HOW TO REACH US

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee Services</td>
<td>1-800-444-9137, TTY: 711</td>
</tr>
<tr>
<td>Online</td>
<td><a href="http://www.humana.com/KentuckyMedicaid">www.humana.com/KentuckyMedicaid</a></td>
</tr>
<tr>
<td>Transportation</td>
<td>1-888-941-7433</td>
</tr>
<tr>
<td>Mail</td>
<td>Humana</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 14546</td>
</tr>
<tr>
<td></td>
<td>Lexington, KY 40512-4546</td>
</tr>
<tr>
<td>Concierge Services for Accessibility</td>
<td>1-877-320-2233</td>
</tr>
</tbody>
</table>

Hours of Service

Enrollee Services is open 7am to 7pm, Monday through Friday. After business hours, or when our office is closed, you can reach us by:

- Choosing an option from our phone menu that meets your needs

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

Humana is closed on the following days it observes major holidays:

- New Year’s Day: Wednesday, January 1, 2020
- Memorial Day: Monday, May 25, 2020
- Independence Day: Saturday, July 4, 2020
- Labor Day: Monday, September 7, 2020
- Thanksgiving Day: Thursday, November 26, 2020
- The day after Thanksgiving: Friday, November 27, 2020
- Christmas Eve: Thursday, December 24, 2020
- Christmas Day: Friday, December 25, 2020
You are now an enrollee of Humana, welcome!

Thank you for joining Humana! We are happy to have you as an enrollee. Our main goal is to keep you healthy and we aim to keep it simple for you. We know that the health care system can be complicated. This handbook has everything you need to know about your health care plan.

Humana is a managed care health plan serving the Commonwealth. This handbook will answer many of your questions. Please take time to read it and keep it in case you need to look something up.
WORDS TO KNOW

Abuse – The payment for items or services when there is no legal entitlement to that payment and the health care provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Advance Directives – Legal papers you create and sign in case you become seriously ill or if you want to name a Health Care Surrogate. These documents let your doctor and others know how you want to be treated if you get very sick and cannot speak for yourself.

Appeal – A statement from you saying you are unhappy with a decision or action taken by Humana and requesting reconsideration of a decision or action.

Appointment – A visit you set up to see a provider.

Authorized Representative – A person the enrollee allows in writing to make his or her health-related decisions.

Benefits – What is covered by Humana.

Care Management – A process for Humana to assign someone to help you get the care you need.

Claim – Bill for services.

Covered Services – Medically necessary health care services Humana must pay for.

Disenrollment – The removal of an enrollee from Humana benefits.

Dual Eligible – A person who has Medicaid and Medicare.

Durable Medical Equipment – Equipment that can be used more than once for health services.

Durable Power of Attorney for Healthcare – A written agreement between you and another person that lets the other person make medical and/or financial decisions for you if you cannot speak for yourself.

Expedited Appeal – Review done fast to meet an enrollee’s health need.

Federal Poverty Level (FPL) – Income guidelines used by programs such as WIC or SNAP as a way to set eligibility criteria.

Formulary – List of generic and brand name medications that we cover.
**Fraud** – Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

**Grievance** – A complaint about the plan or its health care providers.

**Health Care Services** – Care related to the health of an enrollee, such as preventive, diagnostic or treatment.

**Health Care Surrogate** – An adult who you have picked to make health decisions for you when you are not able to.

**HIPAA** - the Health Insurance Portability and Accountability Act, a US law designed to provide privacy standards to protect patients’ medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

**Medical Home** – The relationship you have with your primary care provider (PCP) is considered your “medical home.”

**Medically Necessary** – Services or supplies to diagnose, treat, correct, or prevent an enrollee’s illness or injury.

**Enrollee** – A person eligible for Medicaid who has joined the plan and gets health care services.

**Notice of Action** – A response from Humana giving a decision.

**Out of Network** – A doctor, hospital, pharmacy or other licensed health care professional who has not signed a contract to provide services to Humana enrollees.

**Participating Provider** – A doctor, hospital, pharmacy or other licensed health care professional who has signed a contract agreeing to provide services to Humana enrollees. They are listed in our Provider Directory.

**Pharmacy** – Drug store.

**Presumptively Eligible** – Enrollees, including pregnant women and children up to age one (1), may be “presumptively eligible” if s/he is a resident of Kentucky and meets certain income levels. This means prenatal care for the pregnant woman or other services will be given while an application for Medicaid is being processed.

**Primary Insurance** – Insurance you may have that is not Medicaid.

**Post-Stabilization Care** – This is care you get after you have received emergency medical services. It is to help you return to better health.
Power of Attorney – A written agreement between two people that lets one person act and decide for another person on certain matters; the durable power of attorney (see above) remains when you can no longer make decisions.

Preferred Drug List (PDL) – A list of covered pharmacy medicines.

Preventive Care – Care that an enrollee gets from a doctor to help keep the enrollee healthy.

Primary Care Provider (PCP) – A participating provider you have chosen to be your own doctor. Your PCP works with you to coordinate your health care.

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

Provider Directory – A list of the doctors and other health care providers you can go to for care.

Provider Network – A list of all health care providers actively participating with the plan (“participating providers”). The Provider Directory is created from this list.

Referral – A request from a PCP for his or her patient to see a specialist, such as a surgeon.

Supplemental Security Income – A federal funding program designed to help aged, blind, and disabled people, who have little or no income; and provides cash to meet basic needs for food, clothing, and shelter.

Specialist – A doctor who focuses on a particular kind of health care such as a surgeon or a cardiologist (heart doctor).

Step Therapy – In managed medical care step therapy is an approach to prescription intended to control the costs and risks posed by prescription drugs. The practice begins medication for a medical condition with the most cost-effective drug therapy and progresses to other more costly or risky therapies only if necessary.

Urgent Care – Needed care for an injury or illness that should be treated within 24 hours, usually not life threatening.

Utilization Management – This is a review process that looks at services delivered to enrollees.

Waste – Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.
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MEDICAID STATE PLAN INFORMATION

Medicaid State Plan Enrollee ID Card

Humana gives all enrollees an ID card. Your State Plan enrollee ID card looks like this. The front side has personal information. The card also has key Humana phone numbers.

Every person in your family who is an enrollee will get their own ID card. Each card is good for as long as the person is an enrollee of Humana or until we send you a new one. You will also get a new card if you ask for one. You will get a new card if you change your PCP.

Always Keep Your Enrollee ID Card with You

Never let anyone else use your enrollee ID card. Be sure to show it each time you get health care services. You need it 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 for any reason
- Get medical supplies
- Get a prescription
- Have medical tests

Be sure to have a picture ID with you. Your doctor or provider may ask you for your Humana ID card and a picture ID.
Remember, when you call us, please have the enrollee ID number on your Humana enrollee ID card available. This will help us serve you faster. Call Enrollee 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 a baby so we can send you an enrollee ID card for your baby
- You have any questions on how to use your Humana enrollee ID card

**Important Phone Numbers**

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee Services</td>
<td>1-800-444-9137</td>
</tr>
<tr>
<td>Behavioral Health Enrollee Services</td>
<td>1-800-444-9137</td>
</tr>
<tr>
<td>24-Hour Nurse Advice Line</td>
<td>1-800-648-8097</td>
</tr>
<tr>
<td>Behavioral Health Crisis Line</td>
<td>1-833-801-7355</td>
</tr>
<tr>
<td>Case Management</td>
<td>1-888-285-1121</td>
</tr>
<tr>
<td>Concierge Services for Accessibility</td>
<td>1-877-320-2233</td>
</tr>
<tr>
<td>Dental</td>
<td>1-800-444-9137</td>
</tr>
<tr>
<td>Department for Community Based Services (DCBS)</td>
<td>1-855-306-8959</td>
</tr>
<tr>
<td>Disease Management</td>
<td>1-888-285-1121</td>
</tr>
<tr>
<td>Vision</td>
<td>1-800-444-9137</td>
</tr>
<tr>
<td>To report Medicaid Fraud and Abuse</td>
<td>1-800-372-2970</td>
</tr>
<tr>
<td>To request a Medicaid State Fair Hearing</td>
<td>1-800-635-2570</td>
</tr>
<tr>
<td>To file a complaint about Medicaid Services</td>
<td>1-800-372-2973</td>
</tr>
<tr>
<td>To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults</td>
<td>1-877-597-2331</td>
</tr>
<tr>
<td>To find out information about domestic violence</td>
<td>1-800-799-7233</td>
</tr>
<tr>
<td></td>
<td>TTY: 1-800-787-3224</td>
</tr>
</tbody>
</table>
SERVICES: WHAT IS COVERED UNDER THE MEDICAID STATE PLAN

We cover all medically necessary Medicaid-covered services. These services are equal to the services that are provided to Medicaid enrollees under the fee-for service program in the same amount, period of time and scope. The services should meet your medical needs as ordered by your physician and help you achieve age-appropriate growth and development; and help you to attain, maintain, or regain functional capacity. Services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the Enrollees ongoing need for such services and supports.

