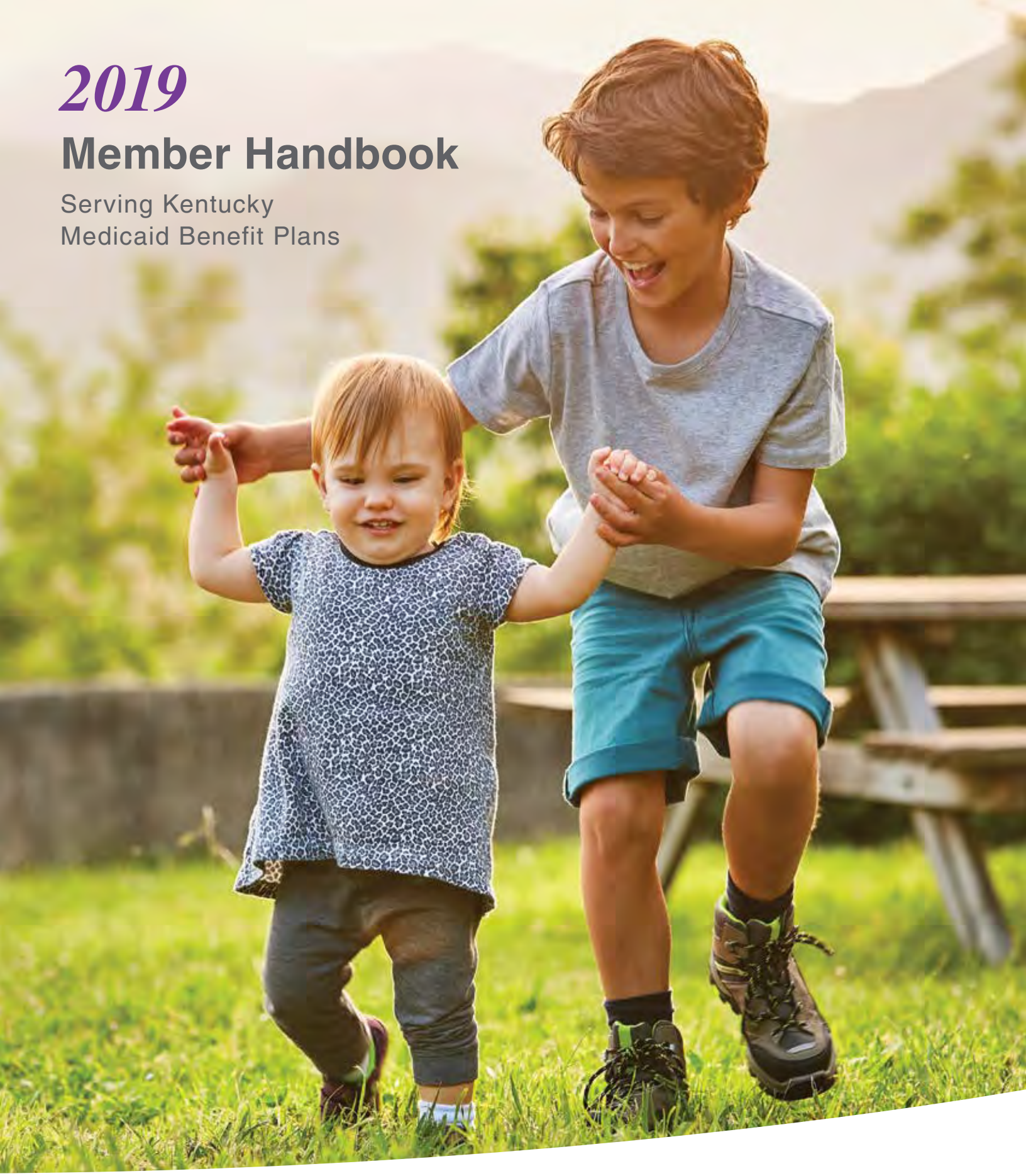

2019
Member Handbook

Serving Kentucky
Medicaid Benefit Plans

Humana® CareSource®

IMPORTANT NEXT STEPS

- Look for your ID card in the mail (page 4)
  - It will come in a separate mailing
- Make an appointment to see your doctor (page 24)
- Read about your covered services and benefits (page 7)
  - Information is also available on our website at **CareSource.com/KY**
- Fill out your Health Risk Assessment (HRA)
  - A copy is included in this mailing
  - You can also fill it out online:
    - CareSource.com/members/kentucky/medicaid/
    - Click on “Health Survey” under Quick Links to get started

Thank you for being a Humana – CareSource member!
It is our pleasure to serve you!

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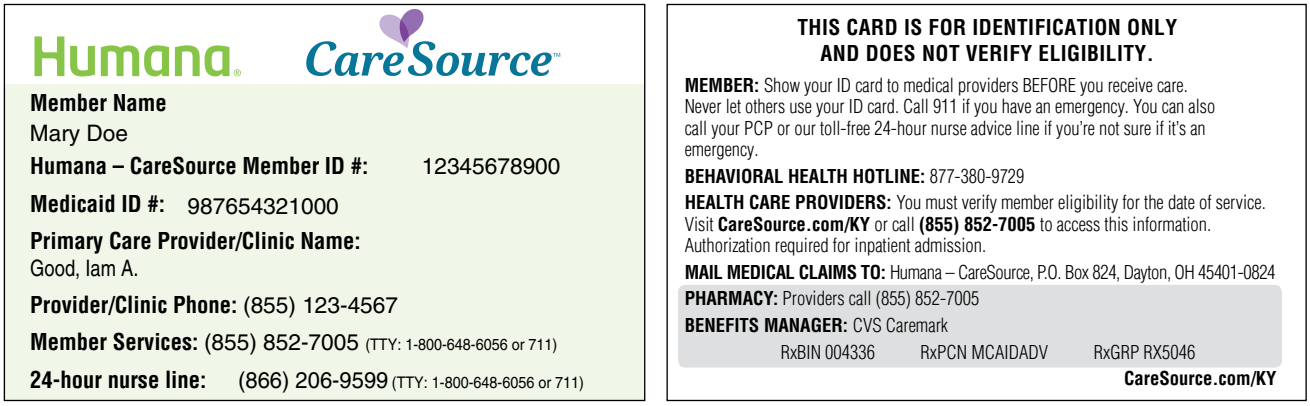
MEDICAID STATE PLAN INFORMATION

Medicaid State Plan Member ID Card

Humana – CareSource gives all members an ID card. Your State Plan member ID card looks like this. The front side has personal information. The card also has key Humana – CareSource phone numbers.



Every person in your family who is a member will get their own card. Each card is good for as long as the person is a member of Humana – CareSource. If you have not yet received your member ID card(s) please call us at: **1-855-852-7005** (TTY: 1-800-648-6056 or 711).

You will get a new card if you ask for one. You will get a new card if you change your PCP. Are you pregnant? Call Member Services when your baby is born. We will send a member ID card for your baby.

Always Keep Your Member ID Card With You

Never let anyone else use your member 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 – CareSource card and a picture ID.

Remember, when you call us, please have the member ID number on your Humana – CareSource member ID card available. This will help us serve you faster

Call Member Services: **1-855-852-7005** (TTY: 1-800-648-6056 or 711) if:

- You have not received your Humana – CareSource member ID card
- Any of the information on the card is wrong
- You lose your card
- You have a baby so we can send you a member ID card for your baby
- You have any questions on how to use your Humana – CareSource member ID card

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 members under the fee-for-service program in the same amount, period of time and scope. The services are expected to 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 Member's ongoing need for such services and supports.

Below is a list of some of the many services you receive as a Humana – CareSource member.

Detailed Benefits Chart

In the chart you will find:

Services covered by Humana – CareSource in the "Covered" section.

Prior Authorization

Services that need a Prior Authorization, marked with a star (*). These are services Humana – CareSource needs to approve before you get them. Your PCP will ask for a prior authorization from us and should schedule these services for you. Humana – CareSource cannot be responsible for services that need prior authorization if those services were received without the prior approval.

Covered Services:

Abortions*	Abortions are covered only if the mother's life is threatened or in cases of reported rape or incest
Allergy Care	Shots and allergy treatments for children and adults
Ambulance (Emergency)*	Ground, Rotary and Fixed are covered. Fixed Wing airplane *
Ambulance (Non-Emergent)*	Includes stretcher services
Bariatric Surgery*	Medical necessity required
Behavioral (Mental) Health Services*	Crisis Services, Care Management, Outpatient Services (some specific services require PA), Day Treatment (PA required after 30 days/120 hours), Therapeutic Behavioral Health Services*, Assertive Community Treatment (ACT), Substance Use Disorder Outpatient Treatment (some specific services require PA), Intensive Outpatient Programs, Residential Services
Chiropractic*	Limited to 26 visits per calendar year for children and adults
Cosmetic Surgery (Plastic Surgery)*	Medical Director review required
Circumcision	
Diagnostic & Radiology Services	Including PET Scan, CT Scan, MR, MRI and X-Rays
Durable Medical Equipment*	Prior Authorization required for rental items that have a purchase price of $750 or more, all customized/powered wheelchairs and supplies, manual wheelchairs rentals greater than 3 months, tube feeding products, CPAPs/BiPAPs, diabetic shoes. Supplies such as wound care products are covered through a durable medical equipment supplier

*Services that need a prior authorization, marked with an asterisk (*)

