Member Handbook for Medicaid

www.anthem.com/kymedicaid
Dear Member:

Welcome to Anthem Medicaid. Your health is important — and our experienced team is ready to help you and your family stay focused on it. Let’s get started!

We’re here to make sure you have the tools and resources you need to stay healthy. Use your member handbook to guide you to helpful benefits and learn about how your health care plan works.

You’ll get your member ID card in a few days. If you need care before you get it, call our Member Services team. When you get your ID card, look it over to make sure all your information is correct. If anything isn’t right, call Member Services, and we’ll send you a new ID card.

If you move, don’t forget to update your address with us and the Department of Community Based Services (DCBS). You could lose your benefits if the state doesn’t have your current address on file. Call DCBS right away at 1-855-306-8959 (TTY 711). Then reach out to Member Services so you don’t miss anything important from us.

We’re a click or call away if you need help:

- Visit us online at www.anthem.com/kymedicaid – read your handbook, search for doctors in your plan and learn about your benefits. Log in to your secure account to change your PCP, update your address, print your ID card and more.
- If you need medical advice, call Care on Call at 1-866-864-2544 (TTY 711) to talk with a nurse. Nurses are available 24 hours a day, 7 days a week, 365 days a year.
- If you’re having a mental health or substance abuse crisis, call our Behavioral Health Crisis Helpline at 1-855-661-2025 any time, day or night.
- Have other questions? Call Member Services at 1-855-690-7784 (TTY 711), 7 a.m. to 7 p.m. Eastern time, Monday through Friday, except holidays. For members who don’t speak English, Member Services also offers free oral interpretation services and translations of written materials. If you’d like this handbook in a different language or format, let Member Services know.

Thank you for being an Anthem Medicaid member.

Sincerely,

Celia Manlove
President
Anthem Medicaid
HEALTH TIPS THAT MAKE HEALTH HAPPEN

YOU NEED TO GO TO YOUR DOCTOR NOW!

When is it time for a wellness visit?
It is important for you to have regular wellness visits. This way, your primary care provider (PCP) can help you stay healthy. When you become a member of Anthem Blue Cross and Blue Shield Medicaid, call your PCP, listed on your Anthem ID card. Make an appointment for you and your child before the end of 90 days from the date you enroll in the plan.

Wellness care for children
Children need more wellness visits than adults. These wellness visits for children are part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) child health program for Kentucky Medicaid and Children’s Health Insurance Program (KCHIP) members under age 21. Your child should get wellness visits at the times listed below:

- Newborn
- 3-5 days old
- 1 month old
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old
- 15 months old
- 18 months old
- 24 months old
- 30 months old
- 3 years old
- 4 years old
- 5 years old
- 6 years old
- Yearly beginning at age 7

What if I become pregnant?
If you think you are pregnant, call your PCP or OB/GYN right away. This can help you have a healthy baby. If you have any questions or need help making an appointment with your PCP or OB/GYN, please call Member Services at 1-855-690-7784 (TTY 711) from 7 a.m. to 7 p.m. Eastern time, Monday through Friday, except holidays.

ALERT! KEEP THE RIGHT CARE. DO NOT LOSE YOUR HEALTH CARE BENEFITS — RENEW YOUR ELIGIBILITY FOR KENTUCKY MEDICAID PROGRAM SERVICES ON TIME. SEE PAGE 50 FOR MORE DETAILS.
Welcome to Anthem Medicaid! You’ll get most of your health care services covered through Anthem Medicaid. This member handbook tells you how to use your health care plan to stay healthy and get the care you need.

Table of Contents

WELCOME TO ANTHEM BLUE CROSS AND BLUE SHIELD MEDICAID!............................. 1
   Mandatory enrollees .................................................................................................... 1
   How to get help ......................................................................................................... 2
      Member Services department .............................................................................. 2
      Care on Call ......................................................................................................... 3
      Other important phone numbers ......................................................................... 4
      Your member handbook ...................................................................................... 5
      Your member ID card .......................................................................................... 5

YOUR PROVIDERS ........................................................................................................... 6
   Picking a primary care provider .............................................................................. 6
   Second opinion ........................................................................................................ 8
   If you had a different primary care provider before you joined Anthem Medicaid .... 8
   If your primary care provider’s office moves, closes or leaves the network .......... 8
   How to change your primary care provider ........................................................... 8
   If your primary care provider asks for you to be changed to another primary care provider ........................................................................................................... 9
   If you want to go to a doctor who is not your primary care provider ................. 9
   Picking an OB/GYN ................................................................................................. 10
   Specialists ............................................................................................................... 10
   Lock-in program ...................................................................................................... 11

GOING TO THE PRIMARY CARE PROVIDER ................................................................. 12
   Your first primary care provider appointment ....................................................... 12
   How to make an appointment ............................................................................... 12
   Wait times for appointments .................................................................................... 13
   What to bring when you go for your appointment ............................................... 15
   How to cancel an appointment .............................................................................. 15
**SPECIAL KINDS OF HEALTH CARE** ................................................................. 43
- Special care for pregnant members ............................................................ 43
  - When you become pregnant .................................................................... 40
  - When you have a new baby ...................................................................... 40
  - After you have your baby ........................................................................ 41
- Disease Management Centralized Care Unit .............................................. 41

**SPECIAL SERVICES FOR HEALTHY LIVING** ........................................... 43
- Health information ........................................................................................ 48
- Health education classes .............................................................................. 43
- Community events ....................................................................................... 49
- Domestic violence ........................................................................................ 44
- Minors ......................................................................................................... 50

**MAKING A LIVING WILL (ADVANCE DIRECTIVES)** ................................ 51

**GRIEVANCES AND MEDICAL APPEALS** ................................................ 51
- Grievances .................................................................................................... 51
  - Filing a grievance ....................................................................................... 52
- Medical appeals ............................................................................................. 52
- Expedited appeals ......................................................................................... 54
- Payment appeals ........................................................................................... 50
- Your doctor can ask for an outside review .................................................. 51
- Fair hearings .................................................................................................. 51
- Continuation of benefits ................................................................................ 52

**OTHER INFORMATION** ........................................................................... 58
- If you move .................................................................................................... 58
- Renew your Medicaid or KCHIP benefits on time ....................................... 58
- If you are no longer eligible for Medicaid or KCHIP .................................... 58
- How to disenroll ............................................................................................ 58
- Reasons why you can be disenrolled ............................................................ 59
- If you get a bill ............................................................................................... 59
- If you have other health insurance (coordination of benefits) ......................... 60
- Changes in your Anthem coverage ............................................................... 60
- How to tell us about changes you think we should make ............................. 60
- How we pay providers .................................................................................. 61

**YOUR MEMBER RIGHTS AND RESPONSIBILITIES** ............................... 62
- Your rights ..................................................................................................... 62
- Your responsibilities ....................................................................................... 65
HOW TO REPORT SOMEONE WHO IS MISUSING THE MEDICAID PROGRAM..................67
HIPAA NOTICE OF PRIVACY PRACTICES .............................................................................62
WELCOME TO ANTHEM BLUE CROSS AND BLUE SHIELD MEDICAID!

Thanks for being a member of Anthem Medicaid. We’re a managed care organization (MCO). We work with the Kentucky Cabinet for Health and Family Services (CHFS) and the Department for Medicaid Services (DMS) to help you get the care you and your family need to stay healthy. With us, you get all your Medicaid and Kentucky Children’s Health Insurance program (KCHIP) benefits, plus extra benefits just for being an Anthem Medicaid member.

We’re here to help you get affordable health care services, so you have what you need to feel your best.

Mandatory enrollees
Our members include residents of Kentucky in certain service areas, including:
• Individuals eligible for Medicaid as part of Medicaid Expansion under health care reform. The Affordable Care Act (ACA, also referred to as health care reform) expanded Medicaid to cover:
  – Nonelderly, nondisabled adults (childless and parents; male and female) below 133 percent of the federal poverty level
  – Former foster children who must be covered until age 26 if they:
    ▪ Were under state care for more than six months and
    ▪ Aged out of the foster care system by March 23, 2010

Our members include residents of Kentucky in certain service areas who are eligible for Kentucky Medicaid, including:
• Persons eligible for Temporary Assistance to Needy Families (TANF)
• Families and children
• Pregnant women
• Aged, blind or disabled individuals who receive:
  – State supplements
  – Supplemental Security Income (SSI)
• Children enrolled in the Kentucky Children’s Health Insurance Program (KCHIP)
• Persons under age 21 and in an inpatient psychiatric facility
• Children under age 18 who get adoption aid and have special needs
• Those eligible under the 1915(b) waiver, including:
  – Dual eligibles (those eligible for Medicare and Medicaid)
  – Disabled children
This member handbook will help you understand your health plan. It gives you details about your benefits.

How to get help

Member Services department
You can call Member Services at 1-855-690-7784 (TTY 711) from 7 a.m. to 7 p.m. Eastern time, Monday through Friday, except holidays. If you call after 7 p.m., you can leave a message. One of our Member Services representatives will call you back the next working day. Or if you need medical advice and wish to speak with a nurse, call Care on Call at 1-866-864-2544. See the section Care on Call for details.

We can help answer your questions about:
- This member handbook
- Member ID cards
- Your doctors
- Doctor visits
- Health care benefits
- Wellness care
- Special kinds of health care
- Healthy living
- Grievances and appeals
- Your rights and responsibilities (see the section Your member rights and responsibilities for details)
- Our responsibilities to you
- Receiving services from public health departments, community mental health centers, rural health clinics, federally qualified health centers, the Commission for Children with Special Health Care Needs and charitable care providers, such as Shriner’s Hospital for Children

You can also call us:
- To ask for a copy of our Notice of Privacy Practices. This notice describes:
  - How medical information about you may be used and disclosed
  - How you can get access to this information
- To learn more about our Quality Improvement program. We’ll send you our current program summary with details about how we measure up as a health plan. It includes:

Foster children
National Committee of Quality Assurance (NCQA) Healthcare Effective and Data Information Set (HEDIS) standards for managed care organizations and Consumer Assessment of Healthcare Providers and Systems (CAHPS). These scores show we’re doing as a health plan and where we could do more to help members like you.

How we measure our progress to meet annual goals

- If you move. We will need to know your new address and phone number. You should also call these contacts and tell them your new address:
  - Department for Community Based Services at 1-855-306-8959
  - Social Security Administration, for members eligible for Medicare
- If you want to ask for a copy of this member handbook in another language or format.

For members who do not speak English, we offer free oral interpretation services for all languages. If you need these services, call Member Services.

Para miembros que no hablan inglés, ofrecemos servicios gratuitos de interpretación oral para todos los idiomas. Si necesita estos servicios, llame a la línea gratuita de Servicios al Miembro al 1-855-690-7784.

For members who are deaf or hard of hearing:

- Call 711 to connect to Member Services from 7 a.m. to 7 p.m. Eastern time, Monday through Friday, except holidays
- We will set up and pay for you to have a person who knows sign language help you during your doctor visits

Please let us know if you need an interpreter at least 24 hours before your appointment.

**Care On Call**

Call Care On Call at 1-866-864-2544 24 hours a day, 7 days a week, 365 days a year if you need advice on:

- How soon you need to get care for an illness
- What kind of health care you need
- What to do to take care of yourself before you see the doctor
- How you can get the care that is needed

You can also call this same number if you need help completing your health risk assessment or setting up an appointment with a doctor for an urgent medical issue. Care On Call is here for you 24 hours a day, 7 days a week, 365 days a year.
We want you to be happy with all the services you get from our network of providers and hospitals. If you have any problems, please call us. We want to:

- Help you with your care
- Help you correct any problems you may have with your care

Other important phone numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Information</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergencies</td>
<td>Call for an ambulance or go to the nearest hospital emergency room</td>
<td>911</td>
</tr>
<tr>
<td>Office of the Ombudsman for the Kentucky Cabinet for Health and Family Services</td>
<td>For information on the Kentucky Medicaid program, call the Office of the Ombudsman for the Kentucky Cabinet for Health and Family Services.</td>
<td>1-800-372-2973</td>
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<td></td>
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<td>TTY</td>
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<tr>
<td></td>
<td></td>
<td>1-800-627-4702</td>
</tr>
<tr>
<td>Department for Community Based Services</td>
<td>To report family size changes, births, address changes and deaths</td>
<td>1-855-306-8959</td>
</tr>
<tr>
<td>Behavioral Health Substance abuse services</td>
<td>If you need mental health care or substance abuse services, or if you feel you are in crisis, you can call the crisis hotline 24 hours a day, 7 days a week.</td>
<td>1-855-661-2025</td>
</tr>
<tr>
<td>Long-term care services</td>
<td>If you need long-term care services and supports, call Monday through Friday from 7 a.m. to 7 p.m.</td>
<td>1-855-690-7784</td>
</tr>
<tr>
<td>Maternity, family planning and sexually transmitted disease services</td>
<td>If you are pregnant or need information on family planning or sexually transmitted disease (STD) services, call your PCP or Member Services for help.</td>
<td>1-855-690-7784</td>
</tr>
<tr>
<td>Disease management</td>
<td>If you want information about our disease management programs, call our Disease Management Centralized Care Unit (DMCCU) and ask to speak with a DMCCU case manager.</td>
<td>1-888-830-4300</td>
</tr>
<tr>
<td>eyeQuest</td>
<td>If you need routine vision services</td>
<td>1-855-343-7405</td>
</tr>
<tr>
<td>DentaQuest</td>
<td>If you need dental services</td>
<td>1-855-343-7405</td>
</tr>
<tr>
<td>Service</td>
<td>Information</td>
<td>Phone number</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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</tr>
<tr>
<td>Nonemergency medical transportation</td>
<td>This service is not covered by Anthem Blue Cross and Blue Shield Medicaid; this service is covered by Kentucky Medicaid fee-for-service. Call the Office of Transportation Delivery for help arranging a ride.</td>
<td>1-888-941-7433</td>
</tr>
<tr>
<td>Emergency or nonemergency medical transportation with a stretcher</td>
<td>This service is covered when other means of transport could endanger your health. If you need this service, we can help arrange it; call Member Services.</td>
<td>1-855-690-7784</td>
</tr>
<tr>
<td>Smoking cessation classes and tobacco cessation drugs</td>
<td>Call to register for classes. Your plan pays for all brand name and generic tobacco cessation drugs — no prior authorization required for first time use.</td>
<td>1-800-Quit-Now (1-800-784-8669)</td>
</tr>
</tbody>
</table>

**Your member handbook**

If you have questions or need help reading this member handbook, call Member Services. We can provide this handbook in:

- Another language
- A large-print version
- An audiotaped or CD version
- A Braille version

If you want a copy of this handbook in one of these versions, call Member Services. The other side of this handbook is in Spanish.