Below is a list of your covered services you receive as a Humana enrollee.

**Covered Services**

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative Birth Center Services</td>
</tr>
<tr>
<td>Ambulatory Surgical Center Services*</td>
</tr>
<tr>
<td>Behavioral Health Services – Mental Health and Substance Abuse Disorders*</td>
</tr>
<tr>
<td>Chiropractic Services</td>
</tr>
<tr>
<td>Community Mental Health Center Services*</td>
</tr>
<tr>
<td>Dental Services, including oral surgery, orthodontics and prosthodontics*</td>
</tr>
<tr>
<td>Durable Medical Equipment, including prosthetic and orthotic devices, and disposable medical supplies*</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening and special services</td>
</tr>
<tr>
<td>End Stage Renal Dialysis Services</td>
</tr>
<tr>
<td>Family Planning Services in accordance with federal and state law and judicial opinion</td>
</tr>
<tr>
<td>Hearing Services, including hearing aids for enrollees under age 21</td>
</tr>
<tr>
<td>Home Health Services*</td>
</tr>
<tr>
<td>Hospice Services (non-institutional only)*</td>
</tr>
<tr>
<td>Independent Laboratory Services</td>
</tr>
<tr>
<td>Inpatient Hospital Services*</td>
</tr>
<tr>
<td>Inpatient Mental Health Services*</td>
</tr>
</tbody>
</table>
### Covered Services (continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meals and Lodging for Appropriate Escort of Enrollees*</td>
<td>Medical Detoxification, meaning management of symptoms during the acute withdrawal phase from a substance to which the individual has been addicted</td>
</tr>
<tr>
<td>Medical Services, including but not limited to, those provided by Physicians, Advanced Practice Registered Nurses, Physicians Assistants and FQHCs, Primary Care Centers and Rural Health Clinics*</td>
<td></td>
</tr>
<tr>
<td>Organ Transplant Services not considered investigational by the FDA*</td>
<td></td>
</tr>
<tr>
<td>Other Laboratory and X-ray Services</td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital Services*</td>
<td></td>
</tr>
<tr>
<td>Outpatient Mental Health Services*</td>
<td></td>
</tr>
<tr>
<td>Pharmacy and Limited Over-the-Counter Drugs including Mental/Behavioral Health Drugs*</td>
<td></td>
</tr>
<tr>
<td>Podiatry Services</td>
<td></td>
</tr>
<tr>
<td>Preventive Health Services, including those currently provided in Public Health Departments, FQHCs/Primary Care Centers, and Rural Health Clinics</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facilities (Level I and Level II)*</td>
<td></td>
</tr>
<tr>
<td>Specialized Case Management*</td>
<td></td>
</tr>
<tr>
<td>Specialized Children’s Services Clinics*</td>
<td></td>
</tr>
<tr>
<td>Targeted Case Management*</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Evaluation and Treatment, including Physical Therapy, Speech Therapy, Occupational Therapy*</td>
<td></td>
</tr>
<tr>
<td>Transportation to Covered Services, including Emergency and Ambulance Stretcher Services*</td>
<td></td>
</tr>
<tr>
<td>Urgent and Emergency Care Services</td>
<td></td>
</tr>
<tr>
<td>Vision Care, including vision examinations, services of Opticians, Optometrists and Ophthalmologists, including eyeglass for Enrollees Under age 21</td>
<td></td>
</tr>
</tbody>
</table>

*May require prior authorization from Humana first. Please see next section on page 13 for more information on Prior Authorization requirements.

Call Enrollee Services if you do not find something you are looking for or have questions.
SERVICES: WHAT IS NOT COVERED

You will find many examples of service limitations or exclusions from coverage, including those due to moral or religious objections in the list below. It is not possible to provide a complete list of the services that are not covered. If you have a question about if a service is covered, please call Enrollee Services at 1-800-444-9137 (TTY:711). Payment for non-covered services is the responsibility of the enrollee.

- Any laboratory service performed by a provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA);
- Cosmetic procedures or services done just to improve appearance;
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only;
- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, invitro fertilization, etc.);
- Induced abortion and miscarriage performed out-of-compliance with federal and Kentucky laws and judicial opinions;
- Paternity testing;
- Personal service or comfort items;
- Post mortem services;
- Investigational or research/experimental services;
- Sex transformation services;
- Sterilization of a mentally incompetent or institutionalized enrollee;
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services; and/or
- Services over and above the Kentucky Medicaid allowance;
- Services for which the Enrollee Has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage.

Prior Authorization

Covered services that need a Prior Authorization are marked with a star (*) in the previous section on pages 11 and 12. These are services Humana needs to approve before you get them. Your provider will ask for a prior authorization from us and should schedule these services for you. Humana will not pay for these services if they are done without prior approval.
Referrals are not required

You may see any provider within our network to include specialists and inpatient hospitals. Humana does not require referrals from primary care providers (PCP) to see specialists within our network. Your PCP is your medical home and should coordinate your care. You should call your PCP to tell him/her you are going to the other provider. You may self-refer to any in-network provider. PCPs do not need to arrange or approve these services for you as long as you have not reached the benefit limit for the service.

Exceptions to this policy apply to enrollees who are in the Kentucky Lock In Program (KLIP). Please refer to the KLIP section of the handbook.
GENERAL INFORMATION FOR ALL OUR ENROLLEES

Transportation

If you have a medical emergency, call 911. We cover ambulance transportation to and from medical appointments when your provider says you must be transported on a stretcher and cannot ride in a car. Transportation is covered for medical appointments if you are bedridden or paralyzed. You must get prior authorization for non-emergency ambulance or stretcher services.

For non-emergent transportation services, please call 1-888-941-7433 to get help with the closest transportation service available to you.

Copayment

A copay is a fee that is charged for some health care services. If you receive a service that requires a copay, like a doctor’s visit or prescription, you pay the provider at the time of service. You can ask if there is a copay when you schedule an appointment.

If your income is 100% or below Federal Poverty Level (FPL), you cannot be refused services.

Exemptions to copays include, but may not be limited to: Foster care, pregnant women (includes 60-day period after pregnancy ends), terminally ill, people in hospice care and Kentucky Medicaid beneficiaries who have reached their cost sharing limit for the quarter.

There are services that may be exempt from copays such as emergency services, some family planning services, and preventive services.

The chart below lists the services that require a copay:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Health Services</td>
<td>$0</td>
</tr>
<tr>
<td>Office Visits</td>
<td>$3</td>
</tr>
<tr>
<td>Doctor Services</td>
<td>$3</td>
</tr>
<tr>
<td>Brand Name Drug</td>
<td>$4</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$1</td>
</tr>
<tr>
<td>Brand Name Drug Preferred Over Generic</td>
<td>$1</td>
</tr>
<tr>
<td>Chiropractor Visits</td>
<td>$3</td>
</tr>
<tr>
<td>Pregnancy Care</td>
<td>$0</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>$0</td>
</tr>
</tbody>
</table>

Chart continues on the next page.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foot Care</td>
<td>$3</td>
</tr>
<tr>
<td>Dental Care</td>
<td>$3</td>
</tr>
<tr>
<td>Vision Care</td>
<td>$3</td>
</tr>
<tr>
<td>General Ophthalmologist Services</td>
<td>$3</td>
</tr>
<tr>
<td>Rural Health Clinic, Primary Care Center or Federally Qualified Health Center Visits</td>
<td>$3</td>
</tr>
<tr>
<td>Physical, Speech and Occupational Therapy</td>
<td>$3</td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td>$4</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>$0</td>
</tr>
<tr>
<td>Emergency Room Visits for a Non-Emergency</td>
<td>$8</td>
</tr>
<tr>
<td>Inpatient Hospital Visits</td>
<td>$50</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>$4</td>
</tr>
<tr>
<td>Ambulatory Surgery Center Visits</td>
<td>$4</td>
</tr>
<tr>
<td>Lab, Diagnostic or X-ray Services</td>
<td>$3</td>
</tr>
</tbody>
</table>
# Added Benefits

As a Humana enrollee you get more! These extra benefits, tools and services are at no cost to you.