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Benefit for children and adolescents from birth to the end of their 21st birth month. Preventive health care visits (well child visits). See member handbook for more information. EPSDT Preventive services cover regular health checkups (exams) & age recommended screenings for Medicaid members (0 to end of 21st birth month) & KCHIP members (0 to age 19). Visits are recommended at certain ages and include: medical, dental and oral health, vision, hearing, immunizations (shots), lab work (including Lead Level screenings & testing), (nutrition, growth and development mental health & substance use) and health risk assessments and health education. Referrals to specialists or other providers are made when further testing (diagnosis) & treatment is needed following an age recommended EPSDT
EPSDT Special Services*	EPSDT Special Services cover authorized "Medically Necessary" health care, diagnosis and treatment to address conditions discovered during EPSDT preventive care visits or diagnosis during further diagnosis (testing/evaluation). Treatment recommended to improve or maintain the child or adolescent's health condition are covered through EPSDT Special Services. Medicaid members 0 to the end of 21st birth month & some KCHIP members 0 to age 19
Emergency Room Services	If the visit is deemed Non-emergent, there will be a copayment due in the amount of $8
End Stage Renal Disease and Transplants	
Family Planning Services*	Covered through the member's PCP, OBGYN, or a qualified family planning provider listed in the provider directory. Self-referral can be made to a qualified provider. Pregnancy prevention supplies such as Depo Provera injections, Nuvaring, and IUD if received in the provider's office. IUDs (intra uterine device) require PA in the pharmacy setting
Hearing Aids*	Limited to children under 21; Not to exceed $800 per ear every 36 months
Hearing-Audiometric Services	Limited to children under 21
Home Health Services*	Medically necessary (skilled) nursing visits, social worker, and direct personal care home health aide
Hospice*	Home Setting & Inpatient (excludes institutional Hospice)
Hospital Services – Acute Inpatient including Inpatient Behavioral Health Services* Acute Inpatient Hospital Admission	Includes long term acute care admissions, hospitalization for behavioral health, and rehabilitation hospitalizations
Hysterectomy*	

*Services that need a prior authorization, marked with an asterisk (*)

Immunization for Children under 21	Humana – CareSource pays Providers enrolled in Kentucky's Vaccines for Children (VFC) Program, for ages 0-18, the cost of administering the immunization (shot) because the VFC Program provides the immunization (shot) serum free to the Provider for Members from birth through age 18. Immunization (serums) provided by the VFC Program: • Diphtheria • Rotavirus • Haemophilus • Rubella • Influenza type b • Tetanus • Hepatitis A • Varicella (chickenpox) • Hepatitis B • Poliomyelitis • Human Papillomavirus (HPV) • Pneumococcal • Pertussis (whooping cough) • Influenza • Measles • Mumps • Meningococcal • Tuberculosis (TB) Humana – CareSource pays providers the cost of administering immunizations (shots) plus pays for the vaccine (serum) for members 19 to 21 years of age

*Services that need a prior authorization, marked with an asterisk (*)

Immunizations for 21 & over	Adults 21 & over: Humana – CareSource will cover the administration & vaccination/immunization. • Hepatitis B • Pentacel: Dtap/HIB/IPV • Kinrix Dtap/IPV • Meningococcal • Rotavirus • Pneumococcal • Rabies • TD (Tetanus and Diphtheria) • Pneumococcal Conjugate Influenza • Varicella (chickenpox) • Hepatitis A • Boostrix (Polio) • Hemophilus IPV • Influenza B • MMRV (Measles, Mumps, Rubella, and Varicella) • HPV (Human Papilloma Virus) only through age 26 • Diptheria • Tetanus • Pertussis & Hemophilus • Influenza B (DTap - Hib)
Labs (Independent), Other Lab	Performed at/in the doctor's office or independent lab with doctor's order
Mammogram*	Mammograms for members under age 35 require prior authorization. One (1) Screening mammogram covered between the ages of 35-39. One (1) Screening mammogram covered per calendar year for over the age of 39. Mammogram covered for diagnosis and treatment for clinical symptoms indicative of breast cancer regardless of age
Maternity Services	Nurse mid-wife services, Pregnancy-related services 60 days postpartum pregnancy-related services, Alternative Birthing Center Services
Nicotine Replacement Therapy	
Non-network provider services	Urgent Care and ER visits do not require a prior authorization. All other out of non-network services require prior authorization

*Services that need a prior authorization, marked with an asterisk (*)

Nurse Advice Line (24-hour)	Our 24 hour nurse advice line gives unlimited access for members to speak with a registered nurse through the toll free number, 1-866-206-9599. Registered nurses are available 24 hours a day, 7 days a week, 365 days a year. For further information, please see page 23 in this member handbook
Nursing Facility Services*	While admitted in a long-term care facility, Humana – CareSource will cover all medically necessary non-nursing facility services as long as you remain an active Humana – CareSource member. The Department for Medicaid Services will cover the nursing facility services
Nutritional Dietary Consults	Covered for diabetes, pregnancy, complications of obesity surgery or other approved diagnoses. Coverage is provided for 1 nutritional counseling visit per year for diagnosis of obesity
Obesity Health Services*	Coverage may be provided for surgery if determined to be medically necessary
Obesity Screening and Therapy to Promote Sustained Weight Loss	Annually
Occupational Therapy*	Twenty (20) visits combined for habilitation/ rehabilitation per year (Children and Adults). More visits may be covered if medically necessary
Oral Surgery*	
Organ Transplants*	
Orthodontics*	Children under 21; subject to fee schedule limitations and reimbursement not to exceed $3000 – medical necessity review required and coverage dependent upon severity
Over-the-Counter (OTC) Medications	Covered with a prescription from a doctor
Pain Management Services*	Facets, Epidurals, Facet Neurotomy, Trigger Points and SI Joint Injections Pain management services require prior authorization
Physical Therapy*	Twenty (20) visits combined for habilitation/ rehabilitation per year (children and adults). More visits may be covered if medically necessary

*Services that need a prior authorization, marked with an asterisk (*)

Physician Office Services	Physician Office Services includes physicians, certified pediatric and family nurse practitioners, nurse midwives, Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), primary care centers (PCCs), and physician assistants
Podiatry Services	
Prescription Drugs* Preferred Brand Name Drug (no generic equivalent) Non-Preferred Brand Name Drug	Some prescription drugs require prior authorization
Preventive Services	See page 26 for examples of Preventive Services
Private Duty Nursing*	Limited to 2000 hours per year
Prosthetic Devices*	Prior Authorization is required for more than $750 billed services
Speech Therapy*	Twenty (20) visits combined for habilitation/rehabilitation per year (children and adults). More visits may be covered if medically necessary
Sterilization	Consent form required
Substance Use*	Screening, Brief Intervention and Referral Treatment (SBIRT), Assessment & Intervention, Alcohol and/or Drug Prevention, Medication Management, Crisis Services, Care Management, Skill Building, Outpatient Services (some specific services require PA), Day Treatment (PA required after 30 days/120 hours), Residential Services
Tobacco Use	Assessment, Coaching Program, Phone Support, and Medicine (see Nicotine Replacement Therapy in this grid) pregnant women allowed the full amount limit of 4 face to face sessions per quit attempt
Transportation	Transportation to a non-emergent health care appointment may be available from a transportation company. This is a service offered by Kentucky Medicaid. To get a list of companies and find out how to contact them, call 1-888-941-7433. Online visit: https://transportation.ky.gov/TransportationDelivery/Pages/default.aspx. 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

*Services that need a prior authorization, marked with an asterisk (*)

Tuberculosis Screening, Evaluation and Treatment	Testing is recommended when there are high risk factors. (TB testing/Screening, Evaluation & Treatment covered under EPSDT 0-21 where medically necessary)
Urgent Care Services	No Copay
Dental*	Children under 21: Two (2) cleanings per twelve (12) month period, extractions and fillings, x-rays, annual dental and oral health screens, fluoride treatments, sealants for children at risk of tooth decay, diagnostic and treatment services that are medically necessary and restorative care. Adults 21 and over: Two (2) cleanings per 12 month period, limited to twelve (12) dental visits per year, extractions and fillings, one (1) set of standard x-rays per 12 month period. Subject to fee schedule and frequency limitations
Vision*	Members under 21 may receive one pair of glasses per year (additional pair covered if the first pair is lost, broken or the prescription changes); additional glasses may be provided under EPSDT Special Services if medically necessary. Talk to your vision doctor if you have broken your glasses or if your vision has changed. Glasses exceeding $200 will require prior authorization. For K-CHIP2 (Children's Health Insurance program) special population, a limit of no more than two (2) pairs of glasses per year up to $200 each can be imposed. This population is not part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) population. Adults are not covered to receive a glasses benefit

*Services that need a prior authorization, marked with an asterisk (*)

For some services, such as physical therapy or outpatient surgery, a physician's order is required. For other services, look at your Provider Directory or the Find a Doctor/Provider link on our website. Then make an appointment on your own. Always check the benefits chart to see what is needed for you to get the care you need. Please call us if you need help finding a provider for any service.

Payment for these services is the responsibility of the member.

You can also see if "prior authorization" or approval is needed (noted by an asterisk) or if there are special benefit limits. Please look at the chart carefully.

Call Member 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 chart. 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 Member Services: **1-855-852-7005** (TTY: 1-800-648-6056 or 711). Payment for non-covered services is the responsibility of the member.

Cosmetic Surgery (Plastic Surgery)	Cosmetic procedures or services performed solely to improve appearance
Hysterectomy	Hysterectomy procedures, if performed for hygienic reasons or for sterilization only, are not covered
Immunizations – for Children under 21	No coverage for vaccines to travel outside of the United States
Immunizations for 21 & over	No coverage for vaccines to travel outside of the United States
Infertility	Medical or surgical treatment of infertility (e.g., the reversal of sterilization, invitro fertilization, etc.)
Labs (Independent), Other Lab	The screening is not covered for employment drug testing
Obesity Health Services	Exclusions: diet pills, liquid diets
Paternity Testing	
Post mortem services	
Prescription Drugs	Fertility, erectile dysfunction drugs, weight loss drugs not covered
Sterilization	Sterilization of a mentally incompetent or institutionalized member is not covered

GENERAL INFORMATION FOR ALL OUR MEMBERS

You are now a member of Humana – CareSource. Welcome!

