Kentucky Department for Medicaid Services Model Handbook

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Kentucky Department for Medicaid Services Model Handbook Template

Anthem Medicaid

Updated February 2020

You can receive a copy of this handbook by email by calling the Member Services number on your ID card.

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Table of Contents

WELCOME TO ANTHEM 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.

How Managed Care Works

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.
  - Foster children.

How to Use this Handbook

The information in this book tells you how to use your health care plan to stay healthy and get the care you need. Please read it with care. You can always find the most up-to-date member handbook

online at www.anthem.com/kymedicaid. If you would like a printed copy of this member handbook, please call Member Services at 1-855-690-7784 (TTY 711).

Help from Member Services

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 the 24/7 NurseLine at 1-866-864-2544.

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 in this handbook on **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 the doctors and hospitals in our network. You can request a printed copy of the provider directory or access our online version. The online provider directory has the most up-to-date information on all the doctors and hospitals in our network. This includes PCPs, obstetricians/gynecologists, specialists and others.
- 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:
  - National Committee of Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) standards for managed care organizations and Consumer Assessment of Healthcare Providers and Systems (CAHPS). These scores show how 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.

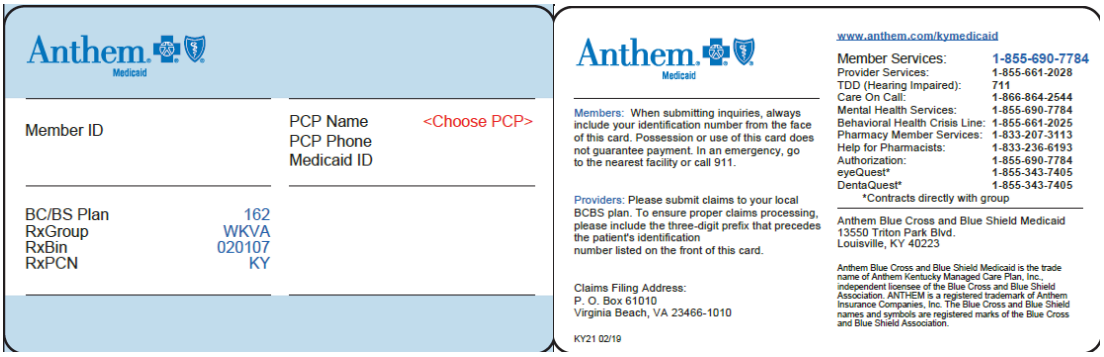
Please let us know if you need an interpreter or someone to use sign language at least 24 hours before your appointment.

Auxiliary Aids and Services

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.

Your Health Plan ID Card



We mailed your Anthem Medicaid 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 Medicaid member ID card.

- Please carry your Anthem Medicaid member ID card and your Medicaid ID card with you at all times.
- Show these cards to any doctor, hospital, provider 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 Medicaid 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 Medicaid 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 Medicaid member.
- Important phone numbers you need to know like:
  - Member Services.
  - 24/7 NurseLine.
  - Behavioral Health Crisis Line.
  - The phone numbers to call to get dental and vision care.

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

Medicaid Rights and Responsibilities

Your Medicaid Rights
As a Medicaid member, you are entitled to the following rights:
- Receive information on beneficiary and plan information.
- Be treated with respect and with due consideration for his or her dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand, regardless of cost or benefit coverage.
- Participate in decisions regarding his or her health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of their medical records and request that they be amended or corrected.
- To voice complaints or appeals about the health plan or the care provided.
- To make recommendations about the member rights and responsibilities policy.

Your Medicaid Responsibilities

As a member of this health plan, you have the responsibility to:

- Give the best information you can so that Medicaid and your providers can take care of you and your family.
- Follow your provider's instructions and care plans.
- Call your provider first when you need medical care.
- Go to providers who take your Medicaid card.
- Show your latest Medicaid card every time you get medical services.
- Make sure that you only see Kentucky Medicaid providers.
- Keep all appointments and be on time.
- Cancel an appointment if you cannot attend or be there on time.
- Pay your copays.
- Follow the rules of your provider's office or clinic. If you or others do not follow the rules, your provider can ask you to leave.
- Ask your provider questions if you do not understand something about your medical care.
- Tell the truth about yourself and your medical problems.
- Report suspected fraud and abuse.
- Understand your rights and responsibilities as a Kentucky Medicaid member.

Part I: First Things You Should Know

Finding providers in your plan
For most services, you will need to see providers in your plan. They are also called “in-network” providers. To find a list of providers in your plan:

- Visit our website at www.anthem.com/kymedicaid and use our Find a Doctor tool.
- Call Member Services for a paper copy of the provider directory. We will mail it to you at no cost to you.

Our provider directory tells you all about the doctors in your plan, including:
- Names, addresses, phone numbers and office hours.
- Gender.
- Specialties.
- Languages they speak.
- Hospitals they work in.
- If they take new patients.
- Where they are located (using an online map).
- Medical school and residency completion.
- Professional achievements.
- Board certification status.

If you need a provider directory or help choosing a doctor who is right for you, call Member Services at 1-855-690-7784 (TTY 711).

How to choose your PCP

The following members are not required to have a primary care provider (PCP) through us:
- Dual-eligible members (those eligible for Medicare and Medicaid)
- Presumptively eligible
- Children with disabilities
- Foster children
- Adults for whom the State is appointed guardian

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 should choose a PCP to be your medical home. They will get to know you and your health history.
- If you haven’t chosen a PCP within 90 days, Anthem Medicaid will assign the provider they believe to be the best fit. You always have the option to change this later.
- Your PCP can help you get quality care.
- Your PCP will give you all of the basic health services you need. They will also send you to other doctors or hospitals when you need special medical and behavioral health services.

If you need care before you have your PCP, please call Member Services.

If you don't have a PCP in your health plan, you will need to choose one. To find a PCP:
- Look in the provider directory that came with your enrollment package.
- Go to **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 their practice and is only seeing members who are current patients.
- The PCP is limiting their 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 they are in the Anthem Medicaid 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, seven days a week.

Family members do not have to have the same PCP.

