Kentucky Medicaid Enrollee Handbook
Plan
Year 2023

January 2023
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1. Welcome to Anthem Medicaid

This handbook will be your guide to the full range of Medicaid healthcare services available to you. If you have questions about the information in your welcome packet, this handbook, or your health plan, call Member Services at 855-690-7784 (TTY 711) or visit our website at anthem.com/kymedicaid. We can also help you make an appointment with your doctor and tell you more about the services you can get with your new health plan.

A. How to Use This Guide

This handbook will tell you how your Managed Care Plan will work. This handbook is your guide to health and wellness services. It tells you the steps to take to make the plan work for you. The first several pages will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time. When you have a question, check this handbook, ask your Primary Care Provider (PCP) or call 855-690-7784 (TTY 711). You can also visit our website at anthem.com/kymedicaid.

2. How Managed Care Works

A. The Plan, Our Providers, and You

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

Anthem Medicaid has a contract with the Kentucky Department for Medicaid Services to meet the healthcare needs of people with Kentucky Medicaid. In turn, Anthem Medicaid partners with a group of healthcare providers to help us meet your needs. These providers (doctors, therapists, specialists, hospitals, home care providers, and other healthcare facilities) make up our provider network. You will find a list in our provider directory. You can visit our website to find the provider directory online at anthem.com/kymedicaid. You can also call Member Services to get a copy of the provider directory.

When you join Anthem Medicaid, our providers are there to support you. For example, if you need to have a test, see a specialist, or go into the hospital, your PCP can help arrange it.

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

3. Help from Member Services

There is someone to help you. Just call Member Services at 855-690-7784 (TTY 711).

For help with non-emergency issues and questions, call Member Services at 855-690-7784 (TTY 711) 7 a.m. to 7 p.m. Eastern time, Monday through Friday, except holidays. In case of a medical emergency, call 911.

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

If you are or become pregnant, your child will become part of Anthem Medicaid on the day your child is born. You should call us and your local Department of Community Based Services right away if you become pregnant and let them help you to choose a doctor for both you and your newborn baby before he or she is born.

If English is not your first language (or if you are reading this on behalf of someone who doesn’t read English), we can help. We want you to know how to use your healthcare plan, no matter what language you speak. Just call us and we will find a way to talk with you in your own language (See Appendix I). We have a group of people who can help.

If English is not your first language (or if you are reading this on behalf of someone who doesn’t read English), we can help. We want you to know how to use your healthcare plan, no matter what language you speak. Just call us and we will find a way to talk with you in your own language (See Appendix I). We have a group of people who can help.

If you use a wheelchair or have trouble hearing or understanding, call us if you need extra help. If you are reading this on behalf of someone who is blind, deaf-blind or has difficulty seeing, we can also help. We can tell you if a doctor’s office is wheelchair accessible or is equipped with special communications devices. Also, we have services like:

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

4. Auxiliary Aids and Services

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

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

These services are available to members with disabilities for free. To ask for aids or services, call Member Services at 855-690-7784 or TTY (for hearing impaired): 711.

Kentucky Medicaid complies with federal civil rights laws and does not leave out or treat people differently because of race, color, national origin, age, disability, or sex. If you believe that your Managed Care Plan failed to provide these services, you can file a complaint. To file a complaint or to learn more, call Member Services at 855-690-7784 or TTY (for hearing impaired): 711.

5. Your Health Plan ID Card

Your health plan ID card is mailed to you together with your welcome packet and member handbook within five days after you enroll in your health plan. We use the mailing address on file at your local Department for Community Based Services (DCBS) and to check your address is correct.

Your card will have your Primary Care Provider’s (PCP’s) name and phone number on it. It will also have your Medicaid Identification Number and information on how you can contact us if you have any questions. If anything is wrong on your ID card, call 855-690-7784 right away.

If you lose your card, we can help -- call Member Services at 855-690-7784 or TTY (for hearing impaired): 711. Carry your ID card always and show it each time you go for care.
PART I: First Things You Should Know

1. How to Choose Your Primary Care Provider (PCP)

Your Primary Care Provider (PCP) is a doctor, nurse practitioner, physician assistant or another type of provider who will care for your health, coordinate your needs, and help you get referrals for specialized services if you need them. When you enroll, you will have an opportunity to choose your own PCP. To choose your PCP, call Member Services at 855-690-7784 (TTY 711). If you do not select a PCP, we will choose one for you. You can find your PCP’s name and contact information on your ID card. (See “How to Change Your PCP” to learn how you can change your PCP.)

When deciding on a PCP, you may want to find a PCP who:
- You have seen before.
- Understands your health problems.
- Is taking new patients.
- Can speak in your language.
- Is easy to get to.

Each family member enrolled can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Call Member Services at 855-690-7784 (TTY 711) to get help with choosing a PCP that is right for you and your family.

You can find the list of all the doctors, clinics, hospitals, labs, and others who partner with your health plan in our provider directory. The provider directory lists the address, phone number, professional qualifications, medical school attended, residency completion, board certification status and special training of the doctors. You can visit our website to look at the provider directory online. You can also call Member Services to get a copy of the provider directory.

American Indian members have the right to receive healthcare services from an Indian Health Services, Tribal Health, or Urban Indian Health (I/T/U) provider and/or choose an I/T/U provider as their PCP.

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

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

If your provider leaves our provider network, we will tell you within 15 days from when they know about this. If the provider who leaves is your PCP, we will contact you to help you choose another PCP.
2. How to Change Your PCP

You can find your Primary Care Provider’s (PCP’s) name and contact information on your ID card. You can change your assigned PCP within 90 days from the date you receive your ID card. Just call Member Services. After that, you can change your PCP up to one time each year without cause. You do not have to give a reason for the change.

If you want to change your PCP more than once a year, you can change at any time if you have a good reason (good cause). For example, you may have good cause if you:

- Disagree with your treatment plan.
- Your PCP moves to a different location that is not convenient for you.
- You have trouble communicating with your PCP because of a language barrier or another communication issue.
- Your PCP is not able to accommodate your special needs.

Call Member Services to learn more about how you can change your PCP at 855-690-7784 (TTY 711).

3. How to Get Regular Healthcare

“Regular healthcare” means exams, regular check-ups, shots, or other treatments to keep you well, give you advice when you need it, and refer you to the hospital or specialists when needed. It means you and your Primary Care Provider (PCP) work together to keep you well or to see that you get the care you need.

Be sure to call your PCP whenever you have a medical question or concern. If you call after hours or on weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how your health plan works.

Your PCP will take care of most of your healthcare needs. You will need an appointment to see your PCP. If ever you cannot keep an appointment, call to let your PCP know.

Making your first regular healthcare appointment. As soon as you choose or are assigned a PCP, call to make a first appointment. There are several things you can do to help your PCP get to know you and your healthcare needs. Your PCP will need to know as much about your medical history as possible. Make a list of your medical background, any problems you have now and the questions you want to ask your PCP. Bring your medications and supplements with you that you are taking. In most cases, your first visit should be within three months of you joining the plan.
If you need care before your first appointment, call your PCP’s office to explain your concern. Your PCP will give you an earlier appointment. You should keep the first appointment to talk about your medical history and ask questions.

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

<table>
<thead>
<tr>
<th>IF YOU CALL FOR THIS TYPE OF SERVICE</th>
<th>YOUR APPOINTMENT SHOULD TAKE PLACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult preventive care (services like routine health check-ups or immunizations)</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Urgent care services (care for problems like sprains, flu symptoms, or minor cuts and wounds)</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Emergency or urgent care requested after normal business office hours</td>
<td>Immediately (available 24 hours a day, 7 days a week, 365 days a year)</td>
</tr>
</tbody>
</table>

Mental Health

<table>
<thead>
<tr>
<th>IF YOU CALL FOR THIS TYPE OF SERVICE</th>
<th>YOUR APPOINTMENT SHOULD TAKE PLACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine services</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Urgent care services</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Emergency services (services to treat a life-threatening condition)</td>
<td>Immediately (available 24 hours a day, 7 days a week, 365 days a year)</td>
</tr>
<tr>
<td>Mobile crisis management services</td>
<td>Within 30 minutes</td>
</tr>
</tbody>
</table>

Substance Use Disorders

<table>
<thead>
<tr>
<th>IF YOU CALL FOR THIS TYPE OF SERVICE</th>
<th>YOUR APPOINTMENT SHOULD TAKE PLACE</th>
</tr>
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</tr>
</tbody>
</table>

If you are having trouble getting the care you need within the time limits described above, call Member Services at 855-690-7784 (TTY 711).

4. How to Get Specialty Care – Referrals

If you need specialized care that your Primary Care Provider (PCP) cannot give, your PCP will refer you to a specialist who can. A specialist is a doctor who is trained and practices in a specific area of medicine (like a cardiologist or a surgeon). If your PCP refers you to another doctor, we will pay for your care. Talk with your PCP to be sure you know how referrals work.

If you think a specialist does not meet your needs, talk with your PCP. Your PCP can help you if you need to see a different specialist.

There are some treatments and services that your PCP must ask us to approve before you can get them. Your PCP will be able to tell you what they are.
If you have trouble getting a referral you think you need, contact Member Services.

If we do not have a specialist in our provider network who can give you the care you need, they may refer you to a specialist outside your plan. This is called an out-of-network referral. Your PCP or another network provider must ask for approval before you can get an out-of-network referral.

Sometimes, we may not approve an out-of-network referral because we have a provider in the Plan who can treat you. If you do not agree with our decision, you can appeal our decision. (See page 35 of this handbook.)

Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from our provider. If you do not agree with our decision, you can appeal our decision. (See page 35 of this handbook.)

If you have a complex health condition or a special healthcare need, you may be able to choose a specialist to act as your PCP. Contact our Member Services department.

5. Out-of-Network Providers

If we do not have a specialist in our provider network, we will work with your PCP to get the care you need. The care may be from a specialist outside our plan, or an out-of-network provider. For help and more information about getting services from an out-of-network provider, talk to your PCP or call 855-690-7784 (TTY 711).

Second Opinions

You have the right to a second opinion about your care. This means you can talk with a different provider to see what they think about your care. The second provider will give you their point of view. This may help you decide if certain services or treatments are best for you. There is no cost to you for a second opinion. Your PCP, case manager, or Member Services can help find a provider to give you a second opinion. You can pick any of our in-network providers. If you are unable to find a provider with us, we will help you find a provider that is not in our provider network. If you need to see a provider that is not in our provider network for the second opinion, we must approve it before we will pay for you to see them.