We are happy to have you as a member. Our main goal is to keep you healthy and we aim to keep it all 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 – CareSource is a managed care health care plan serving all 120 counties in 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.

You can also visit our website at **CareSource.com/KY** for information about:

- how to get emergency services or use 911
- how to get specialty health, hospital, and behavioral health service
- how to get care when you are away from home
- your rights and responsibilities
- searching our provider directory to find a doctor
- our quality program
- the Notice of Privacy Practices, how information about you can be used, and how you can ask to restrict release of your personal health information
- our Care Management program and how you or your caregiver can access it
- our Disease Management program and how you can join
- your doctor's education, professional training and qualifications, and certification status
- Pharmacy coverage and how to use it
- submitting a claim if you have to do so on your own
- how to tell us if you are unhappy and how to file a complaint
- how to appeal decisions that may affect your coverage, benefits, or your relationship with Humana – CareSource
- where to call if you have questions about managing your care
- policies and procedures for managing your health and getting second opinions from health care providers that are not part of our network
- getting help or materials if you speak a foreign language

Call us if you have additional questions or don't have internet access, we can help!

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 refer to the covered benefits section of the Medicaid plan for which you are enrolled.

Copayment Update

What's changing?

As our member we want to ensure you are aware of any changes that may impact your health insurance. Starting January 1, 2019, the Commonwealth of Kentucky is requiring that all Medicaid Managed Care Organizations impose cost sharing requirements. On January 1, 2019 you will be subject to copayments for certain services. You will not be required to pay more than five percent of your household's income in a quarter. Exemptions may apply. Refer to the copay grid below.

What is a copayment?

A copayment is an amount you are required to pay as your share of the cost for a medical service like a doctor's visit or a prescription. Benefits that require a copayment are:

Service or Item	Copayment Amount
Preferred and non-preferred generic drug	$1.00
Preferred brand name drug that does not have a generic equivalent	$4.00
Non-preferred brand name drug	$4.00
Chiropractor	$3.00
Dental – for members not enrolled in the Alternative Benefit Plan	$3.00
Podiatry	$3.00
Optometry – for members not enrolled in the Alternative Benefit Plan	$3.00
General ophthalmological services – for members not enrolled in the Alternative Benefit Plan	$3.00
Office visit for care by a physician, physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, nurse midwife, or any behavioral health professional	$3.00
Physician service	$3.00
Office visit to a rural health clinic, primary care center, federally qualified health center, or federally qualified health center look-alike	$3.00
Outpatient hospital service	$4.00
Emergency room visit for a non-emergency service	$8.00

All Inpatient hospital admission	$50.00
Physical therapy, speech therapy, occupational therapy	$3.00
Durable medical equipment	$4.00
Ambulatory surgical center	$4.00
Laboratory, diagnostic, or x-ray service	$3.00

Exemptions may apply but are not limited to:

Foster children, preventive services, pregnant women, terminally ill and hospice care, emergency services, and some family planning services.

Added Benefits

As a Humana – CareSource member you get more! These extra benefits, tools and services are at no cost to you. If you are pregnant or have a baby, regular checkups are important before and after your baby is born. Get the prenatal care you and your baby deserve – and get rewards for taking care of yourself and your baby!

The **Humana – CareSource Babies First Program** is for pregnant women and children up to 18 months of age. You can earn up to $150 in rewards for receiving prenatal, postpartum, and well-baby care. We want to help you celebrate new life just for getting the care that you and your baby need! Here's how it works:

Sign up for the Babies First program on our website or by calling Member Services. You will receive your rewards card in the mail.

- Have your first prenatal appointment during your first 3 months of pregnancy
- Keep all your scheduled prenatal visits
- Visit a doctor 3–8 weeks after your baby is born for your postpartum check up
- Get your baby preventive checkups during his/her first 18 months

After you complete certain doctor's visits, rewards will be loaded on your card. You will get a letter in the mail when this happens. Call Member Services at **1-855-852-7005** (TTY: 1-800-648-6056 or 711) for more information or if you have questions.

myStrength

Take charge of your mental health and try our 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://bh.mystrength.com/humana_caresource for more information and to sign up.

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.

Tool for Easy Access

Mobile App

Use your Humana – CareSource plan on the go with the free CareSource mobile app. The app lets you safely use your My CareSource account from your mobile device to:

- View your Member ID card,
- Find a network provider
- Review your plan benefits
- Call the nurse advice line
- Call and speak with Member Services and more!

This mobile app can be used by both iPhone and Android systems. Get it free through the Apple App Store or Google Play by searching CareSource.

My CareSource® Account

Your My CareSource account is a private, personal online account that can help you get the most out of your member experience. You can:

- Change your doctor
- Request a new Member ID card
- View claims and plan details
- Take the Health Risk Assessment
- And more

Sign up now! It's fast, easy, and secure. Visit MyCareSource.com to get started.

CONTACT US

Member Services Phone: 1-855-852-7005 (TTY: 1-800-648-6056 or 711)

Online: CareSource.com/KY

24-Hour Nurse Advice Line: 1-866-206-9599 (TTY: 1-800-648-6056 or 711)

Transportation:

State plan members call: 1-888-941-7433

https://transportation.ky.gov/TransportationDelivery/Pages/default.aspx

Hours of Service

Member Services is open Monday through Friday from 7 a.m. to 7 p.m. Eastern Standard Time (EST), except on the days listed below.

Note: 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
- Sending an email through our website, at **CareSource.com/KY** and fill out the "Tell us" Form

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

- New Year's Day: Tuesday, January 1, 2019
- Memorial Day: Monday, May 27, 2019
- Independence Day: Thursday, July 4, 2019
- Labor Day: Monday, September 2, 2019
- Thanksgiving Day: Thursday, November 28, 2019
- The day after Thanksgiving: Friday, November 29, 2019
- Christmas Eve: Tuesday, December 24, 2019
- Christmas Day: Wednesday, December 25, 2019

Mail Us!

Humana – CareSource
P.O. Box 221529, Louisville,
KY 40252-1529

Our hours are Monday – Friday from 7 a.m. to 7 p.m. EST, except on the days it observes major holidays as listed above.

Office Address:
10200 Forest Green Boulevard, Suite 400,
Louisville, KY 40223

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 ideas are important. We want you to be a healthy and happy member.

MEMBER SERVICES AND CARESOURCE.COM

Call Member Services or visit CareSource.com/KY to learn more about:

- Benefits, claims 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 member ID card
- Reporting a lost ID card
- Selecting or changing your primary care provider (PCP)
- Help we have for members who don't speak or read English well
- How we can help members understand information due to vision or hearing problems
- Filing a complaint about Humana – CareSource or a provider

For faster service, please have your member ID number on your Humana – CareSource member ID card handy. More information about your member ID card can be found on page 4.

My CareSource® is a private, personal online account that can help you get the most out of your member experience. You can:

- Change your doctor
- Request a new member ID card
- Sign up to receive email and text notifications when documents are available
- View claims and plan details
- And more

Sign up now! It's fast, easy, and secure. Visit MyCareSource.com to get started.

Let Us Know if Your Information Changes

We want to make sure we are always able to connect with you about your care. We don't want to lose you as a member, so it is 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 include:

- Change of physical/mailing address or change in contact information
- Household income changes. For example, increase or decrease in work hours, increase in pay rate, change in self-employment, beginning a new job, or leaving a job
- Household size or relationship changes. For example, someone moved into or out of your household, marries or divorces, becomes pregnant, or has a child
- You or other members qualify for other health coverage such as health insurance from an employer, Medicare, Tricare, or other types of health coverage
- Changes in immigration status
- Being in jail or prison
- You start or stop filing a federal income tax return
- Changes to your federal income tax return such as a change in dependents 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. To locate a DCBS office near you please visit https://prdweb.chfs.ky.gov/Office_Phone/index.aspx;
- Submitting a change in writing and mailing to: DCBS, P.O. Box 2104, Frankfort, KY 40601;
- Calling DCBS at 1-855-306-8959; or
- Through the benefind Self Service Portal, www.benefind.ky.gov

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 – CareSource cannot provide them with your valid address. You may remain disenrolled until either the Department or Humana – CareSource can locate you and eligibility can be reestablished.

Interpreter Services

Is there a Humana – CareSource member in your family who:

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

If so, we can help. We can get you sign and language interpreters. Oral interpretation is also provided for all languages.

They can help members talk with us or their health care provider. Interpreters can also help you with a grievance or an appeal when you are not happy with a decision (see page 44). They can help over the phone or in person. Please call Member Services to ask for sign language services 5 business days before the scheduled appointment. Please call Member Services to ask for interpreter services 24 hours before the scheduled appointment. We also can get printed translated materials in Spanish and each prevalent non-English language as well as the top 15 non-English languages as released by the U.S. Department of Health and Human Services, Office for Civil Rights in other languages or alternative formats, like large print and Braille, and other auxiliary aids and services. We can read materials to you in any language, if needed. You can get these services at no cost to you. Just call us at **1-855-852-7005** (TTY: 1-800-648-6056 or 711) to arrange interpreter service.

OTHER INSURANCE?

If you have other medical insurance, please call Member Services: 1-855-852-7005 (TTY: 1-800-648-6056 or 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.