Second opinion
You have the right to ask that Anthem Medicaid provide for a second opinion from an in-network provider for any covered health care services relating to:
- Surgical procedures.
- Diagnosis and treatment of complex and/or chronic conditions.

Or Anthem Medicaid can arrange to obtain a second opinion from an out-of-network provider at no cost to you. Call Member Services and we can help you find the right doctor. 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.

How to change your PCP

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** to view the provider directory online.
- Call Member Services.

You may change your PCP at any time, for any 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 Medicaid member ID card in the mail within 10 working days.
- You can still get care while you wait for your member 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

You do not need a referral to see doctors or other providers in your plan. If you go to a doctor or provider not in your plan, you may need to get our approval first. See the section called **If you get care from a doctor who is not in your health plan** for more details about prior authorizations (or preapprovals).

How to get Regular Health Care

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 Medicaid 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 Medicaid 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:

Emergency medical services	
Facilities with emergency medical services	Available 24 hours a day, seven days a week
Urgent care clinics or smaller walk-in clinics	Offer extended hours and many provide a full range of medical services for all ages
Visits to your primary care provider*	
Routine, nonurgent or preventive care visits	Within 30 days of request
Urgent care	Within 48 hours of request

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 they need to work on 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

You will need to 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 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.

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

Except in the case of an emergency, 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 the 24/7 NurseLine for help.

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

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.

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 they 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 24/7 NurseLine can help you decide if you should see your PCP or an OB/GYN.

How to get Specialty Care

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)

If your PCP gives you a referral, be sure to bring it with you to the specialist. However, you do not need a referral to see a specialist. If you go to a specialist outside your plan, you may need our approval first.

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 or call Member Services.

Behavioral health (mental health/substance use disorder)
Sometimes, dealing with all of the tasks of a home and family can lead to stress. Stress can lead to depression and anxiety. It can also lead to marriage, family and/or parenting problems. Stress can also lead to alcohol and drug use.

If you or a family member is having these kinds of problems, you can get help. Call Anthem Blue Cross and Blue Shield Medicaid Member Services at 1-855-690-7784 (TTY 711). You can also get the name of a behavioral health specialist who will see you if you need one.

Your benefits include many medically needed services, such as:
- Inpatient mental health care
- Outpatient mental health care and/or substance use treatment
- Partial hospitalization
- Mental health rehabilitative treatment services

You don’t need a referral from your PCP to get these services or to see a behavioral health specialist in your network.

If you think a behavioral health specialist does not meet your needs, talk to your PCP. He or she can help you find a different kind of specialist.

There are some treatments and services your PCP or behavioral health specialist must ask Anthem Medicaid to approve before you can get them. Your doctor will be able to tell you what they are.

If your specialist closes or leaves the network
Sometimes, specialists close or leave our plan. If that happens, we will call or send you a letter within 30 days of when we're notified. We will work with you to find another specialist in your plan and make sure you keep getting the care and services you need.

In some cases, you may be able to keep seeing a provider even if they leave the plan. Call Member Services for more information.

How to get Specialty Care - Referrals

You do not need a referral to see a specialist. If you go to a specialist outside your plan, you may need our approval first.

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 may be assigned to certain providers for:

- Primary care.
- Controlled medicines.
- Pharmacy services.
- Hospital for nonemergency care.

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 may have to pay 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 Medicaid
  HCMS - Lock-In Appeals Processing, - 3rd Floor
  13550 Triton 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.

Out of Network Providers

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 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 a 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 nonemergent services, if medically necessary and prior approved, 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 they 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 they need.

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

If you get care from a doctor who is not in your health plan
Anytime you see a doctor who isn't in our plan, you need to get an authorization or approval from us. This includes but isn't limited to: office visits, second opinions or specialty 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.
  - 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**.

Emergencies

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 lasting harm or 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 Medicaid.**

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 Medicaid.

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. After regular hours, your PCP will have an on-call service. Call your PCP's office to speak with someone from their on-call service.
- Follow your PCP's instructions. Your PCP may tell you to go to:
  - Their 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 the 24/7 NurseLine at 1-866-864-2544 (TTY 711) if you need advice about urgent care.

We want you to stay healthy

Wellness care for children and adults
All Anthem Medicaid 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 Medicaid 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 their 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 them 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 their 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, they 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 their PCP when scheduled.

From ages 7-20, your child should see their 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 ages 3 and 6 if they have not been tested before.

Your child's PCP will take a blood sample by pricking your child's finger or taking blood from their vein. The test will tell if your child has lead in their 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 their PCP says a shot is needed.
2) Use the chart below as a guide to help keep track of the shots your child needs.

IMMUNIZATION (SHOT) SCHEDULE FOR CHILDREN

AGE ➡ / VACCINE ⬇	Birth	1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	19-23 mo	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-18 yrs
Hepatitis B	HepB	HepB			HepB								HepB series if not given		
Rotavirus			RV	RV	RV, if needed										

Diphtheria, tetanus, pertussis			DTaP	DTaP	DTaP			DTaP			DTaP	Tdap if not given	Tdap	Tdap if not given
Haemophilus influenzae type b			Hib	Hib	Hib, if needed		Hib							
Pneumococcal			PCV	PCV	PCV		PCV			PPSV if high-risk		PPSV if high-risk		
Inactivated poliovirus			IPV	IPV	IPV						IPV	IPV series if not given		
Influenza					Influenza (Yearly)							Influenza (Yearly)		
Measles, mumps, rubella							MMR				MMR	MMR series if not given		
Varicella							Varicella				Vari-cella	Varicella series if not given		
Hepatitis A							HepA (2 doses)			HepA series if high-risk				
Meningococcal						MCV4 if high-risk							MCV4	MCV4 if not given (booster at age 16)
Human papillomavirus													HPV (2 doses) (both males and females)	HPV 2-dose series if not given