6. Services without a Referral

You do not need a referral from your PCP to get these services:

- Primary care vision
- Primary care dental
- Family planning
- Maternity care
• Women’s healthcare
• Children’s Screening and Local Health Department Services
• Sexually transmitted disease screening, evaluation, and treatment
• Testing for HIV, HIV-related conditions, and other communicable diseases
• Chiropractic services
• Behavioral Health Services

7. Emergencies

You are always covered for emergencies. An emergency medical condition is when your life could be threatened, or you could be hurt forever if you don’t get care right away. Some examples of an emergency are:
• A heart attack or severe chest pain
• Bleeding that won’t stop or a bad burn
• Broken bones
• Trouble breathing, convulsions or loss of consciousness
• When you feel you might hurt yourself or others
• If you are pregnant and have signs like pain, bleeding, fever, or vomiting
• Drug overdose

Some examples of non-emergencies are colds, upset stomach or minor cuts and bruises.

If you believe you have an emergency, call 911 or go to the nearest emergency room. You do not need approval from your plan or your PCP before getting emergency care, and you are not required to use our hospitals or doctors.

If you’re not sure, call your PCP or the 24-hour/7 days a week 24/7 NurseLine toll free at 866-864-2544 (TTY 711). Tell the person you speak with what is happening. They can:
• Tell you what to do at home;
• Tell you to come to the PCP’s office; or
• Tell you to go to the nearest urgent care emergency room.

When you have an emergency if you are out of the area, go to the nearest emergency room. Remember: Use the Emergency Department only if you have an emergency.

8. Urgent Care

You may have an injury or an illness that is not an emergency but still needs quick care and attention. This could be:
• A child with an earache who wakes up in the middle of the night and won’t stop crying.
• The flu or if you need stitches.
• A sprained ankle or a bad splinter you cannot remove.
You can walk into an urgent care clinic to get care the same day or make an appointment for the next day. Whether you are at home or away, call your PCP anytime, day or night. If you cannot reach your PCP, call Member Services at **855-690-7784 (TTY 711)**. Tell the person who answers what is happening. They will help you with what you can do.

9. Care Outside Kentucky

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

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

If you have any questions about getting care outside of Kentucky or the United States, talk with your PCP or call Member Services at **855-690-7784 (TTY 711)**.

10. Your Benefits

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

KY Medicaid Managed Care provides **benefits** or healthcare services covered by your plan.

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

- Are pregnant.
- Are sick or injured.
- Experience a substance use disorder or have behavioral health needs.
- Need assistance with things like eating, bathing, dressing or other activities of daily living.
- Need help getting to the doctor’s office.
- Need medications.

A. Services Covered by Your Health Plan’s Network

The section below describes the specific services covered by Medicaid. Ask your PCP or call Member Services at **855-690-7784 (TTY 711)** if you have any questions about your benefits.
You must get the services below from the providers who are in our provider network. Services must be medically necessary and provided or referred by your PCP. Talk with your PCP or call Member Services if you have any questions or need help with any health services.

B. Regular Healthcare
- Office visits with your PCP, including regular check-ups, routine labs, and tests
- Referrals to specialists
- Eye/hearing exams
- Well-baby care
- Well-child care
- Immunizations (shots) for children and adults
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for members under age 21 (see page 30 of this handbook)
- Help with quitting smoking or dipping

C. Maternity Care
- Pregnancy care
- Childbirth education classes
- OB/GYN and hospital services
- One medically necessary post-partum home visit for newborn care and assessment following discharge (but no later than 60 days after delivery)
- Care management services for high-risk pregnancies during pregnancy and for two months after delivery (see below for more information)

D. Hospital Care
- Inpatient care
- Outpatient care
- Labs, X-rays, and other tests

E. Home Health Services
- Must be medically necessary and ordered by your doctor
- Time-limited skilled nursing services
- Specialized therapies, including physical therapy, speech-language therapy, and occupational therapy
- Home health aide services (help with activities such as bathing, dressing, preparing meals and housekeeping)
- Medical supplies

F. Personal Care Services/Private Duty Nursing
- Must be medically necessary and ordered by your doctor
- Help with common activities of daily living, including eating, dressing, and bathing, for individuals with disabilities and ongoing health conditions
G. Hospice Care
- Hospice helps patients and their families with their special needs that come during the final stages of sickness.
- Hospice provides medical, supportive, and palliative care to terminally ill individuals and their families or caregivers.
- You can get these services in your home, in a hospital or in a nursing home.

H. Vision Care
- Services provided by ophthalmologists and optometrists, including routine eye exams and medically necessary lenses.
- Specialist referrals for eye diseases

I. Pharmacy
Your drug benefit is provided by a pharmacy benefit manager (PBM), MedImpact Healthcare Systems, Inc. Their member service team is available 24 hours a day, 7 days a week by calling 800-210-7628. Your ID card has important information for your pharmacy. Before you go, make sure the pharmacy accepts KY Medicaid. To find a pharmacy or see what is covered, go to kportal.medimpact.com.
- Prescription drugs
- Some medicines sold without a prescription (also called “over-the-counter”)
- Insulin and other diabetic supplies (like syringes, test strips, lancets, and pen needles)
- Stop smoking drugs, including over-the-counter
- Special formula
- Birth control
- Medical and surgical supplies

J. Emergency Care
- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.
- After you have received emergency care, you may need other care to make sure you remain in stable condition.
- Depending on the need, you may be treated in the emergency department, in an inpatient hospital room or in another setting.

K. Specialty Care
- Respiratory care services
- Podiatry services
- Chiropractic services
- Cardiac care services
- Surgical services
L. Nursing Home Services

- Must be ordered by a physician and authorized by your health plan
- Includes short term, or rehabilitation stays initial services
- You must get this care from a nursing home that is in your health plan’s provider network.

M. Behavioral Health Services and Substance Use Disorder Services

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

- Services to help figure out if you have a mental health need (diagnostic assessment services)
- Individual, group, and family therapy
- Mobile crisis management services
- Facility-based crisis programs
- Specialized behavioral health services for children with autism
- Outpatient behavioral health services
- Outpatient behavioral health emergency room services
- Inpatient behavioral health services
- Research-based intensive behavioral health treatment
- Partial hospitalization
- Other Supportive Services such as: Peer Supports, Comprehensive Community Supports and Targeted Case Management

Substance Use Disorder Services

- Outpatient opioid treatment
- Outpatient withdrawal management
- Non-hospital medical withdrawal management
- Alcohol and drug abuse treatment center withdrawal management crisis stabilization
- Peer Support Services and Targeted Case Management

If you believe you need access to more intensive behavioral health services that your plan does not provide, talk with your PCP or call Member Services at 855-690-7784 (TTY 711).

Anthem Medicaid does not deny covered services due to moral or religious objections.

N. Transportation Services

If you need emergency transportation (an ambulance), call 911. Non-emergency medical transportation is available if you can’t get a free ride to a covered service.
Kentucky Medicaid will pay to take some members to get medical services covered by Kentucky Medicaid. If you need a ride, you must talk to the transportation broker in your county to schedule a trip.

Each county in Kentucky has a transportation broker. You can only use the transportation broker for a ride if you can’t use your own car or don’t have one. If you can’t use your car, you have to get a note for the transportation broker that explains why you can’t use your car. If you need a ride from a transportation broker and you or someone in your household has a car, you can:

- Get a doctor’s note that says you can’t drive.
- Get a note from your mechanic if your car doesn’t run.
- Get a note from the boss or school official if your car is needed for someone else’s work or school.
- Get a copy of the registration if your car is junked.

Kentucky Medicaid doesn’t cover rides to pick up prescriptions.

For a list of transportation brokers and their contact information, please visit [www.chfs.ky.gov/dms](http://www.chfs.ky.gov/dms) or call Kentucky Medicaid at 800-635-2570. For more information about transportation services, call the Kentucky Transportation Cabinet at 888-941-7433.

The hours of operation are Monday through Friday, 8 a.m. to 4:30 p.m. and Saturday 8 a.m. to 1 p.m., Eastern Standard Time (EST). If you need a ride, you have to call 72 hours before the time that you need the ride. If you have to cancel an appointment, call your broker as soon as possible.

You should always go to a medical facility that is close to you. If you need medical care from someone outside your service area, you must get a note from your PCP. The note has to say why it is important for you to travel outside your area. (Your area is your county and the counties next to it.)

**O. Family Planning**

You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can also visit one of our family planning providers. Either way, you do not need a referral from your PCP. You can get birth control and birth control devices (IUDs, implantaible contraceptive devices, and others) that are available with a prescription and emergency contraception and sterilization services. You can also see a family planning provider for human immunodeficiency virus (HIV) and sexually transmitted infection (STI) testing, as well as treatment and counseling related to your test results. Screenings for cancer and other related conditions are also included in family planning visits.

**P. Other Covered Services**

- Durable medical equipment/prosthetics/orthotics
• Hearing aids products and services
• Telehealth
• Extra support to manage your health
• Home infusion therapy
• Rural Health Clinic (RHC) services
• Federally Qualified Health Center (FQHC) services
• Free Clinic services

If you have any questions about any of the benefits above, talk to your PCP or call Member Services.

Q. Benefits Offered by the State

Most Medicaid services will be provided by your health plan. Some services will still be provided by Kentucky Medicaid. You will use your Medicaid ID card for these services. These services include:

• **First Steps**: A program that helps children with developmental disabilities, from birth to age 3, and their families by offering services through a variety of community agencies. Call 877-417-8377 or 877-41-STEPS for more information.

• **HANDS (Health Access Nurturing and Development Services)**: This is a voluntary home visitation program for new and expectant parents. Contact your local health department for information and to learn about resources.

• **Non-emergency medical transportation**: If you cannot find a way to get to your healthcare appointment, you may be able to get a ride from a transportation company. Call 888-941-7433 for help or see http://chfs.ky.gov/dms/trans.htm for a list of transportation brokers or companies and how to contact them.

• **Services for children at school**: These services are for children, from 3 to 21 years of age, who are eligible under the Individuals with Disabilities Education Act (IDEA) and have an Individual Education Plan (IEP). These services include speech therapy, occupational therapy, physical therapy and behavioral (mental) health services.

R. Extra Support to Manage Your Health

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

The Care Manager will:

• Coordinate your appointments and help arrange for transportation to and from your doctor.

• Support you in reaching your goals to better manage your ongoing health conditions.

• Answer questions about what your medicines do and how to take them.
• Follow up with your doctors or specialists about your care.
• Connect you to helpful resources where you live.
• Help you continue to receive the care you need if you switch health plans or doctors.

