kynect to care

A guide to kynect health coverage and staying healthy

kynect to care is a guide for your **kynect health coverage**. The information, tools, and tips can help you understand and make the most of your health coverage.

Coverage Is Just the Beginning.

kynect to care Contents

Health Coverage Common Words

Health Coverage term: **Review the Common Words on each page for common words used when talking or reading about health coverage.**

Visit our website pages right from this booklet.

To open a link from the booklet, open your smartphone or tablet camera and point it at the QR code. Your phone or tablet will open the webpage.

kynect tip: **Look for these tips on the pages ahead for cost-saving facts and other kynect information.**

kynect to care

start

A guide to kynect health coverage and staying healthy

Types of Coverage

kynect provides health coverage through these programs:

- »Qualified Health Plan (QHP)
- »Medicaid
- »KCHIP

Eligibility Basedon

- »Income
- »Household size
- »Kentucky residency
- »Other factors

Selecting Coverage

- »Think about the coverage you need
- »Consider costs
- »Decide if the network is convenient for you

Who Can Help

- »Your Qualified Health Plan (QHP) or Managed Care Organization (MCO) can help with coverage questions
- »Agents can help you choose and enroll in a QHP
- »kynectors can help you apply and enroll and answer questions about Medicaid, KCHIP, and QHPs

Understanding Your Coverage

- »Learn what your plan covers
- »Know your network
- »Understand your out-of-pocket costs

Prioritizing Your Health

- »Make healthy choices every day
- »Keep a file for your medical information
- »Find a primary care physician and get regular health screenings

Where to Get Care

- »Your Primary Care Provider (PCP) is where you get most of your care
- »Emergency Department visits are for life-threatening situations
- »Use Urgent Treatment Centers when your situation is not life-threatening but you cannot wait for a PCP appointment
- »Your PCP may refer you to a specialist for specialized care

Finding a Provider

- »Your plan has a list of providers you can use

Appointments

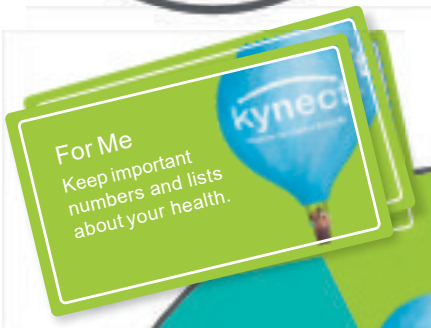
- »New patients must provide a health history summary
- »It may take longer to get an appointment for routine visits

Ways to kynect

Online: kynect.ky.gov

Free Local Help: An Agent or kynector can help you apply and help you with your eligibility and enrollment

By phone: Call 855-4kynect (855-459-6328) to apply over the phone



Provider Visits

- »Take notes or bring a friend if you need help remembering what the doctor says
- »Bring your insurance card to your doctor appointments
- »Be open and honest with your provider and share your family medical history

After Your Appointment

- »Follow your provider's recommendations
- »Fill any prescriptions
- »Schedule follow-up visits

Your Provider as a Partner

- »A provider is a trusted source for medical, mental, and preventive care
- »Work together with your provider to stay healthy

Appeals and Grievances

- »You have a right to appeal decisions about your health care

Health Coverage Common Words

- »Learn and understand common words about health coverage

kynect
Together for a better Kentucky

finish

For Me

This kynect to care Booklet Belongs to:

_____

Health Plan Name_____

Policy Number_____

Group Number_____

Your Health Care Team

Health Plan Phone Number_____

Primary Care Provider Name and Phone Number

_____

Other Providers_____

Pharmacy_____

Allergies_____

Emergency Contact_____

List of Medications_____

_____

kynector or Agent Name_____

Agent or kynector Contact_____

kynect Username_____

Other_____

Electronic records: Many providers offer online access to your medical records, known as an electronic health record. Speak with your MCO or provider about how to access your electronic health records.

List of Current Medications:

_____

_____

_____

_____

Allergies:

_____

_____

_____

_____

Important: Keep your personal information in a safe place and protected.

Applying on kynect

The **kynect** application helps guide you through entering the information needed to determine your eligibility for health coverage. There are short videos, information icons, and instructions throughout to help you apply.

There are several ways to apply for health coverage with kynect:

Online: kynect.ky.gov

Agent or kynector: An Agent or kynector can help you apply and help you with your eligibility and enrollment

By phone: Call 855-4kynect (855-459-6328) to apply over the phone

kynect tip: **Remember you can stop and start your online application at any time. Just hit "Save and Exit."**

Information you will need when you apply:

- Address
- Identification numbers from documents such as Social Security card, immigration documents, or government-issued ID like a driver's license
- Household information such as names, dates of birth, and Social Security numbers (SSN) of all persons in your household
- Income and expenses information
- Health insurance information if you have insurance through a job
- Cost of employer-provided insurance

You may be asked to send proof of information you enter into the application. Documents may be uploaded at kynect.ky.gov.

Eligibility Notice

After submitting your application, the system will generate an eligibility notice. This notice tells you in what health coverage you are eligible to enroll.

Enrollment

After you apply, you may select a plan and enroll. **kynect** screens will help you through the available plans and show plan and coverage details.

Types of Coverage

Health coverage is important

- Health coverage helps you get care when you are sick.
- Coverage includes things you may need when you are not ill, like screenings and vaccines.
- Health coverage allows you to get tests and see specialists when needed. It also covers some or all prescription costs.
- Health coverage helps protect you from high costs if you are ever in an accident.
- Coverage protects you when you need emergency care.

kynect Eligibility Options

There are several ways you may be covered with kynect.

When you apply on **kynect**, the system will let you know if you or your household qualify for a Qualified Health Plan (QHP), Medicaid, or KCHIP or if you are dual eligible for both Medicaid and Medicare. Read more details about each coverage option on the following pages.

kynect tip: **Sometimes people within the same household qualify for different coverage programs.**

Whatever Your Situation or Need, There's a Way to kynect.

kynect offers a mobile-friendly, online application. Apply or report changes online at **kynect.ky.gov**.

Health Coverage

Programs covering Qualified Health Plans (QHP) and Advance Premium Tax Credit (APTC) also known as Payment Assistance and Cost Sharing Reductions to help your family get Health Coverage.

Benefits

Programs covering food assistance (SNAP), Medicaid, child care assistance, financial aid for children and caregivers (KTAP), and many more state assistance programs.

Health Coverage Common Words

Eligibility: **A determination of ability to enroll in a program based on the requirements of the program.**

MCO: **Commercial organizations that manage health care for Medicaid enrollees. Each MCO has a network, just like other health coverage carriers. You may know your Medicaid coverage by the name of the insurance company.**

Qualified Health Plan: **A health insurance plan that is certified by kynect and meets requirements under the Affordable Care Act.**

Household: **kynect generally considers your household to be you, your spouse if you're married, and your tax dependents. Basically, the people on your tax return each year. If you do not file taxes, it may be important to list anyone who lives with you as a member of your household.**

kynect health coverage provides health coverage with Medicaid, Qualified Health Plans, and KCHIP. Each type of coverage has its own coverage and eligibility rules.

Medicaid

Medicaid provides medical assistance to income-eligible Kentuckians. Medicaid is a state program authorized and jointly funded by the federal government to provide health care for income-eligible adults, children, families, pregnant women, the aged, and the disabled. Eligibility is determined by a number of factors, including family size, income, and the Federal Poverty Level.

- No premiums
- Usually enrolled in a Managed Care Organization (MCO)
- May enroll anytime
- May qualify for retroactive coverage for up to three months
- Large network areas
- Pregnant persons with higher incomes can be eligible
- May be eligible for and enroll in Medicaid at the same time as employer-sponsored insurance

MCO

Managed Care Organizations (MCO) administer the coverage and benefits for the Medicaid program. Members may interact more with their MCO than directly with the Kentucky Department for Medicaid. Many people are more familiar with the insurance company name of their MCO.

KCHIP

The Kentucky Children's Health Insurance Program (KCHIP) is free health insurance for children younger than 19 without health insurance. Children may be eligible even when their parents have other coverage. KCHIP income limits are higher than for Medicaid.

QHP(Private Insurance)

A Qualified Health Plan (QHP) is an insurance plan that is certified by **kynect** and provides essential health benefits and meets other requirements under the Affordable Care Act. Individuals can be eligible for payment assistance. The Advance Premium Tax Credit (APTC) can reduce monthly premiums, and Cost Sharing Reductions (CSRs) can reduce out-of-pocket costs. Persons who are above the income limit for Medicaid may qualify for payment assistance.

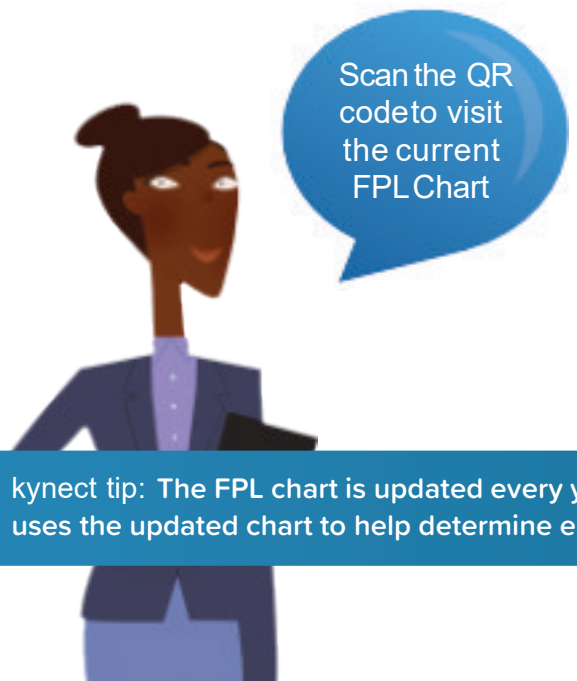
- There may be premiums or other costs
- Individuals who qualify will choose and enroll in a QHP
- Individuals can only enroll during Open Enrollment or if they experience a qualifying life event
- Individuals generally do not qualify for retroactive coverage
- Network areas (where coverage is accepted) are relatively small
- Coverage can be terminated if monthly premiums are not paid

Dual Eligibility

Dual-eligible individuals are enrolled in Medicare Part A, in Medicaid (full benefits), and/or in Medicare Savings Programs, also known as MSPs. MSPs cover costs such as Medicare Part A premiums and Medicare Part A and B deductibles, co-insurance, and co-payments.