Please let us know if you or any Humana – CareSource member in your family has seen a doctor for an injury or illness caused by someone else or at a business. Examples are:

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

Call Member Services: **1-855-852-7005** (TTY: 1-800-648-6056 or 711) to let us know. Another insurance company might have to pay the doctor or hospital bill. 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.

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 – CareSource.

If you have questions about your Medicaid eligibility, please contact your local DCBS office. To find your local DCBS office, go to https://prdweb.chfs.ky.gov/Office_Phone/index.aspx

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.
1-866-206-9599 (TTY: 1-800-648-6056 or 711).

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 Humana – CareSource 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 – CareSource and have not chosen a PCP, you can still get care. Just call Member Services: 1-855-852-7005 (TTY: 1-800-648-6056 or 711). We can help you get the care you need and set you up with a PCP.

Choosing a PCP will help you take care of your health care needs. You may choose a PCP from Humana – CareSource's Provider Directory. You can start seeing that PCP on the first day you are signed up. If you need care before you have a PCP, you may visit any provider in our network.

There may be a reason that a specialist will be your PCP, "specific to your needs including those with a gynecological or obstetrical health care need, a disability, or chronic illness." If you think you need a specialist to be your PCP, please call Member Services.

What happens if you don't choose a PCP?

If you are not receiving Social Security income* and do not choose a PCP at the time you sign up, 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. If you need care and do not have a PCP yet, you may also get care from any provider in our network. You can find a PCP in your area by visiting Find a Doctor/Provider on **CareSource.com/KY**. You can also look in your provider directory.

**Social Security income is money you get now that was paid by you in the past in the form of social security taxes when you were working.*

If you are receiving Social Security income and don't qualify for both Medicare and Medicaid, you will get:

- a letter asking you to choose a PCP
  - if you do not choose a PCP within 30 days, a second letter will be sent to you asking you to choose a PCP
  - after 60 days, if you have still not chosen a PCP, we will send a third letter
  - if you do not choose a PCP we will assign one for you and give you the name of your new PCP. Please remember to please call us if you need any help choosing a PCP in our network.

Special Cases:

- For members who have been adopted, a PCP will be assigned based on the adoptive parents' residence.
- If you are pregnant and may be eligible for Medicaid you do not have to choose a PCP.
- If you are a dual eligible member, a member who is presumptively eligible ("presumptive eligible" – see page 72), 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 and Humana – CareSource insurance, you do not have to choose a PCP.

We encourage all members to choose a PCP and have a medical home.

Changing Your PCP or Specialist

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

If you are a new patient to your PCP, please call the office to schedule a visit. Member Services can also help you make your first appointment. You may not be able to change if the new PCP or specialist you want is not taking new patients or has other restrictions. Please call us if you need help.

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

Humana – CareSource can sometimes end a doctor's participation with us. This is called an involuntary termination. If this happens with your PCP or specialist, we will let you know by mail within 15 days. We will also help you find a new doctor.

We will also let you know if any hospitals in your region stop accepting Humana – CareSource. When you choose your Primary Care Provider, call the office and make an appointment. Please schedule appointments with your doctor as far ahead as possible.

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. If you miss too many visits, your doctor may ask that you choose another doctor.

Doctor Visits

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

Preventive care includes:

- Regular checkups
- Immunizations for children
- Tests and screenings, when needed

Routine care includes things such as:

- Colds/flu
- Earache
- Rash
- Sore throat

You should visit your PCP within 90 days of joining Humana – CareSource.

Here are some things to remember before going to the doctor:

- Always take your Humana – CareSource 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 any
  - your doctor is someone you can trust and rely on
  - ask about any concerns you may have
- If you have to cancel an appointment, please do so 24 hours in advance

PROVIDER DIRECTORY

Humana – CareSource will give you a Provider Directory. 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 directory may change and you can always call us to see if any new PCPs 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 Member Services: **1-855-852-7005** (TTY: 1-800-648-6056 or 711), or you can visit our website at findadoctor.CareSource.com.

Find-a-Doctor

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 findadoctor.CareSource.com.

If you have not chosen a PCP yet, please:

- Look in the provider directory book that we mail you
- Look on our website at findadoctor.CareSource.com.
- Call Member Services: **1-855-852-7005** or TTY: 1-800-648-6056 or 711

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.

Referrals are not required

You may see any provider within our network to include specialists and inpatient hospitals. Humana – CareSource does not require referrals from primary care providers (PCP) to see specialists within our network. 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. Please refer to the benefit grid on page 6.

Exceptions to this policy apply to members who are in the Kentucky Lock In Program (KLIP). Please refer to the KLIP section of the handbook on page 50.

You may go to out of network providers, without a referral, for:

- Emergency care
- Care at community mental health centers
- Family planning services provided at qualified family planning providers (e.g., Planned Parenthood)
- Care at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

All other out of network providers are required to have a referral from your in network PCP or Specialist.

Using a provider that is not in our network

The provider directory lists all of the providers you can use to get services. The only time you can go to a provider that is not in our network is for:

- Emergency services
- Family planning services from any Qualified Provider of Family Planning services
- Care at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Post Stabilization service or care you get after emergency services
- An out of network service that we cannot provide within our network to meet your medical need; however, these services need prior authorization

A prior authorization is needed for all other covered services if you plan to use a provider that is not in our network. A prior authorization means that you have approval from Humana – CareSource for the service. Your PCP can request this approval for you. We will first check to see if there is a provider in our network who can treat you. If not, we will help you find a provider that is not in our network. If you use a provider not in our network without prior approval, you will need to pay for the services.

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:

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

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 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 for members from birth through the end of their 21st birth month. Humana – CareSource 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 birth 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 members (birth to the end of their 21st birth month) with special health care needs can get Care Management services.

EPSDT well care exams and health screens include:

- Medical/physical exams
- Complete health and development history
- Height and weight checks with nutrition counseling when needed
- Hearing tests
  - hearing tests start when your child is a newborn
  - hearing tests and risk assessments happen at each EPSDT visit
- Eye exams (vision)
  - eye exams start when your child is a newborn
  - eye exams and risk assessments happen at each EPSDT visit
- Dental visits
  - during EPSDT visits, oral health assessments are provided at recommended ages and referrals made to a dentist when needed
  - referrals 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)
  - 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
  - intervention and/or referral needs for identified risk behaviors
  - car seat safety, seat belts, alcohol/substance use, sexual activity, mental health, developmental delays
- Health and safety education

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 members 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 – CareSource recommends scheduling the first EPSDT well care exam within 90 days of becoming a member.

You or your child's PCP may suspect a problem that needs more than 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 members (birth to the end of their 21st birth 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 – CareSource 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 Member Services if you have a question about coverage or services that require prior authorizations.

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

Infancy

- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months

Early Childhood

- 15 months
- 18 months
- 24 months
- 30 months
- 3 years * for ages 3 and above, EPSDT visits are once a year

Middle Childhood

- 4 years
- 5 years
- 6 years
- 7 years
- 8 years
- 9 years
- 10 years

Adolescence and Young Adults

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

SHOULD I GO TO THE EMERGENCY ROOM?

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 call our 24-hour nurse advice line. Call: **1-866-206-9599** to talk to a nurse.

Emergency services are for a medical problem that you think is so serious that it must be treated right away by a doctor. Humana – CareSource 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.

- Miscarriage/pregnancy with vaginal bleeding
- Severe chest pain
- Shortness of breath
- Loss of consciousness
- Seizures/convulsions
- Uncontrolled bleeding
- Severe vomiting
- Rape
- Major burns

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: **1-866-206-9599** (TTY: 1-800-648-6056 or 711).

Remember, if you have an emergency:

- Call 911 or go to the nearest ER. Be sure to tell them that you are a member of Humana – CareSource. Show them your Member ID card.
- If the provider that takes care of your emergency thinks that you need other medical care to treat the problem that caused it, the provider must call Humana – CareSource.
- 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 – CareSource 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 **1-866-206-9599** (TTY: 1-800-648-6056 or 711). 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.

If you have an emergency, call 911 or go to the nearest ER.

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 – CareSource will cover services such as doctor's services, therapy services, oxygen, etc., as long as you are a member with us. Keep in mind that after 30 days in long-term care you may no longer be Medicaid eligible. The Cabinet for Health and Family Services will cover all other services provided within the nursing facility. If you have questions, please call Member Services: **1-855-852-7005** (TTY: 1-800-648-6056 or 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 – CareSource network for a second opinion, you must get prior approval from us (see page 6).

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 – CareSource. Your PCP will look at the second opinion and help you decide the best treatment.

PREGNANCY AND FAMILY PLANNING

Humana – CareSource wants you to have a healthy pregnancy. These services are confidential and private for all members regardless of age. Here is how you can take advantage of the services and benefits we have to offer.

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 – CareSource network. If the provider you wish to see is not in the Humana – CareSource network, you will need to call Member Services: **1-855-852-7005** (TTY: 1-800-648-6056 or 711) to let them know who you will be seeing for your sexually transmitted disease services.

Family Planning Services

Humana – CareSource 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 – CareSource network. If the provider you wish to see is not in the Humana – CareSource network, you may need a prior authorization before your visit. Call Member Services: **1-855-852-7005** (TTY: 1-800-648-6056 or 711) to let them know who you will be seeing for your family planning.

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 members 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– CareSource health partner network. Family planning services and any follow-up services are confidential for you, including members 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
- Take folic acid every day
- Don’t drink alcohol, smoke, or use illegal drugs

If you are pregnant, make an appointment with an obstetrician (OB). You can find an OB in your provider directory. If you need help, call Member Services: **1-855-852-7005** (TTY: 1-800-648-6056 or 711). Be sure to make an appointment as soon as you know you are pregnant.