<table>
<thead>
<tr>
<th>Value Added Services</th>
<th>Details and Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Obesity Program</td>
<td>Child Obesity program to help kids reach and maintain a healthy weight</td>
</tr>
<tr>
<td>Dental Services for Adults</td>
<td>1 additional cleaning per year</td>
</tr>
<tr>
<td>Moms First Gift Card Program</td>
<td>Prenatal Care: 1st, 5th, and 12th Prenatal visits ($20 gift card for making it to the 1st, 5th, and 12th visit) Up to $60 total Postpartum visit: One (1) visit $20 gift card Well child visits: Seven (7) visits for babies up to 18 months -(10 gift card for each visit), up to $70 total</td>
</tr>
<tr>
<td>Healthy Behaviors Gift Card Program</td>
<td>Preventive Visit: HbA1C-$10 Preventive Visit: Retinal Eye Exam-$10 Preventive Visit: Micro albumin-$10 Preventive Visit: Pap Smear-$10 Preventive Visit: Screening Mammogram-$10 PCP well visit within 90 days of enrollment-$10 Enrollee f/u with practitioner within 7 days after psychiatric ER visit-$10</td>
</tr>
<tr>
<td>Text Program for Expectant Mothers</td>
<td>Text program for expectant mothers to encourage prenatal care</td>
</tr>
<tr>
<td>GED Testing</td>
<td>GED exam and test preparation costs-(up to $500 per enrollee)</td>
</tr>
<tr>
<td>Criminal Expungement Services</td>
<td>Cost of criminal record expungement for Class D felony-(up to $300 per enrollee)</td>
</tr>
<tr>
<td>Cell Phone Services</td>
<td>1,000 voice minutes per month; 1GB data per month; Unlimited text messages per month; Calls to Humana Enrollee Services for health plan assistance and 911 for emergencies are free even if you run out of minutes; must make at least 1 phone call or send 1 text message every month in order to keep the benefit.</td>
</tr>
<tr>
<td>Immunizations for Adult</td>
<td>Rabies vaccination</td>
</tr>
<tr>
<td>*How To Enroll In Healthy Behaviors &amp; Moms First Gift Card Programs</td>
<td>To enroll into reward programs, enrollees must call Enrollee Services at 1-800-444-9137 (TTY: 711). Once enrolled, enrollees will be able to earn rewards after finishing certain health tasks. Only tasks finished after enrollment will be rewarded. Enrollees who have not called to enroll will not be sent any rewards.</td>
</tr>
</tbody>
</table>

*Requires Enrollment*
Tools for Easy Access

MyHumana App

- Use your Humana plan on the go with the free MyHumana mobile app. The app allows you to safely use your mobile device to:
  - Review your latest health summary including status, summary and detailed information
  - Access your Humana enrollee ID card instantly with a single tap
  - Find a provider by specialty or location. *The MyHumana app can even use your current location to locate the closest in-network provider no matter where you are

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

May require location sharing enabled on your phone.

MyHumana Account

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

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

Call Enrollee Services 1-800-444-9137 or visit www.humana.com/KentuckyMedicaid to learn more about:

• Benefits or eligibility
• If prior authorization or approval is necessary for a service
• What services are covered and how to use them
• How to get a new enrollee ID card
• Reporting a lost enrollee ID card
• Selecting or changing your primary care provider (PCP)
• Help we have for enrollees who don't speak or read English well
• How we can help enrollees understand information due to vision or hearing problems
• Filing a complaint

For faster service, please have your enrollee ID number on your Humana enrollee ID card handy. More information about your enrollee ID card can be found on page 9.

Let Us Know If Your Information Changes

We want to make sure we are always able to connect with you about your care. We don't want to lose you as an enrollee, so it is really important to let us know if information from your Medicaid application changes. You must report any changes to the Department for Community Based Services (DCBS) within 30 days. Failure to report changes within 30 days may result in loss of medical benefits. Examples of changes you must report within 30 days include:

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

- Visiting a DCBS office in person or locate a DCBS office near you please visit https://chfs.ky.gov/agencies/dcbs/Pages/default.aspx
- Submitting a change in writing and mailing to:
  - DCBS, P.O. Box 2104, Frankfort, KY 40601;
  - Calling DCBS at 1-855-306-8959

The Department for Medicaid Services may disenroll you from the Medicaid program if the Department 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 the Department or Humana can locate you and eligibility can be restored.

**Loss of Medicaid**

The Department for Community Based Services (DCBS) decides who is eligible for Medicaid. If the DCBS says you can no longer have Medicaid, then we would be told to stop your membership. You would no longer be covered by Humana.

If you have questions about your Medicaid eligibility, please contact your local DCBS office or call 1-855-306-8959.

**Other Insurance?**

If you have other medical insurance, please call Enrollee Services at 1-800-444-9137 (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 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
- You are hurt in a car wreck
- You are bitten by a dog
- You fall and are hurt in a store
Another insurance company might have to pay the doctor or hospital bill if you are in an accident that involves other people. Please tell us the name of:

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

This information will help avoid delays in processing your benefits.

**Interpreter Services**

Is there a Humana enrollee in your family who:

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

If so, we can help. Humana offers sign and language interpreters at no cost (in-person, video remote interpretation or over the phone) at all Humana touch-points. Oral interpretation is provided in over 200 languages.

If you require assistance with speaking with us or a healthcare provider, we can help you, please contact Enrollee Services. Interpreter services are available at all Humana touch-points and can assist with grievances or appeals, see pages 41-42.

Printed materials are available in English and Spanish. Materials are read over the phone in over 200 languages and are available in alternative formats in print format (Braille, Large Print, Accessible PDF, Daisy and Audio). Just call us at 1-800-444-9137 (TTY:711) or the Concierge Service for Accessibility (1-877-320-2233) to request alternative formats or interpreter services (in-person, video remote interpretation or over the phone).

**24-HOUR NURSE ADVICE LINE**

You can call any time to talk with a caring, experienced registered nurse. This is a free call. You can call 24 hours a day, 7 days a week, 365 days a year at 1-800-648-8097.

**Our nurses can help you:**

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

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

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

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

Choosing a PCP

If you are new to Humana and have not chosen a PCP, you can still get care. Just call Enrollee Services at 1-800-444-9137 (TTY: 711). We can help you get the care you need and set you up with a PCP.

If you are new to Humana and already have a PCP, we want to help you keep him or her. Call Enrollee Services at 1-800-444-9137 (TTY:711) and we can help you.

There may be a reason that a specialist will be your PCP. Examples include but are not limited to, women who have diabetes while pregnant and enrollees recovering from a heart attack. If you think you need a specialist to be your PCP, please call Enrollee Services.

What happens if you don’t choose a PCP?

If you do not choose a PCP at the time you signed up with Humana we will notify you within 10 days of enrollment on how to choose a PCP. If you do not choose a PCP we will assign one for you. You can start seeing your PCP on the first day you are enrolled.

Special Cases

- If you are pregnant and may be eligible for Medicaid you do not have to choose a PCP.
- If you receive Medicare and Medicaid (dual eligible), presumptively eligible ("presumptive eligible" – see page 68), or are in foster care, an adult under state guardianship, or a disabled child under the age of 18, you do not have to choose a PCP.
- If you have both Medicare (from another health plan) and Humana insurance, you do not have to choose a Humana PCP.
Changing Your PCP

Choosing a PCP will help you take care of your health care needs. You may choose a PCP from Humana’s Provider Directory. You can start seeing that PCP on the first day you are signed up. To view our directory, please visit www.humana.com or call our Enrollee Services at 1-800-444-9137 (TTY: 711).

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

Sometimes PCPs tell us that they are moving away, retiring, or leaving our network. This is called a voluntary termination. If this happens with your PCP, we will let you know by mail within 30 days. We will also help you find a new doctor.

It is important to keep your scheduled visits. Sometimes things happen that keep you from going to the doctor. If you have to cancel your appointment, please call the doctor’s office at least 24 hours before your appointment.

Doctor Visits

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

<table>
<thead>
<tr>
<th>Preventive care includes</th>
<th>Routine care includes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular checkups</td>
<td>Colds/flu</td>
</tr>
<tr>
<td>Immunizations for children</td>
<td>Earache</td>
</tr>
<tr>
<td>Tests and screenings, when needed</td>
<td>Rash</td>
</tr>
<tr>
<td></td>
<td>Sore throat</td>
</tr>
</tbody>
</table>

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

- Always take your Humana enrollee ID card
- Take your prescriptions
  - It’s good for your doctor to know what medications you take
- Prepare any questions for your doctor ahead of time so you don’t forget anything
  - Your doctor is someone you can trust and rely on
  - Ask about any concerns you may have
PROVIDER DIRECTORY

Humana will give you a Provider Directory if requested. The Provider Directory is a list of the doctors and providers you can use to get services. This list is called our provider network. Keep in mind our Provider Directory may change and you can always call us to see if any new providers have been added or removed since the directory was printed. We can also give you more details about providers if you need it, or give you a more current Provider Directory. Just call Enrollee Services at 1-800-444-9137 (TTY: 711), or you can visit our website listed below.