**Your member ID card**

We mailed your Anthem member ID card. If you don’t receive it soon, call Member Services. You will also receive a Medicaid ID card from the Kentucky Department for Community Based Services. Each Anthem-covered family member will get an Anthem member ID card.

- Please carry your Anthem member ID card and your Medicaid ID card with you at all times.
• Show these cards to any doctor, hospital or pharmacy you visit.
• If your ID card has the wrong PCP listed and you need care, call Member Services.
• If you need care before you get your ID card, call Member Services.

Your Anthem member ID card identifies you as a member of our health plan. It tells providers and hospitals we will pay for medically needed services listed in the section Your Health Care Benefits.

Your Anthem ID card shows:
• The name and phone number of your PCP if you have a PCP through us
• Your Medicaid or KCHIP ID number
• The date you became an Anthem member
• Important phone numbers you need to know like:
  – Member Services
  – Care on Call or 24/7 NurseLine
  – The phone numbers to call to get dental and vision care

If your Anthem ID card is lost or stolen, call Member Services right away. We will send you a new one.

YOUR PROVIDERS

Picking a primary care provider
The following members are not required to have a primary care provider (PCP) through us:
• Dual-eligible members (those eligible for Medicare and Medicaid)
• Children with disabilities
• Foster children

All other members must have a PCP.
• Your PCP must be in our network. An in-network provider is one who’s signed up with your health plan to give you services.
• You or Anthem will choose a PCP for your medical home. That means he or she will get to know you and your health history.
• Your PCP can help you get quality care.
• Your PCP will give you all of the basic health services you need. He or she will also send you to other doctors or hospitals when you need special medical services and behavioral health.

If you need care before you are assigned or get your PCP, please call Member Services.
You should have picked a PCP when you enrolled. If you didn’t choose a PCP, Member Services assigned one to you. We picked one that should be close by you. The name and phone number of your PCP is on your Anthem ID card. If we assigned a PCP to you, you can pick a new one.

- Look in the provider directory that came with your enrollment package.
- Go to [www.anthem.com/kymedicaid](http://www.anthem.com/kymedicaid) to view the provider directory online or use the Find a Doctor tool. Then, log in to your secure account to change your PCP right from the website.
- Call Member Services for help picking a PCP. Member Services will guide you through the selection process.

If you are already seeing a PCP, you can look in the provider directory to see if that provider is in our network. If so, you can tell us you want to keep that PCP.

There may be times when the PCP you choose is not approved. Reasons for this may include:

- The PCP is limiting his or her practice and is only seeing members who are current patients
- The PCP is limiting his or her practice and is only seeing members in relation to age range or gender

If this happens, we will let you know, and you can pick a new PCP.

Your PCP can be any of the following, as long as he or she is in the Anthem network:

- Licensed or certified health care practitioner, including a doctor of medicine or doctor of osteopathy
- Advanced practice registered nurse, including a nurse practitioner, nurse-midwife or clinical specialist
- Physician assistant
- Clinic, including a federally qualified health center (FQHC), primary care center or rural health clinic
- Primary care physician residents

Your PCP must:

- Have admitting rights at an in-network hospital or
- Have a formal referral agreement with an in-network PCP who has admitting rights at an in-network hospital and
- Agree to provide primary health care services 24 hours a day, 7 days a week
Family members do not have to have the same PCP.

**Second opinion**
Upon enrollment, you should have received a written notice regarding your right to ask for a second opinion for any covered health care services relating to:
- Surgical procedures
- Diagnosis and treatment of complex and/or chronic conditions

You can get a second opinion from an in-network or out-of-network provider. Call Member Services and we can help you find the right doctor. This is at no cost to you.
- Your PCP will also send copies of all related records to the doctor who will give the second opinion.
- Your PCP will tell you and us the outcome of the second opinion.

**If you had a different primary care provider before you joined Anthem Medicaid**
You may have been seeing a PCP who is not in our network for an illness or injury before you joined Anthem. In some cases, you may be able to keep seeing this PCP for care while you pick a new PCP so that you can still get care.
- Call Member Services to find out more.
- We will make a plan with you and your providers. This is so we all know when you will start seeing your new network PCP.

**If your primary care provider’s office moves, closes or leaves the network**
Your PCP’s office may move, close or leave our network. If this happens, you can call Member Services. We will:
- Call or send you a letter to tell you. In some cases, you may be able to keep seeing this PCP while you pick a new PCP.
- Make a plan with you and your PCP so we all know when you will start seeing your new Anthem network PCP.
- Help you pick a new PCP if you ask us for help.
- Send you a new member ID card within 10 working days after you pick your new PCP.

**How to change your primary care provider**
If you need to change your PCP, you may pick another PCP from the network. For a list of PCPs in our network, do one of the following:
- Look in the provider directory that came with your enrollment package.
- Go to [www.anthem.com/kymedicaid](http://www.anthem.com/kymedicaid) to view the provider directory online.
Call Member Services.
You may change your PCP 90 days after the initial assignment and once a year regardless of reason

When you ask to change your PCP:
• We can make the change the same day you ask for it
• The change will take effect no later than the next calendar day
• You will get a new Anthem member ID card in the mail within 10 working days
• You can still get care while you wait for your Anthem ID card

Call the PCP’s office if you want to make an appointment. The phone number is on your member ID card. If you need help, call Member Services. We will help you make the appointment.

If your primary care provider asks for you to be changed to another primary care provider
Your PCP may ask for you to be changed to another PCP. Your PCP may do this if:
• Your PCP does not have the right experience to treat you
• The assignment to your PCP was made in error (like an adult assigned to a child’s PCP)
• You fail to keep your appointments
• You do not follow your PCP’s medical advice over and over again
• Your PCP agrees that a change is best for you

If you want to go to a doctor who is not your primary care provider
If you want to go to a doctor who is not your PCP, talk to your PCP first. Your PCP may need to give you a referral so you can see another provider. This is done when your PCP cannot give you the care you need. If you go to a provider your PCP has not referred you to, the care you get may not be covered.
Please read the section Specialists to learn more about referrals. Also, read the sections Services That Do Not Need a Referral and If you get care from a doctor who is not in your health plan for more details about referrals and prior authorizations (or preapprovals).
Picking an OB/GYN
Female members can see a network obstetrician and/or gynecologist (OB/GYN) for OB/GYN health needs. These services include:

- Well-woman visits
- Prenatal care
- Care for any female medical condition
- Family planning
- Referral to a special provider within the network

You do not need a referral from your PCP to see an OB/GYN. If you don’t want to go to an OB/GYN, your PCP may be able to treat your OB/GYN health needs.

- Ask your PCP if he or she can give you OB/GYN care. If not, you will need to see an OB/GYN.
- Choose an OB/GYN from the list of OB/GYNs in our network.
  - Find the latest provider directory online at www.anthem.com/kymedicaid or
  - Call Member Services if you need help picking an OB/GYN

If you are pregnant, your OB/GYN can be your PCP. The nurses on our Care on Call line can help you decide if you should see your PCP or an OB/GYN.

Specialists
Your PCP can take care of most of your health care needs, but you may also need care from other kinds of providers. We offer services from many different kinds of providers who give other medically needed care. These providers are called specialists because they have training in a special area of medicine.

Examples of specialists are:

- Allergists (allergy doctors)
- Dermatologists (skin doctors)
- Cardiologists (heart doctors)
- Podiatrists (foot doctors)

Your PCP will refer you to a specialist in the network if he or she can’t give you the care you need.

In most cases, you need to have a referral from your PCP to see a specialist.

- Your PCP will give you a referral so you can see the specialist. The referral tells you and the specialist what kind of health care you need.
- Be sure to take the referral with you when you go to the specialist.
In a few cases, a referral is not needed. Read the section in this handbook Services That Do Not Need a Referral for more details.

Sometimes, a specialist can be your PCP. This may happen if you have a special health care need that is being taken care of by a specialist. If you believe you have special health care needs, you can:

- Talk to your PCP
- Call Member Services

**Lock-in program**

The Lock-in program is for members who need help with managing certain health care services such as specialty care or prescription medicines. If you are in the Lock-in program, you will be assigned to certain providers for:

- Primary care
- Controlled medicines
- Pharmacy services

If a specialty provider is medically needed, lock-in providers will decide who is approved by lock-in referral. Lock-in providers are not required to give services, medicines or referrals unless medically needed. Also, lock-in providers are not required to give services, medicines or referrals if you refuse to follow their medical advice.

If you access nonemergent services from a non-lock-in provider, you will be held liable for those medical bills. You must always arrange services through the assigned providers. If you are placed in the Lock-in program and have questions about how the program works, call Member Services at 1-855-690-7784 (TTY 711).

If you’re placed in the Lock-in program and wish to appeal this decision, you can appeal in two ways:

- Call Member Services at 1-855-690-7784 to start the appeal or
- Send us a letter asking for an appeal to:
  Anthem Blue Cross and Blue Shield Medicaid
  13550 Trition Park Blvd
  Louisville, KY 40223

If you call us, you must also follow up in writing.

If you disagree with the findings of your appeal, you or your approved representative may ask for a Medicaid state fair hearing within 45 calendar days of the final appeal
notice of nonapproval. A hearing officer at the Administrative Hearing Branch will conduct the state fair hearing.

To ask for a state fair hearing, send a letter to:
Kentucky Cabinet for Health and Family Services
Department for Medical Services
Division of Program Quality and Outcomes
275 E. Main St., 6C-C
Frankfort, KY 40621-0001
Phone: 1-800-372-2973 (TTY 1-800-627-4702)

Include:
- A copy of the final appeal notice of nonapproval
- Any other information you would like the hearing officer to consider

If the decision to assign you to certain providers is overturned, we will let you know, and the restriction will end.

Access to providers
All Anthem Medicaid provider offices are required to comply with applicable federal, state and local laws, including ADA. These locations must provide adequate space, supplies, sanitation and fire and safety procedures applicable to health care facilities. If you have a problem with any of these things at a provider facility, call Member Services.

GOING TO THE PRIMARY CARE PROVIDER

Your first primary care provider appointment
You can call your primary care provider (PCP) to set up your first visit.
- Call your PCP for a wellness visit (a general checkup) within 90 days of enrolling.
- If you have already been seeing the PCP who is now your Anthem network PCP, call the PCP to see if it is time for you to get a checkup. If it is, set up a visit as soon as you can.
- If you want help setting up your first visit, just call Member Services.

By finding out more about your health now, your PCP can take better care of you if you get sick.

How to make an appointment
It is easy to set up a visit with your PCP.
- Call the PCP’s office. The phone number is on your Anthem ID card.
- Let them know what you need (for example, a checkup or a follow-up visit).
- Tell the PCP’s office if you are not feeling well. This will let them know how soon you need to be seen.

If you need help, call Member Services. We will help you make the appointment.

**Wait times for appointments**
We want you to be able to get care at any time. When your PCP’s office is closed, an answering service will take your call. Your PCP or a partner on call should call you back within 30 minutes. Talk to your PCP or the partner on call and set up an appointment.

You will be able to see providers as follows:

<table>
<thead>
<tr>
<th><strong>Emergency medical services</strong></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Facilities with emergency medical services</td>
<td>Available 24 hours a day, 7 days a week</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Urgent care clinics or smaller walk-in clinics</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Offer extended hours and many provide a full range of medical services for all ages</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Visits to your primary care provider</strong>*</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine, nonurgent or preventive care visits</td>
<td>Within 30 days of request</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 48 hours of request</td>
</tr>
</tbody>
</table>
### Visits to a specialist*

| Referral appointments | • Within 30 days of referral for routine care  
|                       | • Within 48 hours for urgent care  
| Behavioral health services | • Life threatening emergency — immediately  
|                         | • Crisis stabilization — within 24 hours for emergency care  
|                         | • Urgent care — within 48 hours  
|                         | • Care by a behavioral health provider after discharge from inpatient care — within seven calendar days  
|                         | • Routine behavioral health care — within 30 calendar days  

### Hospital care

| Transport time | • May not exceed 30 minutes for urban areas  
|               | • May not exceed 60 minutes for nonurban areas and behavioral health or physical rehab services  

### General dental services

| Regular appointments | Within three weeks of request  
| Urgent care | Within 48 hours of request  

### General vision, lab and radiology services

| Regular appointments | Within 30 days of request  
| Urgent care | Within 48 hours of request  

### Visits for initial prenatal care*

| Newly enrolled pregnant women in the first trimester | Within 14 days of request for an appointment  
| Members who become pregnant | Within 42 days of request for an appointment  
| Newly enrolled pregnant women in the second trimester | Within seven days of postmark date on your new member welcome packet  
| Newly enrolled pregnant women in the third trimester | Within three days of postmark date on your new member welcome packet  

*Same-day, medically needed appointments are also available during normal business hours.