After Your Baby is Born

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 – CareSource 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 Member 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. Members may need to try one drug before taking another.

A member must try a medicine on the formulary before a drug that is not on the formulary would be approved by Humana – CareSource. 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. This is called generic substitution.

Members 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 a member 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. This is called Therapeutic Interchange. 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 a member 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: **1-855-852-7005** (TTY: 1-800-648-6056 or 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 **CareSource.com/ky/plans/medicaid/benefits-services/pharmacy/preferred-drug-list/** on our website at **CareSource.com/KY** to 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 – CareSource has an exception process that allows the member or the member'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 member or member's representative must initiate the request by calling Member Services. Humana – CareSource 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, call us: **1-855-852-7005** (TTY: 1-800-648-6056 or 711).

Medication Therapy Management

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

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

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

This service, and the pharmacist's help and information, are part of being a Humana – CareSource member 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

You can call Member Services: **1-855-852-7005** (TTY: 1-800-648-6056 or 711) to ask about our list of covered medications and those that need prior authorization.

BEHAVIORAL HEALTH SERVICES

Behavioral 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 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 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.

Call us: **1-877-380-9729**. We are here to help. 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 by choosing the Behavioral Health Crisis line prompt.

We also offer Care Management services for members with medical and/or behavioral health needs. We will work with you to make sure you get the best care possible. We can help make sure that all of your health care providers are working together to help you get well. We can:

- Give you information about your health care needs
- Help you find providers who know how to help with your specific needs
- Help you to fix problems that keep you from getting the care you need

Call us if you have questions or feel that you need these services. You can reach Care Management Support Services at **1-866-206-0272**.

CARE MANAGEMENT AND OUTREACH SERVICES

We offer Care Management services to all members who can benefit from this service. Members 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 1-866-206-0272.

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

Members with these conditions are automatically enrolled into the Disease Management program. If you do not want to be in this program please call **1-844-768-2010**.

Tobacco Free Program

If you smoke or use other tobacco products, Humana – CareSource 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. However, 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. They will also 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 **1-844-724-3957**. If you are pregnant call **1-844-768-2010** 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 Transition team at 1-866-870-9849.

GRIEVANCES AND APPEALS

We hope you will be happy with Humana – CareSource 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 Member Services.

Grievances (Complaints)

If you are unhappy with Humana – CareSource or one of our providers, this is called a grievance. You, or someone you have chosen to represent you, should call us. You may file a grievance orally or in writing. If you ever want information about grievances please ask us. Call Member Services: **1-855-852-7005** (TTY: 1-800-648-6056 or 711). If needed, we can help you file a grievance. You can also get help from others. They can be:

- 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 Member Services at **1-855-852-7005** (TTY: 1-800-648-6056 or 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 member number from the front of your Humana – CareSource 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 1-855-262-9794
- Mail the form or letter to:

  Humana – CareSource
  Grievance and Appeals Department
  P.O. Box 1947
  Dayton, OH 45401-1947

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:

- A member who files a grievance
- A provider that supports a member's grievance or files a grievance on behalf of a member 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 Action, 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 ten (10) calendar days from your telephone request.

If needed, we can help you file an appeal. You can also get help from others. They can be:

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

You can file an appeal by:

- Calling Member Services: **1-855-852-7005** or (TTY: 1-800-648-6056 or 711)
  - We will start on your appeal, but we still need the request in writing within ten (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 member number from the front of your Humana – CareSource 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 1-855-262-9794
- Mail the form or letter to:

Humana – CareSource
Grievance and Appeals Department
P.O. Box 1947
Dayton, OH 45401-1947

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 Consent 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 – CareSource must receive it within ten (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 he or she disagrees 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 member's case file before and during the appeals process.
  - This includes medical, clinical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by us, or at the direction of the Contractor, 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 a member's life, physical health, or ability to attain, maintain, or regain maximum function.

We make decisions on expedited appeals within 72 hours or as fast as needed based on your health.

Negative actions will not be taken against:

- a member or provider who files an appeal
- a provider that supports a member's appeal or files an appeal on behalf of a member 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 – CareSource 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 (TTY: 1-800-627-4702 or 711)

Write: Kentucky Department for Medicaid Services
Division of Program Quality and Outcomes
275 E. Main Street, 6C-C
Frankfort, KY 40621

Fax: 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 – CareSource benefits to continue, you must file a request with us (Humana – CareSource) within 10 days from the date you receive our decision.

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 continued benefits linked to the state fair hearing.

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 40621-0001

1-800-372-2973 (TTY: 1-800-627-4702)

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 members. We monitor and take action on all provider, pharmacy, or member fraud, waste, and abuse. Examples of provider fraud, waste, and abuse include doctors or other health care providers who:

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

Examples of pharmacy fraud, waste, and abuse include:

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

Examples of member fraud, waste, and abuse include:

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

- Too many ER visits for problems that are not emergencies
- Misrepresenting eligibility for Medicaid

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

- Be required to pay back money that we paid for services that were determined to be a misuse of benefits
- Be prosecuted for a crime and go to jail
- Lose Medicaid benefits
- Be locked in to one PCP, one controlled substance provider, one pharmacy and/or one hospital for non-emergency services.
  - See Kentucky Lock-In Program (KLIP) for details (see page 50 for more details)

If You Suspect Fraud, Waste or Abuse

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

- Call **1-855-852-7005** (TTY: 1-800-648-6056 or 711)
  - 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
  - You can go to our website, **CareSource.com/KY**, and fill out the form.
- Send it to:

  Humana – CareSource
  Attn: Special Investigations Unit
  P.O. Box 1940 Dayton, OH 45401-1940

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 fraud@caresource.com
- Fax us at 1-800-418-0248

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

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

KENTUCKY LOCK-IN PROGRAM (KLIP)

Humana – CareSource tracks how often some drugs are filled, if these drugs are filled at different pharmacies, and how many doctors members visit. In some cases, we may limit a member 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 **CareSource.com/ky/providers/education/patient-care/pharmacy/lock-in-program/medicaid/.**

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. All UM requests are reviewed carefully by our review team of nurses and doctors. Doctors can decide if a service cannot be covered.

We check the work of our reviewers regularly. We 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 business days. This can be done more quickly if needed because of the member'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 Member Services: **1-855-852-7005** (TTY: 1-800-648-6056 or 711). You can also send us an email at any time through our website at **CareSource.com/KY**.

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. We may decide that a new development 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 member surveys
- How many members leave our plan
- Benefits, eligibility, claims, or participating providers

If you want to tell us about things you think we should change, please call Member Services: **1-855-852-7005** (TTY: 1-800-648-6056 or 711).

QUALITY IMPROVEMENT

Program Purpose

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

- 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 – CareSource members.

There are two guiding tenets for the Program:

- Our mission, which is our heartbeat, is to make a lasting difference in our members' 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 the per capita cost of care for the benefit of communities.

The Humana – CareSource Quality Improvement Program includes both clinical and non-clinical services and is revised as needed to remain responsive to member needs, provider feedback, standards of care, and business needs. The goals and objectives of the program are:

- Commendable Accreditation Compliance with NCQA Accreditation standards
- High level of HEDIS performance
- High level of CAHPS performance
- Comprehensive Population Health Management Program
- Comprehensive Provider Engagement Program

Program Scope

The Humana – CareSource Quality Improvement Program governs the quality assessment and improvement activities for Humana – CareSource 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 member 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 – CareSource Program is effectively serving members with culturally and linguistically diverse needs
- Ensuring that Humana – CareSource Program is effectively serving members with complex health needs
- Assessing the characteristics and needs of the member population
- Assessing the geographic availability and accessibility of primary and specialty care providers

The quality program is overseen by the Humana – CareSource Medical Director and implementation is facilitated by the Vice President, Quality Improvement and Performance Outcomes. On an annual basis, Humana – CareSource makes information available about its Quality Program to providers on the Humana – CareSource website. Humana – CareSource gathers and uses provider performance data to improve quality of services.

Quality Measures

Humana – CareSource continually assesses and analyzes the quality of care and services offered to our members. This is accomplished by using objective and systematic monitoring and evaluation to implement programs to improve outcomes.

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

The HEDIS tool is used by America's health plans to measure important dimensions of care and service 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 – CareSource 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 – CareSource uses the annual member survey and CAHPS® surveys to capture member perspectives on health care quality. CAHPS is a program overseen by the United States Department of Health and Human Services – Agency for Healthcare Research and Quality (AHRQ).

Potential CAHPS measures for the plan 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 – CareSource recommends evidenced based nationally accepted standards and guidelines to help inform and guide the clinical care provided to Humana – CareSource members. Guidelines are reviewed at least every two years or more often as appropriate, and updated as necessary.

The use of these guidelines allows Humana – CareSource to measure the impact of the guidelines on outcomes of care. Review and approval of the guidelines are completed by the CareSource Clinical Advisory Committee every two years or more often as appropriate. The guidelines are then presented to the Humana – CareSource Quality Assurance Committee. Topics for guidelines are identified through analysis of members. 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 – CareSource members via member newsletters, the Humana – CareSource member website, or upon request. Preventive guidelines and health links are available to members and providers via the website or hard copy.

Your Health is Important

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

- Establish a relationship with a 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 member ID card 24/7/365.

CareSource has programs that can help you maintain or improve your health. Call us for more information about these programs: **1-855-852-7005** (TTY: 1-800-648-6056 or 711).

