report changes within 10 calendar days may result in loss of medical benefits. Changes you must report within 10 calendar days include:

- Change of physical/mailing address or change in contact information
- Household income changes. For example, increase or decrease in work hours, increase in pay rate, change in job.
- Household size or relationship changes. For example, marries or divorces.
- You or other Members qualify for other health coverage such as health insurance from an employer, Medicare, TRICARE, or other types of health coverage.
- Changes in immigration status
- Being in jail or prison
- You start or stop filing a federal income tax return.
- Changes to your federal income tax return

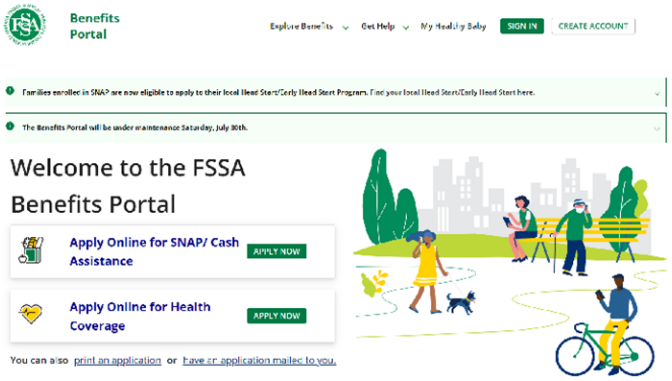
- Change to the taxable income on page one of the income tax form

Report any demographic changes or other information which may affect eligibility to Humana and the Division of Family Resources (DFR) at 800-403-0864 Monday through Friday from 8 a.m.to 4:30 p.m.

If you have any questions call Humana Healthy Horizons in Indiana Member Services: 866-274-5888 TTD/TTY: 711 Monday – Friday 8a.m. to 8p.m. EST.

Manage Your Benefits

Another option to report any changes is through the FSSA Benefits Portal. FSSA has developed an online tool allowing you to manage your benefits, report changes, print proof of eligibility, and view your notices/ correspondence. The Benefits Portal can be found: https://fssabenefits.in.gov/bp/#/.



Primary Medical Provider

The Role of Your PMP

Your Primary Medical Provider or PMP is the main healthcare provider who you visit on a regular basis. Your PMP gets to know your medical history and your health needs. When you need medical care, you will see your PMP first. He or she will treat you for most of your routine health care needs.

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

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

How to Choose your PMP

Now that you have selected Humana Healthy Horizons in Indiana, the next step is choosing a Primary Medical Provider (PMP). If you are enrolled in the Indiana PathWays for Aging program, you will need to choose a Primary Medical Provider (PMP)in network. This is your main doctor that you will see for your annual check-ups, routine sick or well visits and immunizations (shots).

Your PMP may be any of the following:

Advanced Practice Nurses (APN) practitioners	Gynecologists
Endocrinologists (if primarily engaged in internal medicine)	Internal Medicine Physicians
Family medicine physicians	Physician Assistants
General Practitioners	

Geriatricians	

You can choose your PMP, or you can have one assigned to you. If you do not have a PMP, we will assign one to you based on where you live and if the PMP is taking new patients.

Call Member Services at 866-274-5888 (TTD/TTY:711) if you need help selecting a PMP, or you can visit the Find a Provider Portal at humana.com/findadoctor. You can also use this link to see if your current doctor is a Medicaid provider. If they are not, we will not be able to pay for any services you use through them.

Freedom of Choice

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

How to Change your PMP

You can call Member Services to change your PMP. They may ask you why you want to change your doctor. If there comes a time you want or need to change your PMP, please call Member Services for assistance.

Humana Healthy Horizons does not make coverage decisions based on moral or religious beliefs. You may have a health need a certain doctor or hospital cannot treat because of their moral or religious beliefs. If this happens, the doctor should tell you. Then, you can decide to go to a different doctor or hospital to get care.

Changing your Primary Medical Provider

Member Services can assist you in finding your new PMP when:

- You have moved.
- Your doctor has moved or no longer belongs to our network.
- You are not happy with the care you are receiving from your health plan.
- Someone in at your PMP office treated you rudely.
- Your doctor does not return your calls.
- You have trouble getting the care you want, or your doctor says you need.

Sometimes PMPs tell us that they are moving away, retiring, or leaving our network. This is called a voluntary termination. If this happens with your PMP, we will let you know by mail within 30 calendar days before the effective date of the termination or 15 calendar days after we find out that the PMP has been terminated. We will also help you find a new doctor.

Member Services Phone Number 866-274-5888, TTD/TTY: 711

Finding a Provider

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

You can also call Humana at 866-274-5888 (TTD/TTY 711/TTD) to help you find a provider. If you would prefer a PMP that has the same culture, ethnic or racial background as you, call to see if there is someone in the network.

Provider Directory

Humana Healthy Horizons in Indiana provides members with an up-to-date Provider Directory to assist you with finding a provider in our network. The directory can be found on our website and is ready for you to search based on your criteria (some examples include location and specialty). You can visit humana.com/medicaid/indiana/support/provider-directories for Humana Healthy Horizons in Indiana Provider Directories. Call Member Services if you would like a printed Provider Directory mailed to you.

Health Plan Network Updates

Humana Healthy Horizons in Indiana will publish any updates to the provider network no less than 30 calendar days prior to the effective date of the change. This means if there is a change that could impact your care, the health plan will provide the information to you within 15 calendar days.

How to Get Help

It is important that you are receiving the best care from us and your providers. If you have a concern or question, you can call Member Services at 866-274-5888 (TTD/TTY: 711). Member Services can help you with things like:

- Answering questions about any part of your health care
- Finding care and treatment
- Finding a doctor
- Understanding how benefits work

Well Care Medical Care

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

Well care includes things such as immunizations, diabetes screening and health and wellness screenings. Well Care also includes screening for common chronic and Infectious diseases and cancers, clinical and behavioral interventions to manage chronic disease and reduce associated risks, and counseling to support healthy living and self-management of chronic disease.

All Well visits are paid for by Humana Healthy Horizons in Indiana. You are encouraged to use all Well visit services.

See the chart below for preventive care services for adult men and women.

Preventive Care Service	Women 60+	Men 60+
Annual Physical Exam	X	X
Blood Glucose Testing*	X	X
Chlamydia Screening	X	
Cholesterol Testing*	X	X
Colorectal Cancer Screening	X	X
Dental Exams	X	X
Eye Exam	X	X
Mammogram	X	
Pap Smear	X	

*These services are usually provided annually or as otherwise recommended by your doctor.

Immunizations

Immunizations are shots that protect the body from disease and illness. Some immunizations require follow-up shots or "boosters." Check with your doctor to make sure you have all the recommended shots for your age. These are the recommended adult immunizations:

- COVID-19
- DTaP (diphtheria, tetanus, pertussis)
- Flu
- Hepatitis B
- HIB (Haemophilus influenzae type B)
- Pneumococcal conjugate vaccine (PCV15 or PCV20)
- Shingles
- Tdap (tetanus, diphtheria, pertussis booster)

To see a full list of immunizations, please visit the CDC's website at https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html.

These shots are given to you at certain times. It may seem like there several shots, but the shots are needed to prevent disease. If you're not sure if you have all your recommended shots, talk to your doctor right away.

How to Make a Doctor's Appointment

To make an appointment, call your PMP's office and request one. Make sure to have your member ID card in your hand when you call. Tell them you are a Medicaid member and give them your member ID card information.

When you see your PMP, they will help you understand your medical needs. At your first appointment, your PMP will:

- Ask you questions about your current health and your medical history
- Give you information on how to maintain your health
- Schedule any tests and preventive care services you need

Changing or Cancelling Doctor Appointments

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

Appointment Timeframes

To make an appointment with a provider, please call the provider's office. The provider's office will schedule appointments as quickly as possible. If you have trouble scheduling an appointment you can call Member Services for help.

Your Health is Important

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

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

Remember, the 24-Hour Nurse Line 800-449-9039 or TTD/TTY: 711 is available to help you. You can call the number on your Member ID card 24 hours a day, 7 days a week, 365 days a year.

Humana has programs that can help you maintain or improve your health. Call us for more information about these programs: 866-274-5888 (TTD/TTY: 711).

How to Access Care

A PMP is a primary medical provider. Your PMP is your health partner. You should call them first when you need health care. They will work with you on all your health care needs. Your PMP will usually be able to help you with whatever you need. If your PMP is unable to treat your health issue, they will refer you to another place to get care.

Seeing a Specialist

Your PMP may send you to a specialist for special care or treatment. They will help choose a specialist to give you the care you need. You may need permission from us to see a specialist or receive certain care. Your PMP knows when to ask for permission.

Your PMP's office staff can help you get an appointment with a specialist. Make sure to tell your PMP and specialist as much about your health as you can. If your specialist or any other provider is not in the Humana Plan, they must get permission from Humana before they can give you care. You may also need a referral from your PMP.

If you have questions about your care plan, you may want to ask for a second opinion. Asking for a second opinion can help make sure your care plan is right for you. To get a second opinion, call your PMP's office or call Member Services at 866-274-5888 (TTD/TTY 711/TTD).