Your health plan can also connect to you to a Care Manager who specializes in supporting:
• People who need access to services like nursing home care or personal care services to help manage daily activities of living (like eating or bathing) and household tasks.
• Pregnant women with certain health issues (like diabetes) or other concerns (like wanting help to quit smoking).
• Children, from birth to age 5, who may live in stressful situations or have certain health conditions or disabilities.

At times, a member of your Primary Care Provider’s (PCP’s) team will be your Care Manager. To learn more about our how you get can extra support to manage your health, talk to your PCP or you and/or your caregiver can call Member Services at **855-690-7784 (TTY 711)** 7 a.m. to 7 p.m. Eastern time, Monday through Friday, except holidays. You can also visit **anthem.com/kymedicaid**.

**S. Help with Problems beyond Medical Care**

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

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

**Extra Benefits Offered by Anthem Medicaid**

In addition to the Medicaid benefits and services you receive from Kentucky Medicaid and Anthem Medicaid, we also offer these extra benefits and services, for eligible members:
• Up to $200 in gas cards or bus passes to assist with transportation
• $25 Amazon health and wellness voucher
• Electric toothbrush and dental kit
• A Smoking Distraction Kit to help our members quit smoking. This kit is enclosed in a reusable bag and includes a fidget spinner, gum, mints, stress ball, and other items.
• Access to our Online Well-Being Program, a platform that promotes behavioral health and wellness through instruction, games, goal setting, and monitoring
• Our Fitness Coach Program, which includes online fitness and exercise classes and access to resources on nutrition, weight management, and improved self-care
• A WW® (formerly called Weight Watchers) voucher good for the initiation fee and 13 weeks of classes
• Your choice of two Healthy Lifestyle Aids to help you achieve better health, such as:
  o Digital scale
  o Electric breast pump
  o Hearing aid batteries (sizes 10, 13, 312, or 675)
  o Home blood pressure cuff
  o Lumbar pillow
  o Non-slip socks
  o Peak flow meter
  o Personal fan
• Home-delivered meals that are medically tailored to eligible members who:
  o Have been discharged from a hospital, emergency room, or skilled nursing facility in the past 30 days, or homeless members who have recently moved to permanent housing, AND;
  o Have been diagnosed with a behavioral health condition, chronic heart failure (CHF), cancer, chronic obstructive pulmonary disease (COPD), diabetes, HIV/AIDS, or end-stage renal disease (ESRD), AND;
  o Have a medically tailored meal program included in their care plan, as determined by a Case Manager, OR;
  o Are pregnant with a current or historical diagnosis of gestational diabetes OR living with food insecurity.
• Fresh Fruit and Veggies Program, which includes three months of fresh produce
• Sports and school physicals once per year
• No-cost eyeglasses (lenses and frames) or a $50 allowance toward contact lenses, instead of eyeglasses
• A no-cost laptop for members graduating high school with a GPA of 3.0 or higher to help reach education and career goals OR 9–13-year-olds that have completed both doses of the HPV vaccine
• For members enrolled in the federal SafeLink program, we offer an additional 200 minutes at enrollment plus 100 extra minutes for your birthday. The SafeLink program provides a free smartphone that already includes up to 1,000 monthly minutes and unlimited text messaging.
• A Family Activity Coupon Book filled with discounts from local retailers, for members with children under the age of 12
• Boys & Girls Club memberships for children between the ages of 6–18
• A Medicine Safety Kit that includes a lockable medicine box, Rx Destroyer™ gel childproof prescription caps, and pill case covers that reset when opened
• Access to our Substance Use Disorder (SUD) Recovery Support Program, a mobile platform that provides daily motivations and check-ins with peer-to-peer support through discussion groups and messages. The SUD Recovery Support Program
also includes counselor support and messages, care plan reminders, goal setting, journals, high-risk location alerts, and other content to support ongoing recovery.

- Access to Choose Healthy, our program that promotes healthy lifestyles by providing over 1,000 resource materials including videos, articles, and selfcare tools
- Record expungement for eligible members to receive up to $540 toward the application and fees to have criminal records expunged or erased
- General Educational Development (GED) test materials, enrollment, and prep at no cost

Limitations and restrictions apply. These benefits may change. Call Member Services at 855-690-7784 (TTY 711) Monday through Friday from 7 a.m. to 7 p.m. Eastern time, except holidays, for questions. You also can visit anthem.com/kymedicaid for a full list of extra benefits.

Other Programs to Help You Stay Healthy

Call your health plan’s Member Services to learn more about:

**Healthy Rewards program**

It pays to stay healthy — literally. Anthem Medicaid members can receive incentives for completing health screenings, well-visits, prescription refills, and other health-related activities. Earn rewards while you receive the care you need to create your healthy lifestyle.

To begin earning your rewards, here is how you can enroll:

1. Log in to your secure online account at anthem.com/kymedicaid and visit the Benefit Reward Hub. You can also enroll or learn more by calling Healthy Rewards at 888-990-8681 (TTY 711), Monday through Friday from 9 a.m. to 8 p.m. Eastern time.

2. Complete a qualifying healthy activity. Visit the chart below to find out what you might be eligible to earn. Then, we’ll add rewards dollars to your Healthy Rewards account.

3. Redeem your Healthy Rewards dollars for a variety of popular retail gift cards. You can use your gift cards to buy a variety of health and wellness items, including:
   - Baby and children’s care items, such as diapers or baby food.
   - Personal care items, such as dental, hair, or skin care products.
   - Healthy foods, such as fruits, vegetables, or granola bars.
<table>
<thead>
<tr>
<th>Activity</th>
<th>Who is eligible</th>
<th>Reward</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial health screener</td>
<td>All members, all ages, within first 30 days enrolled with Anthem Medicaid</td>
<td>$50</td>
<td>1 per member</td>
</tr>
<tr>
<td>Annual health screener</td>
<td>All members, all ages</td>
<td>$25</td>
<td>1 per 12 months</td>
</tr>
<tr>
<td>First prenatal care visit</td>
<td>Female members, ages 13–55</td>
<td>$30</td>
<td>1 per pregnancy</td>
</tr>
<tr>
<td>Postpartum care visit</td>
<td>Female members, ages 13–55</td>
<td>$50</td>
<td>1 per pregnancy</td>
</tr>
<tr>
<td>Well-child visits in the first 30 months of</td>
<td>Members 0–15 months</td>
<td>$10, $40 max</td>
<td>4 per member</td>
</tr>
<tr>
<td>life — 4 visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-child visits in the first 30 months of</td>
<td>Members 15 months + 1 day–30 months</td>
<td>$10, $20 max</td>
<td>2 per member</td>
</tr>
<tr>
<td>life — 2 visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood &amp; adolescent wellness visit</td>
<td>Members ages 3–21</td>
<td>$30</td>
<td>1 per 12 months</td>
</tr>
<tr>
<td>Childhood dental visit</td>
<td>Members ages 2–20</td>
<td>$30</td>
<td>1 per 12 months</td>
</tr>
<tr>
<td>Adult dental visit</td>
<td>Members ages 21 and older</td>
<td>$25</td>
<td>1 per 12 months</td>
</tr>
<tr>
<td>Adult well visit</td>
<td>Members ages 22 and older</td>
<td>$25</td>
<td>1 per 12 months</td>
</tr>
<tr>
<td>COVID-19 vaccine</td>
<td>Members ages 6 months and older</td>
<td>$100</td>
<td>1 per member</td>
</tr>
<tr>
<td>Flu shot</td>
<td>Members ages 2 and older</td>
<td>$25</td>
<td>1 per 12 months</td>
</tr>
<tr>
<td>Seven-day follow-up visit after behavioral</td>
<td>Members ages 6 and older</td>
<td>$25, $100 max per year</td>
<td>1 per quarter</td>
</tr>
<tr>
<td>health discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressant medication management</td>
<td>Members ages 18 and older</td>
<td>$10, $40 max per year</td>
<td>1 per quarter</td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>Members ages 21 and older</td>
<td>$75</td>
<td>1 per member</td>
</tr>
<tr>
<td>Chlamydia screening</td>
<td>Female members, ages 16–24</td>
<td>$25</td>
<td>1 per 12 months</td>
</tr>
<tr>
<td>HPV vaccination</td>
<td>Members ages 9–12, before 13th birthday</td>
<td>$50</td>
<td>1 per member</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>Female members, ages 21–64</td>
<td>$40</td>
<td>1 per 36 months</td>
</tr>
<tr>
<td>Service</td>
<td>Eligibility</td>
<td>Fee</td>
<td>Frequency</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------------</td>
<td>--------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>Female members, ages 50–74</td>
<td>$25</td>
<td>1 per 12 months</td>
</tr>
<tr>
<td>Colorectal screening</td>
<td>Members ages 45–74 (including 74)</td>
<td>$50</td>
<td>1 per 12 months</td>
</tr>
<tr>
<td>Diabetic HbA1c screening</td>
<td>Members ages 18–75</td>
<td>$50</td>
<td>1 per 12 months</td>
</tr>
<tr>
<td>Diabetic medication management and adherence</td>
<td>Members ages 18–75</td>
<td>$10, $40 max per year</td>
<td>1 per quarter</td>
</tr>
<tr>
<td>Diabetic retinal eye exam</td>
<td>Members ages 18–75</td>
<td>$25</td>
<td>1 per 12 months</td>
</tr>
<tr>
<td>Blood pressure medication refill management</td>
<td>Members ages 18–75</td>
<td>$10, $40 max per year</td>
<td>1 per quarter</td>
</tr>
<tr>
<td>Suicide awareness and prevention quiz</td>
<td>Members 12 and older</td>
<td>$10</td>
<td>1 per 12 months</td>
</tr>
</tbody>
</table>

Limitations and restrictions apply. Anthem Medicaid has the right to change incentives, gift card retailers, and rewards anytime.

Visit anthem.com/kymedicaid or call Healthy Rewards at 888-990-8681 (TTY 711) to learn more about the Healthy Rewards program.

**Special Care for Pregnant Members**

The New Baby, New Life℠ program is available for all pregnant members. It includes prenatal, delivery, and postpartum care, including care for complications of pregnancy. It is important to see your PCP or OB/GYN for care when you are pregnant. This is called prenatal care. Prenatal care is the best way to help you and your baby stay healthy. You will need prenatal care from an OB/GYN for every one of your pregnancies. With New Baby, New Life, members receive health information and rewards for receiving their prenatal and postpartum care.