YOUR RIGHTS

As a member of Humana – CareSource 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 – CareSource'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 – CareSource 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 CFR438.206 through 438.210;
- Any Indian enrolled with Humana – CareSource 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 – CareSource'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 members at cost.
- To say yes or no to having information about you given out unless Humana – CareSource has to provide it by law.
- To be able to get all written member information:
  - At no cost to you
  - In the prevalent non-English languages of members in our service area
  - In other ways to help with the special needs of members who may 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 – CareSource 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 – CareSource 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, Suite 16T70 61 Forsyth Street, S.W.
    Atlanta, GA 30303-8909
  - 1-800-368-1019 or TTY: 1-800-537-7697
  - Fax: 1-404-562-7881
- You have the right to get help with sign language if you are hearing impaired.
- To receive information about Humana – CareSource, our services, our practitioners and providers and member rights and responsibilities.
- To make recommendations to our member rights and responsibility policy.
- If Humana – CareSource 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 a member. There is no cost to you.
- To be free to carry out your rights and know that Humana – CareSource or our providers will not hold this against you.

YOUR RESPONSIBILITIES

As a member of Humana – CareSource you must be sure to:

- Know your rights.
- Follow Humana – CareSource 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 a member, 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) about any changes. To find the nearest DCBS office, visit their website at https://prdweb.chfs.ky.gov/Office_Phone/.
  - Or call the Ombudsman toll-free: 1-800-372-2973 or TTY (for hearing impaired) 1-800-627-4702
- Call your PCP after going to an urgent care center, after a medical emergency, or after getting medical care outside of Humana – CareSource's service area.
- Let Humana – CareSource and the DCBS know if you have other health insurance coverage.
- Provide the information that Humana – CareSource and your health care providers need in order to care for you.
- Report suspected fraud and abuse (see page 48).

We will tell you about changes to our member rights and responsibilities on our website at **CareSource.com/KY** or in newsletters.

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. 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.

Members receive notice annually in the member newsletter that the Notice of Privacy Practices is available on our website. It is posted on our website under "Member Information." Members are also advised as to how they can request a copy of the notice from us. This notice tells you:

- How Humana – CareSource and its contracted business partners may use ` and give out your protected health information to carry out treatment, payment or health care operations and for other purposes permitted or required by law
- What YOUR rights are regarding the access and control of your Medicaid health information
- How Humana – CareSource protects your health information

Our Duty to Protect Your Privacy

Your health information is personal. Humana – CareSource is legally required to protect the privacy of your data. It does so in all aspects of its business. Humana – CareSource has policies about protecting the privacy of your data. These policies comply with State and Federal laws. Humana – CareSource uses and gives out your health information only where required by law or where necessary for business.

Where Do I Send Questions or Requests?

To submit questions about your privacy rights or to submit a written request to Humana – CareSource regarding your privacy rights, contact the Humana – CareSource Privacy Officer at:

Humana – CareSource
Attn: Privacy Officer
P.O. Box 221459
Louisville, KY 40252

Or, you may contact Humana – CareSource at **1-855-852-7005**.

If you have a hearing impairment, you may call the TDD/TTY number at (1-800-648-6056 or 711).

What Type of Information Does Humana – CareSource Have?

The Department for Community Based Services (DCBS) or Social Security Administration (SSA) for Supplemental Security Income (SSI) approved you for

Medicaid. DCBS and SSA send your information to Humana – CareSource. Humana – CareSource then pays your provider for claims they send in. Information sent to Humana – CareSource includes:

- Your individual information including: name, address, phone number, date of birth, social security number, eligibility program information, Medicaid number
- Information on other health insurance policies you may have
- Your medical records (when necessary)
- Your provider's claims for your services. Provider claims contain information on your treatment given and may include x-rays and lab results.

All this information is considered to be your Protected Health Information (PHI).

Humana – CareSource Privacy Responsibility

Humana – CareSource is required to:

- Follow the terms of this Notice.
- Support your privacy rights under the law.
- Give you a paper copy of this privacy notice and post it on our website.
- Mail out a new Notice if our privacy practices change.
- Treat your data as confidential by not using or giving out your information without your written permission, except to support normal business or under the allowable circumstances given in this Notice.
- Tell you what types of information we collect on you.
- Release your health information without your permission in the event of an emergency. The release of your data must be in your best interest.
- Follow state laws regarding the release of your data in the instances where State law provides stronger protection of your data than the HIPAA law.

How Humana – CareSource May Use or Give Out Your Information

Humana – CareSource can use and give out your information without an Authorization (special permission from you) for our normal business and where required by law. This document tells you of some of the ways this can occur. ***All the ways Humana – CareSource may use and give out your information without your express permission will fall within one of the groups listed below.***

Data for Treatment and Payment Purposes

Humana – CareSource and businesses we work with receive and give out your health information for:

- The coordination of your treatment with medical professionals and facilities.
- The billing and payment of your claims.

- The review of your health care and use of benefits.
- The prior authorization of your requested services.
- Data exchanged for your treatment and claim payment involves communications between your health care providers, Humana – CareSource, your insurance carriers and other organizations necessary to receive, review, approve, process and successfully pay for your health care claims.
- For example, your doctor must submit a "bill" to Humana – CareSource listing the treatment he provided to you. Humana – CareSource will then review the "bill" and may forward it to other organizations for payment.
- Humana – CareSource may also exchange your data with providers to authorize any requested services or disclose your data to providers to facilitate any treatments you may be requesting.

Data for Health Care Operations

Humana – CareSource may use and disclose your health information to carry out insurance-related activities related to its operation.

Activities may include:

- Submitting claims to other insurance companies
- Conducting or arranging for medical review for certain medical problems you may be experiencing
- Legal services
- Audit services
- Fraud and abuse detection programs
- Business planning, management and general administration

Case and Utilization Management

Humana – CareSource may use your medical information to approve services or treatments. We may give out information to others who must make decisions about your care.

Other Allowable Uses of Your Health Information without Permission (Authorization)

- Public Health. We may give your data to public health agencies to prevent or control disease, injury, or disability; reporting child abuse or neglect; and reporting domestic violence. Humana – CareSource may also report your data to the Food and Drug Administration (FDA) to notify them of problems with products and reactions to medications.

- Coroners, Medical Examiners and Funeral Directors. Humana – CareSource may give your protected health information to coroners, medical examiners and funeral directors if needed.
- Organ and Tissue Donation. Humana – CareSource may give your data to groups involved in finding, banking, or transplanting organs and tissues. Humana – CareSource can only give this information when you have agreed to organ or tissue donations.
- Public Safety. Humana – CareSource may give your data in order to prevent a serious threat to the health or safety of a particular person or to the general public.
- Security. Humana – CareSource may give your data for military, national security, and prisoner care purposes.
- Government Eligibility. Humana – CareSource will give your data to government entities involved with your health care benefit eligibility.
- Worker's Compensation. Humana – CareSource may give your data as necessary to comply with worker's compensation or similar laws.
- Marketing. Humana – CareSource may use your data to contact you to give your information about relative health-related benefits and services. An example would be notices for Well Baby or WIC clinics to be held in your area. However, Humana – CareSource CANNOT give your information to companies for advertising or solicitation without your permission.
- Research. Humana – CareSource may give your data to people not working for Humana – CareSource that are conducting research ONLY if an independent institutional review board (IRB) approves the disclosure. The research group must also promise to protect the data it receives.
- Business Associates. Humana – CareSource must share your data with other State, Federal and commercial partners it contracts with to perform its normal business. We ask these groups to protect your data through formal agreements.
- Health Oversight and Quality Assurance. Humana – CareSource may use and give out your data to doctors and nurses to help improve your care. Humana – CareSource staff, committees and outside agencies that monitor Medicaid quality of care may also see your data.
- Appointment Reminders. Humana – CareSource may use your health information to remind you of medical appointments. Examples are: shot and checkup reminders, and health screening reminders.
- Health Promotion and Disease Prevention. Humana – CareSource may use your health information to tell you about disease prevention and health care.

- Individuals Involved with Payment of Your Care. Humana – CareSource may give out your health information to a friend or family member who is helping with your care or with payment for your care if necessary.
- Member and Provider Claims Services Department. Humana – CareSource Member Services and Provider Claims Services will answer provider and member calls that involve your protected data.
- Medical and Administrative Appeals. DMS at times may make decisions about claims for services provided to you. You or your provider may appeal these decisions. Your health information may be used to make appeal decisions.
- Lawsuits and Disputes. Humana – CareSource must give your data under a court order. Humana – CareSource must give your data out to court officers and lawyers, if you are involved in a lawsuit.
- Law Enforcement. Humana – CareSource will give out your data to law enforcement only where allowed by federal or state law or required under a court order.

When Humana – CareSource May Not Use or Disclose Your Health Information without Authorization

Other than for the allowed reasons listed above, Humana – CareSource will not use or disclose your data without written permission (Authorization) from you. If you do authorize us to use or disclose your data in other ways, you may revoke your permission in writing at any time. Once you revoke your permission, Humana – CareSource will no longer be able to use or disclose your data for the reasons stated in your original authorization.

Your Individual Privacy Rights under HIPAA

Right to Request Confidential Communications

You have the right to ask DMS to communicate with you at a certain alternative number or location other than your home of record. Humana – CareSource will do this only when necessary to protect your safety or health.

Requests to change our communication with you should be submitted to the Humana – CareSource Privacy Officer. Please be sure to tell us how you want us to contact you in your written request.

Right to Request Restrictions

You have the right to ask that your protected health data not be given out or used. This is called requesting a restriction. Humana – CareSource has the right to deny any requests for restrictions that prevent DMS from conducting its required business processes.