When you go to your PCP’s or specialist’s office for your appointment, you should not have to wait more than 45 minutes to be seen, unless your provider is delayed. Your PCP or specialist may be delayed if he or she needs to work in an urgent case.
If this happens, you should be told right away. If your PCP or specialist expects the wait to be more than 90 minutes, you should be offered a new appointment.

**What to bring when you go for your appointment**

When you go to your PCP’s office for your visit, be sure you bring:

- Your Anthem member and Medicaid ID cards
- Any medicines you take now
- Any questions you may want to ask your PCP

If the appointment is for your child, be sure you bring your child’s:

- Anthem member and Medicaid ID cards
- Shot records
- Any medicine your child takes now

**How to cancel an appointment**

If you make an appointment with your PCP and then can’t go:

- Call the PCP’s office or call Member Services if you want us to cancel the appointment for you.
  - Try to call at least 24 hours before you are supposed to be there.
  - This will let someone else see the PCP at that time.
- Tell the office to cancel the visit.
- Make a new appointment when you call.

If you do not call to cancel your PCP visits over and over again, your PCP may ask for you to be changed to a new PCP.

**How to get to a doctor appointment or to the hospital**

If you need to arrange transportation:

- For nonemergency covered medical services, call the Office of Transportation Delivery at 1-888-941-7433 (TTY 1-800-648-6056).
- For nonemergency ambulance services with a stretcher, call Member Services for help with arranging this service.

**If you have an emergency and need transportation, call 911 for an ambulance.**

- Be sure to tell the hospital staff you are a member of Anthem Blue Cross and Blue Shield Medicaid.
- Call your PCP as soon as you can so your PCP can:
  - Arrange your treatment
Help you get the needed hospital care

**Disability access to network providers and hospitals**

Network providers and hospitals should help members with disabilities get the care they need. If you use a wheelchair, walker or other aid, you may need help getting into an office. If you need a ramp or other help:

- Make sure your provider’s office knows this before you go there. This will help them be ready for your visit.
- Call Member Services if you want help talking to your doctor about your special needs.

**WHAT DOES MEDICALLY NECESSARY MEAN?**

Your primary care provider (PCP) will help you get medically-needed covered services as defined below.

- **Medically-needed covered services** mean health care services that are: Needed to find, cure, ease or stop a disease, sickness, wound, handicap or other health condition, as well as pregnancy
- In keeping with generally-accepted standards of good health practice
- Given for reasons other than convenience of the patient, patient’s caregiver, health care provider, or for cosmetic reasons
- Given in the most proper setting, keeping in mind generally-accepted professional health standards, where the aid may be safely and effectively provided
- Needed and recognized as an emergency medical service, by the average person
- Given along with early and periodic screening, diagnosis and treatment (EPSDT) requirements for patients under 21 years old, as needed to correct or improve physical defects and mental illnesses and conditions

The following are excluded from Medicaid coverage and deemed not medically needed:

- Experimental services
- Investigational services
- Cosmetic services
- Services not approved by the Food and Drug Administration (FDA)

**AFFIRMATIVE STATEMENT**

Anthem Blue Cross and Blue Shield Medicaid follows quality standards set forth by the National Committee for Quality Assurance. All utilization management decisions are based solely on a member’s medical needs and the benefits offered. Anthem policies do
not support underuse of services through our utilization management decision process. Practitioners or others involved in utilization management decisions do not get any type of reward for denial of care or coverage.

YOUR HEALTH CARE BENEFITS

Anthem covered services
Below is a summary of the health care services your health plan covers when you need them. Your PCP will either:
• Give you the care you need
• Refer you to a provider who can give you the care you need

In some cases, your PCP may need to get prior approval from us before you can get a service. Your PCP will work with us to get approval for covered services. We will be liable only for those services that have been approved.

If you have a question or are not sure if we offer a certain service or if there are coverage limits, you can call Member Services for help.

Below is a list of the services covered under your Anthem Medicaid health care plan.

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>COVERAGE LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALTERNATIVE BIRTHING CENTER SERVICES</td>
<td>Covered maternity services include:</td>
</tr>
<tr>
<td></td>
<td>• Nurse-midwife services</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy-related services</td>
</tr>
<tr>
<td></td>
<td>• Services for other conditions that might complicate pregnancy</td>
</tr>
<tr>
<td></td>
<td>• 60 days postpartum pregnancy-related services</td>
</tr>
<tr>
<td>AMBULATORY SURGICAL CENTER SERVICES</td>
<td>Covered services include but are not limited to:</td>
</tr>
<tr>
<td></td>
<td>• General surgery</td>
</tr>
<tr>
<td></td>
<td>• Gynecology</td>
</tr>
<tr>
<td></td>
<td>• Ophthalmology</td>
</tr>
<tr>
<td></td>
<td>• Orthopedics</td>
</tr>
<tr>
<td></td>
<td>• Otolaryngology</td>
</tr>
<tr>
<td></td>
<td>• Plastic surgery, if not for cosmetic reasons</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>COVERAGE LIMITS</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>• Pain blocks</td>
</tr>
<tr>
<td></td>
<td>• Podiatry</td>
</tr>
<tr>
<td></td>
<td>• Urology</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHIROPRACTIC SERVICES</th>
<th>Coverage as medically needed. Services include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Evaluation and management services</td>
</tr>
<tr>
<td></td>
<td>• Chiropractic manipulative treatment</td>
</tr>
<tr>
<td></td>
<td>• Diagnostic X-rays</td>
</tr>
<tr>
<td></td>
<td>• Application of the following to one or more areas:</td>
</tr>
<tr>
<td></td>
<td>- Hot or cold pack</td>
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<tr>
<td></td>
<td>- Mechanical traction</td>
</tr>
<tr>
<td></td>
<td>- Electrical stimulation</td>
</tr>
<tr>
<td></td>
<td>- Ultrasound</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMMUNITY MENTAL HEALTH CENTER SERVICES</th>
<th>Covered services through a community mental health center include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Inpatient and outpatient services</td>
</tr>
<tr>
<td></td>
<td>• Therapeutic rehab services</td>
</tr>
<tr>
<td></td>
<td>• Emergency services</td>
</tr>
<tr>
<td></td>
<td>• Personal home care services</td>
</tr>
</tbody>
</table>

<p>| DENTAL CARE | Covered services include: |
|            | Adults                    |
|            |   • Oral exams            |
|            |   • Emergency visits      |
|            |   • X-rays and extractions|
|            |   • Fillings              |
|            | Children under age 21     |
|            |   • Oral exams            |
|            |   • Emergency visits      |
|            |   • X-rays and extractions|
|            |   • Fillings for all ages |
|            |   • Root canal therapy, crowns and sealants (for severe conditions)* |
|            |   • Prosthodontics         |
|            |   • Denture repair        |</p>
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>COVERAGE LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Oral surgery</td>
<td></td>
</tr>
<tr>
<td>- Braces (for severe conditions)*</td>
<td></td>
</tr>
<tr>
<td>*Prior approval is required.</td>
<td></td>
</tr>
<tr>
<td>DURABLE MEDICAL EQUIPMENT (DME)</td>
<td>Covered as medically needed. Services include:</td>
</tr>
<tr>
<td></td>
<td>- Wheelchairs</td>
</tr>
<tr>
<td></td>
<td>- Hospital beds</td>
</tr>
<tr>
<td></td>
<td>- Orthotic appliances (foot/leg braces)</td>
</tr>
<tr>
<td></td>
<td>- Prosthetic devices (artificial limbs)</td>
</tr>
<tr>
<td></td>
<td>- Disposable medical equipment</td>
</tr>
<tr>
<td></td>
<td>Some items may require prior approval.</td>
</tr>
<tr>
<td>EARLY PERIODIC SCREENING,</td>
<td>EPSDT screenings</td>
</tr>
<tr>
<td>DIAGNOSIS AND TREATMENT (EPSDT)</td>
<td>This program gives routine physicals and well-child checkups for Medicaid members</td>
</tr>
<tr>
<td>WELL-CHILD VISITS</td>
<td>under age 21. Children are checked for medical problems early. Services include:</td>
</tr>
<tr>
<td></td>
<td>- Preventive checkups</td>
</tr>
<tr>
<td></td>
<td>- Growth and development assessments</td>
</tr>
<tr>
<td></td>
<td>- Vision tests</td>
</tr>
<tr>
<td></td>
<td>- Hearing tests</td>
</tr>
<tr>
<td></td>
<td>- Immunizations</td>
</tr>
<tr>
<td></td>
<td>- Lab tests</td>
</tr>
<tr>
<td></td>
<td><strong>EPSDT special services</strong></td>
</tr>
<tr>
<td></td>
<td>This program:</td>
</tr>
<tr>
<td></td>
<td>- Covers medically needed items or services not covered in other Medicaid programs</td>
</tr>
<tr>
<td></td>
<td>- May only be given to persons under age 21</td>
</tr>
<tr>
<td></td>
<td>- Requires prior approval for services</td>
</tr>
<tr>
<td></td>
<td>Call your child’s PCP to schedule checkups and screenings.</td>
</tr>
<tr>
<td>END-STAGE RENAL DIALYSIS SERVICES</td>
<td>Covered services include:</td>
</tr>
<tr>
<td></td>
<td>- Inpatient dialysis</td>
</tr>
<tr>
<td></td>
<td>- Outpatient dialysis</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>COVERAGE LIMITS</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>FAMILY PLANNING CLINIC SERVICES</strong></td>
<td>Covered services include:</td>
</tr>
<tr>
<td></td>
<td>• Physical exams</td>
</tr>
<tr>
<td></td>
<td>• Lab and clinical test supplies</td>
</tr>
<tr>
<td></td>
<td>• Educational materials</td>
</tr>
<tr>
<td></td>
<td>• Counseling and prescribed birth control methods to best suit a person’s needs</td>
</tr>
<tr>
<td><strong>HEARING SERVICES</strong></td>
<td>Covered services for members under age 21 include:</td>
</tr>
<tr>
<td></td>
<td>• Hearing and hearing aid checkups</td>
</tr>
<tr>
<td></td>
<td>• Hearing aids</td>
</tr>
<tr>
<td></td>
<td>• Follow-up visits and checkups</td>
</tr>
<tr>
<td></td>
<td>• Certain hearing aid repairs</td>
</tr>
<tr>
<td><strong>HOME HEALTH SERVICES</strong></td>
<td>Covered services include:</td>
</tr>
<tr>
<td></td>
<td>• Skilled nursing services</td>
</tr>
<tr>
<td></td>
<td>• Physical, speech and occupational therapies</td>
</tr>
<tr>
<td></td>
<td>• Nonroutine medical supplies</td>
</tr>
<tr>
<td></td>
<td>• Medical social services</td>
</tr>
<tr>
<td></td>
<td>• Home health aide services</td>
</tr>
<tr>
<td></td>
<td>Prior approval is required to ensure services:</td>
</tr>
<tr>
<td></td>
<td>• Are medically needed</td>
</tr>
<tr>
<td></td>
<td>• Meet the needs of the individual</td>
</tr>
<tr>
<td><strong>HOSPICE SERVICES (NONINSTITUTIONAL)</strong></td>
<td>Covered services include:</td>
</tr>
<tr>
<td></td>
<td>• Nursing services</td>
</tr>
<tr>
<td></td>
<td>• Counseling services for patients and their families, including dietary, spiritual and bereavement</td>
</tr>
<tr>
<td></td>
<td>• Physical therapy, occupational therapy, speech-language pathology</td>
</tr>
<tr>
<td></td>
<td>• Home health aide and homemaker services</td>
</tr>
<tr>
<td></td>
<td>• Medical supplies</td>
</tr>
</tbody>
</table>

We cover hospice care for members who choose it and have a terminal illness with a life expectancy of six months or less. Hospice care must be reasonable and necessary to manage the member’s illness and conditions.
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>COVERAGE LIMITS</th>
</tr>
</thead>
</table>
| For children, we cover Hospice services as needed, even when the child is still being treated with medication or other medical services in an attempt to cure a terminal or life-threatening disease | • Short-term inpatient care  
• Medical social services  

When needed, special coverage of some services will be offered during periods of crisis or for respite care.  
Hospice benefits consist of these benefit periods:  
• Two 90-day periods  
• One 60-day period  
Each benefit period must be recertified. |
| INDEPENDENT LABORATORY SERVICES                                                | Covered services include medically needed lab services.  
Certain limits apply. Prior approval is not required. |
| INPATIENT HOSPITAL SERVICES                                                    | Covered services include inpatient hospital services that are medically needed.  
Certain limits apply. Copays may apply for certain services. |
| INPATIENT MENTAL HEALTH SERVICES                                               | Certain limits apply. Prior approval is required. |
### COVERED SERVICES