Eligibility Guidelines

- **kynect** uses the information you enter into the application to determine your eligibility for health coverage.
- Each type of coverage has unique eligibility requirements that must be met. All programs look at income and household size as a determining factor for eligibility.
- **kynect** uses the Federal Poverty Level (FPL) as a measure of income for eligibility.
- Individuals who are blind or disabled may qualify regardless of income.
- Children and the aged may qualify for programs based on their age.
- Disability may factor into some eligibility.
- Pregnant women may be eligible.
- Access to employer health coverage may impact eligibility for APTC and CSR.



kynect tip: **The FPL chart is updated every year, and kynect uses the updated chart to help determine eligibility.**

If you are…	You may qualify for…	Estimated cost
Individual 19 or older, making less than $21,600	Medicaid	No Cost
Individual 19 or older, making $22,000	QHP with APTC and CSR	Plans Available for as little as $0 Per Month*
Individual 19 or older making $35,000	QHP with APTC	Plans Available for as little as $50 Per Month*
Individual 19 or older making $55,000	QHP with APTC (premium not to exceed 8.5% of income) newly eligible	Plans Available for as little as $100 Per Month*
Family of four making less than $44,376	Medicaid	No Cost
Family of four making $70,092	QHP with APTC and CSR (children under 19 may be eligible for KCHIP)	Plans Available for as little as $50 Per Month. No cost for Children.*
Family of four making $90,000	QHP with APTC	Plans Available for as little as $100 Per Month*
Family of four making more than $120,000	QHP with APTC (premium not to exceed 85% of income) newly eligible	Cost based on income, family size, and other factors.

**Estimated costs are provided as an example only. Income eligibility limits may change yearly based on updated FPL chart. This chart is accurate as of Plan Year 2025.*

Health Coverage Common Words

Advance Premium Tax Credit (APTC): **A type of payment assistance for QHPs. APTC is a tax credit taken in advance to lower your monthly health insurance payment (or "premium"). You must reconcile APTC on your tax return for the year.**

FPL: **A measure of income issued every year by the Department of Health and Human Services. kynect uses Federal Poverty Levels to determine eligibility for certain programs and benefits, including payment assistance on kynect health coverage, Medicaid, and KCHIP.**

Cost Sharing Reduction (CSR): **Another type of payment assistance for QHPs. CSRs are discounts on the amount you pay for deductibles, co-payments, and co-insurance. If you qualify, you must enroll in a plan in the Silver category to get these special discount savings.**

Employer Sponsored Insurance (ESI): **Health-coverage plan that is available through employment.**

kynect health coverage eligibility is based on a variety of factors. The best way to determine your eligibility is to apply and receive eligibility results. There is no penalty or cost to apply. Once you know your eligibility results, you can choose to enroll or not. If you disagree with your eligibility results, you can appeal.

Medicaid Eligibility

MCO eligibility is determined by the below factors:

- Income
- Household size
- Federal Poverty Level (FPL)
- Pregnant persons with higher income may be eligible
- Children can be eligible in families with even higher incomes
- Aged, blind, or disabled may be eligible regardless of income

KCHIP Eligibility

KCHIP eligibility is based on the below criteria. Although only children may be eligible for KCHIP, other household members may be eligible for other health coverage programs.

- Under 19
- Income
- Household size

QHP Eligibility

QHP eligibility is determined by the below factors and may include eligibility for APTC or CSR:

- Resident of Kentucky
- U.S. citizenship or lawful presence
- Income
- Household size
- FPL
- Access to employer-sponsored insurance (ESI)

Special Note:

- Incarcerated individuals may not enroll in **kynect health coverage**. kynectors can help coordinate enrollment upon release.
- Incarcerated means serving a term in prison or jail.
- Incarceration does not include being on probation, parole, or home confinement.
- You are not considered incarcerated if you're in jail or prison pending disposition of charges – meaning being held but not convicted of a crime.

When Eligibility Changes

It is important to keep your application updated when changes happen, so you are in the best coverage for your situation. This helps protect you from medical bills you may receive if you are not enrolled in the program you are eligible for.

These are examples of changes you should report and update on your kynect application.

- Change in income
- Loss of other health coverage (depending on circumstances)
- Having a child
- Getting married
- Moving to the state or out of your current area
- Release from incarceration
- Change in citizenship or immigration status

kynect tip: Open Enrollment is around the same time every year. The Open Enrollment dates are typically in the months at the end of the calendar year.

Exceptional Circumstances such as being incapacitated, being affected by a natural disaster, experiencing domestic abuse/ violence, or technical or system issues that prevented enrollment may qualify you to enroll outside of Open Enrollment.

When you report a change, you may qualify for a Special Enrollment Period. This is a time outside Open Enrollment when individuals may choose a new plan.

Special Enrollment Periods are available within a limited time from when the change occurs and are available for a limited time.

Keep your coverage

- Make your monthly premium payment
- Report changes within 30 days
- Read your **kynect** notices for information on renewals and re-determination dates

Health Coverage Common Words

Open Enrollment

- QHP: Yearly Open Enrollment when you may enroll in a Qualified Health Plan. This is the only time enrollment is open unless you report a change that qualifies you for a Special Enrollment Period.
- Medicaid: You may apply and enroll in Medicaid anytime during the year. Medicaid's yearly Open Enrollment Period is when you may choose a different MCO.

Special Enrollment Period (SEP):When you report one of the changes mentioned on this page, kynect may allow you a limited time period in which you may enroll in a QHP. This limited time period is your SEP.

Termination Date: The date your health coverage ends.

When your eligibility changes, your coverage or plan may change. Moving to a QHP or to Medicaid may change several things about your coverage.

Moving from a QHP to Medicaid

If you are enrolled in a QHP and then later become eligible for Medicaid, you will likely move to an MCO for coverage. Here are some things to know:

- Medicaid has no premiums or cost sharing.
- The MCO may have a different network. Your doctor, pharmacy, or other health care provider may or may not be in the new plan's network or accept Medicaid.
- The MCO will have new cards and new numbers to call to answer questions about finding providers, billing, etc.

QHP to MCO Timeline:
When moving from a QHP to Medicaid, generally your Medicaid coverage will begin the first of the month of being found eligible.

Moving from an MCOto a QHP

If you are enrolled in Medicaid and then later become eligible for a QHP, here are some things to know:

- The QHP may have a monthly premium. It is important to pay the premium every month to keep your coverage.
- In a QHP, there may be cost sharing, deductibles, co-pays, and/or co-insurance. As an example, this means you may have to pay a copay or co-insurance when you go to the doctor.
- The QHP may have a different network. Your doctor, pharmacy, or other health care provider may or may not be in the new plan's network.
- The QHP will have new cards and new numbers to call to answer questions about finding providers, billing, etc.

Medicaid to QHP Timeline:
When moving from Medicaid to a QHP, generally your QHP coverage will begin the first of the month following plan selection.

Enrollments and coverage dates may follow other timelines depending on reason for eligibility and other factors. See Coverage Effective Dates Fact sheet at ***https://khbe.ky.gov/About/Pages/Facts-and-Resources.aspx****.*

Immigrant and Refugee Eligibility

Immigrants and refugees may be eligible for health coverage depending on their status.

- Immigrants who are lawfully present and meet other basic income eligibility requirements may be eligible for Qualified Health Plans and Advance Premium Tax Credits.
- Immigrants who are lawfully present, have a "qualified immigrant status," and meet basic income eligibility requirements are eligible to enroll in Medicaid or KCHIP.
- Undocumented immigrants and individuals with Deferred Action for Childhood Arrivals (DACA) are not eligible for QHPs, APTC, or Medicaid/KCHIP. However, Medicaid does provide payment for emergency services for treatment of emergency medical conditions if the individual meets all other Medicaid eligibility rules.

kynect tip: **Regardless of immigration status, you may be eligible for Emergency Time Limited Medicaid if you apply within three months of emergency care. Childbirth qualifies as an emergency.**

What is public charge? Some people who apply for a green card (Lawful Permanent Residency) or a visa to enter the U.S. must pass a "public charge" test. In those cases, immigration officials look at whether the person is likely to depend primarily on the government for support in the future.

The ONLY government programs that impact public charge are:

- Cash assistance, like SSI or KTAP, and state and local cash assistance programs
- Long-term institutional care, like a nursing home, at government expense

Examples of programs that do NOT affect public charge:

- Supplemental Nutrition Assistance Program (SNAP), WIC, free or reduced school lunches, food banks, or free meals
- Kentucky Children's Health Insurance Program (KCHIP)
- Medicaid and other health care (except long-term institutional care)
- Housing programs, including Section 8, public housing, and shelters
- Vaccines or testing for communicable diseases
- Earned income and child tax credits

Important to know:

- Most people do not have to worry about public charge at all
- Most government programs do not count in public charge determinations
- Public charge is not just about government services

Federal law requires most "qualified immigrants" meet a five-year waiting period (called the five-year bar) before becoming eligible for Medicaid. Some immigrant statuses may be exempt from the five-year waiting period.

Immigrant Eligibility for Medicaid and KCHIP

Immigrants who are non-citizens and have a "qualified immigrant status" are eligible to enroll in Medicaid or KCHIP if they meet income and state residency criteria.