When and Where to Go for Care

It is important to know when and where to go for the medical care you need. Sometimes it may seem difficult to decide where you should go when Humana has many options for care. The chart below shows some options for care and when they are the best option for you to use.

Primary Medical Provider (PMP)	Check-ups and physicals; immunizations; minor aches and pains
Telehealth	For minor problems when you cannot see your PMP in-office. Telehealth is seeing your doctor remotely, usually by a video call on your phone.
Convenience Care Clinic	For minor problems when your PMP is unavailable.
Urgent Care	For problems that could become emergencies if left untreated for 12 hours.
Emergency Room (ER)	Life-threatening emergencies.

Access to Care

The below chart will provide you with an expectation of when you can expect to obtain an appointment with your provider.

Provider Type	Appointment Category	Appointment Standards
PMP	Routine	Not to exceed 30 calendar days
	Urgent	Within 24 hours
	Emergency	24 hours a day / 7 days a week
	Routine Gynecological Exam/new patient 30 calendar days	30 calendar days
	Annual Physical Exam	90 calendar days
Specialist	Routine	Not to exceed 30 calendar days
	Urgent	Within 24 hours
	Emergency	24 hours a day / 7 days a week
Behavioral Health	Non-life-threatening emergency	Not to exceed 6 hours
	Urgent	Not to exceed 24 hours
	Emergency	24 hours a day / 7 days a week
	Initial visit for routine care	Not to exceed 10 business days
	Follow-up routine care	Not to exceed 30 calendar days based off the condition
	Outpatient follow-up appointment	Within 7 days following discharge for the inpatient behavior health hospitalization

After-hours Care

Primary Medical Provider after-hour coverage is available to you 24 hours a day, 7 days a week. Humana maintains standards your Primary Medical Provider must follow. Your Primary Medical provider (or designated provider) will answer your phone call after normal business hours in English and Spanish. After hour coverage for your PMP may include an answering service or a shared-call service with other medical providers.

24/7 Nurse Line

You can call any time to talk with a caring, experienced registered nurse at 800-449-9039 or TTD/TTY: 711. This is a free call. You can call 24 hours a day, 7 days a week, 365 days a year. The nurse line can help you:

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

Urgent Care

Urgent Care is not Emergency Care. Urgent Care is needed when you have an injury or illness that must be treated within 12 hours. Your health or life are not usually in danger, but you cannot wait to see your PMP, or it is after your PMP's office has closed.

If you need Urgent Care after office hours and you cannot reach your PMP, you can talk to a nurse 24 hours a day by calling the Nurse Line at 800-449-9039 or TTD/TTY: 711. You may also find the closest Urgent Care center to you by going to our website at Humana.com/FindADoctor to view the provider directory or by calling Member Services at 866-274-5888 (TTD/TTY: 711).

Emergency Services

An emergency is a medical condition with severe symptoms that may be life threatening or cause serious damage to you. Examples of health problems needing emergency treatment include:

- A serious accident
- Broken bones
- Fainting, shortness of breath, severe chest pain, severe vomiting
- Overdose
- Major burns
- Poisoning
- Severe chest pain
- Severe diarrhea
- Severe injuries
- Severe stomach pain
- Severe vomiting
- Shortness of Breath
- Thought of hurting yourself or others
- Uncontrolled bleeding, major burns, seizures/convulsions

When seeking emergency care, you have the right to use any hospital or other setting for emergency care. Emergency room visits do not require a prior authorization for emergency services.

For emergency care, call 911 or go to the nearest emergency room (ER). Do not call us prior to calling 911.

If you are not sure if you are having an emergency, please call your Primary Medical Provider (PMP). If you cannot reach your PMP's office, you can call our 24-hour Nurse Line at 800-449-9039 or TTD/TTY: 711.

Post-Stabilization

Post-stabilization care is care you get after you receive emergency medical services. 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. Post-Stabilization care does not require a prior authorization.

24-Hour Behavioral Health Crisis Line

If you are in crisis and not sure if the problem is an emergency, call our Crisis Line at 855-254-1758 or TTD/TTY: 711. This is a free call. Crisis intervention services are available 24 hours a day, 7 days a week, 365 days a year. Our trained behavioral health staff can help you:

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

Transportation

PathWays includes transportation (ride) benefits. Rides to the locations listed below are included in these plans including non-emergency medical transportation.

- Any doctor visit or health care appointment
- Eligibility redetermination appointments with the State
- Urgent (upon approval) and Recurring Appointments

Please schedule a ride at least two business days before your appointment. Remember, if you have an emergency, please call 911 or go directly to the nearest emergency room. If you have questions, please call Member Services at 866-274-5888 (TTD/TTY 711/TTD).

When using ride services, please follow these rules:

- Wait for the driver at the curbside pick-up and drop-off site. The driver is only allowed to wait 30 minutes. If they wait too long, they will leave, you will not be able to get a ride.
- If you must cancel your ride, you must call at least two hours before your set pick-up time.

After you get care, you or the medical office can call the ride company for your return trip home. If you need to have a prescription filled at the office before leaving, work with your doctor to do so before calling your driver for the trip home. Your driver will need to be told about a stop at the pharmacy when scheduling the trip home.

For assistance with your Medicare transportation needs, please contact ModivCare at: 866-588-5122 (TTY: 866-288-3133) between 8:00 a.m. – 8:00 p.m. For help with existing rides, urgent trips, or discharges, please call 866-588-5123 which is open 24 hours a day, 7 days a week.

For assistance with your Medicaid transportation needs, please contact LCP at: 317-291-9318, which is available 24 hours a day, 7 days a week.

If you are not sure which transportation provider you should call, we can help you. Feel free to call our Member Services line at 866-274-5888 (TTD/TTY 711/TTD).

Out-of-Network

If you need medically necessary services, we will allow your out-of-network care if a network provider is not able to provide services. Humana will work with the out-of-network provider to confirm that any cost to you is not greater than it would be if the service were provided by in-network provider. Humana also takes into consideration continuity of care and long-term specialized care needs, such as cancer treatment or transplant services. If you have any questions or need help with getting out-of-network services call Member Services at 866-274-5888 (TTD/TTY 711/TTD).

Right to Refuse Treatment

You have the right:

- To receive information about your health. It may also be given to your Authorized Representative, or it may be given to someone you said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To ask questions and get complete information about your health and treatment options in a way that you can follow. This includes specialty care.
- To have a candid discussion of any appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- To take an active part in decisions about your health care unless it is not in your best interest.

- To say yes or no to treatment or therapy. If you say no, the doctor or Humana must talk to you about what could happen. They will put a note in your medical record.
- To refuse to go through with any medical service, or treatment, or accept any health services if you don't want to or agree based on religious grounds (this is also for a child if the parent or guardian feels this way).

Programs and Covered Services

Humana Healthy Horizons in Indiana provides two types of state benefits packages to our members. First is State Plan Medicaid, which includes the nursing facility, home health, and hospice care. The second, State Plan Medicaid plus Home and Community Based Services (HCBS), is available to all who have been determined to meet the Level of Care needs to receive the HCBS waiver.

State Plan Medicaid services include at a minimum all benefits and services deemed medically reasonable and necessary, meaning you need the services to prevent, diagnose, or treat a medical condition.

State Plan Medicaid Services:

- Anesthesia Services
- Chiropractic services
- Dental Services, including cleanings and x-rays
- Diabetes Self-Management Training
- Durable Medical Equipment
- Emergency services
- End Stage Renal Disease (ESRD) services
- Hearing Services, including hearing aids
- Home Health Agency and Clinic services
- Hospice Care
- Hospital Services, including inpatient and outpatient services
- Intermediate Care Facility services
- Laboratory services
- Long Term Acute Care Hospitalization services
- Medical and Surgical services
- Medical Supplies
- Mental and Behavioral Health services, including inpatient and outpatient services
- Nursing services, including services provided by nurse practitioners
- Nursing Facility services
- Occupational services
- Out-of-State medical services
- Pharmacy services
- Physical Therapy
- Physician's services, including diagnostic and preventive services
- Podiatry services
- Radiology services
- Rehabilitation Unit services

- Residential Substance Use Disorder (SUD) services
- Respiratory Therapy
- Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) services
- Speech Pathology services
- Telehealth services
- Tobacco Dependence Treatment
- Transportation services, including emergency and nonemergency transportation
- Vision Care services, including vision exams and eyeglasses

Home and Community Based Services for HCBS Waiver Members

- Adult Day Services (ADS)
- Adult Family Care (AFC) services
- Assisted Living (AL) services
- Attendant Care services
- Caregiver Coaching and Behavior Management (CCBM)
- Care Management services
- Community Transition services
- Home and Community Assistance
- Home-Delivered Meals
- Home Modification Assessments
- Home Modifications
- Integrated Healthcare Coordination (IHCC)
- Nonmedical Transportation services
- Nutritional Supplements
- Participant-Directed Attendant Care Services (PDACS)
- Personal Emergency Response System (PERS)
- Pest Control services
- Respite services
- Specialized Medical Equipment and Supplies
- Structured Family Caregiving
- Vehicle Modifications

Call Member Services at 866-274-5888 TTD/TTY: 711 to get help accessing these services.