Physician Finder

We have improved our Find a Doctor tool. It is easier than ever to use. Our website includes simple instructions to help you find exactly what you need. Just go to www.humana.com and scroll to the bottom of the page. Select “Find a Doctor” under Member Resources.

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

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

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dizziness</td>
<td>High/low blood pressure</td>
</tr>
<tr>
<td>Swelling of the legs and feet</td>
<td>High/low blood sugar</td>
</tr>
<tr>
<td>Persistent cough</td>
<td>Loss of appetite</td>
</tr>
<tr>
<td>Restlessness</td>
<td>Joint pain</td>
</tr>
<tr>
<td>Colds/flu</td>
<td>Headache</td>
</tr>
<tr>
<td>Earache</td>
<td>Backache</td>
</tr>
<tr>
<td>Constipation</td>
<td>Rash</td>
</tr>
<tr>
<td>Sore throat</td>
<td>Taking out stitches</td>
</tr>
<tr>
<td>Vaginal discharge</td>
<td>Pregnancy tests</td>
</tr>
<tr>
<td>Pain management</td>
<td></td>
</tr>
</tbody>
</table>

See your PCP for preventive care. This means making regular visits to your doctor even if you do not feel sick. Regular checkups, tests, and health screenings can help your doctor find and treat problems early before they become serious.

Preventive care includes things such as immunizations, diabetes screening, obesity screening and routine physicals for children, adolescents, and young adults, from birth to age 21.
EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) preventive (well care) exams and age recommended health screenings are recommended for enrollees from birth through the end of their 21st birthday month. Humana covers EPSDT preventive (well care) exams and health screenings at no cost to you.

EPSDT Preventive Care

EPSDT provides your child with full preventive health care from birth to the end of your child’s 21st birthday month. This preventive health care includes well care physical exams and age recommended health screenings.

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

EPSDT eligible enrollees (birth to the end of their 21st birthday month) with special health care needs can get Care Management services. For more information turn to Care Management and Outreach Services (page 38).

EPSDT well care exams and health screens include:

- Medical/physical exams
- Complete health and development history
- Height and weight checks with nutrition counseling when needed
- Hearing tests
  - hearing tests start when your child is a newborn
  - hearing tests and risk assessments happen at each EPSDT visit
- Eye exams (vision)
  - eye exams start when your child is a newborn
  - eye exams and risk assessments happen at each EPSDT visit
- Dental visits
  - during EPSDT visits, oral health assessments are provided at recommended ages and referrals made to a dentist when needed
  - recommendations to dentists by 12 months or earlier if an issue is identified or a tooth erupts
  - referrals to specialists when needed and recommended regardless of child’s age
• Developmental and Behavioral Health Screening, Exams, and Assessment
• Lab tests, including blood tests, lead level tests, TB risk assessments/tests and urine tests
• Immunizations (shots)
• Health and safety education
  o Guidelines to measure & improve the health & well-being of infants, children, adolescents and their families’ preventive health needs (counseling, evaluations or screenings) of each child/adolescent and their family
  o Intervention and/or referral needs for identified risk behaviors care seat safety, seat belts, alcohol/substance abuse use, sexual activity, mental health developmental

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

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

EPSDT eligible enrollees (birth to the end of their 21st birthday month) with special health care needs can get Care Management services. EPSDT Special Services (other necessary health care, further diagnosis and treatment) are available to your child to correct a physical, developmental, mental health, substance use issue or other condition and to make sure your child’s individual needs are met through better care so they can live healthy lives.

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

EPSDT Preventive Visits (well care) are recommended at these ages:
<table>
<thead>
<tr>
<th>Infancy</th>
<th>Early Childhood</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1 month</td>
<td>• 15 months</td>
</tr>
<tr>
<td>• 2 months</td>
<td>• 18 months</td>
</tr>
<tr>
<td>• 4 months</td>
<td>• 24 months</td>
</tr>
<tr>
<td>• 6 months</td>
<td>• 30 months</td>
</tr>
<tr>
<td>• 9 months</td>
<td>• 3 years* for ages 3 and above, EPSDT visits are once a year</td>
</tr>
<tr>
<td>• 12 months</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Middle Childhood</th>
<th>Adolescence and Young Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 through 10 years annually</td>
<td>11 through 21 years (through the end of the enrollees 21st birthday month annually)</td>
</tr>
</tbody>
</table>
SHOULD I GO TO THE EMERGENCY ROOM?

Emergency services are for a medical problem that you think is so serious that it must be treated right away by a doctor. Humana may cover emergency transportation, too. We cover care for emergencies both in and out of our service area. Here are some examples of when emergency services are needed.

To decide whether to go to an emergency room (ER), urgent care, or your PCP, ask yourself these questions:

- Is it safe to wait and call my doctor first?
- Is it safe to wait and make an appointment in the next day or two with my doctor?
- Is it safe to wait if I can get an appointment today with my doctor?
- If my doctor can’t see me, is it safe to wait to be seen at an urgent care clinic?
- Could I die or suffer a serious injury if I don’t get medical help right away?

If you are not sure if your illness or injury is an emergency, call your doctor or our 24-hour nurse advice line. Call 1-800-648-8097 to talk to a nurse.

Below are a few examples of emergency conditions:

<table>
<thead>
<tr>
<th>Miscarriage/pregnancy with vaginal bleeding</th>
<th>Uncontrolled bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe chest pain</td>
<td>Severe vomiting</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>Rape</td>
</tr>
<tr>
<td>Loss of consciousness</td>
<td>Major burns</td>
</tr>
<tr>
<td>Seizures/convulsions</td>
<td></td>
</tr>
</tbody>
</table>

You do not have to call us for an approval before you get emergency services. If you have an emergency, call 911 or go to the nearest ER. If you are not sure what to do, call your PCP for help, or you can call our 24-hour nurse advice line at 1-800-648-8097.

Remember, if you have an emergency:

- Call 911 or go to the nearest ER. Be sure to tell them that you are an enrollee of Humana. Show them your Enrollee ID card.
- If the provider that takes care of your emergency thinks that you need other medical care to treat the problem that caused it, the provider must call Humana.
- If you are able, call your PCP as soon as you can. Let him or her know that you have a medical emergency. Or have someone call for you. Then call your PCP as soon as you can after the emergency to schedule any follow-up care.
If the hospital has you stay, please make sure that Humana is called within 24 hours.

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

- **If it’s an emergency**, call 911 or go to the nearest emergency room.
- **If it’s not an emergency**: Call your PCP for help and advice.
- **If you’re not sure if it’s an emergency**: Call your PCP or our 24-hour nurse advice line at 1-800-648-8097. We can help you decide what to do.

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

**Post-Stabilization Care**

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

If you need services at a nursing facility for long-term care, we will help you. We will talk to your doctor and the facility to make sure you get the care you need. Once admitted to the nursing facility, Humana will cover services such as doctor’s services, therapy services, oxygen, etc., as long as you are an enrollee with us. Keep in mind that after 30 days in long-term care you may no longer be eligible for the Humana Medicaid Plan. Your nursing facility services will be covered by the Cabinet for Health and Family Services. If you have questions, please call Enrollee Services at 1-800-444-9137 (TTY: 711).

SECOND OPINIONS

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

You may choose any doctor in or out of our network to give you a second opinion. If you can’t find a doctor in our network, we will help you find a doctor. If you need to see a doctor that is not in the Humana network for a second opinion, you must get prior approval from us see (page 13).

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

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

Sexually Transmitted Diseases

Screening, diagnosis, and treatment of sexually transmitted diseases is a service provided without a referral. You may see a provider who is not in the Humana network.

Family Planning Services

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

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

Appointments for counseling and medical services are available as soon as possible within a maximum of 30 days. If it is not possible to receive complete medical services for enrollees who are less than 18 years of age on short notice, counseling and a medical appointment will be provided right away, preferably within 10 days. Family planning services are also provided at qualified family planning health partners (for example, Planned Parenthood) who may not be part of the Humana health partner network. Family planning services and any follow-up services are confidential for you, including enrollees who are less than 18 years old.