- Federal law requires most "qualified immigrants" meet a five-year waiting period (called the five-year bar) before becoming eligible for Medicaid or KCHIP.
- Some immigrant statuses may be exempt from the five-year waiting period.
- Undocumented immigrants and individuals granted Deferred Action for Childhood Arrivals (DACA) are not eligible for QHPs, APTC, or Medicaid/KCHIP.

kynect tip: **Medicaid provides payment for emergency services for treatment of emergency medical conditions if the individual meets all other Medicaid eligibility rules.**

"Qualified immigrants" for Medicaid or KCHIP are:

- Lawful Permanent Residents (LPR/Green Card Holder)
- Asylees
- Refugees
- Cuban/Haitian entrants
- Paroled into the U.S. for at least one year
- Conditional entrant granted before 1980
- Abused or neglected spouses, children, or parents
- Victims of trafficking and their spouses, children, siblings, or parents or individuals with a pending application for a victim of trafficking visa
- Granted withholding of deportation
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Citizens of the Marshall Islands, Micronesia, and Palau who are living in one of the U.S. states or territories (referred to as Compact of Free Association or COFA migrants)

Verifying Status

An individual's immigration status is verified through an electronic immigration status verification system. If the data cannot be confirmed by electronic matches, then the individual must submit appropriate verification documents.

Emergency Time-Limited Medicaid

Emergency Time-limited Medicaid helps people who qualify for Medicaid in every way but their immigration status. This type of Medicaid is limited to emergencies.

What bills does it cover?

Doctor bills, hospital bills, and more – but only to care for an emergency and only for two months at a time. Examples of an emergency include childbirth and COVID-19-related testing, treatment, and vaccination.

What bills are not covered?

Organ transplants and nursing home care are not covered.

Do I have to have low income?

Yes. How low depends on whether you are a child, pregnant woman, adult, elderly person, or person with disabilities.

Applying for Coverage

Call kynect at 1-855-459-6328.

How do I apply? You can fill out an application online at **kynect.ky.gov**. You can apply in person at your local Medicaid and Food Stamps (DCBS) office. Or call **kynect** at 855-459-6328 or DCBS at 855-306-8959. Tell them you want to apply for "Emergency Time-Limited Medicaid." They can also help you find a kynector who is local to you and can assist you free of charge. You can also sign up at a hospital when you have an emergency.

When should I apply? To make sure your bills are covered, you must apply within three months of your emergency care.

Is my information safe?

kynect will only use your information to determine your eligibility for the program. Federal law protects your Medicaid application information.

Immigrant Eligibility for Qualified Health Plans

To enroll in Qualified Health Plans (QHPs) on **kynect health coverage**, an individual must be a U.S. citizen or be lawfully present in the United States. They must also be a Kentucky resident.

Immigration Statuses eligible to enroll in Qualified Health Plans (QHPs) ONLY with employment authorization:

- Registry applicants
- Those with Orders of Supervision
- Applicants for Cancellation of Removal or Suspension of Deportation
- Applicants for Legalization under Immigration Reform and Control Act (IRCA)
- Those with legalization under the LIFE Act

Exceptions

- Individuals granted deferred action under the Deferred Action for Childhood Arrivals (DACA) program are not eligible to enroll in kynect health coverage.
- Applicants for asylum who have been granted employment authorization or are under the age of 14 and had an application pending for at least 180 days are eligible to enroll in kynect health coverage.

kynect tip: Lawfully present immigrants may be eligible for lower costs on monthly premiums and lower out-of-pocket costs based on their incomes.

Immigration Statuses eligible to enroll in Qualified Health Plans (QHPs):

- Lawfully Permanent Resident (LPR/Green Card holder)
- Asylee
- Refugee
- Cuban/Haitian Entrant
- Paroled Into the U.S.
- Conditional Entrant Granted Before 1980
- Battered Spouse, Child, and Parent
- Victim of Trafficking and His/Her Spouse, Child, Sibling or Parent
- Granted Withholding of Deportation or Withholding of Removal, Under the Immigration Laws or Under the Convention Against Torture (CAT)
- Individual With Non-immigrant Status, Includes Worker Visas (such as H1, H-2A, H-2B); Student Visas, U-visa, T-visa, and Other Visas; and Citizens of Micronesia, the Marshall Islands, and Palau
- Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Deferred Action Status (Exception: Deferred Action for Childhood Arrivals (DACA) is not an eligible immigration status for applying for health insurance.)
- Lawful Temporary Resident
- Administrative Order Staying Removal Issued by the Department of Homeland Security
- Member of a Federally Recognized Indian Tribe or American Indian Born in Canada
- Resident of American Samoa
- Temporary Protected Status With Employment Authorization
- Special Immigrant Juvenile Status
- Victim of Trafficking Visa
- Adjustment to LPR Status
- Asylum (See “Exceptions” on the opposite page)
- Withholding of Deportation, or Withholding of Removal, Under the Immigration Laws or Under the Convention Against Torture (CAT) (See “Exceptions” on the opposite page)

Selecting Coverage

Comparing Qualified Health Plans

Before enrolling in a Qualified Health Plan, it is important to compare available plans to ensure you have the coverage you need.

You will see available plan options after your application is submitted online and your enrollment has been approved. Plans may be compared by premium cost, by metal level, or by using other search filters.

Things to consider when comparing plans are:

- The monthly premiums, deductibles, co-pays, and other out-of-pocket costs.
- The frequency in which you need provider care.
- Provider visit limitations.
- Prescription coverage.
- Coverage for Specialists.
- Is your current Primary Care Provider in the plan network?

Help at No Cost

kynect has licensed insurance agents and kynectors to help with the **kynect** application and plan choice.

An insurance agent is a trained insurance professional who can help you enroll in a health insurance plan. Agents may work for a single health insurance company or represent several companies.

A kynector can help you apply and narrow down your plan choices. To find an Agent or kynector, call **kynect** at 1-855-4kynect (459-6328).

kynect tip: **Some plans include dental and/or vision coverage. If the medical plan you choose does not come with dental, you can buy a dental or vision plan by itself. (This will require an additional premium.)**

Health Coverage Common Words

Copay: **An amount you pay each time you get health care, such as when you go to the doctor or hospital or when you get a prescription. Usually, the copay is a set amount, such as $30 for a doctor visit.**

Deductible: **The amount you must pay for health care services or prescriptions before your plan begins to pay. Some plans have separate deductibles for health care services and prescriptions. There may be a separate deductible for each member of the family, as well as the entire family.**

Out of Pocket: **Cost for medical care that is not paid by your plan. Out-of-pocket costs include deductibles, co-insurance, co-payments and any other expenses.**

Premium: **The amount you pay every month to keep health coverage. You will get a bill each month from your insurance company. You must pay the bill every month to keep your coverage.**

Comparing MCO Plans

All MCOs must provide the same benefits. When picking an MCO, consider these questions:

- Which plan has all or most of the doctors my family and I visit?
- Which plan has the hospitals my family and I like to use?
- Do I or any family member have a health problem that needs treatment by a specific type of doctor or specialist?
- Which MCO offers special programs that may be of interest to me and my family?

Many MCOs offer value-added services. These are services and programs the MCO offers in addition to your basic coverage and benefits.

Value-added coverage may change each year.

kynect tip: **Look for value-added services that save costs and help you stay healthy.**

Examples of Value-Added Coverage

Each MCO may offer different value-added items.

- 24/7 behavioral health hot-line
- Acupuncture, massage, chiropractic, etc.
- Basic dental services
- Breastfeeding support
- College scholarship
- Diabetes assistance
- Diapers
- Discounts
- Doula services
- Financial education
- Foster-parent support
- Free baby items
- Free cell phone
- Free eyeglasses for adults 21+
- Free hearing aid batteries
- Free hearing screenings and hearing aid for adults
- GED assistance
- Homelessness support
- Job training
- Laptop/computer
- Life skills training
- Online behavioral-health support, tools, and resources
- OTC discounts or items
- Prenatal and postpartum support
- Reading scholarship
- Respite care
- Smoking cessation
- Substance abuse support
- Supports for formerly justice-involved individuals
- Telehealth
- Text and email notification program
- Transportation
- Vaccines
- Weight management program

Who Can Help

One of the most important things you can know about health coverage is where to go when you have questions. Who you should call usually depends on why you are calling.

It is usually best to start with your plan or your MCO when you have questions.

Your Plan

Your plan phone numbers are usually listed on your insurance card. Contact your insurance company plan for:

- Information about your plan
- Payment information
- Questions about what your plan covers
- Pre-authorizations and referrals

Issuers may also have websites with information and resources for enrolled members.

Your MCO

Your MCO contact information is on the MCO card sent to you by your MCO. Contact your MCO for:

- Questions about what your plan covers
- Pre-authorizations and referrals
- Value-added services
- Reporting a lost card
- Reporting errors printed on your card

Managed Care Organizations also have websites with information and resources for members.

kynect tip: **You may need to use your plan and/or MCO card each time you visit a provider or pharmacy.**

Medicaid Identification Card

- Kentucky Medicaid members are sent Medicaid ID cards like this image. The ID card has the member's name and a Medicaid identification number. Make sure names are spelled correctly.
- The Medicaid identification card is different from your MCO card.
- The Medicaid ID card is valid as long as you are Medicaid eligible. Contact the Department for Community Based Services at (855) 306-8959 if you lose your card, it contains errors, or you need to request a replacement ID.

Front of card

Back of card

kynect

kynect can help by phone with application and enrollment, questions, and other support. Call **kynect** for help with:

- Application for health coverage
- Enrollment support
- Eligibility changes or questions
- Reporting life changes
- Help finding an Agent or kynector

Call **kynect** at 855-4kynect (855-459-6328.

Department for Community Based Services (DCBS may be reached for benefits at 1-855-306-8959.

Agents and kynectors

Agents and kynectors are available in your area and can help with applying and enrolling in health coverage.

They can also assist with changes and questions throughout the plan year and offer phone or in-person assistance.

kynector organizations host many events throughout the year in the communities they serve.

It is helpful to keep your Agent's or kynector's contact name and phone number in case you have questions.

Find Free Local Help: an Agent or kynector

If you do not have a kynector assigned to your case, you can find one by calling 855-4kynect, visiting https://kynect.ky.gov/benefits/s/auth-reps-assisters?language=en_US, or scanning the QR code and click Get Local Help.

kynect tip: **Agents and kynectors do not charge a fee for their services.**

Prioritizing Your Health

Health coverage is for more than when you are ill. Even when you are well, good care is essential for staying healthy.