Continuation of Care You Are Receiving

Humana Healthy Horizons in Indiana will provide continuity of care for the authorization of services as well as choice of providers for ninety (90) days. For a member who meets HCBS Level of Care and has an existing care plan approved by FSSA or another plan, that care plan will be honored for ninety (90) days from the date of enrollment. When receiving members from another plan, fee-for-service, or commercial coverage,

Humana will honor the previous care authorizations for one of the following durations, whichever comes first: ninety (90) calendar days from the member's date of enrollment with the plan, or the rest of the prior authorized dates or service, or until the approved units of service have ended. Humana will identify outstanding prior authorizations.

For new members, Humana will provide for care at the skilled nursing facility as long as you choose to remain in the facility and meet the skilled nursing level of care.

Added Benefits

Indiana PathWays for Aging also offers extra services and/or benefits to their members. These extra benefits, tools, and services are at no cost to you.

Enhanced Service	Description
Dental Services	*For Medicaid Only members:* Up to $500 allowance toward topical fluoride, oral sedation (along with nitrous), post op complications, and mouthguards.
Fall Prevention Kit	If you are at risk for falls may receive a Fall Prevention Kit once per lifetime. Kit contains: • Non-Slip Socks • Reacher/Grabber • Bathmat • Stair Treads You must not reside in a residential facility or nursing facility. Care Coordinator approval required.
Hearing Services	*For Medicaid Only members:* Unlimited visits for fitting and evaluation of hearing aids; up to $1,500 for hearing aids every three years; annual supply of 60 hearing aid batteries.
Home-Based Respiratory Intervention	Members living with respiratory diseases can receive up to $200 per calendar year for the following goods and services: • allergen-free bedding • carpet cleaning • air purifier. Members can select multiple items within one year provided total spend remains within the $200 allowance.
Home-Based Virtual Assistance Technology	Members participating in our Care Management or Disease Management program with the following conditions: • Social isolation • Depression • Memory loss May be eligible to receive 1 artificial intelligence (AI)-enabled virtual assistance device. One device per lifetime, per member. Care Coordinator approval required.

Enhanced Service	Description
Housing Assistance	*For Unaligned members and Medicaid Only members:* Up to $500 per member per year (unused allowance does not roll over to the next year) to assist with the following housing expenses: • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water, gas, or internet (late payment notice required) • Trailer Park and lot rent if this is your permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority Plan approval required: • You must not live in a residential facility or nursing facility • Funds will not be paid directly to you • If the bill is in your spouse's name, a marriage certificate may be submitted as proof Non-waiver members must reside in a home and/or community-based setting.
Name Bands	Members with dementia, Alzheimer's, and/or diabetes and in our Care Management or Disease Management Programs may receive 20 name bands per year. Care Coordinator approval required.
Non-Medical Transportation (NMT)	*For Medicaid Only members:* Up to 12 round trips (or 24 one-way trips) up to 30 miles for non-medical transportation per year to locations such as social support groups, wellness classes, WIC and SNAP appointments, and food banks. This benefit also offers transportation to locations providing social benefits and community integration for members such as community and neighborhood centers, parks, recreation areas, and churches. Non-waiver members must reside in a home and/or community-based setting.
Nutritional Coaching Program	Nutritional Coaching Program delivers health and wellness intervention for members who are 60 and older. You can complete six (6) nutritional management coaching sessions with Health Coach; approximately one call per month for a period of six (6) months.
Personal Emergency Response System (PERS)	*For Aligned members and Medicaid Only members:* If you are in our Care Management or Diseases Management Programs, you may receive 1 personal emergency response system device per lifetime to provide round the clock emergency service. You must not reside in a residential facility or nursing facility. Care Management approval required.

Enhanced Service	Description
Pest Control	*For Unaligned members and Medicaid Only members:* Up to $320 per year for pest control for non-wavier members. • If you reside with caregiver, you must show proof • You must reside in a home and/or community-based setting Must be approved by Care Coordinator.
Photo Albums	If you are in our Care Management or Disease Management Programs, you may receive 1 photo album per year. You must not reside in a residential facility or nursing facility. Care Management approval required.
Pill Box	You will receive one 7-day pill box. You must reside in a home and/or community-based setting.
Podiatry Visits	*For Medicaid Only members:* Up to 6 annual podiatry visits for the following: • If you are in need of medical or surgical treatment of injuries and diseases of the foot. • If you have conditions affecting the legs, such as diabetes.
Home Delivered Meals - Post Discharge	*For Medicaid Only members:* 14 refrigerated home-delivered meals following discharge from an inpatient or residential facility. Limited to 4 discharges per year. Non-waiver members must reside in a home and/or community-based setting.
Transition Assistance into Community Living	All non-waiver members who are moving from a nursing facility into their own home may receive $5,000 per lifetime. • Assistance for paying with security and utility deposits, household furnishings/supplies, and moving expenses • You must be responsible for your own living expenses Care Coordinator approval required.
Vision Services	*For Medicaid Only members:* Up to $150 allowance toward glasses (frames and lenses) or contacts every 24 months.

Go365 for Humana Healthy Horizons®

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

To earn rewards, you must:

- Have a Member ID
- Download the Go365 for Humana Healthy Horizons® App from iTunes/Apple Shop or Google Play on a mobile device. If you do not have a computer or mobile device, you can call customer care line and have a representative redeem your rewards over the phone. You can receive e-gift cards by email or physical gift cards by mail.

* Rewards are not cash and can be used to get gift cards or other merchandise.

These rewards are for Medicaid-only members. Humana Medicare offers other Go365 rewards.	
Healthy Activity	**Reward**
Breast Cancer Screening	Annual $25 reward for female members who obtain a mammogram.
Colorectal Cancer Screening	Annual $25 reward for members who obtain a colorectal cancer screening as recommended by their PMP.
Diabetic Retinal Eye Exam	Annual $10 reward for Diabetic members who complete a retinal eye exam.
Diabetic Screening	Annual $10 reward for Diabetic members who obtain a screening with their PMP for HbA1c and blood pressure.
Fall Prevention Program	$10 in rewards for members who complete education aimed at raising awareness to reduce falls once per year; Members must opt into Go365 mobile app in order to be eligible to receive reward. You can also call Member Services at 866-274-5888 TTD/TTY:711 if you have questions.
Flu Vaccine	Annual $10 reward for members who receive a flu vaccine from their provider, pharmacy or self-reporting if they received a vaccine from another source.
Follow-up After High-intensity Care for Substance Use Disorder	$25 reward for members who received follow-up care within 30 days of an inpatient hospital discharge, residential treatment or detoxification visit for a diagnosis of substance use disorder.
Follow-up After Hospitalization for Mental Illness	$25 reward for members who received follow-up care within 30 days after a hospital discharge for a diagnosis of select mental illness or intentional self-harm.
Health Needs Screening (HNS)	$25 reward for members who complete their Health Needs Screening (HNS) within 90 days of enrollment with Humana, one reward per lifetime; Member must opt into Go365 to be eligible to receive reward.
Nutritional Coaching Reward	Members who enroll in the Nutritional Coaching Program will have two opportunities to earn rewards: • $15 in rewards for completing a wellbeing check up • $15 in rewards for completing the program Members must opt into Go365 to be eligible to receive reward.
Wellness Visit	Annual $25 reward for completing an annual wellness visit.

Program Disclaimer

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

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

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

Services Not Covered by Indiana PathWays for Aging

Indiana PathWays for Aging will not pay for services that are not medically necessary or for the following services or supplies received:

- All anorectics, except amphetamines, both prescription and nonprescription
- Amphetamines when prescribed for weight control or treatment of obesity
- Any new product, service, or technology until such time as the office authorizes the coverage of the product, service, or technology. This does not apply to prescription drugs.
- Augmentation mammoplasties for cosmetic purposes
- Blepharoplasties when not related to a significant obstructive vision problem
- Cybex evaluation or testing or treatment
- Dermabrasion surgery for acne pitting or marsupialization
- Ear lobe reconstruction
- Ear piercing
- Experimental drugs, treatments, or procedures, and all related services
- Experimental radiological or surgical or other modalities and procedures, including, but not limited to, the following:
    - Acupuncture
    - Biofeedback therapy
    - Carbon dioxide five percent (5%) inhalator therapy for inner ear disease
    - Hyperthermia
    - Hypnotherapy
- Fallopian tuboplasty for infertility or vasovasostomy. This procedure is covered only in conjunction with disease.
- Hair transplants
- High colonic irrigation
- Miscellaneous procedures or modalities, including, but not limited to, the following:
    - Autopsy
    - Cryosurgery for chloasma
    - Conray dye injection supervision
    - Day care or partial day care or partial hospitalization except when provided pursuant to 405 IAC 5-20
    - Formalized and predesigned rehabilitation programs, including, but not limited to, the following:
        - Pulmonary
        - Cardiovascular
        - Work-hardening or strengthening
    - Telephone transmitter used for trans-telephonic monitor
    - Telephone, or any other means of communication, consultation from one (1) doctor to another
    - Artificial insemination
    - Cognitive rehabilitation, except for treatment of traumatic brain injury
- Otoplasty for protruding ears unless one of the following applies to the case:
    - Multifaceted craniofacial abnormalities due to congenital malformation or maldevelopment, for