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>COVERAGE LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICAL DETOXIFICATION</strong></td>
<td>Covered services include:</td>
</tr>
<tr>
<td></td>
<td>• Detoxification programs offering supervised nonmedical withdrawal from an alcohol or other drug-induced intoxication and an assessment of a member’s need for further care, including referrals to appropriate resources and</td>
</tr>
<tr>
<td></td>
<td>• The management of symptoms during the acute withdrawal phase from a substance to which the member has been addicted to</td>
</tr>
<tr>
<td><strong>MEDICAL SERVICES</strong></td>
<td>Covered services include services provided by:</td>
</tr>
<tr>
<td></td>
<td>• Physicians</td>
</tr>
<tr>
<td></td>
<td>• Advance practice registered nurses</td>
</tr>
<tr>
<td></td>
<td>• Physician assistants</td>
</tr>
<tr>
<td></td>
<td>• Federally qualified health centers (FQHCs)</td>
</tr>
<tr>
<td></td>
<td>• Primary care centers</td>
</tr>
<tr>
<td></td>
<td>• Rural health clinics (RHCs)</td>
</tr>
<tr>
<td><strong>MEN’S HEALTH SERVICES</strong></td>
<td>• Preventive exams</td>
</tr>
<tr>
<td></td>
<td>• Screenings, such as a prostate exam or screening for an abdominal aortic aneurysm</td>
</tr>
<tr>
<td></td>
<td>• Testing for sexually transmitted diseases</td>
</tr>
<tr>
<td><strong>ORGAN TRANSPLANT SERVICES</strong></td>
<td>Covered services include medically needed organ transplants performed in an acute care facility set to perform transplants.</td>
</tr>
<tr>
<td></td>
<td>Certain limits apply.</td>
</tr>
<tr>
<td></td>
<td>Transplant procedures thought to be experimental are not covered.</td>
</tr>
<tr>
<td><strong>OTHER LAB AND X-RAY SERVICES</strong></td>
<td>Covered services include:</td>
</tr>
<tr>
<td></td>
<td>• X-rays</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>COVERAGE LIMITS</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>• Ultrasounds</td>
<td></td>
</tr>
<tr>
<td>• Computer-assisted tomography (CAT)</td>
<td></td>
</tr>
<tr>
<td>• Magnetic resonance imaging (MRI)</td>
<td></td>
</tr>
<tr>
<td>Certain limits apply. Prior approval is required.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTPATIENT HOSPITAL SERVICES</th>
<th>Certain outpatient hospital and emergency room services are covered, including:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Outpatient surgery (performed in an outpatient hospital setting)</td>
</tr>
<tr>
<td></td>
<td>• Cardiac catheterization</td>
</tr>
<tr>
<td></td>
<td>• Computed tomography (CT) imaging</td>
</tr>
<tr>
<td></td>
<td>• Magnetic resonance imaging (MRI)</td>
</tr>
<tr>
<td></td>
<td>• Ultrasound, following second obstetric ultrasound</td>
</tr>
<tr>
<td></td>
<td>Prior approval is required.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTPATIENT MENTAL HEALTH SERVICES</th>
<th>Covered services include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Individual therapy</td>
</tr>
<tr>
<td></td>
<td>• Group therapy</td>
</tr>
<tr>
<td></td>
<td>• Family therapy (if stated in the plan of care)</td>
</tr>
<tr>
<td></td>
<td>• Intensive in-home services (for children under age 21 who are at risk of being placed outside the home in a psychiatric hospital or hospital unit, residential treatment facility, or foster care)</td>
</tr>
<tr>
<td></td>
<td>• Home visits (if needed to assess difficult cases, provide help right away with a family crisis or offer outreach in high-risk cases)</td>
</tr>
<tr>
<td></td>
<td>• Mobile crisis services</td>
</tr>
<tr>
<td></td>
<td>• Personal care home services</td>
</tr>
<tr>
<td></td>
<td>• Therapeutic rehab services (for adults and children)</td>
</tr>
<tr>
<td></td>
<td>• Partial hospitalization services</td>
</tr>
</tbody>
</table>

Outpatient mental health services are:
- Provided according to a plan of care
- Given on a regularly scheduled basis, with nonscheduled visits arranged during times of increased stress or crisis
- The first point to detect and assess psychiatric problems and
- The source of referrals to other services and agencies
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>COVERAGE LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHARMACY</strong></td>
<td>Certain limits apply.</td>
</tr>
<tr>
<td>Pharmacy and limited over-the-counter drugs, including mental/behavioral health drugs are covered.</td>
<td>We have a list of commonly prescribed drugs. Your doctor can choose from this list of drugs to help you get well. This list is called a preferred drug list (PDL). The covered medicines on the PDL include prescriptions and some over-the-counter medicines.</td>
</tr>
</tbody>
</table>

For a complete list of Anthem network pharmacies:
- Go to [www.anthem.com/kymedicaid](http://www.anthem.com/kymedicaid) to view the provider directory online or
- Call Member Services to request a provider directory

If you do not know if a pharmacy is in our network, ask the pharmacist. You can also call Member Services.

- You, your doctor or your child’s doctor and your pharmacy have access to this drug list; you can view the PDL online at [www.anthem.com/kymedicaid](http://www.anthem.com/kymedicaid).
- Your doctor or your child’s doctor or specialist should use this list when he or she writes a prescription.
- Nonpreferred drugs and certain medicines on the PDL need prior approval.
- You can get an emergency supply of drugs as part of your pharmacy benefits if you need them right away. We’ll pay for a 72-hour supply of the drug if you’re still waiting for prior approval from us and your pharmacy can’t reach your doctor.

Here’s a list of things to remember:
- Take the prescription from your provider to the pharmacy, or your provider can call in the prescription; certain medicines require a written prescription.
- Show your Anthem member ID card to the pharmacy.
- If you use a new pharmacy, tell the pharmacist about all of the medicines you
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>COVERAGE LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVERED SERVICES</td>
<td>are taking; include over-the-counter medicines, too.</td>
</tr>
<tr>
<td>PODIATRY SERVICES</td>
<td>Covered services include a wide range of podiatry services:</td>
</tr>
<tr>
<td></td>
<td>• Routine foot care is covered for certain medical conditions.</td>
</tr>
<tr>
<td></td>
<td>• These conditions must need skilled care.</td>
</tr>
<tr>
<td>PREVENTIVE HEALTH SERVICES</td>
<td>Coverage includes these medically needed preventive, screening, diagnostic,</td>
</tr>
<tr>
<td></td>
<td>rehab and remedial services:</td>
</tr>
<tr>
<td></td>
<td>• Chronic disease service</td>
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<tr>
<td></td>
<td>• Communicable disease service</td>
</tr>
<tr>
<td></td>
<td>• Early and periodic screening, diagnosis and treatment (EPSDT) service</td>
</tr>
<tr>
<td></td>
<td>• Family planning service</td>
</tr>
<tr>
<td></td>
<td>• Maternity service</td>
</tr>
<tr>
<td></td>
<td>• Pediatric service</td>
</tr>
<tr>
<td>PSYCHIATRIC RESIDENTIAL</td>
<td>Psychiatric Residential Treatment Facilities (PRTFs) services are covered for</td>
</tr>
<tr>
<td>TREATMENT</td>
<td>members ages 6 to 21. These members need treatment on an ongoing basis due to:</td>
</tr>
<tr>
<td></td>
<td>• A severe mental illness or</td>
</tr>
<tr>
<td></td>
<td>• A severe psychiatric illness</td>
</tr>
<tr>
<td></td>
<td>PRTFs serve children who:</td>
</tr>
<tr>
<td></td>
<td>• Need long-term, more intense care and a more structured setting than they can</td>
</tr>
<tr>
<td></td>
<td>can get in family and other community-based options to hospitals</td>
</tr>
<tr>
<td></td>
<td>• Are moving from hospitals but are not ready to live at home or in a foster home</td>
</tr>
<tr>
<td></td>
<td>Prior approval is required.</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>COVERAGE LIMITS</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| SPECIALIZED CASE MANAGEMENT SERVICES                  | Coverage includes targeted case management for members:  
  - Age 18 and older with severe mental illnesses  
  - Under age 21 with severe emotional disabilities  
  Covered services when provided by a qualified case manager include:  
  - Assessing the member’s needs  
  - Arranging needed services based on the assessment  
  - Helping the member and family in accessing needed services  
  - Monitoring progress  
  - Performing advocacy activities on behalf of the member and family  
  - Setting up and keeping case records  
  - Doing crisis assistance planning |
| SPECIALIZED CHILDREN’S SERVICES CLINICS                | Covered services for children under age 21 with physical special needs include:  
  - Medical services such as office visits, surgery and hospitalization  
  - Therapy services  
  - Related lab and follow-up care  
  Certain limits apply. Prior approval is required. |
| THERAPY EVALUATION AND TREATMENT                       | Coverage includes therapy evaluation and treatment, including:  
  - Physical therapy  
  - Speech therapy  
  - Occupational therapy |
| TRANSPORTATION TO COVERED SERVICES                    | We cover:  
  - Emergency ambulance stretcher services |
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>COVERAGE LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonemergency ambulance stretcher services</td>
<td>If you need nonemergency transportation to Medicaid-covered services, call the Office of Transportation Delivery at 1-888-941-7433 (TTY 1-800-648-6056) to set up a ride. If you have an emergency, call 911 or go to the nearest emergency room right away.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Covered services include:</td>
</tr>
<tr>
<td>Medically needed emergency care services</td>
<td>• Urgent care</td>
</tr>
<tr>
<td></td>
<td>• Medically needed emergency care services</td>
</tr>
<tr>
<td></td>
<td>Copays may apply for emergency room visits that are not emergencies.</td>
</tr>
<tr>
<td>Vision care</td>
<td>Covered services include:</td>
</tr>
<tr>
<td>For all members</td>
<td>• Exams and certain diagnostic procedures performed by ophthalmologists and optometrists</td>
</tr>
<tr>
<td></td>
<td>For members under age 21</td>
</tr>
<tr>
<td></td>
<td>• Professional dispensing (ordering) services, lenses, frames and repairs</td>
</tr>
<tr>
<td>Women’s health services</td>
<td>Routine OB/GYN care</td>
</tr>
<tr>
<td></td>
<td>Cervical cancer screenings, Pap smears and HPV testing</td>
</tr>
<tr>
<td></td>
<td>Breast cancer screening</td>
</tr>
<tr>
<td></td>
<td>Chlamydia testing</td>
</tr>
<tr>
<td></td>
<td>Osteoporosis screening</td>
</tr>
<tr>
<td>Smoking cessation classes and tobacco cessation drugs</td>
<td>Covered services include 12 one-hour weekly sessions that support:</td>
</tr>
<tr>
<td></td>
<td>• How to use nicotine patches, lozenges, or gum to deal with cravings for nicotine.</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>COVERAGE LIMITS</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>• How to handle urges to smoke.</td>
</tr>
<tr>
<td></td>
<td>• How to avoid weight gain.</td>
</tr>
<tr>
<td></td>
<td>• How to support and be supported by other nonsmokers.</td>
</tr>
<tr>
<td></td>
<td>• Tobacco cessation drugs, including brand name and generic, are covered for first time use — no prior authorization needed.</td>
</tr>
</tbody>
</table>

Extra benefits
We also offer our members special benefits and services like:

• No copays
• Free eyeglasses or a credit for contacts for adults 21 years of age and older
• Our prenatal program with:
  ▪ Free crib or car seat when you go to your PCP or OB/GYN at least seven times while you are pregnant
  ▪ Free gift card when you get prenatal and postpartum checkups on time, plus health resources and coaching
• Free sports physicals for members 6-18
• Free cellphone with monthly minutes, texts and data, plus free calls to Member Services and health coaching
• Free Entertainment® Book with discounts on local and online retailers
• Anthem Kids Club, our program for kids ages 5-12 — join the adventures with Habit Heroes as they show kids and adults how to practice healthy habits
• Health A to Z, our online health and wellness information site, with a symptom checker, health encyclopedia and support groups
• Free Care on Call to speak to a nurse about your medical questions or concerns 24 hours a day, 7 days a week, 365 days a year
• Free disease management programs to help you manage difficult health conditions like asthma, diabetes and COPD
• Free health education materials and resources
• Reminders to help you visit your doctor, get your kids shots and renew your health care coverage
• Free hearing aid batteries in common sizes of 10, 13, 312 or 675
• **Free tornado preparedness kit** with tips on how to prepare for a tornado, lessen the risk and create a family communication plan

We give you these benefits to help you stay healthy and to thank you for choosing Anthem Blue Cross and Blue Shield Medicaid as your health care plan.

**SERVICES COVERED UNDER THE KENTUCKY STATE PLAN OR FEE-FOR-SERVICE MEDICAID**

Some services are covered by the Kentucky fee-for-service Medicaid program instead of Anthem. These services are called carved-out services. Even though we do not cover these services, your primary care provider (PCP) or specialist will:

• Give all required referrals
• Assist in setting up these services

Carved out benefits include:

• Community- and home-based services for older and physically disabled persons
• Long-term care services
• School based services for children, except for services provided by a doctor, physician assistant, advanced registered nurse practitioner or Registered Nurse who works for the Public Health Department
• Services provided by HANDS for pregnant and new parents

For details on how you can access these services, call the Kentucky Cabinet for Health and Family Services (CHFS), Department for Medicaid Services at 1-502-564-3130.

**PRIOR AUTHORIZATIONS**

Some services and benefits require prior approval. This means that your provider must ask us to approve those services before you get them. Services that require prior authorization include:

• MRA
• MRI
• CAT scans
• Nuclear Cardiac
• ECHO
• All Inpatient services
• All out-of-network services
If you need to receive authorization, contact your provider who will call Provider Services to obtain one for you.

These services do not require prior approval:
- Emergency services
- Post-stabilization services
- Urgent care
- Family planning services

If your Service Authorization Request is denied and you proceed to get the service and appeal the denial, you may be liable for the cost, if the appeal is in Anthem’s favor. Contact Member Services at 1-855-690-7784 (TTY 711) if you have any questions.

**UTILIZATION MANAGEMENT NOTICE**

Sometimes, we need to make decisions about how we cover care and services. This is called utilization management (UM). Our UM process is based on the standards of the National Committee for Quality Assurance (NCQA). 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 health care.
- We don’t tell or encourage providers to underuse services.
- Providers and others involved in UM decisions do not get any type of reward for limiting or denying care.
- We don’t base our decision to contract with providers on whether they might or we think they might deny or would be likely to 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 STAFF

We have a Utilization Review team that looks at service approval requests. The team will decide if:
- The service is needed
- The service is covered by your health plan

You or your doctor can ask for a review if we say we will not pay for care. We will let you and your doctor know after we get the 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 questions about an approval request or a denial you received, call Member Services. A member of our Utilization Review team can speak with you if you like.