- Physical activity, healthy eating, preventive services, and even relaxation and sleep all help you prioritize your health.
- Preventive services include health care such as screenings, checkups, and patient counseling. These services help prevent illness, disease, and other health problems. They also detect medical conditions at an early stage when treatment is likely to work best.
- Your Primary Care Provider (PCP) can help recommend preventive services to keep you healthy.

Healthy Choices

When you prioritize your health, you make small decisions every day that impact your long-term health.

Here are some small choices that may have big impacts on health:

- Food choices and how often you eat or snack
- Making time for exercise each week
- Choosing water over sugary or high-calorie options
- Regular use of maintenance medicines when prescribed
- Adequate sleep every night
- Seeking preventive care before you are ill
- Minding your mental and emotional well-being

kynect tip: **Many Managed Care Organizations and issuers have online tools, trackers, and other resources to keep you on track to a healthy lifestyle. Visit your MCO or plan's website for more information.**

Health Coverage Common Words

Provider: A provider can be a doctor, nurse practitioner, behavioral-health professional, or other health care provider you see.

Primary Care Provider: Your Primary Care Provider is the provider you see the most and will help you keep track of your health over time.

Understanding Your Coverage

Now that you have health coverage, you will need to understand all the services that are covered and how to use your coverage.

Health coverage pays for provider services, medications, hospital care, and special equipment when you're sick.

Coverage is also essential when you're not sick.

Most coverage includes free immunizations for children and adults, annual visits, health screenings, and more.

Before seeking care, you may want to check with your provider to ask if specific services or procedures are covered. Provider offices may offer a Good Faith estimate on services and procedures before they are provided.

Most plans do not cover elective procedures, and some services require a referral from your provider.

Check with your plan or MCO to understand what services and providers your plan will pay for and how much each visit or medicine will cost.

kynect tip: If you receive services that are not covered by your plan, you will be responsible for the total amount or cost of the service or procedure.

kynect offers health coverage through MCOs and QHPs. Coverage and cost information may be specific to QHPs or MCOs

You only need the information specific to the program in which you are enrolled.

Essential Health Benefits (EHB)

Essential Health Benefits (EHB) are 10 categories of services all health plans must cover under the Affordable Care Act. Some plans cover more services, but the 10 EHBs are:

- Ambulatory patient services
- Emergency services
- Hospitalizations
- Pregnancy, maternity, and newborn care before and after birth
- Pediatric care
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Mental health and substance use disorder services
- Laboratory services
- Preventive and wellness services and chronic disease management

Your coverage offers many free services or provides standard care that may not require a copay or other out-of-pocket costs. Services must be provided in your plan's network.

No-cost Preventive Services Include:

- Alcohol misuse screening and counseling
- Aspirin use to prevent cardiovascular disease
- Blood pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screening for adults 45 to 75
- Depression screening
- Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese
- Diet counseling for adults at higher risk for chronic disease
- Fall prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over who are living in a community setting
- Hepatitis B screening for people at high risk
- Hepatitis C screening for adults ages 18 to 79 years
- HIV screening for everyone ages 15 to 65 and other ages at increased risk
- Lung cancer screening for adults 50 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use
- Obesity screening and counseling
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Statin preventive medication for adults 40 to 75 at high risk
- Syphilis screening for adults at higher risk
- Tobacco-use screening for all adults and cessation interventions for tobacco users
- Tuberculosis screening for certain adults without symptoms at high risk

Immunizations for Adults:

Doses, recommended ages, and recommended populations vary:

- Chickenpox (Varicella)
- Diphtheria
- Flu (influenza)
- Hepatitis A
- Hepatitis B
- Human Papilloma Virus (HPV)
- Measles
- Meningococcal
- Mumps
- Whooping Cough (Pertussis)
- Pneumococcal
- Rubella
- Shingles
- Tetanus

Health Coverage Common Words

Preventive Services: Routine health care that includes screenings, checkups, and patient counseling to prevent illnesses, disease, or other health problems or to detect illness at an early stage, when treatment is likely to work best. (This can include services like flu and pneumonia shots and vaccines as well as screenings like mammograms or depression/behavioral-health screenings.)

Coverage for Pregnant Women or Women Who May Become Pregnant

Coverage for women or women who may become pregnant offers many free services or provides standard care that may not require a copay or other out-of-pocket costs. Services must be provided by a provider in your plan network.

No-cost Services for Pregnant Women or Women Who May Become Pregnant:

- Breastfeeding support and counseling from trained providers; access to breastfeeding supplies for pregnant and nursing women
- Birth control
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visits
- Maternal depression screening for mothers at well-baby visits
- Preeclampsia prevention and screening for pregnant women with high blood pressure
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening
- Expanded tobacco intervention and counseling for pregnant tobacco users
- Urinary tract or other infection screening

kynect tip: **Your provider may recommend other services or frequency of screenings or tests.**

Other Covered Preventative Services for Women:

- Bone density screening for all women over age 65 or women aged 64 and younger who have gone through menopause
- Breast cancer genetic test counseling (BRCA) for women at higher risk
- Breast cancer mammography screenings every two years for women 50 and over and as recommended by a provider for women 40 to 49 or women at higher risk for breast cancer
- Breast cancer chemo prevention counseling for women at higher risk
- Cervical cancer screening
- Pap test (also called a Pap smear) for women ages 21 to 65
- Chlamydia infection screening for younger women and other women at higher risk
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
- Domestic and interpersonal violence screening and counseling for all women
- Gonorrhea screening for all women at higher risk
- HIV screening and counseling for everyone ages 15 to 65 and other ages at increased risk
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative women at high risk for getting HIV through sex or injection drug use
- Sexually transmitted infections counseling for sexually active women
- Tobacco use screening and interventions
- Urinary incontinence
- Well-woman visits

Pediatric and Child Coverage

There are many services offered for pediatric or child patients that may not require a copay or other out-of-pocket costs. Services must be provided in your plan network.

Pediatric/Child Coverage:

- Autism screening for children at 18 and 24 months
- Behavioral assessments
- Blood screening for newborns
- Developmental screening under age 3
- Fluoride varnish as soon as teeth are present
- Hearing screening
- Hematocrit or hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Obesity screening and counseling
- Vision screening for all children
- Well-baby and well-child visits
- Additional screenings and services may be included in your plan coverage

Immunizations for Children From Birth to Age 18 May Vary Based on Age, Population, and Health:

- Chickenpox (Varicella)
- Diphtheria, tetanus, and pertussis (DTaP)
- Haemophilus influenza type b
- Hepatitis A
- Hepatitis B
- Human Papilloma Virus (HPV)
- Inactivated Poliovirus
- Influenza (flu shot)
- Measles
- Meningococcal
- Mumps
- Pneumococcal
- Rubella
- Rotavirus

Costs

Before Using Your Coverage,Learn About Any Costs You May Have.

» Costs include things like premiums, copayments, deductibles, co-insurance, and out-of-network costs.

» Costs are different depending on if you are enrolled in an MCO or a QHP. Qualified Health Plans may have varying costs between plans.

Medicaid/MCO

» No monthly premiums

» No copay

» No deductible

» Must use providers in network

» Network areas are relatively large

QHP

» May have a monthly premium

» May have copays or co-insurance

» May have a deductible

» Has network areas

» Network areas are relatively small

» Coverage can be terminated if monthly premiums are not paid

Health Coverage Common Words

Copayment (copay): An amount you may be required to pay for your share of the cost for a medical service or supply. A copayment is usually a set amount, rather than a percentage.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe.

Premium: The amount that must be paid for your health insurance plan. You will usually pay it monthly. The premium is not counted toward your deductible, your copayment, or your co-insurance. If you don't pay your premium, you could lose your coverage.

One of the most important things to know about your coverage is what providers are in-network. You may be responsible for all or some costs if you receive care from an out-of-network provider without prior authorization.

In-network

In-network providers are a network of doctors and health care facilities (such as hospitals) that provide health services covered by your plan. Usually, it is cheaper to go to an in-network provider.

Out-of-network

Out-of-network providers are doctors and health care facilities (such as hospitals) that provide health services but are not in your plan's network and may not be covered by your plan. You may pay more or 100% of the cost if you use out-of-network providers.

Surprise Billing

There are protections in place for people enrolled in health coverage to avoid surprise medical bills.

These protections ban surprise bills for most emergency services, out-of-network cost sharing for most emergency and some non-emergency services, and out-of-network charges getting care at an in-network facility.

Providers can give you a Good Faith estimate before receiving care. If you receive a bill you disagree with, you may be able to dispute the charges.

Contact your insurance company to find out which providers are in-network.

If a provider is out-of-network, it might cost more to see them.

Networks can change. Check with your provider each time you make an appointment so you know how much you will need to pay.

Health Coverage Common Words

Network: The facilities, providers, and suppliers your health insurer has contracted with to provide health care services.

Surprise Billing: Unexpected costs when a person is unknowingly treated by an out-of-network provider or had a procedure scheduled with an in-network surgeon without being told that other providers on their care team were out-of-network.

Deductibles

Your QHP plan may have a deductible. This is the amount you pay for covered health care services before your insurance plan starts to pay.

Example: With a $1,000 deductible, you pay the first $1,000 of covered services out of your own pocket.

After you have met your deductible, you usually pay only a copayment or co-insurance for covered services and your insurance company pays the rest.

Some services are paid by your plan even if you have not met your deductible amount. These are services like a checkup or disease management and preventive services.