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		
Exam type	**Who needs it?**	**How often?**
Blood pressure check	Members age 18 and over. High blood pressure is 140/90 or higher.	Every two years if less than 120/80 or below
		Every year if 120/80 or higher
Cholesterol screening	At-risk members: Age 20 and over	As recommended by your PCP
	Men age 35 and older should be screened for lipid disorders. At-risk members should begin screenings at age 20.	
	Women age 45 and older should be screened for lipid disorders. At-risk members should begin screenings at age 20.	
Diabetes screening	At-risk members	As recommended by your PCP
Colorectal cancer (CRC) screening	Members age 50 and over	As recommended by your PCP
	At-risk members: May need to begin screenings before age 50	
Other cancer screenings	Based on members' personal health history	As recommended by your PCP
Depression	Members should talk to their PCP if they have been feeling down or sad.	As recommended by your PCP
Problem drinking and substance use disorder screening	Members should share any history of drug or alcohol use with their PCP.	As recommended by your PCP
Females		
Pap test	Women ages 21-65	Every 1-3 years
Chlamydia test	Women under age 24 who are sexually active	As recommended by your PCP
	Women age 24 and older who are at increased risk	
Mammogram	Most doctors recommend a mammogram screening every 1 to 3 years.	As recommended by your PCP
Osteoporosis testing	Women under age 65	As recommended by your PCP

WELLNESS VISITS SCHEDULE FOR ADULT MEMBERS		
	Women age 65 and older	At least once
Males 50-65 and older		
Screening for sexually transmitted diseases (STDs)	At-risk men	As recommended by your PCP
Screening for abdominal aortic aneurysm	Men ages 65-75 who have ever smoked	One-time screening

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 their PCP on time, we will send you a postcard reminding you to make your child's wellness appointment.

Start earning Healthy Rewards
It pays to stay healthy — literally. When you sign up for Healthy Rewards and complete a qualifying healthy activity, you can earn $25 or $50.

It's simple. Here's what you have to do:
1. **Enroll** either:
   - Online at mss.anthem.com/HealthyRewards.
   - By calling 1-877-868-2004 (TTY 711).
2. **Complete a qualifying heathy activity**. See the chart for details. Then, we'll add money to your very own Healthy Rewards debit card.
3. **Swipe your card at checkout at any of these stores:**
   - CVS
   - Dollar General
   - Family Dollar
   - Rite Aid
   - Walgreens
   - Walmart

You can use your card to buy a variety of health and wellness items, such as:
- Baby and children's care (diapers, baby food, etc.)
- Personal care items (dental, hair, and skin care, etc.)
- Healthy foods (fruits, vegetables, granola bars, etc.)
- And much more!

Healthy activities	Who's eligible	Rewards	Limits
Youth well visit	Members 3-20 years old	$50	Once per 12 months
HPV vaccine (two shots total)	Members 9-13 years old	$50	Once per member

Healthy activities	Who's eligible	Rewards	Limits
Adult well visit	Members 20+ years old	$25	Once per 12 months
Initial adult well visit completed within 90 days of joining Anthem Medicaid	Members 20+ years old	$25	Once per member
Breast cancer screening	Women members 50-74 years old	$50	Once per 12 months
Cervical cancer screening	Women members 21-64 years old	$50	Once per 12 months
Flu shot	All ages	$25	Once per 12 months
Diabetes HbA1c screening	Members 18-75 years old	$25	Twice per 12 months
Get your first three antidepressant refills on time	Members 18+ years old	$50	Once per member
Annual dental visit	All ages	$25	Once per 12 months
Health Risk Assessment (HRA) completed within the first 90 days of joining Anthem Medicaid	Members 18+ years old	$25	Once per member

Certain limits apply. Anthem Medicaid has the right to change incentives, stores and rewards anytime.

For more information
Visit mss.anthem.com/HealthyRewards or call us at 1-877-868-2004 to:

- Find a store near you.
- Get the full list of approved items you can buy with your debit card.
- Check the balance on your Healthy Rewards card.
- Request a new card if yours is lost or stolen.

SPECIAL KINDS OF HEALTH CARE

Birth control that's right for you

Birth control, or contraception, gives people some control over when and if they become parents. Both you and your partner should talk to each other about how you feel and be involved in the planning process. There are many types of birth control methods to choose from.

Keep in mind, even the most effective birth control methods can fail. But your chances of getting pregnant are lowest if the method you choose is always used the right way and used every time you have sex. The most effective forms of birth control are long-acting reversible contraception such as implants and intrauterine devices.

Long-acting reversible contraception (LARC)

How would you like to have a birth control method that helps keep you from getting pregnant 99 percent of the time without having to think about it?

An implantable device is a long-acting, reversible birth control that's placed inside your body by your provider. It's left in place until you want to get pregnant or want it removed. And we'll pay for it. There's no cost to you.

What are the types of implantable devices?

- Intrauterine device or IUD: small device shaped like a T that goes in the uterus
- Implant: matchstick-sized, flexible rod put under the skin of the upper arm

Each birth control method has side effects. The only way to prevent sexually transmitted infections (STIs) is to abstain from all types of sexual contact. The best way to reduce the chance of getting an STI is to use a condom. Other methods of birth control don't prevent STIs.
If you just had a baby, an IUD or implant may be inserted after delivery before you're discharged. Be sure to discuss this with your doctor before you deliver.

Even if you or your partner is using another type of birth control, agree to use a condom every time you have sex, to reduce the risk to both of you for HIV and most other STIs. Talk to your provider about which method might work best for you.

To begin with, you can check to see which types of birth control are covered in your benefit plan. Just call Member Services at 1-855-690-7784 (TTY 711), Monday through Friday from 7 a.m. to 7 p.m. Eastern time (except holidays) or visit www.anthem.com/kymedicaid. Then talk to your health care provider about the method that's right for you and your partner.

Special care for pregnant members
New Baby, New Life℠ is our program for all pregnant members. It is very important to see your 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 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 care 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 of your care while you're pregnant. My Advocate®, which is part of our New Baby, New Life program, gives you information and support throughout your pregnancy.

Get to know My Advocate®

My Advocate® delivers maternal health education by phone, text messaging and smartphone app that is helpful and fun. You will get to know Mary Beth, My Advocate's automated personality. Mary Beth will respond to your changing needs as your baby grows and develops. You can count on:

- Education you can use.
- Communication with your care manager based on My Advocate® messaging should questions or issues arise.
- An easy communication schedule.
- No cost to you.