Before You Are Pregnant

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

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

If you are pregnant, make an appointment with an obstetrician (OB). You can find an OB in your provider directory. If you need help, call Enrollee Services at 1-800-444-9137 (TTY: 711). Be sure to make an appointment as soon as you know you are pregnant.
After Your Baby is Born

Congratulations! Please call the Department for Community Based Services (DCBS) to tell them you have had a baby.

You can reach DCBS at 1-855-306-8959. If you are getting Social Security income, you will need to apply with DCBS to ensure your baby receives benefits.

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

Humana covers all medically necessary Medicaid-covered drugs. We use a preferred drug list (PDL). These are drugs that we prefer your provider use. To learn more about how to use our drug management program, look in the summary section of the PDL found on our website. If you do not have access to the internet, please call Enrollee Services and they will assist you.

Typically, our preferred drug list (formulary) includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. Many alternative drugs are just as effective as other drugs and do not cause more side effects or other health problems. Enrollees may need to try one drug before taking another.

An enrollee must try a medicine on the formulary before a drug that is not on the formulary would be approved by Humana. Certain drugs will be covered only if Step Therapy is used. A pharmacy will provide a generic drug if available in place of a brand-name drug.

Enrollees can expect the generic to produce the same effect and have the same safety profile as the brand-name drug. If a brand-name product is requested when a generic equivalent is available, a prior authorization request will need to be submitted by your provider.

Sometimes an enrollee might have a drug allergy or intolerance, or a certain drug might not be effective and a non-formulary agent is requested. The provider will then need to submit a prior authorization request. We may also ask that your provider send us information (a prior authorization request) to tell us why a specific drug or a certain amount of a drug is needed. We must approve the request before you can get the drug.

Reasons why we may need prior authorization for certain drugs:

- A generic or other alternative drug can be used
- The drug can be misused
- There are other drugs that must be tried first. Some drugs may also have quantity (amount) limits on how much can be given to an enrollee at one time.
- Some drugs are never covered, such as drugs for weight loss.

If we do not approve a request for a drug, we will let you know how you can appeal our decision. We will also let you know about your right to a state fair hearing. You can call us at 1-800-444-9137 (TTY: 711) to ask about or receive a copy of our PDL, updated PDL lists, and drugs that need prior authorization. You can also go to www.humana.com and search the preferred drug list.
Our PDL and list of drugs that need prior authorization can change. You or your provider should check on this when you need to fill or refill a prescription. Humana has an exception process that allows the enrollee or the enrollee’s representative to make a request for an exception. Reasons for exceptions may include intolerance or allergies to drugs, or inadequate or inappropriate response to drugs listed on PDL. The enrollee or enrollee’s representative must initiate the request by calling Enrollee Services.

Humana then reaches out to the provider to obtain the appropriate documentation.

**Specialty Pharmacy**

Some drugs are for diseases that need special attention. They may also need to be handled differently than drugs you pick up at your local pharmacy. They are called specialty drugs and may need to be given to you by a doctor or nurse.

Most of these medications need a prior authorization from your doctor. Your doctor’s office will help you get that done. If it is approved, we will work with your doctor and the specialty pharmacy to get the drugs you need.

For more information about specialty pharmacy needs, call us at 1-800-444-9137 (TTY: 711).

**Medication Therapy Management (MTM)**

At Humana, we understand the impact that proper medication use can have on your health. That’s why we have an MTM program for our enrollees. This program is geared towards helping you learn about your medications, prevent, or address medication-related problems, decrease costs, and stick to your treatment plan.

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

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

You can call Enrollee Services at 1-800-444-9137 (TTY: 711) to ask about our list of covered medications and those that need prior authorization.
This service, and the pharmacist’s help and information, are part of being a Humana enrollee and are available at no cost to you. MTM benefits:

- Improves safe use of medications
- Improves coordination with all your doctors and other caregivers
- Increases knowledge of your medications and how to use them correctly
- Improves overall health
Behavioral/mental health is an important part of your overall wellness. Our goal is to help you take care of all your health needs. We want to make sure that you get the right care to help you stay well.

You have many behavioral/mental health services available to you. These include:

- Outpatient services such as counseling for individuals, groups and families
- Peer Support
- Help with medication
- Drug and alcohol screening and assessment
- Substance use services for all ages, including residential services
- Therapeutic Rehabilitation Programs (TRP)
- Day treatment for children under 21
- Psychological Testing
- Crisis Intervention
- Other community support services to help you feel better

It is okay to ask for help. You can use behavioral/mental health care to help you cope with all sorts of issues. They include stress, trauma, worries or sadness. Sometimes you may just need someone to talk to. We can help you figure out what type of care you need and we can help connect you with an experienced provider.

We are here to help please call Enrollee Services at 1-800-444-9137. A staff member can help you with finding a provider or scheduling an appointment. Crisis intervention services are available 24 hours a day, 7 days a week at 1-833-801-7355.

**myStrength**

Take Charge of your Mental Health and try a wellness tool called myStrength. This is a safe and secure tool designed just for you. It offers personalized support to help improve your mood, mind, body and spirit. You can access it online or on your mobile device at no cost to you. myStrength offers online learning, empowering self-help tools, wellness resources and inspirational quotes and articles.

You can visit https://www.mystrength.com/r/humanakymedicaid for more information and to sign up. During Sign Up, use Access Code: **HUMANAKYMEDICAID**. Complete the myStrength signup process and personal profile. You can also download the myStrength app for iOS and Android devices at www.mystrength.com/mobile and SIGN IN using your login email and password.
CARE MANAGEMENT AND OUTREACH SERVICES

We offer Care Management services to all enrollees who can benefit from this service. Enrollees can self-refer too. Children and adults with special health care needs can often benefit from care management. We have registered nurses, social workers, and other outreach workers. They can work with you one-on-one to help coordinate your health care needs. This may include helping you find community resources you need. They may contact you if:

- Your doctor asks us to call you
- You ask us to call you
- Our staff feels their services would be helpful to you or your family

We may ask questions to learn more about your health. Our staff will give you information to help you understand how to care for yourself and get services. They can also help you find local resources.

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

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

Please call us if you have questions or feel that you need these services. We are happy to help you. You can reach Care Management Support Services at 1-888-285-1121.

Complex Care Management

Medicaid enrollees may be eligible to get Complex Care Management services if they have experiences multiple hospitalizations or have complex medical needs that require frequent and ongoing assistance. Complex Care Management is provided to Medicaid enrollees by Humana nurses specially trained in care management. A team of Physicians, Social Workers and Community Service Partners are on hand to make sure your needs are met and all efforts are made to improve and optimize your overall health and well-being. The care management program is optional.

To get additional information about the Complex Care Management Program, self-refer or opt out of the Complex Care Management Program, you may contact our Care Management Support Services at 1-888-285-1121.
Disease Management

We offer free Disease Management programs. We can help you learn about your condition and how you can better take care of your health. We have programs for:

- Asthma
- Diabetes
- Hypertension

We can:

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

Enrollees with these conditions are contacted for enrolling in the Disease Management program. If you would like to enroll or have questions please call our Care Management Support Team at 1-888-285-1121 or Enrollee Services.
**Tobacco Free Program**

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

They will listen to you, help you understand your habits, and, they work with you to take action. There are also medicines your doctor may recommend. To reach a coach, who can help you quit, call 1-800-444-9137. If you are pregnant call 1-888-285-1121 to get help quitting.

**Care Transitions**

We offer a program to help you when you are able to leave the hospital.
We can:

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

If you or your family member needs help when you get out of the hospital, or if you need help transitioning back to your home from other places where you were treated, please call let us know. You can reach a member of the Care Management Support team at 1-888-285-1121 or Enrollee Services.
GRIEVANCES AND APPEALS

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

Grievances and appeals are not the same thing. At any time during the grievance or appeal process you can request copies of the documents pertaining to your case free of charge by contacting Enrollee Services.

Grievances (Complaints)

If you are unhappy with Humana or one of our providers, this is called a grievance. You, or someone you have chosen to represent you, should call us. You may file a grievance orally or in writing. If you ever want information about grievances please ask us. Call Enrollee Services at 1-800-444-9137 (TTY: 711). If needed, we can help you file a grievance. You can also get help from others. People who can help you are:

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

You can let us know about your grievance by:

- Calling Enrollee Services at 1-800-444-9137 (TTY: 711)
- Filling out the form in the back of this handbook
- Writing us a letter
  - Be sure to put your first and last name, the enrollee 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 problem
- Faxing your grievance to 1-800-949-2961
- Mail the form or letter to:
  
  Humana
  Grievance and Appeals Department
  P.O. Box 14546
  Lexington, KY 40512-4546

We will send you a letter within five (5) business days from the day we receive your grievance to let you know we received it.
We will then review it and send you a letter within 30 calendar days to let you know our decision. Negative actions will not be taken against:

- An enrollee who files a grievance
- A provider that supports an enrollee’s grievance or files a grievance on behalf of an enrollee with written consent

**Appeals**

If you are unhappy with a decision or action we take, you or your authorized representative can file an appeal. You must file your appeal within 60 calendar days from the date you receive our response, the Notice of Adverse Benefit Determination, from us. You can file by calling or writing to us. If you file by phone, you must follow up with a written, signed appeal within 10 calendar days from your telephone request.