For members who do not speak English, we offer free oral interpretation services for all languages. If you need these services, Member Services can help. If you are deaf or hard of hearing, call 711.

HEALTH RISK ASSESSMENT

Helping you stay healthy is what Anthem does best. And it starts when you join our plan.

We’ll ask you to complete a health risk assessment to help us:
- Learn about your health and
- Arrange your care in a way that meets your individual needs

It’s simple and only takes a few minutes to do. You can:
- Log in and complete the health questions online at www.anthem.com/kymedicaid or
- Fill out and return the paper copy you receive in the mail

Based on your answers, you may qualify for case management. We may also ask you to complete a more comprehensive health assessment. **There is no charge to you for this service.** If you agree to case management, we can help you get the services you need, and we’ll get more information about your needs.

Questions?
Call us toll free at 1-855-690-7784 (TTY 711) from 7 a.m. to 7 p.m. Eastern time, Monday through Friday.

The information you share with us will remain private and will not be shared with anyone who does not need to know about it.

**CASE MANAGEMENT**

We provide case management for members eligible for Medicaid and KCHIP services. A case manager will work with you and your family (or a representative) to look at your strengths and needs.

The review should result in a service 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 health care needs
- Developing a plan of care
- 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 functioning to help them in planning, delivering and monitoring services

To collect and assess this information, your case manager will conduct phone interviews or home visits with you and your representative, if you have one. To complete the assessment, the case manager will also get information from your PCP, specialist and other sources to set up and decide your current medical and nonmedical service needs.

You can also call Member Services if you think you need case management services. Member Services will refer you to our Case Management department.

**CARE COORDINATION**

Our Care Coordination program offers individualized services to support the behavioral, social, environmental and functional needs of members.

**What does care coordination mean to you?**
It means a member-centric service provided by a trained Case Management nurse, social worker or specialist; service coordination includes but is not limited to:

- Identifying your needs
- Conducting a brief health assessment
- Deciding a course of action with you

**What can you expect from your care coordinator?**

Your care coordinator will:

- Conduct phone interviews to evaluate your physical, behavioral, functional, social and long-term service needs
- If needed and you agree, include your family members and natural supports to help assess your needs
- Work with you to develop a plan to address your individual needs identified during your discussions with us
- Help coordinate timely access to providers
- At a minimum, contact you every three months to:
  - Review your care needs
  - Ensure your needs are met and services are provided

**EPSDT Care Coordination program**

- The EPSDT Care Coordination program is all about helping kids stay healthy and making sure they get the preventive care they need as they grow up. This program is available at no cost to you.

**SERVICES THAT DO NOT NEED A REFERRAL**

It is always best to ask your primary care provider for a referral. But you can get these services without a referral from your primary care provider:

- Preventive and routine services from a network OB/GYN, including physicians, physician assistants and nurse practitioners within the scope of their practice
- Primary vision, dental and oral surgery services, as well as exams by orthodontists and prosthodontists
- Special health care needs that require a special course of treatment or need to be checked on a regular basis
- EPSDT screenings
- Routine shots
- Screening or testing for sexually transmitted diseases, including HIV
- Family planning
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.

DIFFERENT TYPES OF HEALTH CARE

Routine, urgent and emergency care: What’s the difference?

Routine care
In most cases when you are not feeling well and need medical care, you call your primary care provider (PCP) to make an appointment. Then you go to see your PCP. This type of care is known as routine care.

Some examples are:
- Most minor illnesses and injuries
- Regular checkups

You should be able to see your PCP within two weeks for routine care. But this is only part of your PCP’s job. Your PCP also takes care of you before you get sick. This is called wellness care. See the section in this handbook Wellness Care for Children and Adults.

Urgent care
You should seek urgent care if you have a condition that’s not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment.

Some examples are:
- Throwing up
- Minor burns or cuts
- Earaches
- Headaches
- Sore throat
- Fever over 101 degrees Fahrenheit
- Muscle sprains/strains

If you need urgent care:
- Call your PCP. Your PCP will tell you what to do.
- Follow your PCP’s instructions. Your PCP may tell you to go to:
  - His or her office right away
  - Some other office to get immediate care
  - The emergency room at a hospital for care; see the next section about emergency care for more details

You can also call Care on Call at 1-866-864-2544 if you need advice about urgent care.

**Emergency care**
What’s an emergency? **An emergency is when you need to get care right away.** If you don’t get it, it could cause your death. It could also cause very serious harm to your body. This means that someone with an average knowledge of health and medicine can tell the problem may threaten your life or cause serious harm to your body or harm your unborn child if you are pregnant.

Here are some examples of problems that are most likely emergencies:
- Trouble breathing
- Chest pains
- Loss of consciousness
- Very bad bleeding that does not stop
- Very bad burns
- Shakes called convulsions or seizures

If you have an emergency, do one of the following:
- Call 911.
- Go to the nearest hospital emergency room.

You should be able to see a physician right away. Medical emergencies do not need prior approval by Anthem.

After you visit the emergency room:
- Call your PCP as soon as you can.
- If you cannot call, have someone else call for you.
Your PCP will give or set up any follow-up care you need. This is called **post-stabilization care**. You get these services to help keep your condition stable. These services do not need prior approval by Anthem.

**How to get health care when your primary care provider’s office is closed**

Except in the case of an emergency (see previous section) or when you need care that does not need a referral, you should always call your PCP **first** before you get medical care. If you call your PCP’s office when it is closed, your call will be answered by:

- An answering service that will contact your PCP or another designated medical practitioner or
- A recording directing you to call another number to reach your PCP or another medical practitioner whom your PCP has designated to return the call

If it is not an emergency, someone should call you back soon within 30 minutes to tell you what to do. You may also call Care on Call for help.

**If you think you need emergency services, call 911 or go to the nearest emergency room right away.**

**When you are out of the service area or can’t get to a doctor in your plan**

The Anthem Medicaid service area includes all of Kentucky and some surrounding areas. Any provider signed up with Anthem Medicaid is a provider who’s in your plan.

- **If you need routine or urgent care,** call your primary care provider (PCP). Your PCP will tell you what to do.

- **If you see a provider who is out of our service area,** you may have to pay the bill. The provider must be willing to bill Anthem Medicaid, get a Medicaid ID number and call us before you get the service to approve care. You can also get in touch with Member Services if you need help finding provider in your area that’s signed up with us.

- **If there isn’t a provider in your plan available for you to get covered services,** if medically necessary, we’ll pay for your visit to a provider who’s not in your plan.

- **Emergency care is covered as part of your benefits inside and outside the service area.** If you are not in the service area and have a true emergency, go to the nearest emergency room. A true emergency is when you think a medical situation is a threat to your life or long-term health if you don’t get care right away.
• **Out-of-state EPSDT services** If your child needs EPSDT services and you’re either out of state or can’t get the services your child needs locally, we’ll cover those services if:
  - The out-of-state services are required because of an emergency.
  - Your child’s health would be at risk if he or she had to travel back to your home state.
  - The needed services are easier to get in the other state.
  - The area you’re in usually uses the services of an out-of-state provider, like in areas that border another state.

• We include out-of-state providers to help make sure you or your child can choose from a variety of services and have access to the care he or she needs.

*If you are outside of the United States and get health care services, they will not be covered by Anthem Blue Cross and Blue Shield Medicaid or the Medicaid program.*

**How to get health care when you cannot leave your home**

If you cannot leave your home, we will find a way to help take care of you. Call Member Services right away. We will put you in touch with a case manager who will help you get the medical care you need.

**If you get care from a doctor who is not in your health plan**

Any time you see a doctor who isn’t in our plan, you need to get an authorization from us. This includes but isn’t limited to: office visits, second opinions or speciality services you get from a doctor outside the plan.

You probably won’t need to see a doctor who’s not in your plan but in case of an emergency when you’re out of the service area:

- Call your PCP first if you need routine or urgent care.
- If you see a doctor who isn’t in your plan for nonemergency care, your doctor needs to ask us for prior approval. If the services are denied, you might have to pay a bill.
- We’ll pay for your care if:
  - It’s medically necessary for your health (see the section **What Does Medically Necessary Mean?**).
  - There isn’t a doctor available in your plan who can give you the care you need.
- It’s emergency care, even if you go to a doctor outside your plan. If you need more guidance about the difference between emergency, routine or urgent care, see the section Different Types of Health Care.

- Make sure to give us the following information so we can help you:
  - The name and phone number of the doctor you saw.
  - The account number from the doctor, not the collection agency.
  - The total amount of the bill if you have it.

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**WELLNESS CARE FOR CHILDREN AND ADULTS**

All Anthem members need to have regular wellness visits with their primary care provider (PCP). During a wellness visit, your PCP can see if you have a problem. If you do, your PCP can help you before it is a bad problem. When you become an Anthem member:

- Call your PCP.
- Make your first appointment within 90 days of when you enroll in the plan.

**Wellness care for children**

**Why well-child visits are important for children**

Children need more wellness visits than adults. These wellness visits for children are for anyone in Medicaid who is under age 21. Babies need to:

- See their PCP at least seven times by the time they are 12 months old
- Go more times if they get sick

Your child may have special needs or an illness like asthma or diabetes. If so, one of our case managers can help your child get checkups, tests and shots.

Your child can get checkups from his or her PCP or any network provider. You do not need a referral for these visits.

At these wellness visits, your child’s PCP will:

- Make sure your baby is growing well
- Help you care for your baby, talk to you about what to feed your baby and how to help your baby go to sleep
- Answer questions you have about your baby
• See if your baby has any problems that may need more health care
• Give your baby shots to help protect him or her from getting sick

When your child should get wellness visits

Well-child care in your baby’s first year of life
The first well-child visit will be in the hospital. This happens right after the baby is born. For the next seven visits, you must take your baby to his or her PCP’s office. Set up a visit with the doctor when the baby is:
• Between 3-5 days old
• 1 month old
• 2 months old
• 4 months old
• 6 months old
• 9 months old
• 12 months old

Well-child care in your baby’s second year of life
Starting in your baby’s second year of life, he or she should see the doctor at least four more times:
• 15 months
• 18 months
• 24 months
• 30 months

Well-child care for children ages 3 through 20
Your child should see the doctor again at ages 3, 4, 5 and 6. Be sure to set up these visits. It is important to take your child to his or her PCP when scheduled.

From ages 7-20, your child should see his or her PCP at least one time each year for a wellness visit.

Blood lead screening
Your child’s primary care provider (PCP) will begin to screen your child for lead poisoning at every well-child visit. Your child’s PCP will give your child a blood lead test at 12 and 24 months unless your child’s PCP decides it should be done at other times. Your child’s PCP will also give your child blood lead tests between 3 and 6 years of age if he or she has not been tested before.
Your child’s PCP will take a blood sample by pricking your child’s finger or taking blood from his or her vein. The test will tell if your child has lead in his or her blood.

**Vision screening**
Your child’s PCP should check your child’s vision at every well-child visit.

**Hearing screening**
Your child’s PCP should check your child’s hearing at every well-child visit.

**Dental screening**
Your child’s PCP should check your child’s teeth and gums as a part of each well-child visit. Children should start seeing a dentist when they get their first tooth or by their first birthday. Your child should then keep seeing the dentist every six months.

**Immunizations (shots)**
It is important for your child to get shots on time. Follow these steps:
1) Take your child to the doctor when his or her PCP says a shot is needed.
2) Use the chart below as a guide to help keep track of the shots your child needs.