example, Pierre Robin syndrome
    - You have pending or actual employment where protruding ears would interfere with the wearing of required protective devices
- Penile implants
- Perineoplasty for sexual dysfunction
- Personal comfort or convenience items, including, but not limited to, television, radio, or telephone rental
- Physician samples
- Radial keratotomy
- Reconstructive or plastic surgery unless related to disease or trauma deformity
- Removal of keloids caused from pierced ears unless one of the following is present:
    - Keloids are larger than three (3) centimeters
    - Obstruction of the ear canal is fifty percent (50%) or more
- Rhinoplasty or bridge repair of the nose in the absence of a significant obstructive breathing problem
- Rhytidectomy
- Scar removals or tattoo removals by excision or abrasion
- Services for the remediation of learning disabilities
- Services provided outside the scope of a provider's license, registration, certification, or other authority to practice under state or federal law
- Services that are not prior authorized under the level-of-care methodology
- Sliding mandibular osteotomies unless related to prognathism or micrognathias
- Treatments or therapies of an educational nature
- Under federal law, drug efficacy study implementation drugs not covered by Medicaid

Excluded Services

The benefits outlined below are not covered in the Indiana PathWays for Aging program. If a member is receiving or will receive the following services, they will be disenrolled from the Indiana PathWays for Aging Program. These benefits are available under traditional Medicaid or other waiver programs and are excluded from the programs as described below. Humana will be responsible for the member's care until the member is disenrolled. Listed below are the services excluded from the PathWays program:

- **Psychiatric treatment in a state hospital**
- **Intermediate care facilities for individuals with intellectual disabilities:** Indiana PathWays for Aging member who are admitted to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) will be disenrolled from the program and enrolled in Traditional Medicaid. Before the stay will be reimbursed by the **State**, the level of care must be approved. Humana will coordinate for members that are transitioning into an ICF/IID by working with the facility and is responsible for payment for up to sixty (60) calendar days for members placed in an ICD/IID while the level of care determination is pending.
- **Traumatic brain injury waiver:** This waiver provides home and community-based (HCBS) services to individuals who would require institutional care.
- **Community integration and habilitation waiver:** This waiver is a Medicaid HCBS waiver for children and adults with intellectual and developmental disabilities.
- **Family supports waiver:** This waiver is a Medicaid HCBS waiver for children and adults with intellectual and developmental disabilities.

Co-Pays

Humana Healthy Horizons in Indiana will not include copayment requirements from any PathWays member for Medicaid-covered services. Some members may be responsible for paying out-of-pocket costs required by the Medicare program or other Medicaid waiver liability.

Self-Referral Services

Some services will never require a referral from your Primary Medical Provider.

Indiana PathWays for Aging includes some benefits and services that are available to members on a self-referral basis. We cannot require that you receive such services from our network providers, unless otherwise noted. However, you may not self-refer to a provider who is not enrolled in IHCP.

The following services are considered self-referral services:

- Behavioral health services are self-referral if rendered by an in-network provider. You may self-refer, within our network, for behavioral health services not provided by a psychiatrist, including mental health, substance abuse and chemical dependency services rendered by mental health specialty providers.
- Chiropractic services may be provided by a licensed chiropractor, enrolled as an Indiana Medicaid provider.
- Diabetes self-management services are self-referral if rendered by a self-referral provider.
- Emergency services are covered without the need for prior authorization or the existence of a health plan contract with the emergency care provider. Emergency services shall be available twenty-four (24)-hours-a-day, seven (7)-days-a-week [subject to the "prudent layperson" standard] of an emergency medical condition.
- Eye care services, except surgical services may be provided by any provider licensed.
- Routine dental services
- Family planning services require a freedom of choice of providers and access to family planning services and supplies. (Additional information above)
- Immunizations are self-referral to any IHCP-enrolled provider. Immunizations are covered regardless of where they are received.
- Podiatric services may be provided by any provider licensed.
- Psychiatric services may be provided by any provider licensed.
- Urgent care services are covered for members on a self-referral basis.

The mental health and addiction providers to which the member may self-refer within network are:

- Advanced practice nurses (APN) under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Community mental health centers (CMHC)
- Health services providers in psychology (HSPPs)
- Independent practice school psychologists
- Licensed clinical social workers (LCSW)
- Licensed psychologists
- Licensed social workers (LSW)
- Outpatient mental health clinics
- Persons holding a master's degree in social work, marital and family therapy or mental health

counseling (under the Clinic Option)
- Psychiatric nurses
- Psychologists

Behavioral Health Services and Substance Use Disorder Services

All Indiana PathWays for Aging members can receive mental health or substance use disorder services. You may see any in-network doctor without a referral for outpatient treatment. Sometimes your PMP may be able to help with behavioral health conditions. This may be but not limited to anxiety and depression. Your PMP may suggest finding a doctor that specializes in your condition if additional help is needed.

All members have access to services to help with mental health issues like depression or anxiety, or to help with alcohol or other substance use disorders. These services include:

- Behavioral Health Services
- Services to help figure out if you have a mental health need (diagnostic assessment services)
- Individual, group, and family therapy
- Facility-based crisis programs
- Outpatient behavioral health services
- Outpatient behavioral health emergency room services
- Inpatient behavioral health services
- Intensive behavioral health treatment
- Partial hospitalization
- Other Supportive Services such as: Peer Support, Comprehensive Community Support, Caregiver Support, and Complex Care Management
- Substance Use Disorder Services

If you are having negative thoughts or feel that you may hurt yourself or someone else, call the Behavioral Health Crisis Line at 988 or 855-254-1758 or TTD/TTY: 711 immediately for help.

If you have additional questions, you can call Humana's Member Services 866-274-5888, TTD/TTY: 711

Behavioral Health Crisis Line

There may be a time where you need support and need to speak with someone right away. You can call the 24-Hour Behavioral Health Crisis Line at 988 or 855-254-1758 or TTD/TTY: 711 and receive help, 24 hours a day, 7 days a week. The behavioral health professional will guide you to the appropriate support based on your reported crisis.

If you have contacted the Behavioral Health (BH) Crisis Line...

If you have contacted the Crisis Line, a care coordinator will follow-up with you within (1) business day to ensure that you have received the needed care, offer assistance and evaluate your ongoing needs, including the potential to benefit from Care Coordination and Service Coordination and/or SDOH support.

Utilization Management (UM)

Some services may require prior authorization before you receive them. For example, we review surgeries

or stays at a hospital (unless they are emergencies). This is called utilization management (UM). It makes sure you get the right amount of care you need when you need it. We do not reward providers or our own associates for denying or limiting coverage or services. 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.

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

Managing and Coordinating Your Care

Care Coordination

As a state, Indiana strives to make sure everyone who receives long-term services and supports (LTSS) can live, learn, work, and enjoy life in the most integrated setting. The goal is for people to lead lives that are meaningful to them. To do this, we must have a person-centered support system that helps people:

- Build or maintain relationships with their families and friends
- Engage in productive activities, such as employment
- Live as independently as possible
- Participate in community life

Based on your eligibility you may select or be assigned a care coordinator and/or a service coordinator. Care and Service Coordinators are specially trained health professionals who work with you and your doctors to make sure you get the right care when and where you need it. You may change your coordinator at anytime. In general, your Care Coordinator will help you coordinate your medical needs, whereas your service coordinator specializes in supporting all your non-medical needs. Your Care and Service Coordinator (Care Team) will work together to support you in the most efficient way possible.

Your Care Team will use the information you share through the completion of a health needs screening and a more detailed comprehensive health assessment to identify your needed medical, behavioral health, and non-medical services. On an ongoing basis, your Care Team will check in with you to ensure the care and services you receive continue to meet your needs; your Care Team will make changes to your plans at any time to ensure you are getting the support you need to live your best life. These periodic updates to your plan can occur during the regular Care Team outreach to you, as your Care Team becomes aware you have experienced a change, or at your request.

In addition, with the appropriate consent, your care coordinator and/or service coordinator will notify your integrated care team if you are hospitalized or receive emergency treatment for behavioral health issues, including substance use disorder.

By engaging in person-centered practices throughout your service plan development and implementation, you are assured the opportunity to engage fully in your community to the extent you so choose. Your Service Coordinator will check in with you throughout the year to ensure your service plan continues to meet your needs.

Care Management

Care Management is the foundational Care Coordination level of service that shall be made available to all Humana Healthy Horizons in Indiana members and is intended to provide you with assistance with care coordination activities, making preventive care appointments, and/or accessing care for needed health or social services to address your chronic health condition(s). Care Management services include coordination

of care across care and service providers to assist you with scheduling, location of specialists and specialty services, intellectual and developmental disability services, transportation needs, twenty-four (24)-hour Nurse Line use, general preventive (e.g., mammography) and disease specific reminders, pharmacy refill reminders, tobacco quitting services and education regarding use of primary care and Emergency services.