To ask for a restriction on the use of your information, send a written request to Humana – CareSource Privacy Officer. The request should include:

- What information you wish to restrict and how you want it restricted.
- Whether you wish to restrict the use or information, disclosure of information, or both.

Right to Withdraw Authorization for Usage and Disclosure

Humana – CareSource must have your written permission (authorization) to use or give out your information for reasons other than the special exceptions described above. Humana – CareSource may ask you to give permission by signing a form called an Authorization.

- You may cancel this permission at any time. To cancel, send a letter to the Humana – CareSource Privacy Officer.
- When Humana – CareSource receives your cancellation, we will stop using or giving out the information permitted by your Authorization.
- Releases made before we received your authorization cancellation cannot be taken back.

Right to Access

You have the right to look at and get a copy of your personal health information maintained by Humana – CareSource. This is called a designated record set. Humana – CareSource designated record set includes enrollment, claims data, and payment records made in your behalf.

******Humana – CareSource Does NOT Keep Complete Copies of your Medical Records. If You Would Like a Copy of Your Medical Records, Please Contact your Doctor******

If you would like a copy of your information, please send a written request to the Humana – CareSource privacy officer.

- Humana – CareSource will provide one copy of records per 12-month period free of charge. You may be charged for additional copies.
- Humana – CareSource will respond to requests within 30 days of receipt. Humana – CareSource may ask for an extra 30 days if necessary. We will let you know if we need the extra time.
- Humana – CareSource has the right to keep you from having or seeing all or parts of your records for specific reasons related to HIPAA and State law.
- Humana – CareSource will tell you the reasons in writing.
- Humana – CareSource will give you information on how to file an appeal if you disagree with our decision.

Right to Amend

You have the right to ask that information in your records be changed, if they are not correct. Humana – CareSource will respond within 60 days of receipt.

******If You Wish to Change Your Medical Records, You Must Contact the Doctor or Facility Who Wrote the Record to Request a Change******

Humana – CareSource may deny the request for change if:

- The information was not written or is not kept by Humana – CareSource.
- The information is information you are not allowed to see and copy.
- The information is already correct and complete.

To request a change, you must do the following:

Send a written request to the Humana – CareSource Privacy Officer. Include the reason you are asking for a change.

Right to an Accounting of Disclosures

You have the right to ask for a list of people who have asked for your health records. This will tell you every time Humana – CareSource gave your personal data to people or organizations, other than you, that was not a part of normal Humana – CareSource business activities (treatment, payment, and operations.) To request this report, send a written request to the Humana – CareSource. Specify the time period that you want to know about. The time period may not be longer than six years. It also may not involve dates before the law's effective date of April 14, 2003. Humana – CareSource will respond within 60 days of receipt.

Right to Paper Copy of Notice

You have the right to receive a paper copy of this Notice at any time. To receive a paper copy, send a written request to Humana – CareSource. You can also find it online at https://chfs.ky.gov/Pages/index.aspx.

Changes to This Notice of Privacy Practices

Humana – CareSource has the right to change this Privacy Notice at any time. If we do make a change, we will revise this Notice and promptly distribute it to all Medicaid recipients. Humana – CareSource is required by law to comply with the current version of this Notice until a new version has been mailed out.

Complaints

If you believe your privacy rights have been violated, and wish to make a complaint you may file a complaint by calling/writing to the Humana – CareSource Privacy Officer.

The Secretary of Health and Human Services: Secretary of Health and Human Services, Room 615F 200 Independence Ave. SW, Washington, D.C. 20201

For additional information, call 877-696-6775.

United States Office for Civil Rights by calling 1-866-OCR-PRIV (866-627-7748) or 866-788-4989 TTY.

Policy of Non-Retaliation

Humana – CareSource cannot take away your health care benefits or retaliate in any way if you choose to file a privacy complaint or exercise any of your privacy rights.

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 CareSource.com/members/education/planning-ahead/advance-directive/.

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 – CareSource. Please let us know about your problems or concerns. We can help you.

You may ask to stop your membership with Humana – CareSource. 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 Kentucky Department for Medicaid Services (DMS) at the following address:

KDMS – 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 Kentucky DMS each year. It will let you know when your open enrollment period is and how to change. You will be disenrolled from Humana – CareSource if you are no longer eligible for Kentucky Medicaid or if you move out of our service area.

WORD MEANINGS

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 – CareSource and requesting reconsideration of a decision or action.

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

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

Benefits – What is covered by Humana – CareSource.

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

Claim – Bill for services.

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

Disenrollment – The removal of a member from Humana – CareSource benefits.

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 a member's health need.

Formulary – List of generic and brand name medications that we cover.

Fraud – Purposeful misuse of benefits.

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

Health Care Services – Care related to the health of a member, 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.

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

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

Notice of Action – A response from Humana – CareSource 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 – CareSource members.

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

Pharmacy – Drug store.

Presumptively Eligible – Members, 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 a member gets from a doctor to help keep the member 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.

Social Security Income – Money you may be receiving now from paying social security tax at a previous job.

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 members.

Waste – Overusing benefits when they are not needed.

Kentucky Medicaid MCO
Member Appeal Request

Check the box of the plan in which the member is enrolled	MCO	Phone	Fax
	☐ Anthem BCBS Medicaid	1-855-661-2027 Ext. 26740	1-855-443-7820
	☐ Coventry Cares/Aetna Better Health	1-855-300-5528	1-855-454-5585
	☐ Humana – CareSource	1-877-892-7487	1-855-262-9794
	☐ Passport Health Plan	1-800-578-0636	502-585-8461
	☐ WellCare of Kentucky	1-877-389-9457	1-866-201-1657

Please complete all appropriate fields

If you need assistance with this form, call your MCO at the number listed above
All Appeals must be filed within 30 days from the date of MCO action

Date _____

Person filing request _____ **Email** _____ **Phone** _____

☐ **I am a Medicaid member** ☐ **I am filing request on behalf of a Medicaid member**

If filing on behalf of member, state relationship to member _____

Who is the Appeal for?

Member's name_____

Member's Social Security Number_____ Member's DOB_____

Member's address _____ County _____

Why are you requesting an appeal?

Procedure or Service you are requesting_____

Doctor or Provider of service _____ Phone_____

Doctor or Provider address _____

Reason for procedure/service _____

_____

_____

Please give as much detail as possible about this request:

_____

_____

_____

_____

_____

_____

_____

Attach a copy of the denial letter along with any other correspondence concerning this request.

☐ **By signing this document, I authorize the person submitting this form to do so on my behalf**

Signature of Member_____ Date _____

Signature of person filing request _____ Date _____

Members have the right to request a continuation of benefits while the Appeal is being processed

This form complies with the Appeal process as outlined in KAR 17:010

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Kentucky Medicaid MCO
Member Grievance Form

Check the box of the plan in which the member is enrolled	MCO	Phone	Fax
	☐ Anthem BCBS Medicaid	1-855-661-3027 Ext. 26748	1-855-443-7820
	☐ Coventry Cares/Aetna Better Health	1-855-300-5528	1-855-454-5585
	☐ Humana – CareSource	1-877-892-7487	1-855-262-9794
	☐ Passport Health Plan	1-800-578-0603	502-585-8340
	☐ WellCare of Kentucky	1-877-389-9457	1-866-388-1769

Please complete all appropriate fields

If you need assistance with this form, call your MCO at the number listed above

Date _____

Person filing grievance_____**Email** _____ **Phone** _____

☐ **I am a Medicaid member** ☐ **I am filing a grievance on behalf of a Medicaid member**

If filing on behalf of member, state relationship to member _____

Who is the Grievance/Complaint about?

Member's name_____ _____ _____

Member's SSN _____Member's Date of Birth _____ _____

Member's address _____ _____ County _____

What is the Grievance/Complaint about?

☐ I am having trouble finding a healthcare provider
☐ I have a complaint about my doctor/healthcare provider
☐ I have a complaint about my facility and/or its staff (Nursing, Assisted Living, Adult Family Care Home, Hospice)
☐ I am receiving bills from healthcare providers
☐ I want to change my plan and need help
☐ I am a new member and have not received any plan information
☐ I am having trouble obtaining the following prescriptions: _____ _____
☐ I am having trouble obtaining the following service: (Check all that apply)

☐ Behavioral Health	☐ Dental	☐ Home Health
☐ Medical Equipment/Supplies	☐ Transportation	☐ Substance Abuse Treatment
☐ Occupational/Physical/Speech Therapy	☐ Other_____	

*Please give as much detail as possible about this co*mplaint/grievance:

_____

_____

_____

_____

_____

_____

☐ **By signing this document, I authorize the person submitting this form to do so on my behalf**

Signature of Member_____ _____ Date _____

Signature of person filing grievance _____ _____ Date _____

This form complies with the Grievance process as outlined in KAR 17:010

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Member Consent/HIPAA Authorization Form

This form lets CareSource Management Group Co. and its affiliated health plans ("Humana – CareSource®"), share your health information as described below. All of this form must be filled out. Mail or fax it to the address listed at the end of this form. Or, you may choose to fill out this form online at www.caresource.com.

Section 1: Member Information

Member Last Name	MI	Member First Name	Member Date of Birth	
Member Street Address	City		State	Zip Code
Member Home Phone	Member Cell Phone		Member ID Number (Found on Plan ID Card)	
By giving your cell phone number, you are saying that Humana – CareSource may use it to contact you.				

Section 2: Consent to Share Health Information

The Humana – CareSource policy is to share your health information. This includes Sensitive Health Information (SHI). SHI can be information related to drug and/or alcohol treatment, genetic testing results, HIV/AIDS, mental health, sexually transmitted diseases (STD), or communicable/other diseases that are a danger to your health. This information is shared to handle your care and treatment or to help with benefits. This info is shared with your past, current, and future treating providers. It also is shared with Health Information Exchanges (HIE). An HIE lets providers view health information that Humana – CareSource has about members. You have the right to ask for a list of everyone who was given your health information by Humana – CareSource.