With My Advocate®, you information is kept secure and private. Each time Mary Beth calls, she'll ask you for your year of birth. Please don't hesitate to tell her. She needs the information to be sure she's talking to the right person.

Helping you and your baby stay healthy

My Advocate® calls give you answers to your questions, plus medical support if you need it. There will be one important health screening call followed by ongoing educational outreach. All you need to do is listen, learn and answer a question or two over the phone. If you tell us you have a problem, you'll get a call back from a care manager. My Advocate® topics include:

- Pregnancy and postpartum care.
- Well-child care.
- Dental care.
- Immunizations.
- Healthy living tips.

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 the 24/7 NurseLine if you need help.

We will send you an educational book, called the Pregnancy and Beyond Resource Guide. The book includes:

- Self-care information about your pregnancy.
- A section of the book for writing down things that happen during your pregnancy.
- Details on My Advocate® that tells you about the program and how to enroll and get health information to your phone by automated voice, text message or smartphone app.
- A Labor, Delivery and Beyond section with information on what to expect during your third trimester.

- Healthy Rewards program information on how to redeem your rewards for prenatal, postpartum and well-baby care.
- A section of the book on having a healthy baby, postpartum depression, and caring for you newborn, with helpful resources.
- Information about Making a Family Life Plan and long acting reversible contraception (LARC) with information on long acting reversible birth control.

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

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.

- It's important to have a follow-up visit with your OB provider after you deliver. It would be best to see them within 1-3 weeks, but no later than 12 weeks after delivery. Your health is important to the whole family.
- Your doctor may want to see you sooner than three weeks if you had certain issues before or during delivery, such as high blood pressure or if you had a cesarean section (C-section).

Disease Management/Population Health Programs
A Disease Management (DM)/Population Health program can help you get more out of life. As part of your Anthem Medicaid benefits, we're here to help you learn more about your health, keeping you and your needs in mind at every step.

Our team includes registered nurses called DM/Population Health case managers. They'll help you learn how to better manage your condition, or health issue. You can choose to join a DM/Population Health program at no cost to you for free.

What programs do we offer?
You can join a Disease Management/Population Health program to get health care and support services if you have any of these conditions:

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

How it works
When you join one of our DM/Population Health programs, a DM/Population Health care manager will:

- Help you create health goals and make a plan to reach them.
- Coach you and support you through one-on-one phone calls.
- Track your progress.
- Give you information about local support and caregivers.
- Answer questions about your condition and/or treatment plan (ways to help health issues).
- Send you materials to learn about your condition and overall health and wellness.
- Coordinate your care with your health care providers, like helping you with:
  - Making appointments.
  - Getting to health care provider visits.
  - Referring you to specialists in our health plan, if needed.
  - Getting any medical equipment you may need.
  - Offer educational materials and tools for weight management and tobacco cessation (how to stop using tobacco like quitting smoking).

Our DM/Population Health team and your primary care provider (PCP) are here to help you with your health care needs.

How to join

We'll send you a letter welcoming you to a DM/Population Health program, if you qualify. Or, call us toll free at 1-888-830-4300 (TTY 711) Monday through Friday from 8:30 a.m. to 5:30 p.m. local time.

When you call, we'll:

- Set you up with a DM/Population Health case manager to get you started.
- Ask you some questions about your or your child's health.
- Start working together to create your or your child's plan.

You can also email us at dmself-referral@anthem.com.

Please be aware that emails sent over the internet are usually safe, but there is some risk third parties may access (or get) these emails without you knowing. By sending your information in an email, you acknowledge (or know, understand) third parties may access these emails without you knowing.

You can choose to opt-out (we'll take you out of the program) of the program at any time. Please call us toll free at 1-888-830-4300 (TTY 711) from 8:30 a.m. to 5:30 p.m. local time Monday through Friday to opt out. You may also call this number to leave a private message for your DM/Population Health case manager 24 hours a day.

Useful phone numbers:
In an emergency, call 911.

Disease Management/Population Health
Toll free: 1-888-830-4300 (TTY 711)
Monday through Friday 8:30 a.m. to 5:30 p.m. local time
Leave a private message for your case manager 24 hours a day.

After-hours:
Call the Anthem Medicaid 24/7 NurseLine
24 hours a day, seven days a week

Healthy Family Lifestyle program
Healthy Family Lifestyle is a six-month program for ages 7-17. The goal of the program is to help families form healthy eating habits and become more active.
For kids who qualify, parents will get one-on-one coaching phone calls with us to:

- Create health goals just for your child that are clear and that they can meet.
- Make a plan to reach those goals.
- Talk about getting and staying active and healthy food choices.

- Help find resources to support a healthy life in your area.

Find out if your health plan has extra benefits to help with living a healthier life. **Learn more and join.** Give us a call at 1-844-421-5661 Monday through Friday 8:30 a.m.-5:30 p.m. local time to find out more about the Healthy Family Lifestyle program. We'll ask you some questions about your child's health to see if they qualify.

Disease Management/Population Health rights and responsibilities

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

- Get details about us, such as:
  - Programs and services we offer.
  - Our staff and their qualifications (skills or education).
  - Any contractual relationships (deals we have with other companies).
- Opt out of DM/Population Health services.
- Know which DM/Population Health case manager is handling your DM/Population Health services and how to ask for a change.
- Get support from us to make health care choices with your health care providers.
- Ask about all DM/Population Health-related treatment options (choices of ways to get better) mentioned in clinical guidelines (even if a treatment is not part of your health plan), and talk about options with treating health care providers.
- Have personal data and medical information kept private.
- Know who has access to your information and how we make sure your information stays secure, private and confidential.
- Receive polite, respectful treatment from our staff.
- Get information that is clear and easy to understand.
- File complaints to Anthem Medicaid by calling 1-888-830-4300 (TTY 711) toll free from 8:30 a.m. to 5:30 p.m. local time Monday through Friday and:
  - Get help on how to use the complaint process.
  - Know how much time Anthem Medicaid has to respond to and resolve issues of quality and complaints.
  - Give us feedback about the Disease Management/Population Health program.

You also have a responsibility to:

- Follow the care plan that you and your DM/Population Health case manager agree on.
- Give us information needed to carry out our services.
- Tell us and your health care providers if you choose to opt out (leave the program).