Care coordinators want to learn more about you. Then they can help you learn self-care and how to get help from others. Care coordinators may meet with your PMP and other health resources to make sure they are working together. Care coordinators work to make sure you have all the services you need, including non-medical services like food and housing. If you think you need Care Management, call Member Services at 866-274-5888.

Complex Case Management

Complex Case Management is a program is for members with complex needs who need help to manage their healthcare. Our nurses and social workers will team up with you and your provider to ensure you are receiving the best care. We will contact you if:

- Your doctor recommends it.
- You ask for it.
- Our nurses and social workers see you have health issues they can help with.

To see if you qualify or get additional information about Complex Case Management Program, self-referrals, or to opt-out of the Complex Case Management Program call Member Services at 866-274-5888.

Care Coordination and Service Coordination for Members Receiving Behavioral Health Services

You may be eligible for Complex Case Management if you have been discharged from an inpatient psychiatric or substance use disorder hospital, or if you are at risk for an inpatient psychiatric, drug overdose, or substance use re-hospitalization.

A Care Coordinator or Service Coordinator will be assigned to you for at least ninety (90) calendar days following your inpatient hospitalization. They will help you understand your condition so that you improve your health and optimize your well-being without using the emergency room. Learning more about your condition and your needs will keep you informed and prepare you for your follow-up doctor visits.

Complex Case Management and Service Coordination

Members who are determined to need the level of care provided in a nursing home but are receiving supports and services in their home or community-based setting of their choice will also receive service coordination. Service Coordination is a process of assessment, discovery, planning, facilitation, advocacy, collaboration, and monitoring of the holistic long-term supports and services (LTSS) and related environmental and social needs of everyone.

Your Service Coordinator will support your health and safety so that you can continue to live where you choose and prevent or delay unnecessary institutional placement. Your Service Coordinator will:

- Collaborate with your care coordinator
- Create and implement your person-centered support plan (“Service Plan”)
- Help you access long-term services and supports
- Help you access medical, social, housing, educational, and other services, regardless of the funding source for the services
- Review and update the LTSS-specific Service Plan with you, your caregivers (with your consent), and your interdisciplinary care team (ICT).

If you have any questions about long-term care service and supports, call your Service Coordinator or Care Coordinator a at 866-274-5888.

Right Choices Program (RCP)

The Right Choices Program is part of Indiana Medicaid. It is for members who need help with using their health coverage appropriately. Its goal is to make sure your medical care is happening at the right time and place. If you are placed in the Right Choices Program, it can help you learn to use your health coverage the right way.

If you are enrolled in the Right Choices Program, you will still have all your benefits. You will have one Primary Medical Provider, also called a PMP. You will be assigned one pharmacy. Any special doctors you see will need approval from your PMP.

Pharmacy Information

Managing your medicines is important. We want you to feel comfortable knowing what medicines your plan covers. As an enrollee of the PathWays program, you can access a full range of safe and effective medicines. These medicines are part of a formulary or a Preferred Drug List (PDL). These are drugs that we prefer your provider use when choosing the best medicine to treat you and your condition.

Your provider will the use the PDL to choose the best medicine to treat you and your condition. Occasionally, your provider may need to get our approval if he or she wants you to use a medicine that is not on our PDL. Your provider also will need to get approval (sometimes referred to as prior authorization) if covered medicines have a limit such as:

- Age limit: covered for certain age group
- Quantity limits: a limit on the number of drugs you can get at one time
- Prior authorization: requires approval before it can be covered
- Step therapy: a preferred drug(s) must be tried first.

We will not cover some medications, including:

- Drugs used for eating problems or weight gain
- Drugs used for erectile dysfunction
- Drugs that are for cosmetic purposes or to help you grow hair
- Drug Efficacy Study Implementation (DESI) drugs and drugs that are identical, related, or like such drugs
- Investigational or experimental drugs
- Drugs used for any purpose that is not medically accepted

The PDL may change from time to time. New drugs are added or removed as needed. Don’t worry we will notify you if your medicine is removed from the PDL. You can find the most up to date PDL on our website at Humana.com or call Member Services at 866-274-5888 TTD/TTY: 711 for help.

Medicare Part D

Medicare Part D drug benefit plans cover prescription drugs as approved by the Centers for Medicare and Medicaid Services (CMS). For full benefit dual eligible members, Indiana Medicaid covers medically necessary, federally and State reimbursable prescription drugs that are excluded from coverage by CMS under Medicare Part D benefit plans. Drugs eligible for coverage under Medicare Part D will not be covered under Medicaid if the member refuses Part D coverage.

Participating Pharmacies

You can fill your prescription at any pharmacy that accepts Humana Healthy Horizons in Indiana. Use our online Find a Pharmacy service at Humana.com/FindaPharmacy to find an in-network pharmacy near you. Make sure to bring your member ID card with you to the pharmacy. If you have any questions call Member Services at 866-274-5888 TTD/TTY: 711.

As a Humana member, you can use Humana's mail-order pharmacy, CenterWell Pharmacy®, which will send medicine to your home.

If you need medicine to treat a complex or long-lasting condition like cancer, HIV, or multiple sclerosis, for example, you may need to get your prescription filled at a specialty pharmacy. Medicines to treat complex or long-lasting conditions may only be available at certain locations.

You may be able to fill your specialty prescriptions at our CenterWell Specialty Pharmacy®. This pharmacy will fill and mail your specialty prescription to your home or provider.

For more information, go to CenterWellPharmacy.com.

Pharmacy Copay

You may have to pay the full cost of your prescription if you fill your prescription at an out-of-network pharmacy or if the drug is not on our Preferred Drug List.

Additional Information:

We hope you don't have to pay for any medicines out of pocket. If you do, let us know by filling out a reimbursement claim form, and you may get a refund. You can find the prescription drug reimbursement claim form at Humana.com

Please contact Member Services at 866-274-5888 (TTD/TTY: 711) for help with your pharmacy questions.

Prior Authorizations and Timeframes

To request a prior authorization, you can speak with the prescribing doctor or call Humana Healthy Horizon's Member Services to get started.

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

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

- Standard review: We will decide about your request within five (5) business days of receiving the request.
- Expedited (faster) review: We will decide about your request within forty-eight (48) hours of receiving the request.
- Pharmacy request: We will decide your request within twenty-four (24) hours of receiving the request.

Note: Both timeframes for standard and expedited reviews can be extended up to 14 calendar days if the Member or the provider requests an extension, or if the Humana Healthy Horizons in Indiana justifies a need for additional information and the extension is in the member's best interest.

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

What if I Receive a Bill from My Doctor?

Humana Healthy Horizons in Indiana only pays your provider for the covered services you get.

Your provider can only bill you for non-covered services. The provider must tell you if we do not cover a service before they provide it to you. They may only charge you for the non-covered service if they told you, it was not covered before providing it, and you agreed to pay for it in writing.

If you get a bill for a service, you should take care of it right away. If you do not, it could be sent to a collection agency. To handle a bill, you should:

- Call your doctor/provider and make sure they know you are a Medicaid member.
- If you feel like the bill is wrong, contact Member Services and we will assist you with how to handle the bill. Be sure to have the bill in your hand when you call.

Additional Information

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

Changes to your Plan

Humana Healthy Horizons in Indiana will inform you of any change in your coverage including benefits, services or service delivery sites or termination of your plan to you at least thirty (30) days before the change goes into place.

Just Cause Grievances

There might be a time when you want to change your health plan but are not in your plan selection time. You may be able to due to certain reasons called “just cause.” If you have one of these reasons, you need to file a just cause grievance with us to see if you can change plans. Just cause reasons include:

Disenrollment for Cause

After you are enrolled into the plan you can change plans, when you feel you have good reason to do so. You will need to call and file a grievance to share this information with us. Please call us at 866-274-5888 or TTD/TTY 711/TTD. We will answer your questions, review your request, help you file a grievance or help you change your health plan.

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

- You lose your Medicaid Eligibility
- You move outside the State of Indiana
- You knowingly use your Member ID card incorrectly or let someone else use your Member ID card
- You fake or forge prescriptions
- If FSSA is unable to contact you by first class mail and if Humana cannot provide them with your valid address. You may remain disenrolled until either FSSA or Humana can locate you and eligibility can be restored.

If you need help changing plans Call Indiana PathWays for Aging at 877-284-9294 TTD/TTY: 711.

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

Redetermination

To continue receiving health coverage you must renew your benefits. This is called a redetermination. Depending on your income at the end of each year of your coverage, you may have to show you are still eligible. Prior to your health coverage ending, a letter will be mailed to you from Family and Social Services

Administration (FSSA). The letter is called “Notice of Renewal”. Be sure to carefully read the directions that come with your renewal form. You may be required to sign the form and return it with some information. Contact the Division of Family Resources (DFR) to ask questions. It can take about 45 days to complete your redetermination process. You will receive a notice from the Division of Family Resources and Humana Healthy Horizons in Indiana to remind you about redetermination.