With the New Baby, New Life program, you receive:
- Electric breast pump
- $175 gift card to purchase baby items of your choice for completing prenatal and postpartum visits on time

The New Baby, New Life program also focuses on maternal care for our pregnant members. Nurse Care Managers work closely with you to provide:
- Education
- Emotional support
- Help following your doctor’s care plan

Our nurses also work directly with doctors and help with other services members may need. The New Baby, New Life program strives to promote better health for members and the delivery of healthy babies.
Helping you and your baby stay healthy

Having a healthy, happy baby starts with a healthy pregnancy. Our tools and resources make it easier for you to keep track of your care while you’re pregnant. My Advocate®, which is part of our New Baby, New Life program, gives you information and support throughout your pregnancy.

Get to know My Advocate

My Advocate delivers helpful maternal health education by phone, web, and through a smartphone app at no cost to you and if you choose the phone version, you will get to know MaryBeth, My Advocate’s automated personality. MaryBeth will respond to your changing needs as your baby grows and develops. My Advocate provides:

- Education you can use.
- Communication with your Care Manager based on My Advocate messaging if you have questions.
- An easy communication schedule.

My Advocate is secure, and your information is always kept private. When you use My Advocate, you will be asked to confirm your identity by answering one or more health-related security questions. This ensures your private medical information stays confidential.

You can receive answers to your questions, plus medical support when you need it. You will be contacted for an important health screening, followed by ongoing educational calls. You can listen to the information on the call and learn about material and prenatal health information. You may be prompted to answer one, or more, questions. If you tell us you have a problem, you’ll get a call back from a Care Manager. My Advocate topics include:

- Pregnancy care
- Postpartum care
- Well-child care

When you become pregnant

If you think you are pregnant, you should:

- Call your doctor right away. You do not need a referral from your PCP to see an OB/GYN doctor.
- Call Member Services at 855-690-7784 (TTY 711) if you need help finding an OB/GYN in the network. You can also call our 24/7 NurseLine anytime at 866-864-2544 (TTY 711).
- Visit our Pregnancy and Women’s Health page at anthem.com/ky/get-help/healthwellness/pregnancy-and-womens-health.html for information and resources on how to keep you and your baby healthy. If you would like to receive pregnancy information by mail, please call Member Services at 855-690-7784 (TTY 711).

You can find information about:
- Self-care during your pregnancy.
- My Advocate and how to enroll or how to receive health information to your phone by automated voice, web, or smartphone app.
The Healthy Rewards program, such as how to redeem your incentives for prenatal, postpartum, and well-baby care.

o Having a healthy baby, postpartum depression, and caring for you newborn.

**When you are pregnant**

While you are pregnant, it’s important that you:

- Take good care of your health. You may be able to get healthy food from the Women, Infants, and Children (WIC) program. You can call Member Services at **855-690-7784 (TTY 711)** for help contacting a WIC office close to you.
- See your PCP or OB/GYN at least:
  - Every four weeks for the first six months.
  - Every two weeks for the seventh and eighth months.
  - Every week during the last month.

Your PCP or OB-GYN may want to see you more often than this, based on your health needs.

- Quit smoking. This is even more important when you find out you’re pregnant, to help make sure you and your baby are healthy. Talk to your PCP about quitting or call Member Services at **855-690-7784 (TTY 711)** to learn more about benefits we offer to help you quit.

**When you have a new baby**

When you deliver your baby, you and your baby may stay in the hospital for at least 48 hours after a vaginal delivery and 72 hours after a cesarean section (C-section). You may stay in the hospital less than this if your PCP or OB/GYN and the baby’s provider advise. If you and your baby leave the hospital early, your PCP or OB/GYN may ask you to have an office or in-home nurse visit within 48 hours.

After you have your baby, you must:

- Call Member Services at **855-690-7784 (TTY 711)** as soon as you can to let us know you had your baby. We will need some information about your baby to add them to your Anthem Medicaid benefits.
- Call your caseworker with the Cabinet for Health and Family Services (CHFS) at **800-372-2973 (TTY 800-627-4702)** to also tell them you had your baby.

**After you have delivered your baby**

After your baby is born, the My Advocate program will switch from prenatal education to postpartum and well-child education for up to 12 weeks after your delivery.

- It’s important to have a follow-up visit with your OB/GYN provider after you deliver for your postpartum visit. It would be best to see them within 1 to 3 weeks, but no later than 12 weeks after delivery. Your health is important.
- Your doctor may want to see you sooner than three weeks if you had complications before or during delivery, such as high blood pressure or if you had a cesarean section (C-section).
- Take your baby for their covered newborn screening.
Population Health Program
As part of your Population Health Anthem Medicaid benefits, we offer a case management and Chronic Condition Management program.

Case Management Program
Our case management program is here to assist you with your health risks and needs, conditions, and preferences and provide the support you need at no cost to you. Our team of Care and Disease Managers are here to help our members as well as their families, primary care providers and caregivers. You, your caregiver, your PCP, a discharge planner, or other healthcare provider can identify and refer you to our Population Health programs. These programs include care coordination, complex case management and chronic condition management.

If you choose to join a case management program, our team of clinical nurses and social workers in collaboration with our Empowerment team will help you learn about your benefits, community resources available to you, and how to better manage your condition or health issue.

A case manager will work with you and your family/caregiver (or a representative) to assess your health risk, functional health needs, along with your social and behavioral needs. The review should result in a care plan that:
- You, your family or representative, and case manager agree on.
- Meets your medical, functional, social, and behavioral health needs in the most unified setting.

The case manager can help with:
- Assessing your healthcare needs.
- Developing a plan of care with you.
- Giving you and your family the information and training needed to make informed decisions and choices.
- Giving providers the information they need about any changes in your health to help them in planning, delivering and monitoring services.

In addition to case managers, we have an Empowerment team made up of community health workers (CHWs) and social workers that can help you with the following:
- Finding housing and food resources.
- Transportation resources.
- GED and expungement.

Your case manager may assist by:
- Going to doctor appointments with you.
- Finding a doctor for you, including specialists.
- Following up with you when you miss an appointment.
To collect and assess this information, your case manager or community health worker will conduct phone interviews or home visits with you or your representatives. To complete the assessment, the case manager will also get information from your primary care provider (PCP) and specialists and other sources to set up and decide your current medical and nonmedical service needs.

You or your representative can call Member Services at 855-690-7784 (TTY 711) 7 a.m. to 7 p.m. Eastern time, Monday through Friday, except holidays, if you think you need case management services. We will refer you to our Case Management department to assess your needs.

**Chronic Condition Management**

You can join a Chronic Condition Management Program within the Population Health program to get healthcare and support services if you have any of these conditions:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder – adult
- Major depressive disorder – child
- Schizophrenia
- Substance use disorder

**How it works**

When you join one of our Chronic Condition Management programs within the Population Health programs, a Care Manager will:

- Help you create health goals and make a plan to reach them.
- Coach and support you through one-on-one phone calls.
- Track your progress.
- Give you information about local support and caregivers.
- Answer questions about your condition or treatment plan and provide ways to help your health issues.
- Send you materials to learn about your condition and overall health and wellness.
- Coordinate your care with your healthcare providers. They may help you to:
  - Make appointments.
  - Find transportation to your doctor visits.
  - Refer you to specialists in our health plan, if needed.
  - Coordinate with providers on any medical equipment you may need.
  - Offer educational materials and tools for weight management, diabetes prevention and tobacco cessation (stopping tobacco use).

Our Chronic Condition Case Management team and your primary care provider (PCP) are here to help you with your healthcare needs.
How to join the Chronic Condition Management Program
We will send you and/or your representative a letter welcoming you to the program, if you qualify. You can call the Population Health program toll-free at 888-830-4300 (TTY 711) Monday through Friday from 8:30 a.m. to 5:30 p.m. Eastern time. You can also email Condition-Care-Self-Referral@anthem.com. If you choose to email us, you understand that third parties may access your email without your knowledge. Do not provide personal information over an unsecured email.

When you join, we will set you up with a Chronic Condition Management case manager and ask you some questions about your or your child’s health.

You can choose to opt-out of the program at any time. Please call 888-830-4300 (TTY 711) toll free Monday through Friday from 8:30 a.m. to 5:30 p.m. Eastern time to opt out. You may also call this number to leave a private message for your Population Health case manager 24 hours a day.

Chronic Condition Management Population Health rights and responsibilities
When you join a Population Health program, you have certain rights and responsibilities. You have the right to:

• Understand all the programs and services we offer.
• Know your case manager’s qualifications, skills, or education.
• Know any contractual relationships or deals we have with other companies.
• Understand which Population Health case manager is handling your Population Health services and how to ask for a change.
• Receive support from us to make informed healthcare choices with your doctors.
• Ask about all Population Health-related treatment options mentioned in clinical guidelines, even if a treatment is not part of your health plan, and talk about options with treating doctors.
• Your personal data and medical information kept private.
• Know who has access to your information and how we make sure your information stays secure, private, and confidential.
• Receive polite, respectful treatment from our staff.
• Receive information that is clear and easy to understand.
• File complaints to Anthem Medicaid by calling 888-830-4300 (TTY 711) toll free Monday through Friday from 8:30 a.m. to 5:30 p.m. Eastern time and:
  o Receive help on how to use the complaint process.
  o Know how much time Anthem Medicaid has to respond to and resolve issues of quality and complaints.
  o Give us feedback about the Population Health program.

You also have a responsibility to:

• Follow the care plan that you and your Population Health case manager agree on.
• Give us information needed to carry out our services.
• Tell us and your doctors if you choose to opt out.
Population Health does not market products or services from outside companies to our members. Population Health does not own or profit from outside companies on the goods and services we offer.

You can log in to your secure account, or register, at anthem.com/kymedicaid to ask us to join a Population Health program. You’ll need your member ID number to register (located on your member ID card). Using your secure account, you can send a secure message to Member Services and ask to join the program.

To find out if you qualify to join a Population Health program or for more information, call Member Services at 855-690-7784 (TTY 711) 7 a.m. to 7 p.m. Eastern time, Monday through Friday, except holidays.

**Healthy Family Lifestyle program**
Healthy Family Lifestyle is a six-month program for members ages 7 to 17. The goal of the program is to help families form healthy eating habits and become more active.

For kids who qualify, parents will receive one-on-one coaching phone calls to:
- Create clear, attainable health goals tailored to your child.
- Make a plan to reach those goals.
- Talk about being and staying active, and healthy food choices.
- Help find resources to support a healthy life in your area.