Disease Management/Population Health does not market products or services from outside companies to our members. DM/Population Health does not own or profit from outside companies on the goods and services we offer.

You can log in to your secure account, or register, at www.anthem.com/kymedicaid to ask us to join a DM/Population Health program. You'll need your member ID number to register (located on your member ID card).

Using your secure account, you can send a secure message to Member Services and ask to join the program.

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. The 24/7 NurseLine 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. They 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 the 24/7 NurseLine 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, seven days a week.

Part II: Your Benefits and Plan Procedures

What is benefind?
benefind is a website, benefind.ky.gov, where you can apply for benefits like:
- Supplemental Nutrition Assistance Program (SNAP) – helps you buy healthy foods for you and your family.
- Medicaid – helps cover medical care costs.
- Kentucky Transitional Assistance Program (KTAP) – helps pay for basic needs like rent, utilities, and other household expenses.

Checking Benefit Eligibility You can use benefind to check if you may be eligible to receive benefits if:
- You are unsure if you qualify for benefits.
- You are new to Kentucky's public assistance program.
- You have never received benefits before.

Simply select the benefits you would like to see if you qualify for and answer questions about yourself and your household.

Services Covered by Anthem Medicaid

What are my Benefits?
The following is an overview of services that we cover and the copayments that may apply. Copayments, also called Copays, refer to the dollar amount you, as the member, may be responsible for paying when you receive certain services such as office visits, supplies, or prescriptions.

Benefit	Copay	Limits
Inpatient Medical Hospitalization		
Acute Inpatient Hospital Services	$50	Per admission
Inpatient Physician/Surgeon Services	$0	Cosmetic surgery is not covered (except for post-mastectomy re-constructive surgery)
Transplant	$0	
Emergency Services		
Emergency Room (ER)	$0 $8	$8 for non-emergency use of the ER
Emergency Ambulance (ground or air)	$0	
Ambulatory Patient Services		
Physician Office Services	$3	
Outpatient Hospital/Ambulatory Surgical Center	$4	Cosmetic surgery is not covered (except for post-mastectomy re-constructive surgery)
Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC) & Primary Care Center (PCC)	$3	Per visit
Dental Services (adults)	$3 $0 for children	Per visit
Home Health Care	$0	
Benefit	**Copay**	**Limits**
Vision Services (adults)	$3	1 eye exam per year
Vision Services (children)	$0	1 eye exam per year
Urgent Care	$3	Per visit

Radiation Therapy	$0	
Chemotherapy	$0	
Family Planning	$0	
Podiatry	$3	
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0	
Maternity Services	$0	
Prescription Drugs		
Prescription Drugs Pharmacy and limited over-the-counter drugs, including mental/behavioral health drugs are covered.	$1 Generic $4 Brand Name – no generic	For a complete list of Anthem Medicaid network pharmacies: • Go to **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.

Benefit	Copay	Limits
Rehabilitative and Habilitative Services and Devices		
Skilled Nursing and Rehabilitation	$0	
Chiropractic Services	$3	Per visit 26 visits per 12 month period
Durable Medical Equipment	$4	Per item
Hearing Aids/Audiometric Services	$0	Limited to children under 21
Orthotic/Prosthetic Devices	$4	Per item
Physical / Occupational / Speech Therapy	$3	Per visit; 20 visits per therapy per year No copay for children
Private Duty Nursing	$0	2,000 hours per year (outpatient only)
Laboratory, Diagnostic and Radiology Services		
Laboratory, Diagnostic, and Radiology Services (outpatient)	$3	Per visit Per service
Pediatric Services		
Autism Spectrum Disorders	$0	Up to age 21
Early Periodic Screening, Diagnosis and Treatment (EPSDT) Special Services	$0	Limited to medically necessary services and must be prior authorized
Commission for Children with Special Health Care Needs	$0	Limited to children who meet the eligibility criteria of the Kentucky Commission for Children with Special Health Care Needs
Specialized Children's Services Clinics	$0	Services limited to children under age 18 and must be performed by specialized clinics
Targeted Case Management: Severe emotional disability (SED) Children	$0	Limited to children who meet Kentucky's statutory definition of SED

Benefit	Copay	Limits
First Steps Services	$0	Services are available to children from birth through age two who have developmental delays or diagnosed physical or mental conditions associated with developmental delay.
Mental Health and Substance Use Disorder Services		
Targeted Case Management	$0	
Inpatient Mental Health/Substance Use Services	$50	Per Admission
Outpatient Mental Health/Substance Use Services	$3	Per visit
Psychiatric residential treatment facilities (PRTFs)	$0	Services for residents ages 6 to 21
Preventive Services and Chronic Disease Management		
Smoking/Tobacco Cessation	$0	
Allergy Services	$0	
Wellness services (Immunizations and other preventive health services such as annual check-ups, pap smears, blood pressure screenings, etc.)	$0	
Other		
Non-Emergency Transportation	$0	
Family Planning	$0	
Hospice	$0	
Second Opinion	$0	
TeleHealth	$0	
Renal Dialysis/Hemodialysis (outpatient)	$0	

Pharmacy benefits

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.

- 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**.
- Your doctor or your child's doctor or specialist should use this list when they write 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 Medicaid member ID card to the pharmacy.
- If you use a new pharmacy, tell the pharmacist about all of the medicines you are taking; include over-the-counter medicines, too.