We may assist you in redetermination process. However, it is important to keep your address and phone number updated so you receive notices. If your phone number or address changes, contact the Division of Family Resources (DFR) at 1-800-403-0864 as well as Humana Healthy Horizons in Indiana at 866-274-5888 TTD/TTY: 711.

How and When to Report Changes

It is important that your information is up to date. Whenever you have a change of information, you need to report it to us. Call Humana Healthy Horizons in Indiana Member Services at 866-274-5888 (TTD/TTY: 711). In some cases, you will also need to report your changes to the Department of Family Resources (DFR).

We should be updated on your contact information. This can be things like:

- Name
- Address
- Phone number
- Change in insurance (such as getting another insurance)

To the Division of Family Resources (DFR)

The Division of Family Resources should be updated on all of your general information. If you have a change in any of these, you must let DFR know. You can call 800-403-0864 to report your changes to DFR on go online.

- Name
- Address
- Phone number
- Change in family size
- Change in income

We want to hear what you think of us. If you have ideas about how we can improve, ways we can serve you better, or tell us about things you think we should change please let us know. Your feedback is important. We want you to be happy and healthy. You can provide feedback by calling Member Services at 866-274-5888 TTD/TTY: 711.

Member Rights

As a member, you have the RIGHT to:

- Be treated with dignity and respect when getting health services
- Be given information on your medical benefits and plan information
- Receive language assistance and information in accessible formats
- Be given privacy for you and your medical records
- Be given easy-to-understand explanations of your medical problems and treatment choices
- Stay involved in decisions about your treatment choices

- Be given access to care 24 hours a day, 7 days a week
- Get timely answers to your complaints or appeals
- Appeal decisions made about health care you receive
- Use buildings and services that meet the standards of the Americans with Disabilities Act (ADA). This means that persons with disabilities or physical problems can get into medical buildings and use important services.
- Get a second opinion from a different doctor
- Request and receive a copy of your medical records and request that they be changed or corrected
- The right to say no to treatment or therapy. If you say no, the health care provider or health plan must talk to you about what could happen, and a note must be place in your medical record about the treatment refusal.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations. This means a doctor cannot make you do something you do not want to do. The doctor cannot try to get back at you for something that you may have done.
- Free from any restrictions on freedom of choice among network providers.
- Receive information on available treatment options and alternatives, presented in a way that is right for your condition and that you can understand.
- To choose between receiving your long-term care needs in a Nursing Facility or while living your own home and receiving care and services through Home and Community Based Services to meet your long-term care needs.
- Make recommendations regarding the members rights and responsibilities policy. Get a copy of your health and claims records
- Ask to fix your health and claims records if you think they are wrong or not complete
- Ask for private communications
- Ask us to limit what we use or share
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Give us consent to speak to someone on your behalf
- File a complaint if you feel your rights are violated.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

- sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201.
- calling 1-877-696-6775.
- visiting their website at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Member Responsibilities

As a member, you have the RESPONSIBILITY to:

- Tell your doctor (PMP) about your medical conditions to the best of your ability.
- Call your personal doctor (PMP) for all your medical care.
- Keep all your appointments. If you cannot keep an appointment, call to cancel or reschedule as soon as you can.
- Tell your doctor if you do not understand what he or she tells you about your condition, care, or what you need to do.

- Call your doctor if you are not sure if you are having a true emergency.
- Follow plans and instructions for care that they agree to with their practitioner.
- Follow the rules of your doctor's office.

Your information is protected in many ways. This includes your information that is written, spoken, or available online. Humana Healthy Horizons in Indiana is trained on how to protect your information. Very few people can access your information. We are required by law to keep the privacy and security of your health information. If a breach occurs and any of your information is exposed, we will let you know quickly.

Humana Healthy Horizons in Indiana must follow the duties and privacy practices described in this notice. We must give you a copy of it. Humana Healthy Horizons in Indiana will not use or share your information other than as listed here unless you tell us we can in writing.

You may change your mind at any time. Let us know in writing if you change your mind.

You will not be treated any differently if you call with a complaint or grievance.

Outreach and Education Regarding Critical Incidents

You will find important information in your Humana Healthy Horizons in Indiana welcome packet and on the website about all types of critical incidents (CI). HCBS providers are required to submit an incident report for any reportable incident within forty-eight (48) hours of the time of the incident or becoming aware of the incident. However, if an initial report involves a member death, or an allegation or suspicion of abuse, neglect or exploitation, the report must be submitted within twenty-four (24) hours of "first knowledge" of the incident. A Critical Incident may include but is not limited to:

- Alleged, suspected, reported, observed, or actual abuse, neglect, or exploitation done to you (ANE)
- Unexpected death; or
- Significant injuries requiring emergent medical intervention, including, but not limited to, the following:
    - o A fracture
    - o A burn greater than first degree
    - o Choking that requires intervention
    - o Contusions or lacerations
- Suicidal thoughts or suicide attempt that had the potential to cause physical harm, injury, or death
- Admission of an individual to a nursing facility, excluding respite stays
- Member elopement or missing person
- Inadequate formal or informal support for you, including inadequate supervision which endangers you
- Medication errors resulting in outcomes that require medical treatment beyond an ER/physician evaluation or monitoring vital signs
- A residence that compromises your health and safety due to any of the following:
    - o A significant interruption of a major utility
    - o An environmental, structural, or other significant problem
- Environmental or structural problems associated with a dwelling where individuals reside that compromise the health and safety of the individuals
- A residential fire resulting in any of the following:
    - o Relocation.
    - o Personal injury
    - o Property loss

- Suspected or observed criminal activity by:
  - A staff member, employee, or agent of the provider
  - Your family member
  - You; when your care is impacted or potentially impacted
- Police arrest you or any person responsible for your care
- A major disturbance or threat to public safety created by you. The threat can be:
  - toward anyone, including staff; and
  - in an internal setting; and
  - need not be outside your residence
- Any use of restraint that results in harm to you
- Falls with injury, in accordance with the U.S. Center for Disease Control's (CDC) Behavioral Risk Factor Surveillance System (BRFSS)

Any incident of abuse, neglect or exploitation should be reported to Adult Protective Services. Here are the ways to submit a report:

- By Phone: 800-992-6978
- Online Reporting: https://aps-govcloud.my.site.com/APSOnlineReport/s/

For more information, visit https://www.in.gov/fssa/da/adult-protective-services/

ANE, death and any other critical incident that occurs within any HCBS (Home and Community Based Services) setting should be reported to FSSA (Family and Social Services Administration) website at https://ddrsprovider.fssa.in.gov/IFUR/.

Grievances and Appeals

Inquiry (Questions)

An inquiry refers to a concern, issue, or question expressed by you. Humana must resolve your inquiries by the close of the next business day after receipt. If an inquiry is not resolved in this timeframe, it becomes a grievance.

Grievances

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

Grievances and appeals are not the same thing. You can use the appeal or grievance process, depending on what type of issue you are experiencing. An appeal is a request for Humana to review an adverse benefit determination (benefit denial). A grievance is any other dissatisfaction that does not involve an adverse benefit determination. Once an appeal or grievance is received, we will provide you with a copy of your file/records.

If you have a complaint or problem with the care you are getting, you can file a grievance with us. You can file a Grievance in writing or by calling Member Services, you can also complete your Grievance on Humana.com.

You can first talk to your doctor or provider if you have any questions or concerns about your care. They can work with you on fixing the problem. If the problem isn't fixed, you can call Member Services.

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

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

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

- Calling Member Services at 866-274-5888 (TTD/TTY: 711).
- Filling out the form in the back of this Member Handbook
- Writing us a letter
    - Be sure to put your first and last name, the Member number from the front of your Humana Member ID card, and your address and phone number in the letter. This will allow us to contact you if we need to. You should also send any information that helps explain your problem.
- Submitting a request online on humana.com
- Faxing your grievance to 800-949-2961
- Mailing the form or letter to:

    Humana

    Grievance and Appeals Department

    P.O. Box 14169

    Lexington, KY 40512

We will send you a letter within three (3) business days from the day we receive your grievance to let you know we received it.

We will then review it and send you a letter within 30 calendar days to let you know our decision. If your grievance is a result of a health crisis, please request an expedited (faster) review. Expedited grievances will be reviewed within 48 hours of receipt.

Negative actions will not be taken against:

- You if you file a grievance
- A provider that supports your grievance or files a grievance on your behalf, with written consent

Appeals

If you have questions or concerns about not getting the care you need, you can file an appeal with Humana. You can file an appeal in writing, by calling Member Services, or completing your appeal online at Humana.com.

If you are unhappy with a benefit denial or action we take, you or your authorized representative can file an appeal. An appeal is asking for a review because you do not agree with a decision the State, or Humana has made. You have the right to file an appeal if you disagree with the decision. You do not have to pay to file an appeal. You can also appeal if Medicaid or Humana stop providing or paying for all or part of a health care service, supply, or prescription drug you think you still need.

You must file your appeal within 60 calendar days from the date on the denial letter which is called the Notice of Adverse Benefit Determination. You can file by calling or writing to us.