To learn more, call 844-421-5661 Monday through Friday from 8:30 a.m. to 5:30 p.m. Eastern time. We’ll ask you some questions about your child’s health to see if they qualify.

**Cancer Care Navigator Program**
The Cancer Care Navigator program is a free wellness benefit. It is a way to help and support members who have been diagnosed with cancer. Our Cancer Care Navigators can help find resources and navigate your treatment as needed. We also can help you connect and work with other health professionals. The goal of the program is to help make the cancer journey easier for our members. If you would like to join this program, call a Cancer Care Navigator at 833-649-0669 (TTY 711). Plus, we have even more health support programs on the mobile app or online. To check them out:

1. On the Anthem Medicaid app:
   a. Select More, then choose My Health Dashboard.
   b. Choose Programs – view all.
2. Online:
   a. Log in to anthem.com/kymedicaid.
   b. Select My Health Dashboard, and then choose Programs.
Benefits You Can Get from Your Health Plan OR a Medicaid Provider

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Plan members under age 21 can get any treatment or health service that is medically necessary to treat, prevent or improve a health problem.

This special set of benefits is called Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Members who need EPSDT benefits include:

- EPSDT services through their health plan or any Medicaid provider.
- Do not have to pay any copays for EPSDT services.
- Help with scheduling appointments and arranging for free transportation to and from the appointments.

EPSDT includes any medically necessary service that can help treat, prevent, or improve a member’s health issue, including:

- Comprehensive health screening services (well-child checks, developmental screenings, and immunizations)
- Dental services
- Health education
- Hearing services
- Home health services
- Hospice services
- Inpatient and outpatient hospital services
- Lab and X-ray services
- Mental health services
- Personal care services
- Physical and occupational therapy
- Prescription drugs
- Prosthetics
- Rehabilitative services
- Services for speech, hearing, and language disorders
- Transportation to and from medical appointments
- Vision services
- Any other necessary health services to treat, fix or improve a health problem

If you have questions about EPSDT services, talk with your child’s Primary Care Provider (PCP). You can also find more information online by visiting our website at anthem.com/kymedicaid or call 855-690-7784 (TTY 711).

Call your health plan’s Member Services to learn more about additional health plan services.
Kentucky Medicaid only pays for services that are medically necessary. If you use services that Kentucky Medicaid does not pay for, you will have to pay for them.

Services NOT Covered include:

- Services from providers who are not Kentucky Medicaid providers
- Services that are not medically necessary
- Massage and hypnosis
- Abortion (unless the mother’s life is in danger, or in the case of incest or rape)
- In vitro fertilization
- Paternity testing
- Hysterectomy for sterilization purposes
- Hospital stays if you can be treated outside the hospital
- Cosmetic surgery
- Fertility drugs
- Braces for teeth, dentures, partials, and bridges for persons 21 and over
- Glasses and contact lenses for persons 21 and over
- Hearing aids for persons 21 and over
- Fans, air conditioning, humidifiers, air purifiers, computers, home repairs
- Services not covered (including those listed above)
- Unauthorized services
- Services provided by providers who are not part of your health plan.

This list does not include all services that are not covered. To determine if a service is not covered, call Member Services at 855-690-7784 (TTY 711).

If You Get a Bill

If you get a bill for a treatment or service and you do not think you should pay for, do not ignore it. Call Member Services at 855-690-7784 (TTY 711) right away. We can help you understand why you may have gotten a bill. If you are not responsible for payment, your health plan will contact the provider and help fix the problem for you.

You have the right to ask for Fair Hearing if you think you are being asked to pay for something Medicaid or your health plan should cover. A Fair Hearing allows you or your representative to make your case before an administrative law judge. See the Fair Hearing section in this handbook for more information. If you have any questions, call Member Services at 855-690-7784 (TTY 711).

Member Copayment

Member Copayments (co-pay) are not required for any service.
PART II: Plan Procedures

1. Service Authorization and Actions

Anthem Medicaid will need to approve some treatments and services before you receive them. Anthem Medicaid may also need to approve some treatments or services for you to continue receiving them. This is called preauthorization. You can ask for this. The following treatments and services must be approved before you get them:

- All inpatient and residential services
- All out-of-network services
- All rented medical supplies and equipment
- Some medical equipment
- Some medical procedures and tests
- Home healthcare
- Therapies (physical, occupational, speech)

This is not a complete list, and it may change at any time. Visit our member website at anthem.com/kymedicaid for a complete list. Your provider can visit mediproviders.anthem.com/ky/pages/precert.aspx for a comprehensive list.

To request prior authorization, your primary care provider (PCP) or another provider can call us at 855-661-2028. You can also call Member Services for help with prior authorizations at 855-690-7784 (TTY 711).

Asking for approval of a treatment or service is called a service authorization request. To get approval for these treatments or services, you or your doctor need to call us. Your doctor can call us at 855-661-2028. You can call Member Services at 855-690-7784 (TTY 711).

If your Service Authorization Request is denied and you proceed to get the service and appeal the denial, you may be responsible for the cost. Please call Member Services at 855-690-7784 (TTY 711) if you have any questions.

2. Service Authorization Requests for Children under Age 21

Special rules apply to decisions to approve medical services for children under age 21 receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. To learn more about EPSDT services, see page 30 or visit our website at anthem.com/kymedicaid.
3. What Happens After We Get Your Service Authorization Request

The health plan has a review team to be sure you get the services we promise. Qualified healthcare professionals are on the review team. Their job is to be sure that the treatment or service you asked for is covered by your plan and that it will help with your medical condition. They do this by checking your treatment plan against medically acceptable standards.

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

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

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

4. Preauthorization and Timeframes

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

- **Standard review**: We will make a decision about your request within two (2) business days of receiving the request. The timeframe for a standard authorization request may be extended up to fourteen (14) days if you or your doctor requests it.
- **Expedited (fast track) review**: We will decide about your request, and you will hear from us within twenty-four (24) hours.

In most cases, if you are receiving a service and a new request is made to keep receiving a service, we must tell you before we change the service if we decide to reduce, stop, or restrict the service. **If we approve a service and you have started to receive that service, we will not reduce, stop, or restrict the service during the approval period unless we determine the approval was based on information that was known to be false or wrong.**

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

There are times when we need to make decisions about how we pay for care and services. This is called utilization management (UM). All UM decisions are based solely on a member’s medical needs and the benefits offered. We do this for the best possible health outcomes for our members.

- We don’t create barriers to getting healthcare.
- We don’t tell or encourage providers to underuse services.
- Providers and others involved in UM decisions do not receive any type of reward for limiting or denying care.
- We don’t base our decision to contract with providers on whether they might deny benefits.
- We don’t limit the number of medically necessary screenings for children (from birth through age 20). Interperiodic, or periodic screenings, for kids may not need prior authorization (or preapproval) from us.

Access to Utilization Management (UM) staff

We have a Utilization Review team that will decide if a service request is:
- Medically needed, and
- Covered by your health plan.

You or your doctor can ask for a review if we decide we will not pay for the service. We will let you and your doctor know after we get an appeal request. The request can be for services that:
- Are not approved.
- Have changed in amount, length, or scope, resulting in a smaller amount than first requested.

If you have UM questions, call Member Services at 855-690-7784 (TTY 711) Monday through Friday from 7 a.m. to 7 p.m. Eastern time, except holidays. We can also help if you need help in another language.

New medical advances

Our medical directors and network providers look at new medical advances and studies. They decide if:
- These advances should be covered benefits.
- The government has agreed the treatment is safe and effective.
- The results are as good as, or better than, covered treatments in effect now.

Anthem Medicaid Board of Directors

Anthem Medicaid has a governing body, called the Board of Directors, that oversees the company. For more information on our Board of Directors, you can call Member Services at 855-690-7784 (TTY 711).
5. Information from Member Services

You can call Member Services at 855-690-7784 (TTY 711) to get help anytime you have a question. You may call us to choose or change your Primary Care Provider (PCP), to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report the birth of a new baby, get more information on the structure and operation of Anthem Medicaid and physician incentive plans, or ask about any change that might affect you or your family’s benefits. We can answer any of the questions you may have about the information in this handbook.

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

People with disabilities: If you use a wheelchair or have trouble hearing or understanding, call us if you need extra help. If you are reading this on behalf of someone who is blind, visually impaired, or deaf-blind, we can also help. We can tell you if a particular doctor’s office is wheelchair accessible or is equipped with special communications devices. Also, we have services like:

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

6. How You Can Help with Plan Policies

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

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

Call Member Services at 855-690-7784 (TTY 711) to learn more about how you can help.

7. Appeals

If you are not satisfied with our decision about your care, you can file an appeal.

If you are not satisfied with an action we took or what we decide about your service authorization request, see page 32 of this handbook about service authorizations and actions, you can file an appeal or a request for us to review the decision. You have 60 days after you get a written notice from us to file an appeal.
You can do this yourself or your authorized representative can do it for you. You can call Member Services at 855-690-7784 (TTY 711) or visit our website at anthem.com/kymedicaid if you need help filing an appeal.

The appeal can be made by phone or in writing. **If you call us, you must also file your appeal in writing.** We can help you complete the appeal form.

If your appeal review needs to be expedited (reviewed more quickly than the standard timeframe) because you have an immediate need for health services, you do not need to follow up in writing after you call us. We will let you know in writing that we received your request for an expedited appeal within 24 hours of receiving it.

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

To file an appeal, write to:
Central Appeals Processing
Anthem Medicaid
P.O. Box 62429
Virginia Beach, VA 23466-2429

To file an appeal by phone, call Member Services at 855-690-7784 (TTY 711).

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

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

**If you need help with understanding the Appeals process, you can contact the Medicaid Managed Care Ombudsman Program.** For more information about the Ombudsman Program, see page 48 of this handbook.

8. **Timeframes for Appeals**

**Standard appeals:** If we have all the information we need, we will tell you our decision in writing within 30 days from your appeal.

**Expedited (fast track) appeals:** If we have all the information we need, we will call you and send you a written notice of our decision within 3 days from your appeal.

If we need more information to make either a standard or an expedited decision about your appeal, we will:
• Write you and tell you what information is needed. For expedited appeals, we will call you right away and send a written notice later.
• Explain why the delay is in your best interest.
• Make a decision no later than 14 days from the day we asked for more information.

If you need more time to gather your documents and information, just ask. You, your provider or someone you trust may ask us to delay your case until you are ready. We want to make the decision that supports your best health. This can be done by calling Member Services at 855-690-7784 (TTY 711) or writing to Central Appeals Processing, Anthem Medicaid, P.O. Box 62429, Virginia Beach, VA 23466-2429.