If you do not want your health information (including SHI) to be shared for treatment, to manage your care and help with benefits, check here: ☐

If you check the box above, none of your health information (including SHI) will be shared. It will not be shared with your providers. (It will be shared with the provider who treats you for the specific SHI.) If you do not approve sharing, all providers helping care for you may not be able to manage your care as well as if they could if you did approve sharing.

Section 3: Representative Designation

If you would like to name someone that Humana – CareSource may speak to on your behalf, please fill out this section. Humana – CareSource will share all of your health information with the person you name. If you name a group, like a law firm, the group is called an entity. Please give the entity's info and the name of a contact person at the entity.

Last Name	First Name	MI	Entity Name (if law firm or other entity)
Street Address	City	State	Zip Code
Home Phone	Cell Phone		

Section 4: Review and Approval

By signing my name, I agree:
To let Humana – CareSource share my health information as marked in Sections 2 and/or 3. I agree that signing this form is my choice. I agree the information shared may be subject to being shared again by the person or entity receiving it. After that it may no longer be protected by federal privacy laws. Substance use disorder information from specific treatment programs (42 CFR Part 2), may be kept private and not allowed to be shared again without my permission. I agree this form is not making a Health Care Power of Attorney. I agree that I may cancel this permission at any time. To cancel permission, I must send a written letter to Humana – CareSource. I can send the letter to the address at the bottom of this form. I can also fax it to the number at the bottom of this form. Or, I may cancel my permission on www.caresource.com. I agree that if I cancel this permission, it will not change any actions Humana – CareSource took before I cancelled permission. I agree that my treatment, payment, enrollment or eligibility for benefits do not depend on whether I sign this form. ***Please sign below.***

Member/Minor Member's Parent Signature or Designated Legal Representative Signature*:	Date:
Date this Permission Ends: *If no date given, the permission will remain on your record unless/until you ask us to cancel it. For minor members, it will end on their 18th birthday.*	
****If signed by someone other than the member/minor member's parent, that person must be a designated legal representative. A designated legal representative is someone who has been given the authority to act on the behalf of the member. If you have not already done so, you must provide a copy of the Power of Attorney or court papers that prove the person is a designated legal representative. Also complete these fields:***	

Legal Representative (print full name)	Legal Relationship to Member, e.g., Power of Attorney, Court-Appointed Guardian or Custodian:		
Legal Representative's street address	City	State	Zip code

Please send your completed form to:
Humana – CareSource/ Attn: Privacy Office, P.O. Box 8738, Dayton, OH 45401-8738, ***or***,
Fax it to 1-833-334-4722, ***or***,
you may choose to fill out this form online at www.caresource.com.

Humana CareSource

If you, or someone you're helping, have questions about Humana – CareSource, you have the right to get help and information in your language at no cost. Please call the member services number on your member ID card.

ARABIC
إذا كان لديك، أو لدى أي شخص تساعده، أية استفسارات بخصوصٍ Humana – CareSource، فيحق لك الحصول على مساعدةٍ ومعلومات مجاناً وباللغة التي تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، رجى الاتصال على رقم خدمة الأعضاء الموجود على بطاقة تعريف العضو الخاصة بك.

AMHARIC
እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Humana – CareSource ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር እባክዎን በመታወቂያ ካርዱ ላይ ባለው የአገልግሎቶች ቁጥር ይደውሉ።

BURMESE
Humana – CareSource အကြောင်း သင် သို့မဟုတ် သင်အကူအညီပေးနေသူ တစ်စုံတစ်ယောက်က မေးမြန်းလာပါက သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ ဘာသာပြန်တစ်ဦးအား ခြေးဖျက၊ ပပြု သကြ်၏ အသကြ်၊ ကြ်ကြက်ပေေါ်ရှိ အသကြ်၊ ကြ် ဝက်ေ ငကြ်င်မှုဝက်ျဝ်နံ့က်သိုသို့ ဇာ၏ိုနါ။

CHINESE
如果您或者您在帮助的人对 Humana – CareSource 存有疑问，您有权免费获得以您的语言提供的帮助和信息。 如果您需要与一位翻译交谈，请拨打您的会员 ID 卡上的会员服务电话号码。

CUSHITE – OROMO
Isin yookan namni biraa isin deeggartan Humana – CareSource irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, Maaloo lakkoofsa bilbilaa isa waraqaa eenyummaa keessan irra jiruun tajaajila miseensaatiif bilbilaa.

DUTCH
Als u, of iemand die u helpt, vragen heeft over Humana – CareSource, hebt u het recht om kosteloos hulp en informatie te ontvangen in uw taal. Als u wilt spreken met een tolk. Bel naar het nummer voor ledendiensten op uw lidkaart

FRENCH (CANADA)
Des questions au sujet de Humana – CareSource? Vous ou la personne que vous aidez avez le droit d'obtenir gratuitement du soutien et de l'information dans votre langue. Pour parler à un interprète. Veuillez communiquer avec les services aux membres au numéro indiqué sur votre carte de membre.

GERMAN
Wenn Sie, oder jemand dem Sie helfen, eine Frage zu Humana – CareSource haben, haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache Hilfe und Information zu bekommen. Um mit einem Dolmetscher zu sprechen, Bitte rufen Sie die Mitglieder-Servicenummer auf Ihrer Mitglieder-ID-Karte an

GUJARATI જો તમે અથવા તમે કોઈને મદદ કરી રહ્યાં તેમ ાંથી કોઈને Humana – CareSource વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિ િનો અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર્ છે. દ ભ વષર્ો િ તિ કરિ મ ટે,કૃપા કરીને તમારા સભ્ય આઈડી કાર્ડ પર સભ્ય સેવા માટે ના નંબર પર ફોન કરો.

HINDI
यदि आपके, या आप जिसकी मदद कर रहे हैं उसके Humana – CareSource के बारे में कोई सवाल हैं तो आपके पास बगैर किसी लागत के अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिए से बात करने के लिए कॉल करें, कृपया अपने सदस्य आईडी कार्ड पर दिये सदस्य सेवा नंबर पर कॉल करें।

ITALIAN
Se Lei, o qualcuno che Lei sta aiutando, ha domande su Humana – CareSource, ha il diritto di avere supporto e informazioni nella propria lingua senza alcun costo. Per parlare con un interprete. Chiamare il numero dei servizi ai soci riportato sulla tessera di iscrizione.

JAPANESE
ご本人様、または身の回りの方で、Humana – CareSource に関するご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます（無償）。 通訳をご利用の場合は、お持ちの会員IDカードにある、会員サービスの電話番号までお問い合わせ下さい。

KOREAN
귀하 본인이나 귀하께서 돕고 계신 분이 Humana – CareSource에 대해 궁금한 점이 있으시면, 원하는 언어로 별도 비용 없이 도움을 받으실 수 있습니다. 통역사가 필요하시면 다음 번호로 전화해 귀하의 회원 ID 카드에 적힌 회원 서비스 팀 번호로 전화하십시오.

PENNSYLVANIA DUTCH
Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Humana – CareSource, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, Bel alstublieft met het Ledenservice nummer op uw lid ID -kaart.

RUSSIAN
Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно Humana – CareSource, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком. Пожалуйста, позвоните по телефону отдела обслуживания клиентов, указанному на вашей идентификационной карточке клиента.

SPANISH
Si usted o alguien a quien ayuda tienen preguntas sobre Humana – CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete. Por favor, llame al número de Servicios para Afiliados que figura en su tarjeta de identificación.

UKRAINIAN
Якщо у вас, чи в особи, котрій ви допомагаєте, виникнуть запитання щодо Humana – CareSource, ви маєте право безкоштовно отримати допомогу та інформацію вашою мовою. Щоб замовити перекладача, Зателефонуйте за номером обслуговування учасників, який вказано на вашому посвідченні учасника

VIETNAMESE
Nếu bạn hoặc ai đó bạn đang giúp đỡ, có thắc mắc về Humana – CareSource, bạn có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên. Vui lòng gọi số dịch vụ thành viên trên thẻ ID thành viên của bạn.

KY-MMED-1207

Notice of Non-Discrimination

Humana – CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. Humana – CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

Humana – CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, Humana – CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please call the member services number on your member ID card.

If you believe that Humana – CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

Humana – CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-844-539-1732, TTY: 711
Fax: 1-844-417-6254

CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of 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)

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

GOVERNMENT OFFICE CONTACT INFORMATION

Department for Community Based Services (DCBS)

- To find the nearest DCBS office to you go to https://prdweb.chfs.ky.gov/Office_Phone/.
- Call 1-855-306-8959

Kentucky Department for Medicaid Services (KDMS)

- Cabinet for Health and Family Services
  Office of the Secretary
  275 E. Main Street
  Frankfort, KY 40621
- 1-800-635-2570 or TTY: 1-800-627-4702 or 711
- Fax: 1-502-564-6917

Kentucky Medicaid Transportation

- 1-888-941-7433

Kentucky Ombudsman

- 1-800-372-2973 or TTY: 1-800-627-4702 or 711

Office for Civil Rights

- Sam Nunn Atlanta Federal Center, Suite 16T70
  61 Forsyth Street, S.W.
  Atlanta, GA 30303-8909
- 1-800-368-1019 or TTY: 1-800-537-7697
- Fax: 1-404-562-7881

CareSource.com/KY

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