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 Enrollee Services at 1-800-444-9137 (TTY: 711)
- We will start on your appeal, but we still need the request in writing within 10 calendar days of your phone call in order to complete the appeal review
- 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 enrollee 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.
- Faxing your appeal to 1-800-949-2961
- Mail the form or letter to:
  
  Humana
  Grievance and Appeals Department
  P.O. Box 14546
  Lexington, KY 40512-4546
We will send you a letter within five (5) business days from the receipt of your appeal request to let you know we received it. If your appeal request was received by telephone, the letter you receive will have a Written Appeal Request Form for you to sign and return to us. We will consider this to be your written request. It is very important that you sign and return the form right away. Humana must receive it within 10 calendar days from your telephone call.

If we extend the timeframe for your appeal or expedited appeal (we are requesting it, not you) we will make reasonable efforts to give you prompt oral notice of the delay; give you written notice, within two (2) calendar days, of the reason for the decision to extend the time frame. We will also inform you of the right to file a grievance if you disagree with that decision. After we complete the review of your appeal, we will send you a letter within 30 calendar days to let you know our decision. You or someone you choose to act for you may:

- Review all of the information used to make the decision
- Provide more information throughout the appeal review process
- Examine the enrollee’s case file before and during the appeals process
  - This includes medical, clinical records, other documents and records, and any new or additional evidence considered, relied upon, or generated in connection with the appeal
  - This information shall be provided, upon request, free of charge and sufficiently in advance of the resolution timeframe

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

- It could seriously jeopardize your life, physical or mental health, or ability to attain, maintain, or regain maximum function.

We make decisions on expedited appeals within 72 hours or as fast as needed based on your health. Negative actions will not be taken against:

- An enrollee or provider who files an appeal
- A provider that supports an enrollee’s appeal or files an appeal on behalf of an enrollee with written consent
State Fair Hearings

You also have the right to ask for a state fair hearing from the Department for Medicaid Services after you have completed the Humana appeal process. You can do so in writing, by mail or fax. You must ask for a hearing within 120 days from the date on our appeal decision letter.

Call: 1-800-635-2570
Write: Kentucky Department for Medicaid Services
       Division of Program Quality and Outcomes
       275 E. Main Street, 6C-C
       Frankfort, KY 40621
Fax: 1-502-564-0223

You may ask anyone - such as a family member, your minister, a friend, or an attorney - to help you with a state fair hearing.

If you request a state fair hearing and want your Humana benefits to continue, you must file a request with us (Humana) within 10 days from the date the Notice of Plan Appeal Resolution is mailed.

If you have an urgent health condition, ask for an expedited hearing. If the hearing finds that our decision was right, you may have to pay the cost of the services provided for the benefits that were continued during the Medicaid fair hearing.

Continuation of Benefits

For some adverse benefit determinations, you may request to continue services during the appeal and Medicaid Fair Hearing process. Services that can be continued must be services that you are already receiving, including services that are being reduced or terminated. We will continue services if you request an appeal within ten (10) days from our notice of adverse benefit determination letter, or before the date we told you they would be reduced or terminated, whichever is later. Your benefits will continue until one of the following occurs:

• Until the original authorization period for your services has ended
• Ten (10) days after we mail the appeal decision
• You withdraw your appeal
• Following a Medicaid Fair Hearing, the administrative law judge issues a decision that is not in your favor

If the appeal was denied and you request a Medicaid Fair Hearing with continuation of services within ten (10) days of the date on the appeal resolution letter, your services will continue during the Medicaid Fair Hearing. (See the Medicaid Fair Hearing section.)

However, if we decide that we agree with our first decision to deny your service, you may be required to pay for these services.
Ombudsman

You may also contact Kentucky’s Ombudsman Program. It helps people who use public services to be treated fairly. The program can help answer questions and work to settle conflicts.

To get help or for more details, please contact:

The Office of the Ombudsman
Cabinet for Health and Family Services
275 East Main Street, 1E-B Frankfort, KY 40621
1-800-372-2973
FRAUD, WASTE AND ABUSE

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

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

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

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

Examples of pharmacy fraud, waste and abuse include:

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

Examples of enrollee fraud, waste and abuse include:

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

- Be required to pay back money that we paid for services that were determined to be a misuse of benefits
- Be prosecuted for a crime and go to jail
- Lose Medicaid benefits
- Be locked in to one PCP, one controlled substance provider, one pharmacy and/or one hospital for non-emergency services.
- See Kentucky Lock-In Program (KLIP) for details on page 48.

If You Suspect Fraud, Waste or Abuse

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

- Call 1-800-614-4126 (TTY: 711), 24 hours a day, 7 days a week
- Select the menu option for reporting fraud
- Complete the Fraud, Waste, and Abuse Reporting Form
- You can write a letter and mail it to us
  
  Sent it to:
  Humana
  Attn: Special Investigations Unit
  1100 Employers Blvd.
  Green Bay, WI 54344

- You can go to our website, www.humana.com/fraud for more information.

You do not have to give us your name when you write or call. There are other ways you may contact us that are not anonymous. If you are not concerned about giving your name, you 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 enrollee ID number, social security number, or health information. Instead, please use the form or phone number above. This can help protect your privacy.
KENTUCKY LOCK-IN PROGRAM (KLIP)

The Lock-In program is designed to give support to enrollees who need assistance in managing health care needs through the establishment of a medical home or providing structured access to controlled substances through the Medicaid program except those needed for legitimate clinical purposes. The Lock-In program restricts an enrollees from seeing too many providers. People who use one doctor, one pharmacy and one hospital get better care. The providers know more about the person’s health and can better diagnose and treat health conditions. Fewer providers help make sure a person gets the right medicine in the right amounts.

Humana tracks how often some drugs are filled, if these drugs are filled at different pharmacies, and how many doctors enrollees visit. In some cases, we may limit a enrollees to fill their drugs at one pharmacy and from one doctor. We may also limit which doctor can prescribe drugs that can be abused. Finally, if you go to several emergency rooms, you may be limited to one hospital. We take these steps to get you the right amount of care, at the right time, and in the right place.

For more details, visit www.humana.com/KentuckyMedicaid.
QUALITY HEALTH CARE

We want to make sure that you get quality health care. We do this by:

- Checking on the care you get from your doctors and other health care providers
- Finding and fixing any problems related to proper medical care
- Making sure care is there for you when you need it
- Teaching you about your health

We keep track of the services you get from health care providers. We talk about some services with your providers before you get them.

This is to make sure they are appropriate and necessary. For instance, 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. UM requests are reviewed carefully by our review team which includes; nurses, licensed behavioral health providers, and doctors. Doctors can decide if a service cannot be covered.

We check the work of our reviewers regularly. We test reviewers by giving each of them the same cases. This makes sure they make the right determinations. We decide if a service can be covered or not within two (2) business days. This can be done more quickly if needed because of the enrollee’s medical condition. We tell your doctor in writing of the determination and the reason for it. If we are not able to cover the service, we also tell you in writing. The letter includes our phone number in case you want to call us for more information.

If you are not happy with the determination, you can appeal it by calling or writing to us. Your case will be re-reviewed by a different doctor from an appropriate specialty area. You will be notified of the determination in writing.

You can contact us at any time about Utilization Management or prior authorization requests. Just call Enrollee Services at 1-800-444-9137 (TTY: 711).

Any decisions we make with your health care providers about the medical necessity of your health care are based only on how appropriate the care setting or services are. We do not reward providers or our own staff for denying coverage or services. We do not offer financial incentives to our staff that affects their decisions. We do not deny or limit the amount, length of time or scope of the service only because of the diagnosis or type of illness or condition. “Any financial incentives for decision makers do not encourage decisions that result in under use of services.”
We may decide that a new treatment not currently covered by Medicaid will be a covered benefit. This might be new:

- Health care services
- Medical devices
- Therapies
- Treatment options

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

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

You can call us to get any other information you want. You can find out about:

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

If you want to tell us about things you think we should change, please call Enrollee Services at 1-800-444-9137 (TTY: 711).
QUALITY IMPROVEMENT

Program Purpose

The Humana Quality Improvement Program includes both clinical and non-clinical services and is revised as needed to remain responsive to enrollee needs, provider feedback, standards of care, and business needs. The goals and objectives of the 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 enrollees

There are two guiding tenets for the program:

- Our mission is to make a lasting difference in our enrollee’s lives by improving their health and well-being.
- Our vision is to transform lives through innovative health and life services

The Institutes for Healthcare Improvement’s Triple Aim:

Simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and lowering the cost of care for the benefit of communities.