<table>
<thead>
<tr>
<th>IMMUNIZATION (SHOT) SCHEDULE FOR CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE VACCINE</td>
</tr>
<tr>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Hepatitis B</td>
</tr>
<tr>
<td>Rotavirus</td>
</tr>
<tr>
<td>Diphtheria, Tetanus, Pertussis</td>
</tr>
<tr>
<td>Haemophilus influenzae type b</td>
</tr>
<tr>
<td>Pneumococcal</td>
</tr>
<tr>
<td>Inactivated Poliovirus</td>
</tr>
<tr>
<td>Influenza</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella</td>
</tr>
<tr>
<td>Disease</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>Hepatitis A</td>
</tr>
<tr>
<td>Meningococcal</td>
</tr>
<tr>
<td>Human Papillomavirus</td>
</tr>
</tbody>
</table>

**Wellness care for adults**

Staying healthy means seeing your primary care provider (PCP) for regular checkups. Use the chart below to make sure you are up-to-date with your yearly wellness exams.
## Wellness Visits Schedule for Adult Members

### Males and females of all ages

<table>
<thead>
<tr>
<th>Exam type</th>
<th>Who needs it</th>
<th>How often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure check</td>
<td>Members age 18 and over&lt;br&gt;High blood pressure is 140/90 or higher</td>
<td>Every two years if 120/80 or below&lt;br&gt;Every year if 120/80 or higher</td>
</tr>
<tr>
<td>Cholesterol screening</td>
<td>At-risk members: Age 20 and over&lt;br&gt;Men age 35 and older should be screened for lipid disorders&lt;br&gt;At-risk members should begin screenings at age 20&lt;br&gt;Women age 45 and older should be screened for lipid disorders&lt;br&gt;At-risk members should begin screenings at age 20</td>
<td>As recommended by your PCP</td>
</tr>
<tr>
<td>Diabetes screening</td>
<td>At-risk members</td>
<td>As recommended by your PCP</td>
</tr>
<tr>
<td>Colorectal cancer (CRC) screening</td>
<td>Members age 50 and over&lt;br&gt;At-risk members: May need to begin screenings before age 50</td>
<td>As recommended by your PCP</td>
</tr>
<tr>
<td>Other cancer screenings</td>
<td>Based on members’ personal health history</td>
<td>As recommended by your PCP</td>
</tr>
<tr>
<td>Depression</td>
<td>Members should talk to their PCP if they have been feeling down or sad</td>
<td>Ask for a referral</td>
</tr>
<tr>
<td>Problem drinking and substance use disorder screening</td>
<td>Members should share any history of drug or alcohol use with their PCP</td>
<td>Ask for a referral</td>
</tr>
</tbody>
</table>

### Females

<table>
<thead>
<tr>
<th>Exam type</th>
<th>Who needs it</th>
<th>How often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pap test</td>
<td>Women ages 21-65</td>
<td>Every 1-3 years</td>
</tr>
<tr>
<td>Chlamydia test</td>
<td>Women under age 24 who are sexually active&lt;br&gt;Women age 24 and older who are at increased risk</td>
<td>As recommended by your PCP</td>
</tr>
<tr>
<td>Mammogram</td>
<td>Most doctors recommend a mammogram screening every one to three years</td>
<td>As recommended by your PCP</td>
</tr>
<tr>
<td>Osteoporosis testing</td>
<td>Women under age 65</td>
<td>As recommended by your PCP</td>
</tr>
</tbody>
</table>
### WELLNESS VISITS SCHEDULE FOR ADULT MEMBERS

<table>
<thead>
<tr>
<th>Males 50-65 and older</th>
<th>Women age 65 and older</th>
<th>At least once</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for sexually transmitted diseases (STDs)</td>
<td>At-risk men</td>
<td>As recommended by your PCP</td>
</tr>
<tr>
<td>Screening for abdominal aortic aneurysm</td>
<td>Men ages 65-75 who have ever smoked</td>
<td>One-time screening</td>
</tr>
</tbody>
</table>

**When you or your child misses one of your wellness visits**

If you or your child does not get a wellness visit on time:
- Set up a visit with the PCP as soon as you can.
- Call Member Services if you need help setting up the visit.

If your child has not visited his or her PCP on time, we will send you a postcard reminding you to make your child’s wellness appointment.

### SPECIAL KINDS OF HEALTH CARE

**Special care for pregnant members**

New Baby, New Life℠ is our program for all pregnant members. It is very important to see your primary care Provider (PCP) or OB/GYN for care when you are pregnant. This kind of care is called **prenatal care**. It can help you have a healthy baby. Prenatal care is always important even if you have already had a baby. With our program, members receive health information and rewards for getting prenatal and postpartum care.

Our program also helps pregnant members with complex health care needs. Nurse case managers work closely with these members to give:
- Education
- Emotional support
- Help in following their doctor’s care plan

Our nurses also work with doctors and help with other services members may need. The goal is 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 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™ – your live support team
My Advocate™ delivers maternal health education by phone, text message and smartphone app all at no cost to you. You’ll get to know Mary Beth, the My Advocate™ automated personality. Mary Beth will respond to your changing needs as your baby grows and develops.

My Advocate™ will help you:
- Learn more about topics like pregnancy and postpartum care, well-child care, dental care, immunizations, healthy living tips and more.
- Get in touch with your case manager if you have questions or an issue comes up. Tell My Advocate™ you need help and you’ll get a call back from your case manager.
- Get answers to your questions any time, wherever you are.

Your information is kept secure and private. Each time Mary Beth calls, she’ll ask you for your year of birth to make sure she’s talking to the right person.

To get started with MyAdvocate™, you’ll get an important health screening call to learn more about you and your baby. All you need to do is answer a few questions over the phone. After your first screening, you’ll get ongoing tips, resources and more.

When you become pregnant
If you think you are pregnant:
- Call your doctor right away. You do not need a referral from your PCP to see an OB/GYN doctor.
- Call Member Services if you need help finding an OB/GYN in the network. You can also call Care on Call if you need help.

We will send you a pregnancy education package. It will include:
- A letter welcoming you to the New Baby, New Life program
- A self-care book with information about your pregnancy; you can also use this book to write down things that happen during your pregnancy
- The New Baby, New Life reward program brochure; it tells you how to get your reward for getting prenatal care
While you’re pregnant, you need to take good care of your health. You may be able to get healthy food from the Women, Infants, and Children (WIC) program. Member Services can give you the phone number for the WIC program close to you.

When you are pregnant, you must go to 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 you to visit more than this based on your health needs.

Quitting smoking 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 our Member Services team 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 at least:
- Forty-eight hours after a vaginal delivery
- Seventy-two hours after a Cesarean section (C-section)

You may stay in the hospital less time if your PCP or OB/GYN and the baby’s provider see that you and your baby are doing well. 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 as soon as you can to let your care manager know you had your baby. We will need to get details about your baby.
- Call your caseworker with the Cabinet for Health and Family Services (CHFS) at 1-800-372-2973 (TTY 1-800-627-4702) to let them know you had your baby.

**After you have your baby**

We will send you the New Baby, New Life℠ postpartum education package after you have your baby. It will include:
- A letter welcoming you to the postpartum part of the New Baby, New Life program
- A baby care book with information about your baby’s growth; you can also use this book to write down things that happen during your baby’s first year
- New Baby, New Life reward program brochure about going to your postpartum visit
- A brochure about postpartum depression
If you used the My Advocate™ tool while you were pregnant, you’ll get tips about postpartum and well-child care through calls, texts or your smartphone app for up to 12 weeks after you have your baby.

It’s important to set up a visit with your PCP or OB/GYN after you have your baby for your postpartum checkup. You may feel well and think you are healing, but it takes the body at least six weeks to mend after delivery.
- This visit should be done between three and eight weeks after you deliver.
- If you have to have surgery to have your baby by Cesarean section, your PCP or OB/GYN may ask you to come back for a two-week post-surgery checkup; you will still need to go back and see your provider within three to eight weeks for your postpartum checkup.

Disease Management Centralized Care Unit
If you have a long-term health issue, you don’t have to go it alone. Our disease management program can help you get more out of life. The program is voluntary, private and on hand at no cost to you. It’s called the Disease Management Centralized Care Unit (DMCCU) program. A team of licensed nurses, called DMCCU case managers, are available to teach about your health issue and help you learn how to manage your health. Your primary care provider (PCP) and our DMCCU team are here to help you with your health care needs.

You can join the program if you have one 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
- Schizophrenia
- Substance use disorder

Our case managers can also help with weight management and smoking cessation services.
DMCCU case managers work with you to make health goals and help you build a plan to reach them. As a member in the program, you will benefit from having a case manager who:

- Listens to you and takes the time to understand your specific needs.
- Helps you make a care plan to reach your health care goals.
- Gives you the tools, support and community resources that can help you improve your quality of life.
- Provides health information that can help you make better choices.
- Assists you in coordinating care with your providers.

As an Anthem Medicaid member enrolled in the DMCCU program, you have certain rights and responsibilities.

You have the right to:

- Have information about your health plan. This includes all our programs and services, as well as our staff’s education and work experience. It also includes contracts we have with other businesses or agencies.
- Refuse to take part in or leave programs and services we offer.
- Know who your case manager is and how to ask for a different case manager.
- Have us help you to make choices with your doctors about your health care.
- Learn about all DMCCU-related treatments. These include anything stated in the clinical guidelines, whether covered by us or not. You have the right to talk about all options with your doctors.
- Have personal data and medical information kept private. Our team will always make sure they’re speaking with the right person before discussing any private health information.
- Know who has access to your information and know our procedures used to ensure security, privacy and confidentiality.
- Be treated with courtesy and respect by our staff.
• File complaints with us and get guidance on how to use the complaint process, including how long it will take us to respond and resolve issues of quality and complaints.
• Get information that is clear and easy to understand.

You are encouraged to:
• Follow health care advice we offer.
• Give us information needed to carry out our services.
• Tell us and your doctors if you decide to disenroll from the DMCCU program.

If you have one of these health issues or would like to know more about our DMCCU, please call 1-888-830-4300 Monday through Friday from 8:30 a.m. to 5:30 p.m. local time. Ask to speak with a DMCCU case manager. Or you can leave a private message for your case manager 24 hours a day, seven days a week. Visit our website at www.anthem.com/kymedicaid or call the DMCCU if you would like a hard copy of DMCCU information you find online. Calling can be your first step on the road to better health.

Healthy Family Lifestyle program
Healthy Family Lifestyle is a six-month program for ages 7-17 designed to help you and your family have healthier lifestyles. With this program, you and your family get:
• Fitness and healthy behavior coaching.
• Written nutrition information.
• Online and community resources.

To learn more or to enroll in the Healthy Family Lifestyle program, call us at 1-888-830-4300.

SPECIAL SERVICES FOR HEALTHY LIVING

Health information
Learn more about health and healthy living. Here are some ways to get health information:
• Ask your PCP.
Call us. Care on Call is available to answer your questions. They can tell you:
   - If you need to see your PCP.
   - How you can help take care of some health problems you may have.

Health education classes
We work to help keep you healthy with our health education programs. We can help you find classes near your home. You can call Member Services to find out where and when these classes are held.

Some of the classes include:
- Pregnancy and Childbirth
- Infant care
- Parenting
- Quitting cigarette smoking
- Other classes about health topics

Some of the larger medical offices (like clinics) in our network show health videos. They talk about immunizations (shots), prenatal care and other important health topics. We hope you will learn more about staying healthy by watching these videos.

We will also mail a member newsletter to you twice a year. This gives you health news about well care and taking care of illnesses. It gives you tips on how to be a better parent and other topics.

Community events
We sponsor and go to community events and family fun days where you can get health information and have a good time. You can learn about topics like healthy eating, asthma and stress.

You and your family can play games and win prizes. We will be there to answer your questions about your benefits, too. Call Member Services or go online to www.anthem.com/kymedicaid to find out when and where these events will be.

Domestic violence
Domestic violence is abuse. Abuse is unhealthy. Abuse is unsafe. It is never OK for someone to hit you. It is never OK for someone to make you afraid. Domestic violence causes harm and hurt on purpose. Domestic violence in the home can affect your children, and it can affect you. If you feel you may be a victim of abuse, call or talk to your PCP. Your PCP can talk to you about domestic violence. He or she can help you understand you have done nothing wrong and do not deserve abuse.
Safety tips for your protection:
- If you are hurt, call your PCP.
- Call 911, or go to the nearest hospital if you need emergency care. Please see the section Emergency care for more information.
- Have a plan on how you can get to a safe place (like a women’s shelter or a friend’s or relative’s home).
- Pack a small bag. Give it to a friend to keep until you need it.

If you have questions or need help:
- Call Care on Call at 1-866-864-2544.
- Call the National Domestic Violence hotline number at 1-800-799-7233 (TTY 1-800-787-3224) 24 hours a day, 7 days a week.

Minors
For most members under age 18, our network doctors and hospitals cannot give them care without a parent’s or legal guardian’s consent. This does not apply if emergency care is needed.

Parents or legal guardians also have the right to know what is in their child’s medical records. Members under age 18 can ask their PCP not to tell their parents about their medical records, but the parents can still ask the PCP to see the medical records.

These rules do not apply to emancipated minors. Members under age 18 may be emancipated minors if they:
- Are married.
- Are pregnant.
- Have a child.

Emancipated minors may make their own decisions about their medical care and the medical care of their children. Parents no longer have the right to see the medical records of emancipated minors.
MAKING A LIVING WILL (ADVANCE DIRECTIVES)

Emancipated minors and members over 18 years old have rights under advance directive law. An advance directive talks about making a living will. A living will says you may not want medical care if you have a serious illness or injury and may not get better. To make sure you get the kind of care you want if you are too sick to decide for yourself, you can sign a living will. This is a type of advance directive. It is a paper that tells your provider and your family what kinds of care you do not want if you are seriously ill or injured.

If you wish to sign a living will, you can:
- Ask your PCP for a living will form.
- Fill out the form by yourself or call us for help.
- Take or mail the completed form to your PCP or specialist. Your PCP or specialist will then know what kind of care you want to get.

You can change your mind any time after you have signed a living will.
- Call your PCP or specialist to remove the living will from your medical record.
- Fill out and sign a new form if you wish to make changes in your living will.

You can sign a paper called a durable power of attorney, too. This paper will let you name a person to make decisions for you when you cannot make them yourself. Ask your PCP or specialist about these forms.

GRIEVANCES AND MEDICAL APPEALS

If you have any questions or concerns about your health plan, please call Member Services. You can also write to us at the address below.

Grievances
If you have a problem with our services or network providers about things such as quality of care or poor customer service from a provider or health plan associate, you may present evidence by:
- Calling or writing us about it
- Telling us in person
- Ask a representative of your choice to call or write to us or to tell us in person

If you ask a provider to call or write to us, we will need your written approval for them to represent you.
Filing a grievance
Member Services will be happy to help you identify, investigate and resolve grievances about health care services. You can do one the following:

- Call Member Services at 1-855-690-7784 (TTY 711) to file your grievance by phone.
- Call Member Services and ask for help with writing a letter; include information such as the date the problem happened and the people involved. Send your letter to:
  
  Grievances and Appeals Department
  
  Anthem Blue Cross and Blue Shield Medicaid
  
  13550 Triton Park Blvd.
  
  Louisville, KY 40223

If you need help with any part of the grievance and/or appeal process, our Member Services and TTY toll-free numbers are open from 7 a.m. to 7 p.m. Eastern time, Monday through Friday, except holidays. Member Services reps and member advocates can help you understand the process and fill out any forms that are needed.