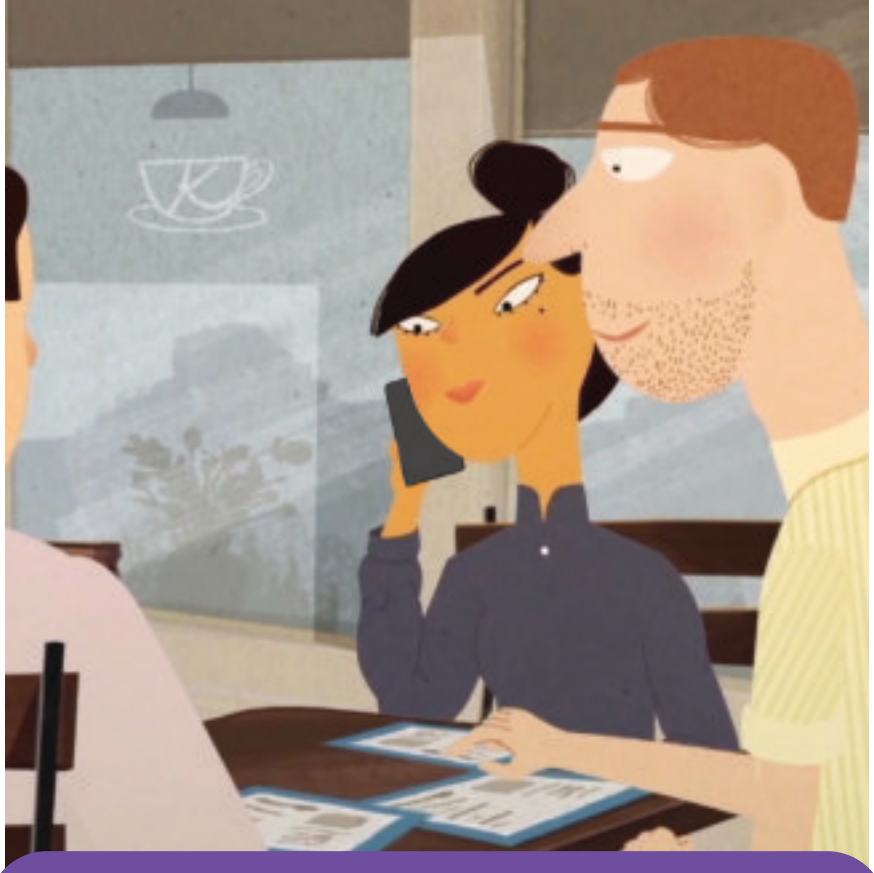
Families may have both an individual deductible, which applies to each person, and a family deductible, which applies to all family members.

Generally, plans with lower monthly premiums have higher deductibles. Plans with higher monthly premiums usually have lower deductibles.

Plans may have a maximum or limit for out-of-pocket costs.

- This is an amount that is the most you will typically pay during the plan year, before your health coverage plan starts to pay 100% of the cost of services.
- There is usually a separate out-of-pocket maximum for each member of the family, as well as the entire family.

kynect tip: Your provider office will let you know what your out-of-pocket costs will be when you receive services.



Health Coverage Common Words

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. (The deductible may not apply to all services.) For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible.

Out-of-Pocket Maximum: The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100%for covered essential health benefits. This limit includes deductibles, co-insurance, copayments, or similar charges and any other expenditure required of an individual for a qualified medical expense.

Prescription Drug Coverage

Prescription drug coverage is the most frequently used benefit of health coverage.

Many plans cover prescription drugs based on a formulary.

A drug formulary is a list of prescription medications that are listed in different categories. Which category determines how much you will pay for that specific medication.

If a medication is "nonformulary," it means it is not included on the insurance company's "formulary" or list of covered medications.

The medications are usually also divided into different levels, called "tiers." Prescription drugs in each tier may have a different cost.

In general, the lowest-tier drugs are the lowest cost.

Examplethree-tier formulary:

Tier	Drugs covered	Your cost
Tier 1	» Most generic drugs	Lowest copay
Tier 2	» Common brand-name drugs » Some high-cost generic drugs	Medium copay
Tier 3	» Preferred brand-name drugs » Nonpreferred brand-name drugs	Highest copay

kynect tip: **Your plan may provide a formulary or "Drug List" to help you confirm your prescription coverage.**

Health Coverage Common Words

Formulary: A system used by health plans to divide drugs into a list of drugs the plan covers.

Formulary Tier: A list of covered drugs, divided into different levels based on cost. The tier a drug is in determines how much the plan covers. Generally, the lower the tier, the lower the cost.

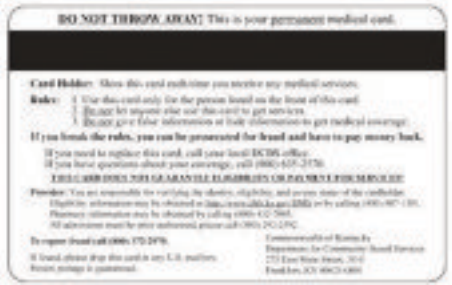
Medicaid Identification Card

» Upon enrollment, Kentucky Medicaid members are sent Medicaid ID cards like this image. The ID card has the member's name and a Medicaid identification number. Make sure names are spelled correctly.

» The Medicaid ID card is valid as long as you are Medicaid eligible. Contact the Department for Community Based Services at (855) 306-8959 if you lose your card, the card has errors, or you need to request a replacement ID.

» The Medicaid Identification Card is different from your MCO card.

Front of card

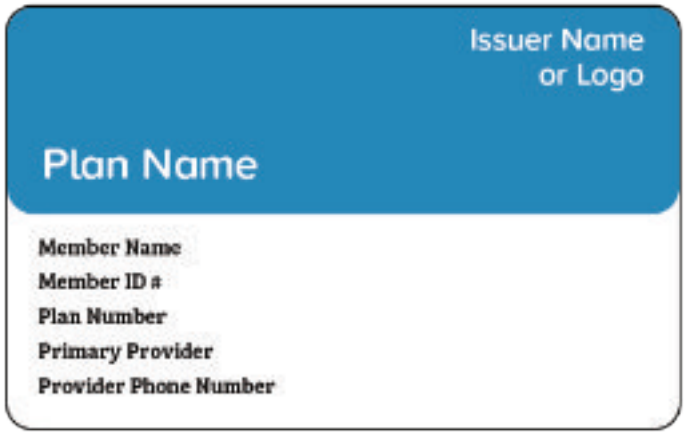


Back of card

kynect tip: You may need to show your card anytime you visit a provider.

When you enroll in a managed care organization (MCO), you also will receive a card from your MCO. Watch your mail for your MCO card. You may need to show your MCO card each time you seek care.

Sample MCO Card



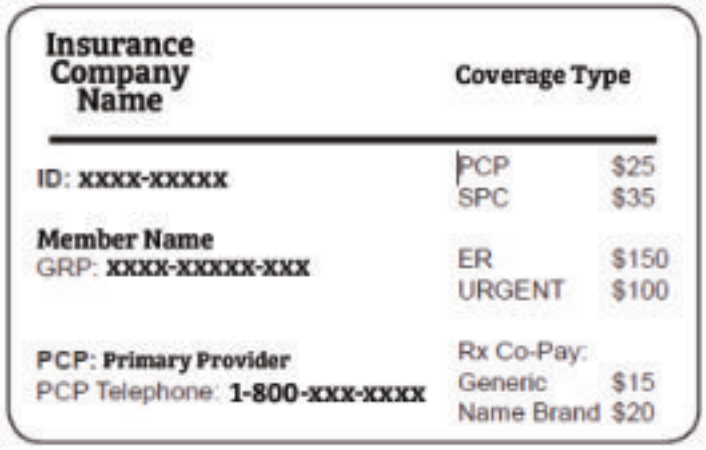
Your MCO will send you a Summary of Benefits after you enroll. The summary of benefits is a packet of information about what services are covered by your plan, instructions on using your coverage, how to communicate with your MCO, and other helpful information.

Qualified Health Plan insurance cards are sent by the plan soon after enrollment. The insurance card provides the following information:

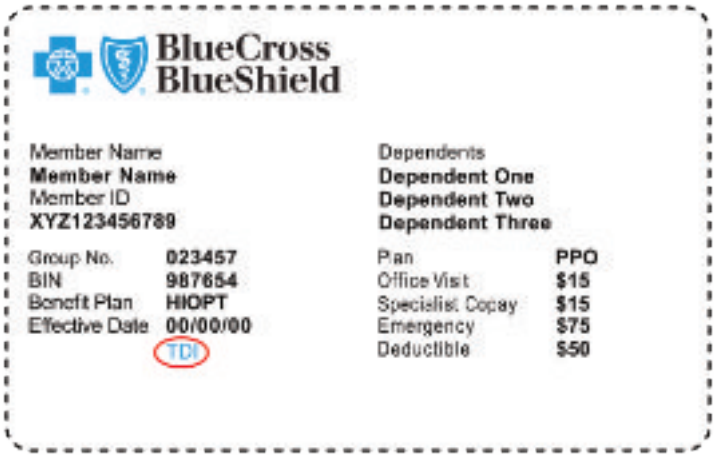
- Member's name and date of birth, identifying the insurance holder to the provider
- Member number so the provider can bill the health plan
- Group number to track the specific benefits of your plan
- Plan type (HMO, PPO, HSA, Open)
- Health care copayment, or the amount you owe when you receive care
- Phone number of your plan in case of questions
- Prescription copayment, or the amount you owe to fill a prescription

kynect tip: Keep your coverage by paying the monthly premiums if you have them. Your coverage may be canceled or terminated if you do not make your payments on time.

Sample Insurance Card



When you receive your insurance card from your plan, check that names and other information are correct.



You will receive a Statement of Benefits and Coverage (SBC) with a summary of a health plan's benefits and coverage. This summarizes the key features of your plan.

The SBC will detail your coverage, covered benefits, cost-sharing provisions, and coverage limitations and exceptions. Can also be found on the kynect website for your plan.

Where to Get Care

There are many places you can get health care. To get routine care and preventive services, a Primary Care Provider is the best option.

You can find Primary Care Providers in offices, clinics, and health centers.

Primary Care Providers help you get the right preventive services, manage chronic conditions, and improve overall health and well-being.

Some offices and clinics offer behavioral-health, dental, vision, transportation, and language interpretation services.

Some places you may find primary care are:

- Private medical groups and practices
- Outpatient clinics/walk-in clinics
- Federally Qualified Health Centers
- Community clinics and free clinics
- School-based health centers
- Indian Health Service, Tribal, and Urban Indian Health Program facilities
- Veterans Affairs medical centers and outpatient clinics

Medicaid/MCO may cover non-emergency medical transportation.

kynect tip: **Not all types of providers and facilities take all insurance plans or types of coverage. Call the office before you go to make sure they see patients with your coverage.**

Health Coverage Common Words

Primary Care Provider: The doctor you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many health plans, you must see your primary care doctor before you see any other health care provider.