Your care means a lot to us. The purpose of the Humana Quality Improvement Program is to ensure that Humana has the necessary ability to:

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

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 Medicaid Program. The scope includes:

- Meeting the quality requirements of the Centers for Medicare and Medicaid Services (CMS) as outlined in the CMS’s Medicare Managed Care Manual, Chapter 5, Quality Assessment; and 42 CFR§422.152
- 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 enrollee and provider satisfaction
- Managing of all quality of care and quality service complaints
- Developing organizational competency of the Institute for Healthcare Improvement’s Model for Improvement
- Ensuring that Humana Program is effectively serving enrollees with culturally and linguistically diverse needs
- Ensuring the Humana Program is effectively serving enrollee with complex health needs
- Assessing the characteristics and needs of the enrollee population
- Assessing the geographic availability and accessibility of primary and specialty care providers

The quality program is overseen by the Humana Medical Director and implementation is facilitated by the Director, Quality Improvement. On an annual basis, Humana makes information available about its Quality Program to providers on the Humana website.

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 enrollees. This is accomplished by using objective and systematic monitoring and evaluation to implement programs to improve outcomes.

Humana uses HEDIS to measure the quality of care delivered to enrollees. HEDIS is one of the most widely used means of health care measurement in the United States. HEDIS is developed and maintained by the NCQA.

The HEDIS tool is used by America’s health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS benchmarks.
HEDIS measures are based on evidence-based care and address the most pressing areas of care. Potential quality measures for Humana are:

- Wellness and prevention
- Preventive screenings (breast cancer, cervical cancer, chlamydia)
- Well-child care
- Chronic disease 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
- Use of imaging studies for low back pain

Humana uses the annual enrollee survey and CAHPS surveys to capture enrollee 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 uses are:

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

Preventive Guidelines and Clinical Practice Guidelines

Humana recommends evidenced based nationally accepted standards and guidelines to help inform and guide the clinical care provided to Humana enrollees. Guidelines are reviewed at least every two years or more often as appropriate, and updated as necessary.

The use of these guidelines allows Humana to measure the impact of the guidelines on outcomes of care. Review and approval of the guidelines are completed by the Humana Clinical Advisory Committee every two years or more often as appropriate. The guidelines are then presented to the Humana Quality Assurance Committee. Topics for guidelines are identified through analysis of enrollees. Guidelines may include, but are not be limited to:

- Behavioral health (e.g., depression)
- Adult health (e.g., hypertension, diabetes)
- Population health (e.g., obesity, tobacco cessation)
Information about clinical practice guidelines and health information are made available to Humana enrollees via enrollee newsletters, the Humana enrollee website, or upon request. Preventive guidelines and health links are available to enrollees and providers via the website or hard copy.

**Your Health is Important**

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

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

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

Humana has programs that can help you maintain or improve your health. Call us for more information about these programs: 1-800-444-9137 (TTY: 711).

**How to join the Quality Enrollee Access Committee**

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

Attending offers you the chance to meet other plan members in your community. You can bring a family member, caregiver or close friend. Humana wants to hear how we can improve your health plan.

If you would like to attend or would like more information, please contact Humana Enrollee Services. Enrollee Services is open 7am to 7pm ET, Monday through Friday.

**Call:** 1-800-444-9137  
**TTY:** 711  
**WRITE:**  
Quality Member Access Committee  
Attn: Community Outreach Department  
Humana  
P.O. Box 14546  
Lexington, KY 40512-4546
YOUR RIGHTS

As an enrollee of Humana you have these rights:

- To receive all services that the plan must provide and to get them in a timely manner.
- To get timely access to care without any communication or physical access barriers.
- To have reasonable opportunity to choose the provider that gives you care whenever possible and appropriate.
- To choose a PCP and change to another PCP in Humana’s network. We will send you something in writing that says who the new PCP is when you make a change.
- To be able to get a second opinion from a qualified provider in or out of our network. If a qualified provider is not able to see you, we must set up a visit with a provider not in our network.
- To get timely access and referrals to medically indicated specialty care.
- To be protected from liability for payment.
- To receive information about your health. It may also be given to someone you have legally approved to have the information, 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 be treated with respect, dignity, privacy, confidentiality, accessibility and non-discrimination.
- To have access to appropriate services and not be discriminated against based on health status, religion, age, gender or other bias.
- To be sure that others cannot hear or see you when you get medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal laws.
- Receive information in accordance with 42 CFR 438.10;
- Be furnished health care services in accordance with 42 CFR 438.206 through 438.210;
- Any Indian enrolled with Humana eligible to receive services from a participating I/T/U provider or an I/T/U primary care provider shall be allowed to receive services from that provider if part of Humana’s network. I/T/U stands for Indian Health Service, Tribally Operated Facility/Program, and Urban Indian Clinic.
- To get help with your medical records in accordance with applicable federal and state laws.
- To be sure that your medical records will be kept private.
- To ask for and receive one free copy of your medical records and to be able to ask that your health records be changed or corrected if needed. More copies are available to enrollees at cost.

- To say yes or no to having information about you given out unless Humana has to provide it by law.

- To be able to get all written enrollee information at no cost to you in:
  - In the prevalent non-English languages of enrollees in our service area, and
  - In other ways to help with the special needs of enrollees who have trouble reading the information for any reason

- To be able to get help from us and our providers if you do not speak English or need help to understand information. You can get the help free of charge.

- To get help with sign language if you are hearing impaired.

- To be told if a health care provider is a student and be able to refuse his or her care.

- To be told if care is experimental and be able to refuse to be part of the care.

- To know that Humana must follow all federal, state and other laws about privacy that apply.

- If you are a female, to be able to go to a woman’s health provider in our network for covered woman’s health services.

- To file an appeal or grievance (complaint) or request a state fair hearing.
  - You can also get help with filing an appeal or a grievance. You can ask for a state fair hearing from Humana and/or the Department for Medicaid Services (DMS). To make advance directives, such as a living will (see page 68).

- To contact the Office of Civil Rights at the address below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran’s status, ancestry, health status, or need for health services.

  
  Office for Civil Rights
  Sam Nunn
  Atlanta Federal Center
  62 Forsyth Street, S.W. Suite 16T70
  Atlanta, GA 30303-8909
  Phone: 1-800-368-1019,
  TDD: 1-800-537-7697
  Fax: 1-202-619-3818

  

- To receive information about Humana, our services, our practitioners and providers and enrollee rights and responsibilities.

- To make recommendations to our enrollee rights and responsibility policy.

- If Humana is unable to provide a necessary and covered service in our network, we will cover these services out of network. We will do this for as long as we cannot provide the service in network. If you are approved to go out of network, this is your right as an enrollee. There is no cost to you.

- To be free to carry out your rights and know that Humana or our providers will not hold this against you.
YOUR RESPONSIBILITIES

As an enrollee of Humana you must be sure to:

- Know your rights.
- Follow Humana and Kentucky Medicaid policies and procedures.
- Know about your service and treatment options.
- Take an active part in decisions about your personal health and care and lead a healthy lifestyle.
- Understand as much as you can about your health issues.
- Take part in reaching goals that you and your health care provider agree upon.
- Let us know if you suspect health care fraud or abuse.
- Let us know if you are unhappy with us or one of our providers.
- If you file an appeal with us, put the request in writing.
- Use only approved providers.
- Report any suspected fraud, waste or abuse using the information provided in this manual.
- Keep scheduled doctor visits. Be on time. If you have to cancel, call 24 hours in advance.
- Follow the advice and instructions for care you have agreed upon with your doctors and other health care providers.
- Always carry your ID card. Show it when receiving services.
- Never let anyone else use your ID card.
- We want to make sure we are always able to connect with you about your care. Let us know of a name, address or phone number change, or a change in the size of your family. Let us know about births and deaths in your family. We don’t want to lose you as an enrollee, so it is really important to let us know.
  - It is also a good idea to tell your local Department for Community Based Services (DCBS) any about any changes. To find the nearest DCBS office, visit their website at https://chfs.ky.gov/agencies/dcbs/Pages/default.aspx
  - Or call the Ombudsman toll-free at 1-800-372-2973
• Call your PCP after going to an urgent care center, after a medical emergency, or after getting medical care outside of Humana’s service area.