When we get your call or letter, we will:

- Send you a letter within five business days to let you know we received your grievance
- Look into your grievance when we get it
- Send you a letter within 30 calendar days of when you first told us about your grievance; it will tell you the decision made by us and all the data we received

If your grievance is urgent or emergent, we will respond within three business days of when you tell us about it. If we need more information, we may extend the grievance process for 14 calendar days. If we do this, we will let you know the reason for the delay within two business days of the decision to extend. You may also ask us to extend the process if you have more details that we should see.

If you are not happy with the decision we make about your grievance, you may also request an appeal. Call Member Services and we will assist you.

Medical appeals
There may be times when we say we will not pay for all or part of the care your provider recommended. If we do this, you (or your provider on your behalf and with your written consent) can appeal the decision.
A medical appeal is when you ask us to look again at the care your provider asked for and we said we will not pay for, including EPSDT services (see Your Health Care Benefits section on Early Periodic Screening, Diagnosis and Treatment (EPSDT)/Well-Child Visits). You must file for a medical appeal within 30 calendar days from the postmark or fax date on our first letter that says we will not pay for a service.

A medical appeal can be filed by:
- You
- A person with written permission to help you, including a legal representative of your estate
- Your primary care provider (PCP) or the provider taking care of you at the time

If you want your PCP to file an appeal for you, they must have your written permission, unless you are asking for an expedited (fast) appeal.

To keep getting services we have already approved, you or your provider must file the appeal:
- Within 30 calendar days from the postmark or fax date on the notice of the adverse benefit determination letter we sent to you to let you know we will not pay for the care already approved or
- Before the date the notice says your service will end

You can appeal our decision in two ways:
- You can call Member Services who can assist with filing your formal appeal. Let us know if you want someone else to help you with the appeal process, such as a family member, friend or your provider. If you call us, we will send you a letter to let you know we got your request for an appeal. We will include an appeal form.
  - Fill out the entire form.
  - Mail it back to us.

If you or your representative asks for an expedited (fast) appeal, you do not need to send us the form. You also don’t have to send in a written request after you make an oral request (for example, if you call it in). Because you’re asking us to make a fast decision, you will have a shorter time than normal to give us information to support your claim (see the section Expedited appeals to learn more).
- You can send us a letter or the appeal form to the address below.
  - Include information such as the care you are looking for and the people involved.
  - Have your doctor send us your medical information about this service.

Central Appeals Processing
Anthem Blue Cross and Blue Shield Medicaid
When we get your letter or appeal form, we will send you a letter within five days. The letter will let you know we got your appeal.

After we receive your appeal:
- A different provider than the one who made the first decision will look at your appeal.
- We will send you and your provider a letter with the answer to your appeal. We will do this within 30 calendar days from when we get your appeal. This letter will:
  - Let you and your provider know what we decide
  - Tell you and your provider how to find out more about the decision and your rights to a fair hearing

If we need more information about your appeal:
- We may extend the appeals process for 14 days
- We will let you or the person you asked to file the appeal for you know in writing the reason for the delay within two business days of the decision to delay.

You may also ask us to extend the process if you know more information that we should consider. You and your representative have the right to look at your case file, including medical records, before, during or after the appeal process.

After you have gone through all of the appeal process, you may ask for a state fair hearing. See the section **Fair hearings** for more details.

While the appeal is pending, we will continue your benefits if all the following are met:
- Member or service provider files a timely appeal or the member asks for a state fair hearing within 120 days from the date on Anthem’s notice of adverse benefit determination
- Appeal states the termination, suspension or reduction of a previously authorized treatment
- Services were ordered by an authorized provider
- The time period covered by the authorization has not expired
- The member requests an extension of benefits

**You have the right to ask for and get copies of all documents, records and other information used to make the adverse benefit determination,**
including any medical or benefit guidelines used. We’ll give you copies at no cost.

**Expedited appeals**
If we or your provider feels that taking the time for the standard appeals process could seriously harm your life or your health, we will review your appeal quickly. We will call you and send you a letter with the answer to your appeal. We will do this within two business days after we receive your request.

If we or your provider does not feel your appeal needs to be reviewed quickly, we will:
- Call you right away
- Send you a letter within two business days of our call to let you know how the decision was made and that your appeal will be reviewed through the standard review process

If the decision on your expedited (fast) appeal upholds our first decision and we will not pay for the care your doctor asked for, we will call you and send you a letter.

This letter will:
- Let you know how the decision was made
- Tell you about your rights to ask for a state fair hearing

**Payment appeals**
If you get a service from a provider and we do not pay for it, you may receive a notice from us called an explanation of benefits (EOB). **This is not a bill.** The EOB will tell you:
- The date you received the service
- The type of service you received
- The reason we cannot pay for the service

The provider, health care place or person who gave you this service will get a notice called an explanation of payment.

**If you receive an EOB, you do not need to call or do anything at that time unless you or your provider wants to appeal the decision.**

A payment appeal is when you ask us to look again at the service we said we would not pay for. You must ask for a payment appeal within 30 days of receiving the EOB. To file a payment appeal, you or your provider can either:
- Call Member Services
- Mail your request and medical information for the service to:
  - Central Appeals Processing
Anthem Blue Cross and Blue Shield Medicaid
P.O. Box 62429
Virginia Beach, VA 23466-2429

We can accept your appeal by phone, but you must follow up in writing. After you have gone through our appeal process, you have the right to ask for a state fair hearing.

Your doctor can ask for an outside review
Under Kentucky statute and regulation 907 KAR 17:035, your doctor can ask for a third-party review of a denied service to see if it’s needed for your health care. Your doctor must:

- Send a letter within 60 calendar days of the date on the letter when we told you we did not approve the requested service.
- Ask in writing any of the ways below:

  Email: KYExternalReview@anthem.com
  Fax: 1-502-212-7336
  Mail: Central Appeals Processing
  Anthem Blue Cross and Blue Shield Medicaid
  P.O. Box 62429
  Virginia Beach, VA 23466-2429
  Electronic: Availity Provider Portal
  - Not send any other information for review.

Fair hearings
You must ask for a state fair hearing within 45 calendar days from the date on the letter we send you telling you the final result of your appeal. If you wish to keep getting benefits during the hearing, your request must be submitted within 14 calendar days from the postmark date on the letter you get from us telling you the results of your appeal.

To ask for a state fair hearing, send a letter to:
Kentucky Cabinet for Health and Family Services
Department for Medicaid Services
Division of Program Quality and Outcomes
275 E. Main St., 6C-C
Frankfort, KY 40621-0001
Once the Cabinet for Health and Family Services (CHFS) gets your letter:
- They will submit a copy of the request to the CHFS Administrative Hearing Branch.
- We will send CHFS a copy of your standard appeal, the information we used to make our decision and a copy of the notice of decision.

After you file your appeal, you will be told the date, time and location of the scheduled state fair hearing. Hearings can often be done by phone.

A hearing officer at the CHFS Administrative Hearing Branch will conduct the state fair hearing. When the hearing is finished, the hearing officer will report the results of the hearing decision to:
- You
- Anthem Blue Cross and Blue Shield Medicaid
- CHFS

If you have any questions about your rights to appeal or request a fair hearing, call Member Services.

**Continuation of benefits**

If CHFS tells us to keep or restore your benefits during the fair hearing process, we will continue coverage of your benefits until one of the following occurs:

1. The enrollee withdraws the appeal;
2. Fourteen (14) days have passed since the date of the resolution letter, if the resolution of the appeal was against the enrollee and the enrollee has not requested a state fair hearing or taken any further action; or
3. A state fair hearing decision adverse to the enrollee has been issued

- You withdraw your request for a fair hearing.
- Fourteen (14) days have passed since the date of the resolution letter, if the resolution of the appeal was not in your favor and you have not requested a state fair hearing or taken further action.
- A fair hearing decision is reached and is not in your favor.
- The approval ends or the approved service limits are met.

If a decision is made in your favor as a result of the fair hearing, we will:
- Start to cover services as quick as you have need for care and no later than 10 calendar days from the date we get written notice of the decision.
• Approve and pay for the services we denied coverage of before.

You may have to pay for the cost of any continued benefit if the final decision is not in your favor.

OTHER INFORMATION

If you move
Call the Department of Community Based Services (DCBS) at 1-855-306-8959 (TTY 711) or update your address online at benefind.ky.gov. You can also go to your local DCBS office to report your new address. **If your mailing address isn’t correct, you could be disenrolled from coverage if you don’t fix it right away.**

Once you contact DCBS, you should then call Member Services. You will keep getting health care services through us in your current area until the address is changed. You must call us before you can get any services in your new area unless it is an emergency.

Renew your Medicaid or KCHIP benefits on time
Do not lose your health care benefits! You could lose your benefits even if you still qualify. Every year, you will need to renew your Kentucky Medicaid program benefits. If you do not renew your eligibility, you will lose your health care benefits.

You will receive a renewal notice. Follow the instructions in the notice to renew your benefits. Call your local CHFS Office of the Ombudsman at 1-800-372-2973 with questions about renewing your benefits. Or go online at http://chfs.ky.gov to renew your benefits.

If you are no longer eligible for Medicaid or KCHIP
You will be disenrolled if you are no longer eligible for Medicaid or KCHIP benefits. If you are ineligible for Medicaid for six months or less and then become eligible again, you will be re-enrolled. If possible, you will be given the same primary care provider (PCP) you had before.

How to disenroll
If you do not like something about your health care plan, please call Member Services. We will work with you to try to fix the problem. If you are still not happy, you may:
• Change to another health plan during the first 90 days of enrolling; you can only change health plans after the first 90 days if you can show good cause.
- Change plans without cause during the annual open enrollment period.
- Change plans without cause upon automatic re-enrollment if you were not eligible for Medicaid or KCHIP coverage for a period of time and missed the annual open enrollment period.

If you need to be disenrolled, call Member Services toll free at 1-855-690-7784 (TTY 711) or write us at:

Anthem Blue Cross and Blue Shield Medicaid
P.O. Box 62509
Virginia Beach, VA 23462

**Reasons why you can be disenrolled**

There are several reasons you could be disenrolled without asking. Some of these are listed below. If you have done something that may lead to disenrollment, we will contact you. We will ask you to tell us what happened.

You could be disenrolled from your health plan if:
- You are no longer eligible for Medicaid.
- You move out of the Anthem service area.
- You are admitted to a nursing facility for more than 31 days.
- You let someone else use your Anthem member ID card.
- You try to hurt a provider, a staff person or Anthem associate.
- You are abusive or threatening, as defined by and reported in Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, to either Anthem, Anthem associates or providers.
- You steal or destroy property of a provider or Anthem.
- You try to hurt other patients or make it hard for you or other patients to get needed care.

If you have any questions about your enrollment, call Member Services.

**If you get a bill**

Always show your Anthem member ID card when you:
- See a provider.
- Go to the hospital.
- Go for tests.

Even if your provider told you to go, you must show your Anthem ID card to make sure you are not sent a bill for services covered by Anthem.
If you do get a bill, send it to us with a letter saying you have been sent a bill. Send the letter and the bill to the address below:

Claims
Anthem Blue Cross and Blue Shield Medicaid
P.O. Box 61010
Virginia Beach, VA 23466-1010

You can also call Member Services for help.

If you have other health insurance (coordination of benefits)
Please call Anthem Member Services if you or your child has other insurance. Always show your Anthem and other health insurance ID cards when you see a provider, go to the hospital or go for tests. The other insurance plan needs to be billed for your health care services before we can be billed. We will work with the other insurance plan on payment for these services.

Changes in your Anthem coverage
Sometimes, we may have to change the way we work, our covered services or our network providers and hospitals. We will mail you a letter when we make changes in the services that are covered. You will get this letter 30 days before the effective date of the change. Your primary care provider’s (PCP’s) office may move, close or leave our network. If this happens, we will call or send you a letter to tell you about this.

We can also help you pick a new PCP. You can call Member Services if you have any questions. We can send you a current list of our network PCPs. Or go online to www.anthem.com/kymedicaid.

How to tell us about changes you think we should make
We want to know what you like and do not like about your health care plan. Your ideas will help us make us better. Please call Member Services to tell us your ideas.

We have a group of members who meet quarterly to give us their ideas. These meetings are called Quality and Member Access Committee meetings. This is a chance for you to find out more about us, ask questions and give suggestions for improvement. If you would like to be part of this group, call Member Services.

We also send surveys to some members. The surveys ask questions about how you like Anthem. If we send you a survey, please fill it out and send it back. Our staff may also
call to ask how you like Anthem. Please tell them what you think. Your ideas can help us make Anthem better.

**How we pay providers**
Different providers in our network have agreed to be paid in different ways by us. Your provider may be paid each time he or she treats you (fee-for-service). Or your provider may be paid a set fee each month for each member whether or not the member actually gets services (capitation).

These kinds of pay may include ways to earn more money. This kind of pay is based on different things like how happy you are with the care or quality of care. It is also based on how easy it is to find and get care.

If you want more details about how our contracted providers or any other providers in our network are paid, please call Member Services or write to us at:
Anthem Blue Cross and Blue Shield Medicaid
P.O. Box 62509
Virginia Beach, VA 23462
YOUR MEMBER RIGHTS AND RESPONSIBILITIES

Your rights

As an Anthem member, you have the right to:

Privacy.
Be sure your medical record is private; be cared for with dignity and without discrimination. That includes the right to:
- Be treated fairly and with respect
- Know your medical records and discussions with your providers will be kept private and confidential
- Receive a copy of your medical records (one copy free of charge) and request that the records be amended or corrected

Take part in making decisions about your health care.
Consent to or refuse treatment and actively take part with your providers in treatment decisions; make a living will (advance directive).