NOTES:

- **All benefits provided must be medically necessary.**
- **Copays apply to all members unless exempt.**
- **Copays are limited to no more than 5% of your family's total income every three months.**

Copayment Exceptions

All Medicaid members are required to pay the copays outlined above except for the following exempt individuals and services:

- Foster children
- Children enrolled in Medicaid
- Pregnant women (includes 60-day period after pregnancy ends)
- Kentucky Medicaid beneficiaries who have reached their cost sharing limit for the quarter (5% of the families total income per quarter)
- Individuals receiving hospice care
- Emergency services
- Some family planning services
- Preventive services

Your Anthem Medicaid benefits

We also offer our members special benefits and services:

- **Free eyeglasses or $50 credit for contacts** each year for members **21 years and up**
- **Free sports physicals** for members ages 6-18
- **Debit card** to use for wellness items for completing certain checkups and screenings
- **Free smartphone** with unlimited texts and up to 1,000 free monthly minutes to call your family, friends and doctors
- **Anthem Medicaid's Prenatal program** with:
  - **Free crib or car seat** for going to at least seven doctor checkups during pregnancy
  - **Baby shower gift**
  - **Gift card** rewards for going to doctor appointments before and after delivery
  - **Free health resources and coaching**
- **Anthem Medicaid's Member Empowerment program**, which helps you in seeking education, job skills and employment opportunities and much more! Members actively participating in this program will have access to:
  - **Up to $600 in transportation services** to work, school or local community resources.
  - **GED test vouchers**: We will provide vouchers that allow you to take your GED test for free at an authorized test center.
  - **Payment for application fees for criminal record expungement.**
- **Medication-assisted treatment for opioid use disorder**, no prior authorization needed
- **Free 24/7 NurseLine** to speak to a nurse about your medical questions or concerns 24 hours a day, seven days a week, 365 days a year
- **Free Disease Management programs** to help you manage difficult health conditions like asthma, diabetes and COPD
- **Free hearing aid batteries** in common sizes of 10, 13, 312 or 675
- **Foster care support services**
- **Smoking cessation kit**
- **Blood pressure monitor**

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

Health Risk Assessment

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

We'll ask you to complete a health risk assessment at least yearly, 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, or

- Answer the questions by phone

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

Questions or need help completing the health risk assessment?
Call us toll free at 1-855-690-7784 (TTY 711) from 7 a.m. to 7 p.m. Eastern time, Monday through Friday, except holidays.

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

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

The review should result in a care plan that:
- You, your family or representative, and care manager agree on.
- Meets your medical, functional, social and behavioral health needs in the most unified setting.

The care 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 care manager will conduct phone interviews or home visits with you and your representative, if you have one. To complete the assessment, with your permission, the care 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 care management services. Member Services will help connect you to our Care 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 care management nurse, social worker, health guide or navigator; care coordination includes but is not limited to:

- Identifying your needs.
- Conducting a brief health risk and/or needs 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 month to:
  - Review your care needs.
  - Ensure your needs are met and services are provided.

Services NOT Covered (if you get a bill)

Always show your Anthem Medicaid 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 Medicaid ID card to make sure you are not sent a bill for services covered by Anthem Medicaid.

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 Medicaid
P.O. Box 61010
Virginia Beach, VA 23466-1010

You can also call Member Services for help.

How Our Providers are Paid

Different providers in our network have agreed to be paid in different ways by us. Your provider may be paid each time they treat 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 Medicaid
P.O. Box 62509
Virginia Beach, VA 23462

Plan Member Copayments

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

If your income is 100% or below Federal Poverty Level (FPL), you cannot be refused services. If your income is over 100% FPL and you do not pay the copay, the provider has the option to refuse services. **Pregnant women and children can never be refused services for inability to pay.**

There is a limit on the total amount of copays you will have to pay. You will not have to pay more than 5% of your family's income each quarter. Quarters are January to March, April to June, July to September, and October to December.

We keep track of the copays you pay. When you reach the limit, you will not have to pay any more copays for the quarter. If you pay a copay after your family has reached the maximum out-of-pocket amount, your provider will refund the copay to you.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The EPSDT program covers screenings and diagnostic services to decide health care needs and other measures to correct or improve:

- Physical or mental defects.
- Chronic conditions.

The EPSDT program consists of two parts:

- EPSDT screenings.
- EPSDT special services.

EPSDT screenings

This program gives routine physicals and well-child checkups for Medicaid members under age 21. Children are checked for medical problems early. Services include:

- Preventive checkups.
- Growth and development assessments.
- Vision tests.

- Hearing tests.
- Immunizations.
- Lab tests.

EPSDT special services
This program:
- Covers medically needed items or services not covered in other Medicaid programs.
- May only be given to persons under age 21.
- Requires prior approval for services.

Call your child's PCP to schedule checkups and screenings.

Service Authorization and Actions

Utilization Management Notice
Sometimes, we need to make decisions about how we cover care and services. This is called utilization management (UM). All UM decisions are based solely on a member's medical needs and the benefits offered. We do this for the best possible health outcomes for our members.
- We don't create barriers to getting 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 will decide if a service request is:
- Medically needed, and
- Covered by your health plan.

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

If you have UM questions, call Member Services at 1-855-690-7784 (TTY 711), Monday through Friday from 7 a.m. to 7 p.m. Eastern time, except holidays. They can also help if you need help in another language.

New Medical Advances
Our medical directors and network providers look at new medical advances and studies. They decide if:

- These advances should be covered benefits.
- The government has agreed the treatment is safe and effective.
- The results are as good as or better than covered treatments in effect now.

Prior Authorizations and Timeframes
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:

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

This is not a complete list, and it may change at any time. For help with the prior authorizations, call us. Our toll-free number is 1-855-690-7784 (TTY 711). You can also visit our member website for a complete list.

These services do not require prior approval:

- Emergency services
- Post-stabilization services
- Urgent care
- Family planning services
- Admission to a neonatal intensive care unit (NICU)
- Vaginal deliveries and cesarean sections

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 Medicaid's favor. Contact Member Services at 1-855-690-7784 (TTY 711) if you have any questions.

Prior Authorization Timeframes	
Type of Service Request	**Decision Time**
Non-Urgent	2 business days*
Urgent	24 hours**
Retro (care you already got)	14 days*

*From when we receive the service request
**From when we receive all necessary information

Appeals and Grievances

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.
- Asking 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 or appeal

We will not discriminate against you or your representative for filing a grievance or appeal.

Member Services will be happy to help you identify, investigate and resolve grievances about health care services. You can do one of the following:

- Call Member Services at 1-855-690-7784 (TTY 711) to file your grievance or appeal 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:

Anthem Medicaid
Attn: Tonya Sain, Manager II Grievance and Appeals Dept.
13550 Triton Park Blvd.
Louisville, KY 40223
Phone: 1-502-619-6800, ext. 106-126-0777

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 or appeal.
- 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 60 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.
- Anyone you choose 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 10 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 at 1-855-690-7784 (TTY 711) 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.