Non-physician Provider: A non-physician specialist is a provider – such as a Nurse Practitioner (NP) or Physician Assistant (PA) – who has more training in a specific area of health.

Specialist: Physician specialists focus on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

FQHC: Federally Qualified Health Center is a federally funded nonprofit health center or clinic that serves medically under served areas and populations. Federally qualified health centers provide primary care services regardless of your ability to pay.

RHC: A Rural Health Clinic serves rural communities to increase access to primary care services. RHCs can be public, nonprofit, or for-profit health care facilities.

To find a provider, it is best to check with your MCO or QHP plan first to make sure the provider is in your network.

Provider Lists may be requested from your MCO or insurance plan. Provider lists may also be found on the MCO or plan website.

Use the list to see if your preferred provider accepts your coverage. Check if there are providers convenient for you to visit.

Community health centers and free or charitable clinics may be found using search sites like these:

https://findahealthcenter.hrsa.gov/

https://nafcclinics.org/

kynect tip: **Low-cost clinics may bill based on your ability to pay.**

Find Clinics

Find clinics near you using **kynect resources**.
Visit **kynect.ky.gov/resources** and search keyword **Clinic** or use the QR code below.

kynect resources can help find local programs and services.

Residents can find programs to help with needs such as food insecurity, housing and employment supports, support groups, health programs, and family-centered help.

Open your phone's camera and point it at this QR code to search.

Health Coverage Common Words

Community Health Center: A center or clinic in a geographical area that offers access to high-quality health care, often for under served communities.

Walk-in Clinic: A walk-in clinic is a medical facility that accepts patients on a walk-in basis with no appointment required.

Charitable Clinics: Clinics that provide care for medically under served people and may offer many different programs such as education, disaster relief, and other patient support.

There may be times you need care immediately or quickly and cannot wait for an appointment with your Primary Care Provider.

It is important to know when it is appropriate to seek emergency care or use an urgent care provider. The chart below provides some guidance for the best place for some types of conditions.

kynect tip: **You may be charged for non-emergency visits to the ER.**

Health Coverage Common Words

Emergency Care: Sudden and life-threatening injuries/illnesses. Call 911.

Urgent Care: Urgent treatment centers – for medical problems, not emergencies.

Primary Care: Routine health care that includes screenings, checkups, and patient counseling to prevent illnesses, disease, or other health problems or to detect illness at an early stage, when treatment is likely to work best. (This can include services like flu and pneumonia shots and vaccines as well as screenings like mammograms and depression/behavioral-health screenings.)

Emergency Department

The emergency department is for sudden and life-threatening injuries or illnesses. This means your life is in danger if you do not receive immediate care. Call 911 or go to the emergency room (ER).

- Fainting
- Chest pain/pressure
- Uncontrolled bleeding
- Coughing/vomiting blood
- Sudden severe pain
- Poisoning
- Major injuries (broken bones)
- Sudden facial drooping

Urgent Treatment Centers

These treatment centers are for medical problems, NOT emergencies. UTCs may have longer hours and be open more days than your Primary Care Provider.

- Cold/flu
- Earache
- Sore throat/cough
- Minor accidents/falls
- Minor sprains
- Minor cuts – not bleeding a lot but requiring stitches
- Fever
- Mild vomiting/diarrhea
- Mild-to-moderate asthma

Call 9-1-1 if you have an emergency or life-threatening injury or illness.

Primary Care Provider
You go when you feel sick and when you feel well.
You call ahead to make an appointment.
You may have a short wait to be called after you arrive but you will generally be seen around your appointment time.
You'll usually see the same provider each time.
Your provider will usually have access to your health record.
Your provider works with you to monitor your chronic conditions and helps you improve your overall health.
Your provider will check other areas of your health, not just the problem that brought you in that day.
If you need to see other providers or manage your care, your provider can help you make a plan, get your medicines, and schedule your recommended follow-up visits or find specialists.
You'll pay your primary care copay, if you have one. This may cost you between $0 and $50.

Emergency Department
You should only go when you're injured or very sick.
You show up when you need to and wait until they can get to you.
You may wait for several hours before you're seen if it's not an emergency.
You'll see the provider who is working that day.
The provider who sees you probably won't have access to your health records.
The provider may not know what chronic conditions you have.
The provider will only check the urgent problem you came in to treat but might not ask about other concerns.
When your visit is over, you will be discharged with instructions to follow up with your Primary Care Provider and/or specialist. There may not be any follow-up support.
You'll likely pay a copay or co-insurance and have to meet your deductible before your health plan pays for your costs, especially if it's not an emergency. Your copay may be between $50 and $150.

In some areas, you may be able to go to an Urgent Care Center. If Urgent Care is available in your area, call your health plan before you go to find out how much you will have to pay.

Finding a Provider That Is Right for You

» Identify providers in your network.

» If you already have a provider you want to keep, call their office and ask if they accept your insurance coverage. Remember that providers outside your insurance network will cost more.

» Call your insurance company, look at its website, or check your member handbook to find providers covered by your plan.

» If you have specific needs such as language translation or mobility and functional impairments, request help from your insurance company.

Ask Around

» Ask friends and family if they have providers they like.

» Find out what type of provider they are and why they like them.

» Use the internet to research what others in the community say about the provider.

kynect tip: **It is best to see a provider that is in-network. There may be times you must go out of network to receive the care you need. You may pay more or all of the costs for using an out-of-network provider.**

Here Are SomeThings to Think About When Choosing a Provider

» Is the provider accepting new patients with your insurance? Call to ask.

» Is the office location convenient for you?

» Does the office have a schedule that meets your needs?

» Does the provider speak your language or provide interpreter services?

» If you have mobility or other functional impairments, is the office infrastructure compatible with your needs?

» Does the provider work with a hospital convenient for you?

» Is the staff respectful and helpful?

Give Them a Try

» You may decide the first provider you choose is ultimately not the one for you.

» Be willing to search again rather than stay with a provider not meeting your needs.

Health Coverage Common Words

Referral: A referral is sometimes a paper or electronic form that may be given to a patient when their provider sends them to see another type of provider or Specialist. Some providers or health coverage plans require a referral to see a Specialist or other provider.

Appointments

When you need to see your provider, you will need to make an appointment.

- If it is your first visit, tell the office you are a new patient.
- You may be asked to share information from your insurance card, like the plan name and number.
- You will also be asked why you need to be seen. Most appointments will be a wellness visit or yearly exam, an acute care visit, or a follow-up visit. How much time your provider spends with you is usually based on the reason you need to be seen.
- If you are ill and need to be seen right away, your appointment may be scheduled with any available provider at that office, instead of your Primary Care Provider.
- If you need help with language services or have other specific needs, make that request when making your appointment.
- Many provider offices now offer appointment scheduling online as well as by phone.

kynect tip: **If you are unable to keep a scheduled appointment, call and cancel or reschedule. If you don't cancel, you may be charged a fee.**

Things to know about appointments:

It may take a few weeks to get an appointment unless you are ill and need to be seen sooner.

If you are ill, you can often get a same-day appointment.

It is important to always take your insurance card with you to appointments. The doctor's office may make copies of your insurance card to keep on file.

Health Coverage Common Words

New Patient: You are considered a new patient when you have not visited the provider or office before. Some providers do not take new patients, so it is best to call to ask first.

Yearly Exam or Wellness Visit: This is typically a once-a-year visit with your doctor to check your overall health and fitness. This helps you and the doctor understand your overall health needs and plan the ongoing maintenance of any health goals. This also helps the doctor identify any new health issues that may have changed since your last visit.

Acute Care: This is typically an appointment for a more immediate illness like strep throat or suspected COVID infection. Many acute care appointments are scheduled the same day.

Follow-up Visit: This may be an appointment that is made in follow up to a previous visit or diagnosis. Follow-up appointments are scheduled in a time period that will help the doctor evaluate how a medication is working or how a diagnosis is responding to treatment.

Provider Visits

When it is time for your appointment, get there early. Many offices will have you fill out paperwork before you arrive or once you check in.

You need to bring your insurance card and other documents the office asks you to bring, like ID.

- It may be helpful to take a list of any medicine you take.
- Some of the paperwork you complete may ask about your medical history and any current medications. Your answers help the doctor understand your health history and what type of lifestyle you lead. This is important information to help maintain and improve your health.
- You may also be asked to pay your copay or co-insurance when you check in. The office will let you know if you have a copay or cost for the visit and will collect that amount during your visit.
- Before you see the provider, you will get your vital signs taken to measure your temperature, blood pressure, and weight.
- When visiting with your provider, they may ask more questions about you and your family's health history and any ongoing health issues.
- The provider may check you physically and ask other health questions. It is important to be open and honest with your provider.

kynect tip: **If your doctor sends you for tests, like x-rays, at another location or recommends you visit a specialist, ask the doctor if the medical providers are in your plan network.**

Be involved in your care

During your visit, take notes if needed. Ask questions or voice any concerns you may have about your health. If you need help, bring a trusted person along with you to help you talk to the provider and capture information.

Health Coverage Common Words

Vital Signs: These measure your body temperature, weight, pulse rate, respiration rate, and blood pressure. They help show how your body is functioning and help detect early signs of health problems.

Family Medical History: Your family medical history is a list of major health issues that have been experienced in close relatives. Understanding this history will help your provider know if you need certain tests or preventive services earlier than is recommended.

Before you leave your appointment, make sure you understand these things:

Your Health Status

- Treatment plan for illness or chronic condition.
- Your treatment options.
- How to get test results.

Next Steps

- Fill prescription and understand directions for taking medications.
- Make additional appointments if necessary.
- Schedule additional tests if necessary.
- Know when to schedule your next visit.

What You Need to Do to Stay Healthy

- Understand duration of prescribed medicine or therapy.
- Follow directions for taking any medication or treatment.
- Go to specialist if necessary.
- Obtain a referral for a specialist or other provider if necessary.

kynect tip: If you are given a prescription and you are worried about the cost, talk to your provider. Many providers have options to reduce the cost of medication or may be able to connect you with programs that help pay for medications.