Receive care without restraint.
Not be restrained or secluded if doing so is:
- For someone else’s convenience
- Meant to force you to do something you don’t want to do
- To get back you or punish you

Have access to health care services.
Get health care services that are similar in amount and scope to those given under fee-for-service Medicaid. That includes the right to:
- Get health care services that will achieve the purpose for which the services are given
- Get services that are fitting and are not denied or reduced due to:
  - Diagnosis
  - Type of illness
  - Medical condition
- Any Native American enrolled in the health plan is eligible to receive care from a participating Indian Health Service, Tribally-operated facility/program, and Urban Indian Clinic, if part of the Provider’s network.
Receive all information in a manner that may be easily understood.
Be given information in a manner and format you can understand. That includes:

- Enrollment notices
- Information about your health plan rules, including the health care services you can get and how to get them
- A full discussion of all treatment options and alternatives with your doctor, even if they are not covered services, presented in a manner appropriate to your condition and ability to understand.
- A complete description of disenrollment rights at least annually
- Notice of any key changes in your benefits package at least 30 days before the effective date of the change
- Information on the grievance, appeal and state fair hearing procedures
- Information on your rights and responsibilities in languages you can understand.

Anthem provides:
- Free oral interpretation services for all languages. Member handbooks are also available in any language spoken by five (5) percent of the potential enrollee or enrollee population, including Spanish, at no charge. If you would like a copy of the Member Handbook in another language, or if you would like oral interpretation services, call Member Services. Anthem complies with the Americans with Disabilities Act of 1990 (ADA) and also provides communications in large print, Braille and audio recording.

Get information about the Anthem health plan prior to joining Anthem.
Get information about Kentucky Medicaid offered through Anthem so that you can make an informed choice. That includes:

- Basic features of the Kentucky Medicaid program
- The populations that may or may not enroll in the program
- Our responsibility to arrange care in a timely manner

Get information on Anthem services.
Anthem provides information deemed mandatory by the Department of Medicaid Services, which includes:

- Covered services
- Procedure for getting services, including any prior approval requirements
- Any copay requirements
- Service area
• Names, locations and phone numbers of, and non-English languages spoken by current contracted providers, including, at a minimum:
  – Primary care providers
  – Specialists
  – Hospitals
• Any restriction on your freedom of choice of network providers
• Names of providers who are not accepting new patients
• Benefits not offered by Anthem but that members can get and how to get them; this includes how transportation is offered

Get information on emergency and after-hours coverage.
Get detailed information on this coverage. That includes:
• What constitutes an emergency medical condition, emergency services and post-stabilization services (Post-stabilization care services are Medicaid covered services that you receive after emergency medical care. You get these services to help keep your condition stable.)
• Post-stabilization rules
• Notice that emergency services do not require prior approval
• The process and procedures for getting emergency services
• The locations of any emergency settings and other sites where providers and hospitals give emergency and post-stabilization covered services
• Your right to use any hospital or other setting for emergency care

Get our policy on referrals.
Get the Anthem policy on referrals for specialty care and other benefits not given by your PCP.

Get help from the Kentucky Cabinet for Health and Family Services, Department for Medicaid Services.
Know the requirements and benefits of the Kentucky Medicaid program.

Get oral interpretation services.
Receive oral interpretation services. That includes the right to:
• Get these services free of charge for all non-English languages, not just those known to be common
• Be told these services are offered and how to access them
Exercise your rights without adverse effects.
Exercise your rights without adverse effects on the way Anthem, our providers or the Kentucky Cabinet for Health and Family Services treats you, including your right to file a grievance or appeal.

Your responsibilities

As an Anthem member, you have the responsibility to:

Learn about your rights.
Learn and understand each right you have under the Medicaid program. That includes the responsibility to:

- Ask questions if you do not understand your rights
- Make recommendations to us concerning our rights and responsibilities policy
- Learn what choices of health plans are available in your area

Learn and follow Anthem and DMS policies and procedures.
That includes the responsibility to:

- Carry your Anthem member and Medicaid ID cards at all times when getting health care services
- Let your health plan know if your Anthem ID card is lost or stolen
- Let your health plan know right away if you have a workers’ compensation claim, a pending personal injury or medical malpractice law suit, or been involved in an auto accident
- Learn and follow your health plan and Medicaid rules
- Understand, when explained by Member Services, how to report suspected fraud and abuse
- Make any changes in your health plan and PCP in the ways established by Medicaid and by the health plan
- Keep scheduled appointments
- Cancel appointments in advance when you cannot keep them
- Always contact your PCP first for your nonemergency medical needs
- Be sure you have approval from your PCP before going to a specialist
- Understand when you should and should not go to the emergency room
- Keep your address and contact information up to date
Tell your providers about your health care needs.
Share information relating to your health status with your health plan and providers so they can arrange and provide the right care and become fully informed about service and treatment options.

That includes the responsibility to:
• Tell your PCP about your health
• Talk to your providers about your health care needs and ask questions about the different ways health care problems can be treated
• Help your providers get your medical records
• Provide your providers with the right information
• Follow the prescribed treatment of care plans and instructions for care you have agreed upon with your provider or let the provider know the reasons the treatment cannot be followed as soon as possible

Take part in making decisions about your health.
Actively participate in deciding service and treatment options and setting treatment goals, make personal choices, and take action to maintain your health. That includes the responsibility to:
• Work as a team with your provider in deciding what health care is best for you
• Understand your health problems and how the things you do can affect your health
• Do the best you can to stay healthy
• Treat providers and staff with respect

Call Member Services if you have a problem and need help.

We provide health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, race, age, religion, national origin, physical or mental disability or type of illness or condition.
HOW TO REPORT SOMEONE WHO IS MISUSING THE MEDICAID PROGRAM

If you know someone who is misusing (through fraud, abuse and/or overpayment) the Medicaid program, you should report him or her.

To report doctors, clinics, hospitals, nursing homes or Medicaid enrollees, write or call us at:

Medicaid Special Investigations Unit
Anthem Blue Cross and Blue Shield Medicaid
4425 Corporation Lane
Virginia Beach, VA 23462
1-800-600-4441

Suspicions of fraud and abuse can be emailed directly to us at medicaidfraud@anthem.com. Or go online at www.anthem.com/kymedicaid. This information is sent directly to the email address above, which is checked every business day.

You can also call the Cabinet for Health and Family Services Office of the Inspector General at 1-800-372-2970 to report Medicaid fraud and abuse.

WE HOPE THIS HANDBOOK HAS ANSWERED MOST OF YOUR QUESTIONS. FOR MORE INFORMATION, CALL MEMBER SERVICES.
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 shown at the end of this notice.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

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’re 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 health care.

Federal law says we must tell you what the law says we have to do to protect PHI that’s 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 can’t 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 is it 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 health care if you tell us it’s 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, health care operations and treatment**
  - To share information with the doctors, clinics and others who bill us for your care
  - When we say we’ll pay for health care or services before you get them
  - To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, health care operations and treatment. If you don’t want this, please visit [www.anthem.com/kymedicaid](http://www.anthem.com/kymedicaid) for more information.
- **For health care 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 health care, if you tell us it’s OK
  - With someone who helps with or pays for your health care, if you can’t speak for yourself and it’s 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 can’t 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’re asked
• To answer legal documents
• To give information to health oversight agencies for things like audits or exams
• To help coroners, medical examiners or funeral directors find out your name and cause of death
• To help when you’ve 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

What are your rights?
• You can ask to look at your PHI and get a copy of it. We don’t 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.
• Sometimes, you can ask us not to share your PHI. But we don’t 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’ve shared your PHI with someone else. This won’t list the times we’ve shared it because of health care, payment, everyday health care business or some other reasons we didn’t list here.
• 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 do we have to do?
• The law says we must keep your PHI private except as we’ve 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’ll 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, like if you’re in danger.
• We must tell you if we have to share your PHI after you’ve asked us not to.
• If state laws say we have to do more than what we’ve said here, we’ll follow those laws.
• We have to let you know if we think your PHI has been breached.

**We may contact you**
You agree that we, along with our affiliates and/or vendors, may call or text any phone numbers you give us, including a wireless phone number, using an automatic telephone dialing system and/or a pre-recorded message. Without limit, these calls or texts may be about treatment options, other health-related benefits and services, enrollment, payment, or billing.

**What if you have questions?**
If you have questions about our privacy rules or want to use your rights, please call Member Services at: 1-855-690-7784 (TTY 711).

**What if you have a complaint?**
We’re here to help. If you feel your PHI hasn’t 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.

**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, Suite 16T70
61 Forsyth St. SW
Atlanta, GA 30303-8909
Phone: 1-800-368-1019
TDD: 1-800-537-7697
Fax: 1-404-562-7881

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’ll tell you about the changes in a newsletter. We’ll also post them on the Web at [www.anthem.com/kymedicaid](http://www.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’s 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’ll let you know before we do anything where we have to give you a chance to say no.
- We’ll tell you how to let us know if you don’t 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.

We can translate this at no cost. Call the Member Services number on your member ID card.
Podemos traducir esta información sin costo. Llame al número de Servicios a Miembros que figura en su tarjeta de identificación de miembro.

Anthem Blue Cross and Blue Shield Medicaid is the trade name of Anthem Kentucky Managed Care Plan, Inc., independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Revised January 20, 2016
Anthem Blue Cross and Blue Shield 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. Or you can call our Director of Medicaid Plan Compliance at 502-619-6800 ext. 26717.

**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 grievance (complaint). File by mail, email, fax, or phone:

Director of Medicaid Plan Compliance  
13550 Triton Park Blvd.  
Louisville, KY 40223  
Phone: 502-619-6800, ext. 26717  
Fax: 502-212-7336  
Email: kimberly.myers2@anthem.com

**Need help filing?** Call our Director of Plan Compliance 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:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf  
- **By mail:** U.S. Dept. of Health and Human Services  
  200 Independence Ave., SW Room 509F, HHH Building  
  Washington, D.C. 20201  
- **By phone:** 1-800-368-1019 (TTY/TDD 1-800-537-7697)

Do you need help with your health care, talking with us, or reading what we send you? We provide our materials in other languages and formats at no cost to you. Call us toll free at 1-855-690-7784 (TTY 711).

¿Necesita ayuda con su cuidado de la salud, para hablar con nosotros o leer lo que le enviamos? Proporcionamos nuestros materiales en otros idiomas y formatos sin costo alguno para usted. Llámenos a la línea gratuita al 1-855-690-7784 (TTY 711).


您需要醫療保健的幫助嗎？請向我們諮詢，或是閱讀我們寄給您的資料。我們以其他語言和格式提供我們的資料，您無需支付任何費用。請撥打免費電話 1-855-690-7784 (TTY 711)。


هل تحتاج إلى مساعدة بخصوص رعايتك الصحية أو التحدث إلينا أو قراءة ما نرسله إليك؟ نحن نقدم المواد الخاصة بنا بلغات وتنسيقات أخرى بدون تكلفة عليك. يمكنك الاتصال على الرقم المجاني 1-855-690-7784 (الهاتف النصي: 711).
Quý vị có cần chúng tôi giúp với việc chăm sóc sức khỏe của quý vị, trao đổi với chúng tôi, hoặc đọc những tài liệu chúng tôi gửi cho quý vị hay không? Chúng tôi cung cấp các tài liệu bằng các ngôn ngữ và định dạng khác, miễn phí cho quý vị. Hãy gọi cho chúng tôi theo số miễn phí 1-855-690-7784 (TTY 711).

Da li vam je potrebna pomoć oko vaše zdravstvene njege, u razgovoru s nama ili u čitanju onoga što vam pošaljemo? Pružamo naše materijale na drugim jezicima i u drugim formatima bez troškova po vas. Pozovite nas besplatno na broj 1-855-690-7784 (TTY 711).

ヘルスケアに関してご質問やご相談はありませんか？当社からお送りした資料のことでお困りですか？資料は英語以外の言語や別のフォーマットでもご用意しています。いずれも無料です。ご希望の方はフリーダイヤル1-855-690-7784 (TTY 711)までお電話ください。

의료 서비스, 당사와의 소통 또는 당사에서 보내는 자료 읽기와 관련해 도움이 필요하십니까? 무료로 자료를 다른 언어나 형식으로 제공해 드립니다. 무료 전화1-855-690-7784 (TTY 711) 번으로 문의해 주십시오.

Kailangan ninyo ba ng tulong sa inyong pangangalagang pangkalusugan, sa pamamagitan ng pakikipag-usap sa amin, o pagbasa kung ano ang ipinapatada namin sa inyo? Nagbibigay kami ng aming mga materyal sa ibang mga wika at anyo na wala kayong gagastusin. Tawagan kami nang walang bayad sa 1-855-690-7784 (TTY 711).

क्या अपनी स्वास्थ्य देखभाल के बारे में, हमसे बात करने के लिए या हमारे द्वारा भेजी गई सामग्री पढ़ने के लिए आपको सहायता चाहिए? हम आपको अपनी सामग्री अन्य भाषाओं और फ़ॉर्मेट में बिना किसी शुल्क के उपलब्ध कराते हैं। हमें टोल फ्री नंबर 1-855-690-7784 (TTY 711) पर फोन करें।
Вам нужна помощь с медицинским обслуживанием, консультацией или материалами, которые мы вам прислали? Мы можем бесплатно предоставить вам материалы на других языках и в других форматах. Позвоните нам по бесплатному телефону 1-855-690-7784 (TTY 711).

In caso si necessiti di assistenza con il servizio sanitario, per parlare con noi o comprendere le informazioni ricevute, sono disponibili materiali gratuiti in altre lingue e formati. Contattare il numero gratuito 1-855-690-7784 (TTY 711).