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

- Someone you choose to act for you, with your written consent
- Your legal guardian

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

You can file an appeal by:

- Calling Member Services at 866-274-5888 (TTD/TTY: 711).
- Filling out the form in the back of this handbook and sending it to us at the address below
- Writing us a letter
    - Be sure to put your first and last name, the Member number from the front of your Humana ID card, and your address and phone number in the letter. This will allow us to contact you if we need to. You should also send any information that helps explain your appeal.
- Submitting a request online at on https://resolutions.humana.com/grievances-appeals-forms/member-info
- Faxing your appeal to 800-949-2961
- Mailing the form or letter to:

    Humana

    Grievance and Appeals Department

    P.O. Box 14169

    Lexington, KY 40512

We will send you a letter within three (3) business days from the receipt of your appeal request to let you know we received it.

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

- Review all the information used to make the decision
- Provide more information throughout the appeal review process
- Examine the Member's case file before and during the appeals process
    - This includes medical records, other documents, and any new or additional evidence considered, relied upon, or generated by us, or at our direction, in connection with the appeal

This information will be provided free of charge and sufficiently in advance of the resolution timeframe.

If you feel waiting for the 30-day timeframe to resolve an appeal could seriously harm your health, you can request that we decide faster and expedite the appeal. For your appeal to be expedited, it must meet the following criteria:

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

We make decisions on expedited appeals within 48 hours, or as fast as needed based on your health. Negative actions will not be taken against:

- You or provider who files an appeal
- A provider that supports your appeal or files an appeal on your behalf, with written consent

If we extend the timeframe for your appeal or decide expedited criteria is not met we will make reasonable efforts to give you prompt oral notice of the delay, and give you written notice of the reason for the decision to extend the timeframe within two (2) calendar days. If we need to extend the timeframe for your appeal, we will:

- Write you and tell you what information is needed. For expedited appeals, we will call you right away and send a written notice later.

- Explain why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You can present, in person or in writing, evidence (such as medical records, supporting statements from a provider, etc.) to include with your appeal submission prior to the end of the appeal resolution timeframe. For a standard appeal, we must receive this information within 30 calendar days of us receiving your appeal. For an expedited appeal, we must receive any supporting information within 48 hours of receipt of the appeal.

External Review by Independent Review Organization

If you do not agree with the appeal decision, you may also request an External Review by an Independent Review Organization (IRO). You or your authorized representative must request the IRO review in writing within 120 calendar days of the date on your appeal decision letter. The IRO will be conducted at no cost to you. Requesting an external review does not limit your ability to request a state fair hearing. You can request review by an IRO and a state fair hearing at the same time.

The IRO will decide your appeal within 15 business days for a standard appeal, or within 72 hours for an expedited appeal. The decision by the IRO is binding, meaning Humana will follow their decision. To request the External Review by an Independent Review Organization, reach out to Humana in writing.

Information to include when requesting an External Review:

- Name
- Medicaid ID number
- Phone number where you can be reached
- Reason for your appeal
- Any information you feel is important to your appeal request (examples include documents, medical records, or provider letters)

State Fair Hearing

Once a decision is made on your appeal, a Notice of Appeal Resolution letter will be sent to you. This letter will tell you the reason for the decision. If you feel the decision is not correct, you may request a State Fair Hearing. You can write a letter telling the State why you think the appeal decision is wrong. Please make sure to also include your name and other important information, like the dates of the decision, which is on the letter. Send your appeal to:

Mail: Office of Administrative Law Proceedings
100 N. Senate Avenue, Room N802,
Indianapolis, IN 46204

Phone: 317-234-3488 or 866-259-3573 (toll free)

Fax: 317-232-4412

Email: fssa.appeals@oalp.in.gov

If you file a state fair hearing request, you must do it within 120 calendar days after the date on the denial letter. If your appeal is about a service you are still using, like in-home healthcare, you will get at least 10 days notice before your service is stopped.

At your state fair hearing, you can speak for yourself or have help, or representation, from legal counsel, a friend, relative, or someone you trust to speak for you. You will be shown your entire medical case file. You will be shown all materials used by FSSA, your county office, the provider or Humana that relate to your appeal and were used to make the original decision.

Continuation of Benefits during the Appeal Process

For some service denials, you may request to continue services during the appeal and Medicaid Fair Hearing process. Services that can be continued must be services that you are already receiving, including services that are being reduced or terminated. Also, the original time period for those services must not have expired. We will continue services if you request a continuation of benefits within ten (10) days from our Notice of Adverse Benefit Determination letter, or before the date we told you the services would be reduced or terminated, whichever is later. Your benefits will continue until one of the following occurs:

- Until the original authorization period for your services has ended
- If you do not request a State fair hearing and your benefits continue for 10 calendar days from the date of the letter of the decision to deny the service or the appeal decision.
- You withdraw your appeal.
- Following a Medicaid Fair Hearing, if the Administrative Law Judge issues a decision that is not in your favor

If the Administrative Law Judge agrees with Humana's first decision to deny your service, then you may be required to pay for these services.

State Ombudsman/Adult Protective Services (APS)

An Ombudsman is an official who investigates complaints and attempts to resolve issues. If you like, the State ombudsman can participate on your interdisciplinary team to the extent that the staff person makes recommendations as necessary to fulfill their APS/any relevant State ombudsman responsibilities. Humana has a designated staff person to serve as your advocate and liaison between APS, any relevant State ombudsman, and you to assist APS and any relevant State ombudsman staff working in developing service options. If you need help contacting an Ombudsman, your Care and/or Service Coordinator can help, or you can find information on how to contact an Ombudsman at 800-622-4484 or 317-232-7134.

Fraud, Waste, and Abuse

Fraud, waste, and abuse means breaking the rules for a personal gain. Fraud can be committed by providers, pharmacies, or members. Examples of provider fraud, waste and abuse include doctors or other health care providers who:

- Bill for more expensive services than provided
- Bill for tests or services that were not provided
- Don't provide patients with medically necessary services due to lower reimbursement rates
- Prescribe medicine, equipment or services that are not medically necessary
- Prevent members from getting covered services, resulting in underutilization of services
- Use wrong medical coding on purpose to get more money
- Schedule more frequent return visits than are medically necessary
- Not dispensing drugs as written
- Submitting claims for a more expensive brand-name drug that costs but giving a generic drug that costs less

Examples of member fraud, waste, and abuse include:

- Inappropriately using services, such as selling prescribed narcotics or trying to get controlled substances from more than one provider or pharmacy
- Changing or forging prescriptions

- Using medications that you do not need
- Sharing your ID card with another person
- Not disclosing that you have other health insurance coverage
- Getting unnecessary equipment and supplies
- Receiving services or medicines under another person's ID (identity theft)
- Giving wrong symptoms and other information to providers to get treatment, drugs, etc.
- Visiting the ER repeatedly for problems that are not emergencies

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

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

Reporting Fraud, Waste, or Abuse

If you think a doctor, pharmacy or Member is committing fraud, waste, or abuse, you must inform us. You can call our fraud reporting line, send an email, or fill out and mail a form. You do not have to tell them your name if you call or write. If you do not give your personal information, we will not be able to call for other information. Do not send any sensitive personal information through email. Your report will be kept confidential to the extent permitted by law.

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

We monitor and take action on all provider, pharmacy, or Member fraud, waste, and abuse. Report it to us in one of these ways:

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

  Humana

  Attn: Special Investigations Unit

  1100 Employers Blvd.

  Green Bay, WI 54344
- You can go to our website, humana.com/legal/fraud-waste-and-abuse and fill out the form.

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

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

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

information. Your report will be kept confidential to the extent permitted by law.

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

This can help protect your privacy.

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

Call toll-free: 800-403-0864, Monday to Friday, 8 a.m. to 4:30 p.m. Select option 5. When prompted, enter your zip code.

Fax: 317-234-2244

Email: ReportFraud@fssa.IN.gov

Fraud Reporting Lines

Call toll-free: 800-403-0864, Monday to Friday, 8 a.m. to 4:30 p.m. Select option 5. When prompted, enter your zip code.

Fax: 317-234-2244

Email: ReportFraud@fssa.IN.gov

Fraud Reporting Mailing Addresses:

FSSA Compliance Division

Room E-414

402 W. Washington St.

Indianapolis, IN 46204

Advance Directives

Advance directives are instructions you give about your future medical care in case there is a time you can't speak or make decisions for yourself. By having an Advance Directive in place this will not take away your right to decide your current health care choices. The Advance Directive also allows you to name a person to make decisions on your health care. They help your family and physician understand your wishes. With advance directives, you can:

- Let your doctor know if you would or would not like to use life-support machines
- Let your doctor know if you would like to be an organ donor
- Give someone else permission to say "yes" or "no" to your medical treatments

Advance directives are only used if you can't speak for yourself. It does not take away your right to make a different choice if you later become able to speak for yourself. You can make an advance directive by:

- Talking to your doctor and family
- Choosing someone to speak or decide for you, known as a health care representative
- Creating a Power of Attorney and/or Living Will

Type of Advance Directives Recognized in Indiana

- Health Care Representative
- Living Will Declaration or Life-Prolonging Procedures Declaration

- Organ and tissue donation
- Out of Hospital Do Not Resuscitate Declaration and Order Physician Orders for Scope of Treatment (POST)
- Power of Attorney
- Psychiatric advance directives

For more information on Advance Directives and to find forms available to you, please visit Indiana Health Care Quality Resource Center https://www.in.gov/isdh/25880.htm.