Patient Rights

Patients have a right to be treated with respect and have their information kept private. If you're not happy with how you were treated during an office visit, ask to speak with an office manager or the provider and tell them your concerns. If you are not comfortable with the provider you saw, if you did not feel understood, or if you think the provider is not a good fit for your needs, you can talk to your plan about other options. You may file an appeal or grievance.

Health Coverage Common Words

Chronic Condition: This may be a condition that is ongoing. Chronic conditions are often managed by taking medication regularly but may never go away.

Treatment: Treatment is the method used to make your illness or condition better. This may include daily or regular medication, therapy, or diet and exercise changes.

Prescription: This is a direction to dispense medication for a prescribed amount, duration, or strength. If you are on medication for chronic conditions, you may have to get refills on your prescription on a regular basis.

After an Appointment

It is very important to follow through on your provider's directions.

- Make any follow-up appointments as soon as you can after your appointment. Use a calendar or other reminder to make sure you remember upcoming appointments.
- Fill any prescriptions your provider gave you. If you are concerned about paying for a prescription, talk to your provider or pharmacist. They may have options to help lower the cost of prescription medication.
- Make arrangements for any tests your provider ordered. This may include scheduling the test and getting pre-authorization. The provider may get the pre-authorization from your Primary Care Provider.
- Get your test results. Many offices will call you or share results using an online app. Knowing your results may give you peace of mind, help you understand the status of your health, and help you take appropriate actions.

kynect tip: **Make sure your pharmacy is in your plan network. If you need to make an appointment with another provider or specialist, ask if they accept your plan and ask about any copays or out-of-pocket costs that may be expected.**

Filling Prescriptions

- **Use a pharmacy that is convenient to you and is in your plan network.**
- **Get all prescriptions filled as soon as you can after an appointment.**
- **Some prescriptions will give no refills while others may be refilled several times before you see your provider again.**
- **Depending on the prescription, your plan may allow a 90-day supply of medicine.**
- **Some medicines have restrictions and may not be refilled. There may be a limit on the amount that may be given.**

Call If You Have Questions

Sometimes you have a medical question or forget something the doctor wanted you to do. Contact your provider office, and they can help you with questions.

Explanation of Benefits

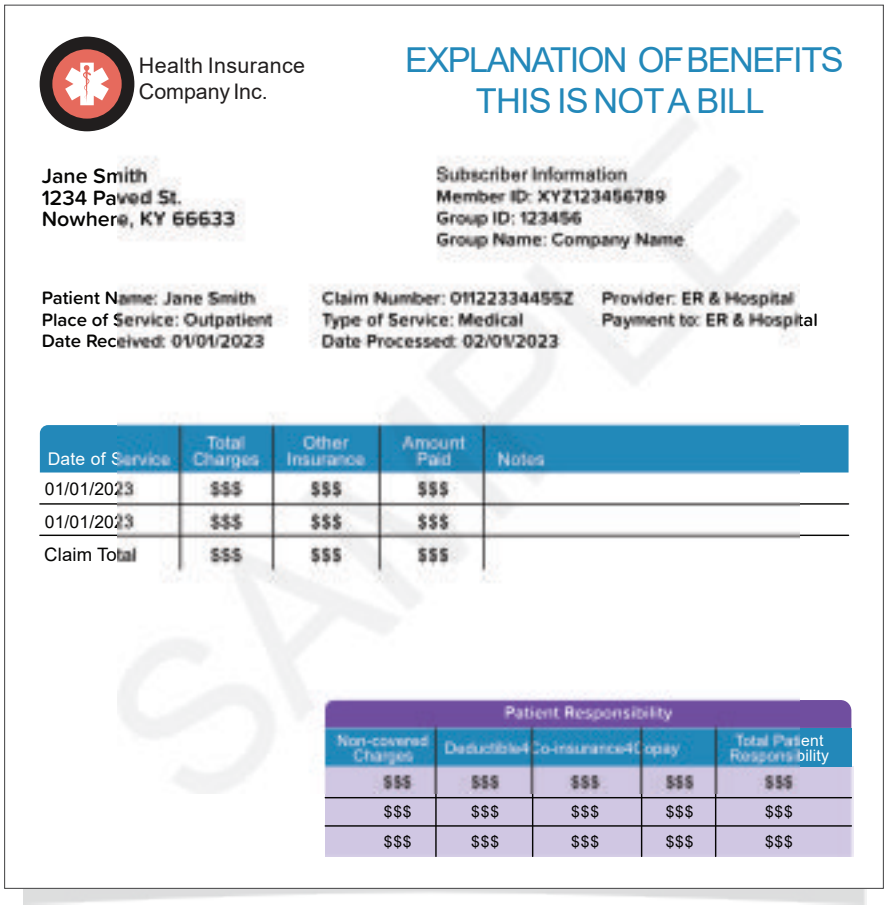
After a visit to your provider, your plan may send you an Explanations of Benefits (EOB). An EOB shows the charges for your visit and the amount you and your health plan will need to pay.

This is NOT A BILL. It is a record of the health care you received and how much your provider is charging your plan. If you must pay more for your care, your provider will send you a separate bill.

Contact your health plan if you have questions about your EOB.

You may get a bill separately from the provider for costs not covered by your plan or other out-of-pocket costs.

kynect tip: **Ask your plan representative if a referral and/or preauthorization is necessary to visit a provider. If you do not, you may have to pay for services the plan would have otherwise covered.**



Health Insurance Company Inc.

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

Jane Smith
1234 Paved St.
Nowhere, KY 66633

Subscriber Information
Member ID: XYZ123456789
Group ID: 123456
Group Name: Company Name

Patient Name: Jane Smith
Place of Service: Outpatient
Date Received: 01/01/2023

Claim Number: 01122334455Z
Type of Service: Medical
Date Processed: 02/01/2023

Provider: ER & Hospital
Payment to: ER & Hospital

Date of Service	Total Charges	Other Insurance	Amount Paid	Notes
01/01/2023	$$$	$$$	$$$	
01/01/2023	$$$	$$$	$$$	
Claim Total	$$$	$$$	$$$	

Patient Responsibility				
Non-covered Charges	Deductible	Co-insurance	Copay	Total Patient Responsibility
$$$	$$$	$$$	$$$	$$$
$$$	$$$	$$$	$$$	$$$
$$$	$$$	$$$	$$$	$$$

Health Coverage Common Words

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Your Provider as a Partner

You and your provider are partners in keeping you healthy and balanced. A Primary Care Provider is your trusted source for medical, mental, and preventive care.

- Seeing your provider regularly helps you build complete medical records and receive care in a timely manner.
- Your provider may have written materials on conditions and treatments they can provide.
- **kynect** encourages you to build trust in your provider and to continue your health journey.

Health Coverage Common Words

Medical Records: A medical record or medical chart is a file with information about your current and past medical conditions and treatments. This helps your provider keep track of your medical background. It helps providers spot trends and track improvements.

Self Diagnose: This is when a person assumes they have an illness or condition without talking to a professional provider. Most assumptions are not correct. It is important to get a diagnosis from your provider to determine the level or severity of an illness and to get appropriate treatment.

kynect tip: **Pay your bills and keep any paperwork. Some providers will not see you if you have unpaid medical bills.**

Why Some People Avoid Doctors

Fear: Some people are afraid of what a provider may tell them or are afraid of experiencing pain or trauma. While it is normal to fear an unknown, it is extremely important to work through any fear and see a provider for screenings and illnesses. If fear is keeping you from seeking care, talk to your provider about your fears. Your provider can help you with ways to reduce your worries and help you through any health information. You can also take a trusted friend or family member with you on visits to help with the fear.

Bad Past Experiences: When something bad happens, it is difficult to turn around and do the same thing that caused the bad thing to happen. If you have had a bad experience with a provider, remember that not all providers are the same. All providers are bound by certain rules and policies when providing care. You are in control of your decisions and can change providers if you have a bad experience.

Cost: The cost of visits, tests, prescriptions, and therapy keeps some people away from making appointments. With health coverage, your plan will cover most, if not all, of your costs. Talk to your provider about any concerns you have with costs. They may know of programs that help with the cost of medication and treatment.

Mistrust: If you experience mistrust in the medical community, it may help to speak with a patient advocate. A patient advocate can help you navigate the processes and procedure and help you understand steps you need to take and what to expect.