**Your Care While You Wait for a Decision**

While you wait for a decision and the health plan’s decision reduces or stops a service you are already receiving, you can ask to continue the services your provider had already ordered while we are making a decision on your appeal. You can also ask an authorized representative to make that request for you.

You must ask us to continue your services within 10 days from the date of the notice that says your care will change or by the time the action takes effect.

• **Call Member Services at 855-690-7784 (TTY 711)** to ask if you can keep getting services. All of these conditions must be met:
  - You ask to extend benefits.
  - The appeal request is filed within 10 calendar days of the mailing date on the denial notice.
  - The appeal involves ending, reducing, or suspending previously approved treatment or services.
  - The services were ordered by an authorized provider.
  - The coverage period previously authorized has not expired.

You may have to pay the costs of services, including EPSDT services, if the first decision isn’t changed.

If you ask your health plan to continue services you already receive during your appeal, the health plan will pay for those services if your appeal is decided in your favor. **Your appeal might not change the decision the health plan made about your services. When your appeal doesn’t change the health plan’s decision, the health plan may require you to pay for the services you received while waiting for a decision.**

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

If you don’t agree with a decision we made that reduced or denied your services you can ask for a Fair Hearing. A Fair Hearing is your opportunity to give more information and facts, and to ask questions about your decision before an administrative law judge. The judge in your Fair Hearing is not a part of your health plan in any way.

You can ask for a fair hearing within 120 days from the day you hear from us about our decision about your appeal.

If you need help with understanding the Fair Hearing process, you can contact us or the Medicaid Managed Care Ombudsman Program (see page 48 of this handbook).

If You Have Problems with Your Health Plan

If you have a problem, talk with your primary care provider (PCP), call Member Services at 855-690-7784 (TTY 711), or write to:

Central Appeals Processing
Anthem Medicaid
P.O. Box 62429
Virginia Beach, VA 23466-2429

Most problems can be solved right away. If you have a problem with Anthem Medicaid, care, providers, or services, you can file a complaint with the plan. This is called a Grievance. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedures described below.

You can ask an authorized representative to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services, or help filing out the forms, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

You can also contact the Office of the Ombudsman for help with problems you have with Anthem Medicaid, care, providers, or services. They will be able to assist you with your Grievance (see page 38 for more information).

10. If You Are Unhappy with Your Plan: How to File a Complaint

If you are unhappy with your health plan, provider, healthcare, or your health services, you can file a Complaint (also called a Grievance). You can file a complaint by phone or in writing at any time.

- To file by phone, call Member Services at 855-690-7784 (TTY 711) Monday through Friday from 7 a.m. to 7 p.m. Eastern time, except holidays.
- To file in writing, you can write us with your complaint to:
What Happens Next

We will let you know in writing that we got your complaint within five days of receiving it.

We will review your complaint and tell you how we resolved it in writing within 30 days from receiving your complaint.

If your complaint is about the denial of an expedited appeal, we will let you know in writing that we got it within 24 hours of receiving it. We will review your complaint about the denial of an expedited appeal and tell you how we resolved it in writing within five days of receiving your complaint.

If you are not happy with how we resolved your issue, you can file a complaint with the Medicaid Managed Care Ombudsman Program. The Ombudsman Program can look into your concerns and help you with your issue (see page 48 of this handbook).

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

If you join Anthem Medicaid from another health plan, we will contact you within five business days from your expected enrollment date with us. We will ask you for the name of your previous plan, so we can add your health information, like your medical records and prescheduled appointments, into our records.

If you leave Anthem Medicaid, we will share your health information with your new plan. You can finish receiving any services that have already been authorized by your previous health plan. After that, we will help you find a provider in our network to get any additional services if you need them.

In almost all cases, your doctors will be Anthem Medicaid providers. There are some instances when you can still see another provider that you had before you joined Anthem Medicaid. You can continue to see your doctor if:

- At the time you join Anthem Medicaid, you are receiving an ongoing course of treatment or have an ongoing special health condition. In that case, you can ask to keep your provider for up to 90 days.
- You are more than three months pregnant when you join Anthem Medicaid and you are getting prenatal care. In that case, you can keep your provider until after your delivery and for up to 60 days of post-partum care.
You are pregnant when you join Anthem Medicaid, and you are receiving services from a behavioral health treatment provider. In that case, you can keep your provider until after your delivery.

If your provider leaves Anthem Medicaid, we will tell you in writing at least 30 days from when we know about this. We will tell you how you can choose a new PCP or choose one for you if you do not make a choice within 30 days. If you are in a course of treatment now, or if you have a special health condition, you may be able to keep seeing your provider for up to 60 days (or up to 90 days if you are receiving inpatient services) until a plan is in place to transition to another provider, or through postpartum care for pregnant members. This is called **continuity of care**.

If you have any questions, call Member Services at **855-690-7784 (TTY 711)**.

12. Member Rights and Responsibilities

A. Your Rights

As a member of Anthem Medicaid, you have a right to:

- Respect, dignity, privacy, confidentiality, accessibility and nondiscrimination;
- Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities;
- A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;
- Consent for or refusal of treatment and active participation in decision choices;
- Have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Ask questions and receive complete information relating to the Enrollee’s medical condition and treatment options, including Specialty Care;
- Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and request a State Fair Hearing from the Contractor and/or the Department;
- Make recommendations regarding the organization’s member rights and responsibilities policy;
- Timely access to care that does not have any communication or physical access barriers;
- Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;
- Assistance with Medical Records in accordance with applicable federal and state laws;
- Timely referral and access to medically indicated Specialty Care;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- Receive information in accordance with 42 C.F.R. 438.10;
- Be furnished healthcare services in accordance with 42 C.F.R. Part 438; and
- Any American Indian enrolled with the health plan is eligible to receive services from a participating I/T/U provider or an I/T/U PCP shall be allowed to receive services from that provider if part of the health plan’s Network.
B. Your Responsibilities

As a member of Anthem Medicaid, you agree to:

- Work with your PCP to protect and improve your health.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that they have agreed to with their practitioners.
- Understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- Find out how your health plan coverage works.
- Listen to your PCP’s advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better or ask for a second opinion.
- Treat healthcare staff with the respect you expect yourself.
- Tell us if you have problems with any healthcare staff by calling Member Services at 855-690-7784 (TTY 711).
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency department only for real emergencies.
- Call your PCP when you need medical care, even if it is after-hours.

13. Disenrollment Options

A. If You Want to Leave the Plan

You may leave Anthem Medicaid and join another health plan at any time during the first 90 days you signed up with us.

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

- You move out of our service area.
- Your PCP is no longer in our network.
- You lack access to covered services.
- You can’t access a provider to treat your medical condition.

B. How to Change Plans

You can ask to change plans. To change plans, you should write or call us with your reason(s) for the request. The following information should be provided:

- First and Last name, Social Security Number (SSN) and/or KY Medicaid ID number of all household members that are requesting disenrollment
- Your current address/phone number
- The reason you are requesting the change
- Please include the name of your primary care physician and the hospital you use.

If we do not approve the change, you may contact either by fax or mail:
The change may take up to 90 days. If you have questions or need help with the process, you may call us at 855-690-7784 (TTY 711) or Kentucky Medicaid Member Services at 800-635-2570 from 8 a.m. – 5 p.m. ET Monday – Friday.

You will get a notice that the change will take place by a certain date. Anthem Medicaid will provide the care you need until then.

14. You Could Become Ineligible for Medicaid Managed Care

You may have to leave Anthem Medicaid if you:
- Lose your Medicaid eligibility
- If you stay in a nursing home for more than 30 days in a row
- If you become eligible for Medicare
- Abuse or harm to plan members, providers, or staff
- Do not fill out forms honestly or do not give true information (commit fraud)

If you become ineligible for Medicaid, all your services may stop. If this happens, call the Department for Community Based Services at:
Phone Number: 502-564-3703 or Fax: 502-564-6907

Mailing Address
275 E. Main St. 3W-A
Frankfort, KY 40621

You can also contact the Medicaid Managed Care Ombudsman Program to discuss your options for appeal (see page 48).

15. Advance Directives

There may come a time when you become unable to manage your own healthcare and a family member or other person close to you is making decisions on your behalf. By planning in advance, you can arrange now for your wishes to be carried out. An advance directive is a set of directions you give about the medical and mental healthcare you want if you ever lose the ability to make decisions for yourself.

Making an advance directive is your choice. If you become unable to make your own decisions, and you have no advance directive, your doctor or behavioral health provider will consult with someone
close to you about your care. Discussing your wishes for medical and behavioral health treatment with your family and friends now is strongly encouraged, as this will help to make sure that you get the level of treatment you want if you can no longer tell your doctor or other physical or behavioral health providers what you want.

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

**A. Living Will**
In Kentucky, a **living will** is a legal document that tells others that you want to die a natural death if you:

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

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

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

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

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

**C. Fraud, Waste and Abuse**
If you suspect that someone is committing Medicaid fraud, report it. Examples of Medicaid fraud include:

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

You can report suspected fraud and abuse in any of the following ways:
• Call Member Services
• Call the Medicaid Fraud, Waste and Program Abuse Tip Line at 800-372-2970.
• Call the U.S. Office of Inspector General’s Fraud Line at 800-HHS-TIPS (800-447-8477).
• Visit our fighthealthcarefraud.com education site. At the top of the page, select “Report it” and complete the “Report Waste, Fraud and Abuse” form.
• Call the SIU fraud hotline at 800-866-1186.
• Write to us:
  Special Investigations Unit
  740 W Peachtree Street NW
  Atlanta, GA 30308

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of Provider Fraud, Waste and Abuse (FWA):
• Altering medical records to misrepresent actual services provided
• Billing for services not provided
• Billing for medically unnecessary tests or procedures
• Billing professional services performed by untrained or unqualified personnel
• Misrepresentation of diagnosis or services
• Overutilization
• Soliciting, offering, or receiving kickbacks or bribes
• Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
• Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.) include:
• Name, address, and phone number of provider, such as doctor, hospital, nursing home, home health agency, etc.
• Medicaid number of the doctor or hospital, if you have it
• Type of provider (doctor, dentist, therapist, pharmacist, hospital, etc.)
• Names and phone numbers of other witnesses who can help in the investigation
• Dates of events
• Summary of what happened