Mental Health Advance Directive

You may also state your specific preferences regarding mental health treatment. For example, you may not want certain types of medication or treatment.

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

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

Living Will

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

- Refuse or request life prolonging treatment (This is a treatment taken to sustain life of a critically ill person to save their life)
- Refuse or request artificial feeding or hydrations (feeding tube or hydration IVs)
- Express your wishes regarding organ donation (Donation of organs)

A Health Care Surrogate is allowed to make health care decisions for you if you lose the ability to decide for yourself.

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

Living Wills must be in writing. They must be signed and dated by you and witnessed according to Indiana law.

Member Advisory Committee

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

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

If you would like to attend or would like more information, please contact us.

CALL: 866-274-5888

TTD/TTY: 711

WEBSITE: humana.com/healthyIndiana

Quality Improvement

Program Purpose

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

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

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

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

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

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

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

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

Program Scope

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

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

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

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

Quality Measures

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

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

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

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

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

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

Potential CAHPS® measures for the plan are:

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

Discrimination is Against the Law

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

Humana Inc .and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - o Qualified sign language interpreters
    - o Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Member Services at 866-274-5888 (TTD/TTY: 711).

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

Discrimination Grievances

P.O.Box 14618

Lexington, KY 40512 – 4618

866-274-5888 (TTD/TTY: 711) or if you use a TTD/TTY, call 711.

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

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building Washington, D.C.20201

1-800-368-1019, 800-537-7697 (TTD/TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Other Plan Details

Privacy Notices

This notice describes how health information about you may be legally used and shared. If your information is used, Humana Healthy Horizons in Indiana must follow the State and federal rules. You have the right to know what was shared.

Choices

You can choose what information we share and with whom we share it. You may have to give written permission to share.

If you can't choose, such as while being unconscious, we may share information if they believe it to be in your best interest.

We may not be able to share your information with people unless you give written consent. These may be people like a family member or close friend who pays for your care.

Uses

Humana uses your information for different things. They use it to help get you better care, to do research, and to follow the law.

Rights and Protections

Notice of Privacy Practices

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

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

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

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

What is nonpublic personal or health information?

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

How do we collect information about you?

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

What information do we receive about you?

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

How do we protect your information?

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

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

How do we use and disclose your information?

We use and disclose your information:

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

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care.
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For healthcare operation activities, including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform, plan administration functions such as eligibility, enrollment, and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission, or your plan sponsor must certify they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you. If you have opted out, we will not contact you.
- To your family and friends if you are unavailable to communicate, such as in an emergency.
- To your family and friends, or any other person you identify. This applies if the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation.
- To public health agencies, if we believe that there is a serious health or safety threat.
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence.
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For law enforcement purposes, to military authorities and as otherwise required by law.
- To help with disaster relief efforts.
- For compliance programs and health oversight activities.
- To fulfill our obligations under any workers' compensation law or contract.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For research purposes in limited circumstances and provided that they have taken appropriate measures to protect your privacy.
- For procurement, banking, or transplantation of organs, eyes, or tissue.
- To a coroner, medical examiner, or funeral director.

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

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

The following uses and disclosures will require your written permission:

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

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

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

What are my rights concerning my information?

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

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. As required under applicable law, we will make this personal information available to you or to your designated representative.
- Adverse Underwriting Decision – If we decline your application for insurance, you have the right to be provided a reason for the denial.
- Alternate Communications – To avoid a life-threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request correction of any of this personal information through amendment or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion of the information in dispute, or of our refusal to make such correction after further investigation. If we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute.*
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information.

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

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

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

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

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

we will not punish or retaliate against you in any way.

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

Our Responsibilities

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

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

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

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

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

- Contacting us at 1-866-861-2762
- Accessing our website at Humana.com and going to the Privacy Practices link
- Send completed request form to:

  Humana Inc. Privacy Office 003/10911

  101 E. Main Street

  Louisville, KY 40202

Other Insurance/Subrogation

If you have other medical insurance, please call Member Services at 866-274-5888 (TTD/TTY: 711) to let us know. You may have medical insurance through your job, or your children may be insured through their other parent.

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

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

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

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

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

- The person at fault;

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

Medical Record Requests

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

- If you would like a copy of your information, please send a written request to the Humana privacy officer or by calling member services.
- Humana will provide you a copy of your medical records at any time.
- Humana will respond to requests within 30 days of receipt.
- Humana may ask for an extra 30 days if necessary. We will let you know if we need the extra time.
- Humana has the right to keep you from having or seeing all or parts of your records for specific reasons related to HIPAA and State law.
- Humana will tell you the reasons in writing.
- Humana will give you information on how to file an appeal if you disagree with our decision.

Words and Acronyms used in this manual

Advance Directives or Living Will	A written explanation of a person's wishes about medical treatments. This often is called a living will. This makes sure wishes are done if a person cannot tell a provider.
Annual Physical	Visits to a Primary Medical Provider (PMP) each year to check your health. This is often referred to as a wellness visit, preventive health exam or checkup.
Appeal	A written or verbal request for a decision to be reversed.
Benefit	Health care service coverage that a Medicaid member receives for the treatment of illness, injury, or other conditions allowed by the State.
Case Management	Program for members with special health conditions that help members manage their conditions by routine contact and help from their health plan.
Copayment	A form of cost sharing. Copayments or "co pays" refer to a specific dollar amount that an individual will pay for a particular service, regardless of the price charged for the service. The payment may be collected at the time of service or billed later.
Covered Service	Mandatory medical services required by CMS and optional medical services approved by the State that are paid for by Medicaid. Examples of covered services are prescription drug coverage and physician office visits.
Division of Family Resources (DFR)	A Division of the Family and Social Services Administration. The State agency that determines eligibility for Medicaid, offers help with job training, public assistance, supplemental nutrition assistance, and other services..
Eligible Member	Person certified by the State as eligible for medical assistance.
Explanation of Benefits (EOB)	An explanation of services rendered by your provider and any payments made toward those expenses..

Family and Social Services Administration (FSSA)	An umbrella agency responsible for administering most Indiana public assistance programs; includes the Office of Medicaid Policy Planning, the Division of Aging, the Division of Family Resources, the Division of Mental Health and Addiction and the Division of Disability & Rehabilitative Services.
Grievance	A compliant about the health plan or providers.
Health Needs Screening (HNS)	A questionnaire members must complete so we are aware of any healthcare conditions. This allows the health plan to match the members with the right programs and services.
Home and Community- Based Services (HCBS)	Services that are provided, pursuant to the Indiana Section 1915(c) waiver, as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility.
Indiana Health Coverage Programs	The name used to describe all of Indiana's public health assistance programs, such as Medicaid, PathWays, and CHIP.
In Network	When a doctor, hospital or other provider accepts your health insurance plan that means they are in network. We also call them participating providers.
Managed Care Entity (MCE) or Managed Care Organization (MCO)	Organizations or health plans that oversee the overall care of a patient so as to ensure cost-efficient quality health care to its members.
Medicaid Identification Number	The unique number assigned to a member who is eligible for Medicaid services. This number can be found on the front of your Member ID card.
Medically Necessary	Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
Non-Participating Provider	A licensed health care professional who has not signed a contract to give services. This could be a doctor, hospital or other provider.
Primary Medical Provider (PMP)	A physician or advanced practice nurse, the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist may be considered a primary medical provider.
Prior Authorization	An authorization required for the delivery of certain services. The Medical Services Contractor and State medical consultants review PA for medical necessity, reasonableness, and other criteria. The PA must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances.

Humana Healthy Horizons Grievance and Appeal Office Appointment of Representative Form

Member name _____

Medicaid 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 of signature

Address _____

Phone number _____

Humana
Healthy Horizons®
in Indiana

Call If You Need Us

If you have questions or need help reading or understanding this document, call us at **866-274-5888 (TTY: 711)**. We are available Monday through Friday, from 8 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, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **866-274-5888** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, **Office for Civil Rights** electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/complaints/index.html**.

Auxiliary aids and services, free of charge, are available to you. **866-274-5888 (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 Indiana is a Medicaid Product of Arcadian Health Plan, Inc.

Language assistance services, free of charge, are available to you.
866-274-5888 (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.

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

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

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

Nederlands (Dutch) Bel het bovenstaande nummer om gratis taalkundige hulp te ontvangen.

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.

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

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

हिंदी (Hindi) भाषा सहायता सेवाएं मुफ्त में प्राप्त करने के लिए ऊपर के नंबर पर कॉल करें ।.

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

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

Polski (Polish) Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

Srpsko-hrvatski (Serbo-Croatian) Nazovite gore navedeni broj ako želite besplatne usluge jezične pomoći.

Italiano (Italian) Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

Questions?

Call member services at 866-274-5888 (TTY: 711)

Humana

Healthy Horizons®
in Indiana

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