Anthem Medicaid
Attn: Tonya Sain, Manager II Grievance and Appeals Dept.
13550 Triton Park Blvd.
Louisville, KY 40223
Phone: 1-502-619-6800, ext. 106-126-0777

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 (if an appeal was filed on your behalf) 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 Medicaid'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.

If you need assistance in the grievance or appeal filing process or questions about your appeal rights, please contact Member Services at 1-855-690-7784 (TTY 711) or:

Anthem Medicaid
Attn: Tonya Sain, Manager II Grievance and Appeals Dept.
13550 Triton Park Blvd.
Louisville, KY 40223
Phone: 1-502-619-6800, ext. 106-126-0777

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:
  Anthem Medicaid
  Attn: Tonya Sain, Manager II Grievance and Appeals Dept.
  13550 Triton Park Blvd.
  Louisville, KY 40223
  Phone: 502-619-6800, ext. 106-126-0777

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: Anthem Medicaid
Attn: Tonya Sain, Manager II Grievance and Appeals Dept.
13550 Triton Park Blvd.
Louisville, KY 40223
Phone: 1-502-619-6800, ext. 106-126-0777

Electronic: Availity Provider Portal

- Do not send any other information for review.

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

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 Medicaid
- CHFS

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

III. Other

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 anytime 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.

Fraud, Waste and Abuse

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

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

Medicaid Special Investigations Unit
Anthem Medicaid
4425 Corporation Lane
Virginia Beach, VA 23462
1-866-847-8247

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.

Third Party Liability (TPL)

We need to know if you have other health insurance along with Medicaid. Contact Anthem Medicaid if you have other insurance coverage or lose insurance coverage from another plan. Call Anthem Medicaid's Member Services department at 1-855-690-7784 (TTY 711), 7 a.m. to 7 p.m. Eastern time, Monday through Friday, except holidays.

When you have other health insurance, your provider should always bill that health insurance first. Medicaid always pays last. This is called "Third Party Liability" (TPL). If your health plan pays the bill when you have other health insurance, your other health insurance will have to pay the money back. If you file a lawsuit or otherwise recover expenses from any other source, you or your attorney must notify your health plan. For questions about TPL, call 1-800-807-1459.

Examples of other insurance are:

- Personal health insurance.
- Veteran's coverage.
- Worker's compensation.
- Auto insurance to cover injury due to an auto accident.
- Recover expenses from a lawsuit or from any other source due to an injury, disease, or disability.
- Insurance that pays you if you have cancer, heart disease, and other disabilities.
- Student health insurance policies.
- Sports health insurance policies.
- Medicare.

Anthem Medicaid and Other Contact Information

Resource	Contact
Anthem Medicaid website	www.anthem.com/kymedicaid. For an online copy of this handbook, click on **Benefits** and **Member Materials**.
Member Services	1-855-690-7784 (TTY 711) Monday through Friday 7 a.m. to 7 p.m. Eastern time, 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.
Long-term care services	1-855-690-7784 (TTY 711)
Maternity, family planning and sexually transmitted disease (STD) services	1-855-690-7784 (TTY 711)
Disease management	1-888-830-4300
EyeQuest DentaQuest	1-855-343-7405
24/7 NurseLine	1-866-864-2544
Nonemergency medical transportation	1-888-941-7433
Behavioral Health Crisis Hotline	1-855-661-2025. Call anytime, day or night. 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, seven days a week. You may select any behavioral health specialist within your plan. Visit www.anthem.com/kymedicaid. Under Care, select Find a Doctor to find one near you.

Important Phone Numbers and Websites

Agency	Web Address
benefind	1-844-407-8398 https://benefind.ky.gov
Department for Medicaid Services (DMS)	1-800-635-2570 https://chfs.ky.gov/agencies/dms/Pages/default.aspx
Kentucky Attorney General Office of Medicaid Fraud and Abuse	https://ag.ky.gov/about/branches/OMFA
Department for Medicaid Services (DMS) Fraud and Abuse	1-800-372-2970 https://chfs.ky.gov/agencies/dms/dpi/Pages/fraud-abuse.aspx
Kentucky Department for Community Based Services (DCBS)	1-855-306-8959 Fax: 502-573-2007 https://prdweb.chfs.ky.gov/Office_Phone/index.aspx
Kentucky Children's Health Insurance Plan (KCHIP)	1-877-524-4718 1-800-662-5397 en español https://kidshealth.ky.gov/Pages/index.aspx
Social Security	1-800-772-1213 https://www.ssa.gov
Office of the Medicaid Ombudsman	1-800-372-2973 TTY 1-800-627-4702 https://chfs.ky.gov/agencies/os/omb/Pages/default.aspx
Child and Adult Abuse	1-800-752-6200
National Domestic Violence Hotline	1-800-799-SAFE (7233)

Medicaid Managed Care Ombudsman Program

Helping you keep your benefits

Each 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.

When you get 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.

Health Insurance Portability and Accountability Act (HIPAA)

Your health information is personal. HIPAA rules give you the right to control your personal health information (PHI). Any health information that can be used to identify you **is** protected health information.

Anyone who takes part in your medical care can see your PHI. Everyone who handles your health information is legally required to protect the privacy of your PHI. Anyone who uses your PHI in a wrong way is responsible for that.

PHI can be legally used in certain ways. A provider who is treating you can see your PHI as a part of your care and treatment.

You can decide to let people use your PHI if you think it is necessary. If you decide to let someone else use your PHI, you need to write a detailed letter stating that person is allowed to use it. **A person has to have a written statement to ask for your PHI, even if that person is a spouse or a family member.**

Where Do I Send Questions?

If you have questions about HIPAA and your PHI, please contact the **Anthem Medicaid** Privacy Officer, in writing.

The address is:
Member Privacy Unit
P.O. Box 62509
Virginia Beach, VA 23466

Complaints:
If you think your PHI has been used incorrectly, you can make a complaint.