D. Important Phone Numbers

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<th>Contact Information</th>
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| **Anthem Medicaid Member Services**           | 855-690-7784 (TTY 711)  
Monday through Friday from 7 a.m. to 7 p.m. Eastern time, except holidays |
|                                               | Call us for information about:                           |
|                                               | • Medicaid benefits and services                          |
|                                               | • Long-term care services                                  |
|                                               | • Maternity, family planning and sexually transmitted disease (STD) services. |
|                                               | • And more.                                              |
|                                               | For members who don’t speak English, Member Services offers free oral interpretation services and translations of written materials. If you’d like this handbook in a different language or format, please call Member Services at 855-690-7784 (TTY 711). |

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<tr>
<td><strong>Anthem Medicaid Member Website</strong></td>
<td>anthem.com/kymedicaid</td>
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<td>Visit our website for a digital copy of this handbook.</td>
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| **Anthem Medicaid Behavioral Health Crisis Hotline** | 855-661-2025 (TTY 711)  
24 hours a day, seven days a week |
|                                               | Call anytime, day or night, if you need mental healthcare or substance abuse services or feel you are in a crisis. |
|                                               | Visit anthem.com/kymedicaid and use our Find a Doctor tool to find a behavioral health specialist in our plan. |
| **Anthem Medicaid 24/7 NurseLine**            | 866-864-2544 (TTY 711)  
24 hours a day, seven days a week |
|                                               | Call 24/7 to speak with a nurse about your health questions. |
## Resource Contact Information

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| MedImpact Pharmacy/Prescriber Services (Prior Authorization Services)  | **844-336-2676**  
Fax: 858-357-2612  
8 a.m. to 7 p.m. ET                                                   |
| Kynect Benefits                                                        | **844-407-8398**  
Monday through Friday 8 a.m. to 4 p.m.                                   |
| Kynect.ky.gov                                                          |                                                                                     |
| Department for Medicaid Services (DMS)                                 | **800-635-2570**  
Monday through Friday from 8 a.m. to 4 p.m.                              |
| chfs.ky.gov/agencies/dms/Pages/default.aspx                            |                                                                                     |
| Kentucky Attorney General Office of Medicaid Fraud and Abuse           | **https://www.ag.ky.gov/about/Office-Divisions/OMFA/Pages/default.aspx**              |
| Department for Medicaid Services (DMS) Fraud and Abuse                 | **800-372-2970**  
Monday through Friday from 8 a.m. to 4 p.m.                              |
| chfs.ky.gov/agencies/dms/dpi/Pages/fraudabuse.aspx                     |                                                                                     |
| Kentucky Department for Community Based Services (DCBS) | **855-306-8959**  
Monday through Friday from 8 a.m. to 4 p.m.  
Fax: 502-573-2007  
[chfs.ky.gov/agencies/dcbs/Pages/default.aspx](chfs.ky.gov/agencies/dcbs/Pages/default.aspx)  
Call DCBS to notify them about changes to your:  
• Family size (births and deaths)  
• Address or phone number |
|---|---|
| Kentucky Children’s Health Insurance Plan (KCHIP) | **877-524-4718**  
**800-662-5397** en español  
[kidshealth.ky.gov/Pages/index.aspx](kidshealth.ky.gov/Pages/index.aspx) |
| Social Security | **800-772-1213**  
[ssa.gov](ssa.gov)  
Representatives will answer your calls from 7 a.m. to 7 p.m. Monday through Friday. Recorded information and services are available 24 hours a day and on weekends. |
| Kentucky Office of the Ombudsman | **800-372-2973 (TTY 800-627-4702)**  
Monday through Friday from 8 a.m. to 4 p.m.  
[chfs.ky.gov/agencies/os/omb/Pages/default.aspx](chfs.ky.gov/agencies/os/omb/Pages/default.aspx) |
| Kentucky Healthcare Customer Service line | **855-459-6328** |

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| Child/Adult Abuse Hotline | **800-752-6200** or **877-597-2331**  
Call to report abuse and neglect. Calls are monitored from 8 a.m. to 4:30 p.m. Eastern time, Monday through Friday. Reports will not be reviewed during evenings, weekends, or state holidays.  
You can also report non-emergency child abuse incidents online: [prd.webapps.chfs.ky.gov/reportabuse/home.aspx](prd.webapps.chfs.ky.gov/reportabuse/home.aspx) |
| National Domestic Violence Hotline | **800-799-SAFE (7233)** |
| KY Medicaid Fraud Hotline | **800-372-2970**  
Monday through Friday, 8 a.m. to 4:30 p.m. Eastern time, or call anytime to leave a message |
Submit your tips or complaints of fraud, waste, or |
abuse via the OIG Hotline in one of these ways:

Online: tips.oig.hhs.gov

By phone: 800-HHS-TIPS (800-447-8477)
TTY: 800-377-4950

By mail:
U.S. Department of Health and Human Services
Office of Inspector General
ATTN: OIG Hotline Operations
P.O. Box 23489
Washington, DC 20026

<table>
<thead>
<tr>
<th>Kentucky Legal Aid</th>
<th>270-782-5740 or 800-782-1924 klaid.org</th>
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<tbody>
<tr>
<td></td>
<td>Call Monday through Thursday from 8:30 a.m. to 6 p.m. ET, except holidays, to apply for help creating an advance directive or other needs.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>The KY Mediation Network</th>
<th>502-573-2350</th>
</tr>
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</table>

| Advance Healthcare Directive Registry | 855-690-7784 (TTY 711) Monday through Friday from 7 a.m. to 7 p.m. Eastern time, except holidays, or call the Kentucky Legal Aid Society at 502-584-1254. |

16. Keep Us Informed

Call Member Services at 855-690-7784 (TTY 711) whenever these changes happen in your life:
- You have a change in Medicaid eligibility.
- You give birth.
- There is a change in Medicaid coverage for you or your children.

If you no longer get Medicaid, check with your local Department of Social Services. You may be able to enroll in another program.

17. Medicaid Managed Care Ombudsman Program

The Medicaid Managed Care Ombudsman Program is a resource you can contact if you need help with your healthcare needs. The Ombudsman Program is an independently operated, non-profit organization whose number one priority is to ensure that individuals and families that receive Kentucky Medicaid get access to the care that they need.

The Ombudsman Program can:
- Answer your questions about your benefits.
- Help you to understand your rights and responsibilities.
• Provide information about Medicaid and Medicaid Managed Care.
• Answer your questions about enrolling or disenrolling with a health plan.
• Help you understand a notice you have received.
• Refer you to other agencies that may also be able to assist you with your healthcare needs.
• Help to resolve issues you are having with your healthcare provider or health plan.
• Be an advocate for Members dealing with an issue or a complaint affecting access to healthcare.
• Provide information to assist you with your appeal, grievance, mediation, or fair hearing.
• Connect you to legal help if you need it to help resolve a problem with your healthcare.

Here is how you can contact the Ombudsman Program:
Phone: 502-564-5497
Fax: 502-564-9523
Toll Free: 800-372-2973

Mailing Address
275 E. Main Street, 2E-O
Frankfort, KY 40621
Email: CHFS.Listens@ky.gov
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

HIPAA notice of privacy practices
The original effective date of this notice was April 14, 2003. The most recent revision date is July 2021.

Please read this notice carefully. This tells you:

• Who can see your protected health information (PHI).
• When we have to ask for your OK before we share your PHI.
• When we can share your PHI without your OK.
• What rights you have to see and change your PHI.

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you are a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Kentucky Children’s Health Insurance Program (KCHIP) after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs, and hospitals so we can OK and pay for your healthcare.

Federal law says we must tell you what the law says we have to do to protect PHI that is told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

• On paper (called physical), we:
  – Lock our offices and files.
  – Destroy paper with health information so others cannot get it.

• Saved on a computer (called technical), we:
  – Use passwords so only the right people can get in.
  – Use special programs to watch our systems.

• Used or shared by people who work for us, doctors, or the state, we:
  – Make rules for keeping information safe (called policies and procedures).
  – Teach people who work for us to follow the rules.

When it is OK for us to use and share your PHI
We can share your PHI with your family or a person you choose who helps with or pays for your healthcare if you tell us it is OK. Sometimes, we can use and share it without your OK:

• For your medical care
– To help doctors, hospitals, and others get you the care you need

• **For payment, healthcare operations, and treatment**
  – To share information with the doctors, clinics, and others who bill us for your care
  – When we say we will pay for healthcare or services before you get them (called prior authorization or preapproval)
  – To find ways to make our programs better, as well as support you and help you get available benefits and services. We may get your PHI from public sources, and we may give your PHI to health information exchanges for payment, healthcare operations, and treatment. If you do not want this, please visit anthem.com/kymedicaid for more information.

• **For healthcare business reasons**
  – To help with audits, fraud and abuse prevention programs, planning, and everyday work
  – To find ways to make our programs better

• **For public health reasons**
  – To help public health officials keep people from getting sick or hurt

• **With others who help with or pay for your care**
  – With your family or a person you choose who helps with or pays for your healthcare, if you tell us it is OK
  – With someone who helps with or pays for your healthcare, if you cannot speak for yourself and it is best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research, or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We cannot take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

**Other ways we can — or the law says we have to — use your PHI:**
• To help the police and other people who make sure others follow laws
• To report abuse and neglect
• To help the court when we are asked
• To answer legal documents
• To give information to health oversight agencies for things such as audits or exams
• To help coroners, medical examiners, or funeral directors find out your name and cause of death
• To help when you asked to give your body parts to science
• For research
• To keep you or others from getting sick or badly hurt
• To help people who work for the government with certain jobs
• To give information to workers’ compensation if you get sick or hurt at work
Your rights

- You can ask to look at your PHI and get a copy of it. We will have 30 days to send it to you. If we need more time, we have to let you know. We do not have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing. We will have 60 days to send it to you. If we need more time, we have to let you know.
- Sometimes, you can ask us not to share your PHI. But we do not have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we shared your PHI with someone else. This will not list the times we shared it because of healthcare, payment, everyday healthcare business, or some other reasons we did not list here. We will have 60 days to send it to you. If we need more time, we have to let you know.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What we have to do

- The law says we must keep your PHI private except as we said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we will do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, such as if you are in danger.
- We must tell you if we have to share your PHI after you asked us not to.
- If state laws say we have to do more than what we said here, we will follow those laws.
- We have to let you know if we think your PHI has been breached.

Contacting you

We, along with our affiliates and vendors, may call or text you using an automatic telephone dialing system and an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we will not contact you in this way anymore. Or you may call **844-203-3796** to add your phone number to our Do Not Call list.