• Let Humana and the DCBS know if you have other health insurance coverage.

• Provide the information that Humana and your health care providers need in order to care for you.

• Report suspected fraud and abuse (see page 46).

We will tell you about changes to our enrollee rights and responsibilities on our website at www.humana.com/KentuckyMedicaid.
NOTICE OF PRIVACY PRACTICES

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

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

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?

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

How do we protect your information?

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

• 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 associates about company privacy policies and procedures
How do we use and disclose your information?

We must use and disclose your information:

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

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care.
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, 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 such as to allow your plan sponsor to obtain bids from other health plans. We will not share detailed health information to your plan sponsor unless you provide us your permission or your plan sponsor has certified they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you if you have not opted out as described below.
- To your family and friends if you are unavailable to communicate, such as in an emergency.
- To your family and friends or any other person you identify, provided the information is directly relevant to their involvement with your 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 whether or not 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 there is a serious health or safety threat.

• To appropriate authorities when there are issues about abuse, neglect, or domestic violence.

• In response to a court or administrative order, subpoena, discovery request, or other lawful process.

• For law enforcement purposes, to military authorities and as otherwise required by law.

• To assist in disaster relief efforts.

• For compliance programs and health oversight activities.

• To fulfill our obligations under any workers’ compensation law or contract.

• To avert a serious and imminent threat to your health or safety or the health or safety of others.

• For research purposes in limited circumstances.

• For procurement, banking, or transplantation of organs, eyes, or tissue.

• To a coroner, medical examiner, or funeral director.

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

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

• Most uses and disclosures of psychotherapy notes

• Marketing purposes

• Sale of protected health information
What do we do with your information when you are no longer an enrollee or you do not obtain coverage through us?

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

What are my rights concerning my information?

The following are your rights with respect to your 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, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.

- **Adverse Underwriting Decision** – You have the right to be provided a reason for denial or adverse underwriting decision if we decline your application or insurance.*

- **Alternate Communications** – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life threatening situation. We will accommodate your request if it is reasonable.

- **Amendment** – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.

- **Disclosure** – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for a period of six years at your request. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

- **Notice** – You have the right to receive a written copy of this notice any time you request.

- **Restriction** – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.
What types of communications can I opt out of that are made to me?

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

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 privacy rights request forms. You may obtain any of the forms by:

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

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

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

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

We follow all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, we follow the law, rule, or regulation which provides greater enrollee protection.
What will happen if my private information is used or disclosed inappropriately?

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

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

American Dental Plan of North Carolina, Inc.
American Dental Providers of Arkansas, Inc.
Arcadian Health Plan, Inc.
CarePlus Health Plans, Inc.
Cariten Health Plan, Inc.
Cariten Insurance Company CHA HMO, Inc.
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
Corphealth Provider Link, Inc.
DentiCare, Inc.
Emphesys, Inc.
Emphesys Insurance Company
HumanaDental Insurance Company
Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.
Humana Behavioral Health
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Company of New York, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of California, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana MarketPOINT, Inc.
Humana MarketPOINT of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Medical Plan of Michigan, Inc.
Humana Medical Plan of Pennsylvania, Inc.
Humana Medical Plan of Utah, Inc.
Humana Pharmacy, Inc.
Humana Regional Health Plan, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Kanawha Insurance Company*
Managed Care Indemnity, Inc.
Preferred Health Partnership of Tennessee, Inc.
The Dental Concern, Inc.
The Dental Concern, Ltd.

*These affiliates and subsidiaries are only covered by the Privacy Notice Concerning Financial Information section.
ADVANCE DIRECTIVES

Advance Directives are forms you fill out in case you become seriously ill or not able to make your own health care decisions. Doctor’s offices and hospitals may have these forms available. If you haven’t thought about this, now is a good time to start. You may want to talk to your family, too. However, Advance Directives are always voluntary. You must be over 18 years old to have an Advance Directive.

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

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

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

**Advance Directives in Kentucky**

In Kentucky, there are different types of Advance Directives. Advance Directives include (1) Medical Order Scope of Treatment (MOST) forms, (2) Living Wills, and (3) Mental Health Treatment Directives.

**Medical Order Scope of Treatment (MOST)**

A MOST is a medical order signed by you, Health Care Surrogate, or other caretaker, and your doctor telling what life-sustaining treatment you wish to have, if any. Unlike other types of Advance Directives, a MOST is a doctor’s order that you have agreed to. It is a standardized form used to complement other types of Advance Directives you may have.

MOST is usually for those who have a serious illness, or for those who want to have some of their wishes set as a medical order. MOSTs are not intended to address all your health care decisions. You may still need other types of Advance Directives.
Living Will

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

- Name a Health Care Surrogate
- Refuse or request life prolonging treatment
- Refuse or request artificial feeding or hydrations
- Express your wishes regarding organ donation

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

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

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

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

Mental Health Treatment Directive

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

Mental Health Treatment 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 www.humana.com.
Others Who May Make Health Care Decisions for You

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

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

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

Guardianship

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

**When will a Guardian be chosen?**
A court will choose a guardian for someone who can no longer make safe choices. This is usually due to legal or mental incapacity. In certain situations a minor may also have a guardian chosen for them.

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

**Who appoints a Guardian?**
Only a court can choose a guardian. The court that chooses a guardian is your local court. This could differ based on where you live. Call your local Health and Family services, local court, local lawyer, or local legal aid service for more information.

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

We want you to be happy with Humana. Please let us know about your problems or concerns. We can help you.

You may ask to stop your membership with Humana. You can do this for any reason. You need to ask in the first 90 days of your enrollment or at the time of re-enrollment. After the first 90 days, you may ask to stop your membership for cause. This means you have a special reason that you need to end your membership. You must send a written request for a hearing to ask for disenrollment. The request must have the reason you are asking to be disenrolled. You can send it to the Department for Medicaid Services (DMS) at the following address:

DMS – Cabinet for Health and Family Services
Office of the Secretary
275 E. Main Street
Frankfort, KY 40621

You may also change to a different managed care plan. You can do this during the annual open enrollment period. You will get a letter from the DMS each year. It will let you know when your open enrollment period is and how to change. You will be disenrolled from Humana if you are no longer eligible for Kentucky Medicaid or if you move out of our service area.
**APPEAL REQUEST FORM**

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

<table>
<thead>
<tr>
<th>Enrollee name:</th>
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<tbody>
<tr>
<td>Enrollee ID number:</td>
<td>Date of birth:</td>
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<tr>
<td>Authorized Representative*:</td>
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<td>Phone Number:</td>
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<td>Address:</td>
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<th>Service or Claim number:</th>
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</thead>
<tbody>
<tr>
<td>Provider name:</td>
<td></td>
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<tr>
<td>Date of service:</td>
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</tr>
</tbody>
</table>

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

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Relationship to enrollee (if Representative)

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

Humana Health Plan, Inc.
Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax: 1-800-949-2961
Discrimination is Against the Law
Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. See our website for more information.

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:
  o Qualified interpreters
  o Information written in other languages
If you need these services, contact Enrollee Services at 1-800-444-9137 (TTY: 711).

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

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512 – 4618
1-800-444-9137 or if you use a TTY, call 711.

You can file a grievance by mail or phone. If you need help filing a grievance, Enrollee 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 (TDD)
Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-444-9137 (TTY: 711).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-444-9137 (TTY: 711).

繁體中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-444-9137 (TTY: 711)

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-444-9137 (TTY: 711).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-444-9137 (TTY: 711).

العربية (Arabic)
لِلرَّفَاعِ وَلِلَّدِعَةِ، اسْتَفْتِ لَاءَنَا وَلَسَدُّوا تَرْكَةَكَ تَرْكَةً: قَطْوِهَا مِنْ أَحْدَاثٍ 1-800-444-9137


日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-444-9137 (TTY: TTY: 711)まで、お電話にてご連絡ください。

Français (French) ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-444-9137 (ATS: TTY: 711).

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-444-9137 (TTY: 711)번으로 전화해 주십시오.


नेपाली (Nepali) ध्वन्य दर्मियोस्: ध्वन्य दर्मियोस्; तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको नम्बरहरू सहयोग हुन्छ। फोन गर्नुहोस् 1-800-444-9137 (टेलिवियाई: TTY: 711)।

Oromiffa (Oromo) XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltidhaan ala, ni argama. Bilbila 1-800-444-9137 (TTY: TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-444-9137 (телетайп: TTY: 711).