The address is:

The Secretary of Health and Human Services

200 Independence Ave. SW, Room 615F
Washington, D.C. 20201

You can call the U.S. Department of Health and Human Services at 1-877-696-6775. You can also call the United States Office of Civil Rights at 1-866-OCR-PRIV (866-627-7748) or TTY 1-866-788-4989.

Discrimination is Against the Law

Anthem Medicaid complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **Anthem Medicaid** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Anthem Medicaid provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Anthem Medicaid also provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the EEO/Civil Rights Compliance Branch.
If you believe that **Anthem Medicaid** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

EEO/Civil Rights Compliance Branch
Cabinet for Health and Family Services
Office of Human Resource Management
275 E. Main St, Mail Stop 5C-D
Frankfort, KY 40621
Telephone: 1-502-564-7770
Fax: 1-502-564-3129

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the EEO/Civil Rights Compliance Branch is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Ave. SW
Room 509F
HHH Building
Washington, D.C. 20201

TDD: 1-800-368-1019, 1-800-537-7697. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

IV. Key Words/Definitions

Appeal: A member's request for Anthem Medicaid to review and change a decision made about coverage for a requested service.

Copayment: The dollar amount you, as the member, may be responsible for paying when you receive certain services such as office visits, supplies, or prescriptions.

Durable medical equipment (DME): Equipment that is medically necessary and ordered by your doctor or other provider

Emergency medical condition: A medical or mental condition with such severe symptoms, such as active labor (go to definition above) or severe pain, that someone with a prudent layperson's knowledge of health and medicine could reasonably believe that not getting immediate medical care could:

- Place your health or the health of your unborn baby in serious danger.
- Cause impairment to a body function.
- Cause a body part or organ to not work right.

Emergency room care: An exam performed by a doctor (or staff under direction of a doctor as allowed by law) to find out if an emergency medical condition exists. Medically necessary services needed to make you clinically stable within the capabilities of the facility.

Emergency medical transportation: Transportation in an ambulance or emergency vehicle to an emergency room to receive emergency medical care.

Excluded services: Services not covered by your health plan.

Grievance: A member's verbal or written expression of dissatisfaction about Anthem Medicaid, a provider, or the quality of care or services provided. A complaint is the same as a grievance.

Habilitation services and devices: They help a person keep, learn, or improve skills and functioning for daily living.

Health insurance: Insurance coverage that pays for medical and surgical expenses by repaying the insured for expenses from illness or injury or paying the care provider directly.

Home health care: Skilled nursing care and other services given at home.

Hospice: Care to reduce physical, emotional, social and spiritual discomforts for a member with a terminal illness (not expected to live for more than six months).

Hospitalization: Admission to a hospital for treatment.

Hospital outpatient care: Care you receive when you have not been formally admitted to the hospital as an inpatient.

Medically necessary: A determination needed for the diagnosis or treatment of your medical condition. It must also meet accepted standards of medical practice.

Medically Necessary Health Care Services: Health care services that a provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:
(a) In accordance with generally accepted standards of medical practice; and
(b) Clinically appropriate in terms of type, frequency, extent, and duration.

Network: A group of doctors, clinics, hospitals and other providers contracted with Anthem Medicaid to provide care.

Nonparticipating provider: A provider not in the Anthem Medicaid network.

Physician services: Services given by a person licensed under state law to practice medicine or osteopathy, not including services offered by doctors while you are admitted in a hospital that are charged in the hospital bill.

Plan: A health insurance program that uses certain doctors, specialists, clinics, pharmacies and hospitals for those enrolled.

Preauthorization: A formal process requiring a health care provider to get approval to provide specific services or procedures.

Participating provider: A doctor, hospital or other licensed health care professional or licensed health facility, including sub-acute facilities that have a contract with Anthem Medicaid to offer covered services to members at the time a member receives care.

Premium: An amount paid for coverage; cost for coverage.

Prescription drug coverage: Coverage for medications prescribed by a provider.

Prescription drugs: A drug that legally requires an order from a licensed provider to be dispensed, unlike over-the-counter (OTC) drugs that do not require a prescription.

Primary care provider (PCP): The licensed provider you have for most of your health care. Your PCP helps you get the care you need. Some care needs to be approved first, unless:

- You have an emergency.
- You need OB/GYN care.
- You need sensitive services.
- You need family planning care.

Provider: A doctor of medicine who can provide health care services to you.

Rehabilitation services and devices: Health care services and devices that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled.

Skilled nursing care: Covered services provided by licensed nurses, technicians and/or therapists during a stay in a Skilled Nursing Facility or in a member's home.

Specialist (or specialty doctor): A doctor who treats certain types of health care problems. For example, an orthopedic surgeon treats broken bones; an allergist treats allergies; and a cardiologist treats heart problems. In most cases, you will need a referral from your PCP to go to a specialist.

Urgent care: Services provided to treat a non-emergency illness, injury or condition that requires medical care. You can get urgent care from an out-of-network provider if network providers are temporarily not available or accessible.

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.

Anthem Medicaid

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** 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.

Contacting you
We, along with our affiliates and/or vendors, may call or text you using an automatic telephone dialing system and/or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other
health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we won't contact you in this way anymore. Or you may call 1-844-203-3796 to add your phone number to our Do Not Call list.

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, Ste. 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**.

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.

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.

Revised December 21, 2017

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (TTY: 711) (رقم هاتف الصم والبكم)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (TTY: 711)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (TTY: 711) 번으로 전화해 주십시오.

Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (TTY: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् (टिटिवाइ: 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (TTY: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, Ni argama. Bilbilaa 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570; 1-800-635-2570 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (телетайп: TTY:711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (TTY: 711).

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona-1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (TTY: 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (TTY-711) Telefon za osobe sa oštećenim governor ili sluhom: 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (TTY: 711)まで、お電話にてご連絡ください。

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 at 1-855-690-7784.

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, or phone:

Dan Sesit, Compliance Manager
13550 Triton Park Blvd.
Louisville, KY 40223

Phone: 1-502-619-6800,
ext. 106-126-6017
Email: Dan.Sesit@anthem.com

Need help filing? Call our Compliance Manager 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. Department 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)

For a complaint form, visit **https://www.hhs.gov/ocr/office/file/index.html**

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