What to do if you have questions

If you have questions about our privacy rules or want to use your rights, please call Member Services at **855-690-7784 (TTY 711).**
What to do if you have a complaint
We are here to help. If you feel your PHI has not been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

You may write to or call the Department of Health and Human Services:
Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Ste. 16T70
61 Forsyth St. SW
Atlanta, GA 30303-8909
Phone: 800-368-1019
TDD: 800-537-7697
Fax: 404-562-7881

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we will tell you about the changes in a letter. We also will post them on the web at anthem.com/kymedicaid.

Race, ethnicity, and language
We receive race, ethnicity, and language information about you from the state Medicaid agency and the Kentucky Children’s Health Insurance Program (KCHIP). We protect this information as described in this notice.

We use this information to:
- Make sure you get the care you need.
- Create programs to improve health outcomes.
- Develop and send health education information.
- Let doctors know about your language needs.
- Provide translator services.

We do not use this information to:
- Issue health insurance.
- Decide how much to charge for services.
- Determine benefits.
- Disclose to unapproved users.

Your personal information
We may ask for, use, and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It is often taken for insurance reasons.
- We may use your PI to make decisions about your:
  - Health
  - Habits
- Hobbies
- We may get PI about you from other people or groups like:
  - Doctors
  - Hospitals
  - Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We will let you know before we do anything where we have to give you a chance to say no.
- We will tell you how to let us know if you do not want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

This information is available for free in other languages. Please contact Member Services at 855-690-7784 (TTY 711) Monday through Friday from 7 a.m. to 7 p.m. Eastern time, except holidays.

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1006373KYMENABS BV 03/21
Appendix I: To Receive This Handbook In Different Languages

You may get this handbook and other plan information in large print for free. To get materials in large print, call Member Services at 855-690-7784 (TTY 711).

If English is not your first language (or if you are reading this on behalf of someone who doesn’t read English), we can help. Call 855-690-7784 (TTY 711). You can ask us for the information in this handbook in your language. We have access to interpreter services and can help answer your questions in your language.

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-502-564-7770 (TTY: 1-502-573-2604).

If English is not your first language (or if you are reading this on behalf of someone who doesn’t read English), we can help. Call 855-690-7784 (TTY 711). You can ask us for the information in this handbook in your language. We have access to interpreter services and can help answer your questions in your language.

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-502-564-7770 (TTY: 1-502-573-2604).


注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-502-564-7770（TTY：11-502-573-2604）。


ملحوظة: إذا كنت تتحدث انجليزية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-502-564-7770.


注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-502-564-7770 （TTY: 1-502-573-2604）まで、お電話にてご連絡ください。


यान + दनु होस: तपाईले नेपाली बोल्नुहुन्छ अने तपाईंको निम्नित भाषा सहायता सेवाहरू निश्चल रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-502-564-7770 (टिटिवाइङ 1-502-573-2604)


Anthem Medicaid follows Federal civil rights laws. We don’t discriminate against people because of their:

- Race
- Color
- National origin
- Age
- Disability
- Sex or gender identity

That means we won’t exclude you or treat you differently because of these things.

**Communicating with you is important**
For people with disabilities or who speak a language other than English, we offer these services at no cost to you:

- Qualified sign language interpreters
- Written materials in large print, audio, electronic, and other formats
- Help from qualified interpreters and written materials in the language you speak

To get these services, call the Member Services number on your ID card at 855-690-7784 (TTY 711).

**Your rights**
Do you feel you didn’t get these services or we discriminated against you for reasons listed above? If so, you can file a complaint. File by mail, email, fax, or phone:

Anthem Medicaid Attn: Compliance Nondiscrimination Phone: 855-690-7784 (TTY 711)
13550 Triton Park Blvd. Email: KYMEDICAIDCOMPLIANCE
Louisville, KY 40223 @anthem.com
Fax: 855-443-7820

Need help filing? Call us at the number above. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- On the web: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail: U.S. Department of Health and Human Services
  200 Independence Ave. SW, Room 509F, HHH Building
  Washington, D.C. 20201
- By phone: 800-368-1019 (TTY/TDD 800-537-7697)

For a complaint form, visit hhs.gov/ocr/office/file/index.html.
Appendix II: Key Words Definition

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

**Advance Directive**: A legal document, such as a living will, that tells your doctor and family how you wish to be cared for if you can’t make your healthcare wishes known.

**Adverse Action**: A decision your plan can make to reduce, stop, or restrict your healthcare services.

**Appeal**: A request you make to the plan to review a decision the plan made to deny, cut back, or stop your healthcare services.

**Authorized Representative**: A trusted person (family member, friend, provider, or attorney) who you allow to speak for you concerning your Medicaid benefits, enrollment or claims.

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

**Benefits**: A set of healthcare services covered by your health plan.

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

**Copayment**: The amount of money you may have to pay for a provider visit, service, or drug prescription. Also called a copay.

**Dual Eligible**: You are eligible for both Medicare and Medicaid.

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

**Early Period Screening, Diagnosis and Treatment (EPSDT)**: A program that is for preventive healthcare and well-child checkups for children under the age of 21.

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

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

**Emergency Services**: Services you receive to treat your emergency medical condition.

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

**Excluded Services**: Healthcare services that are not covered by Medicaid.

**Fair Hearing**: A way you can make your case before an administrative law judge if you are not happy about a decision your plan made that limited or stopped your services after your appeal.

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

**Habilitation Services and Devices**: Services or therapy that help a person with disabilities keep, learn, or improve skills and functioning for daily living. They can be either inpatient or outpatient.

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

**Home Healthcare**: Healthcare services provided in your home such as nurse visits or physical therapy.
Hospice Services: Special services for patients and their families during the final stages of illness and after death. Hospice services include certain physical, psychological, social, and spiritual services that support terminally ill individuals and their families or caregivers.

Hospitalization: Admission to a hospital for treatment that usually requires an overnight stay.

Hospital Outpatient Care: Care in a hospital that usually does not require an overnight stay.

In-Network: A term used when a provider is contracted with your health plan.

Managed Care: An organized way for providers to work together to coordinate and manage all your health needs.

Medicaid: A health plan that helps some individuals pay for healthcare.

Medically Necessary: Medical services or treatments that you need to get and stay healthy.

Member: A person who has Medicaid managed care.

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

Non-Emergency Medical Transportation: Transportation your plan can arrange to help you get to and from your appointments, including personal vehicles, taxis, vans, mini-busses, mountain area transports and public transportation.

Non-Participating Provider: A doctor, hospital or other licensed facility or healthcare provider who hasn’t signed a contract with your health plan.

Participating Provider: A doctor, hospital or licensed facility or healthcare provider who has signed a contract with your health plan to give services to members.

Physician Services: Healthcare services provided or coordinated by a licensed medical physician (M.D. — Medical Doctor or D.O. — Doctor of Osteopathic Medicine).

Plan (or Health Plan): The managed care company providing you with health insurance coverage.

Preauthorization: The approval needed from your health plan before you can get certain healthcare services or medicines. Also called prior authorization.

Premium: The amount you may have to pay for coverage by your health plan.

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

Prescription Drug Coverage: Covers all or part of the cost of prescription drugs.

Primary Care Provider (PCP): The provider who takes care of and coordinates all your health needs. Your PCP is often the first person you should contact if you need care. Your PCP is usually in general practice, family practice, internal medicine, pediatrics, or an OB/GYN.

Provider: A healthcare professional or a facility that delivers healthcare services, like a doctor, hospital, or pharmacy.

Provider Directory: A list of participating providers in your health plan’s network.

Rehabilitation Services and Devices: Healthcare services and equipment that help you recover from an illness, accident, injury, or surgery. These services can include physical or speech therapy.

Referral: When your PCP sends you to another healthcare provider.

Skilled Nursing Care: Services from licensed nurses in your home or in a nursing home.

Specialist: A doctor who is trained and practices in a specialized area of medicine such as cardiology (heart doctor) or ophthalmology (eye doctor).

Substance Use: A medical disorder that includes the misuse or addiction to alcohol and/or legal or illegal drugs.
Urgent Care: Medically needed care for an unexpected illness or injury that you need sooner than a routine visit to your PCP. It is not considered an emergency medical condition. You can get Urgent Care in a walk-in clinic for a non-life-threatening illness or injury (like the flu or sprained ankle).
## Appendix III: Your Medicaid Quick Reference Guide

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<tr>
<th>I WANT TO:</th>
<th>I CAN CONTACT:</th>
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<tbody>
<tr>
<td>Find a doctor, specialist, or healthcare service</td>
<td>My Primary Care Provider (PCP). If you need help with choosing your PCP, call Member Services at <strong>855-690-7784 (TTY 711)</strong>.</td>
</tr>
<tr>
<td>Get the information in this handbook in another format or language</td>
<td>Member Services at <strong>855-690-7784 (TTY 711)</strong>.</td>
</tr>
<tr>
<td>Keep better track of my appointments and health services</td>
<td>Your PCP or your Managed Care Plan.</td>
</tr>
<tr>
<td>Get help with getting to and from my doctor’s appointments</td>
<td>Member Services at your Managed Care Plan. You can also find more information on Transportation Services in this handbook.</td>
</tr>
<tr>
<td>Get help to deal with my stress or anxiety</td>
<td>Your Managed Care Plan, at any time, 24 hours a day, 7 days a week. If you are in danger or need immediate medical attention, call 911. Behavioral Health Crisis Hotline: <strong>855-690-7784 (TTY 711)</strong>.</td>
</tr>
<tr>
<td>Get answers to basic questions or concerns about my health, symptoms, or medicines</td>
<td>Nurse Line at your Managed Care Plan at any time, 24 hours a day, 7 days a week, or talk with your PCP at <strong>855-690-7784 (TTY 711)</strong>.</td>
</tr>
</tbody>
</table>
| • Understand a letter or notice I got in the mail from my health plan  
• File a complaint about my health plan  
• Get help with a recent change or denial of my healthcare services | Member Services at **855-690-7784 (TTY 711)** or the Medicaid Managed Care Ombudsman Program toll free at **800-372-2973**. You can also find more information about the Ombudsman Program in this handbook. |
| Update my address | Call your local Department for Community Based Services (DCBS) office to report an address change at 502-564-3703. A list of offices can also be found at the following website link: [https://kynect.ky.gov/benefits/s/find-dcbs-office?language=en_US](https://kynect.ky.gov/benefits/s/find-dcbs-office?language=en_US) |
| Find my plan’s provider directory or other general information about my plan | Managed Care Plan **855-690-7784 (TTY 711)**. |