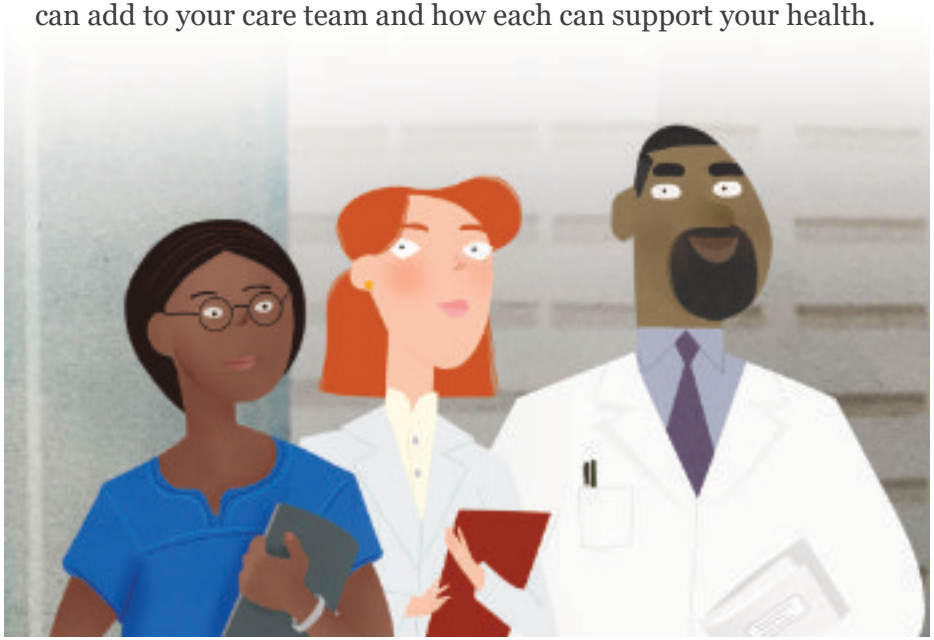
A Team of Care

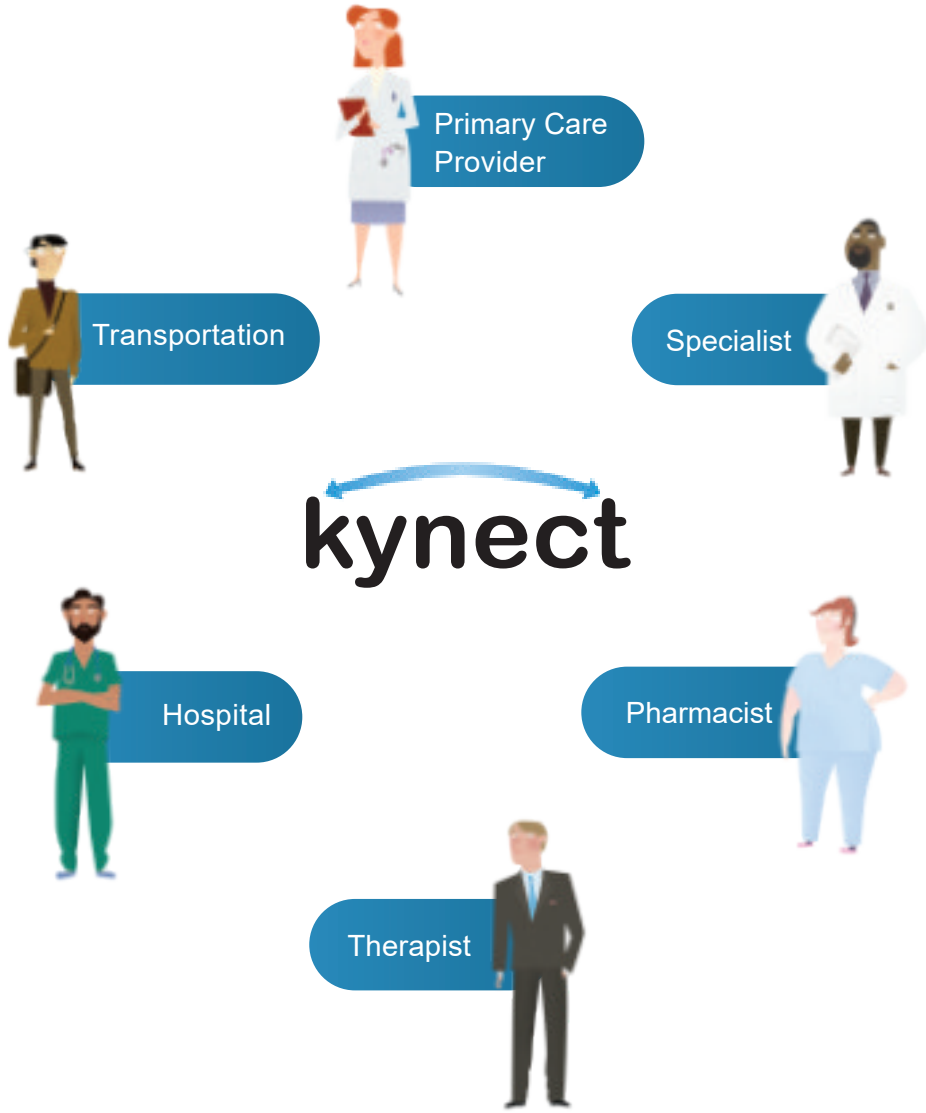
Most everyone has an entire team that supports their health and medical care.

Everyone's care team may look different but may include:

- Primary Physician
- Pharmacist
- Therapists
- Specialists
- Hospitals
- Dietitian
- Nurse Practitioner
- Physicians Assistant
- Social Worker

This team supports you and your health goals. Consider who you can add to your care team and how each can support your health.





Appeals and Grievances for Medicaid or MCO

If you have an inquiry or are dissatisfied with a decision about your Medicaid eligibility or your plan coverage, you may be able to appeal or file a grievance.

Contact your MCO

Your MCO may review and change a decision made about your coverage. If your MCO reduces, stops, or doesn't approve a service, it may be called an Adverse Benefit Determination. You may file an appeal if you receive this determination.

Contact kynect

You can contact **kynect** from your personal page at **kynect.ky.gov/benefits** or you can call your DCBS at 1-855-306-8959. You also have the option to submit a request in writing and return it to DCBS or by mail to:

Families and Children Administrative Hearing Branch
Division of Administrative Hearings
105 Sea Hero Rd., Suite 2
Frankfort, KY 40601

Ombudsman and Administrative Review (OOAR)

The CHFS Ombudsman and Administrative Review (OOAR) is an advocate for citizens and works to ensure those seeking public services are treated fairly. The OOAR office can answer questions about CHFS programs and investigate customer complaints. Contact the OOAR at (502) 564-5497 or email **CHFS.Listens@ky.gov**.

kynect tip: Residents may request hearings to object to decisions made on their cases' eligibility from the kynect dashboard Hearing and Appeals screen. This allows residents to submit an appeal request, track its status, and upload documents to help verify the appeal.

Health Coverage Common Words

CHFS: Cabinet for Health and Family Services.

Appeal: A request to review a decision that denies a benefit or payment.

Grievance: A complaint about a decision about your coverage or quality of care.

OOAR: Ombudsman and Administrative Review is an advocate for citizens and works to ensure those seeking public services are treated fairly.

Hearings

The Health Services Administrative Hearings Branch conducts hearings on Medicaid-covered services. The Division of Administrative Hearings provides impartial hearing officers for administrative hearings to resolve disputes concerning benefits, services, and actions in a variety of programs administered by CHFS and governed by state and federal law.

Appeals and Grievances for QHPs

If you have a complaint or are dissatisfied with a denial of coverage for claims under your health plan, you may be able to appeal or file a grievance.

Contact kynect

Contact **kynect** at 1-855-459-6328 to request an appeal about your Medicaid or QHP eligibility. **kynect** will send the information to the Department of Hearings.

Contact your plan

Your health plan may be able to help you resolve issues with your coverage or claims.

To appeal a coverage decision by your QHP, you may appeal to the Department of Insurance (DOI.

If you think you were charged for tests or services your coverage should pay, keep the bill and call the phone number on your insurance card or plan documentation right away. Insurance companies have call and support centers to help plan members.

A hearing or appeal may be requested online using your **kynect** dashboard. The screens allow residents to request a hearing to object to a decision that was made on their case's eligibility. This module allows residents to submit an appeal request, track the status, and upload documents to help verify the appeal.

If you have a complaint, email **CHFS.Listens@ky.gov** or call the **Ombudsman's Office** at 1-800-372-2973.

kynect tip: There may be restrictions on when you may submit an appeal or grievance. Allow plenty of time as submission is often required by mail or fax.

Health Coverage Common Words

Appeal: A request to review a decision that denies a benefit or payment.

Grievance: A complaint that you communicate to your health insurer or plan.

Ombuds Office: They answer questions about Cabinet for Health and Family Services (CHFS)programs, investigate customer complaints, and work with CHFS management to resolve issues.

Department of Insurance (DOI): The Kentucky Department of Insurance regulates the Commonwealth's insurance market, licenses agents and other insurance professionals, monitors the financial condition of companies, educates consumers to make wise choices, and ensures Kentuckians are treated fairly in the marketplace.

For more information about filing an appeal, scan the QR code or visit

https://insurance.ky.gov/ppc/new_default.aspx

Common Words

Acute Care: This is typically an appointment for a more immediate illness like strep throat or suspected COVID infection. Many acute care appointments are scheduled the same day.

Advance Premium Tax Credit: A tax credit taken in advance to lower monthly health insurance payment (or "premium"). The advance payment is reconciled on the year's tax return.

Appeal: A request to review a decision that denies a benefit or payment.

Charitable Clinics: Clinics that provide care for medically under served people and may offer many different programs such as education, disaster relief, and other patient support.

CHFS: Cabinet for Health and Family Services

Chronic Condition: This may be a condition that is ongoing. Chronic conditions are often managed by taking medication regularly but may never go away.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe.

Community Health Center: A center or clinic in a geographical area that offers access to high-quality health care, often for under served communities.

Copay: An amount you pay each time you get health care, such as when you go to the doctor or hospital or when you get a prescription. Usually, the copay is a set amount, such as $30 for a doctor visit.

Copayment (Copay): An amount you may be required to pay for your share of the cost for a medical service or supply. A copayment is usually a set amount, rather than a percentage.

Cost Sharing Reduction (CSR): CSRs are discounts that lower the amount you pay for deductibles, copayments, and co-insurance. If you qualify, you must enroll in a plan in the Silver category to get these special discount savings.

Deductible: The amount you must pay for health care services or prescriptions before your plan begins to pay. The deductible may not apply to all services. Some plans have separate deductibles for health care services and prescriptions. There may be a separate deductible for each member of the family, as well as the entire family.

Electronic Records: Many providers offer online access to your medical records, known as an electronic health record. Speak with your MCO or provider about how to access your electronic health records.

Eligibility: A determination of ability to enroll in a program based on the requirements of the program.

Emergency Care: Sudden and life-threatening injuries/illnesses.

Employer-Sponsored Insurance (ESI): Health coverage plan that is available through employment.

Excluded Services: Health care services your health coverage or plan doesn't pay for.

Explanation of Benefits (or EOB): A summary of health care charges your insurance company sends you after you see a provider or get a service. It is not a bill. It is a record of the health care you or individuals covered on your policy got and how much your provider is charging your insurance company.

Family Medical History: Your family medical history is a list of major health issues that have been experienced in close relatives. Understanding this history will help your provider know if you need certain tests or preventive services earlier than is recommended.

Follow-up Visit: This may be an appointment that is made in follow up to a previous visit or diagnosis. Follow-up appointments are scheduled in a time period that will help the doctor evaluate how a medication is working or how a diagnosis is responding to treatment. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible.

FPL: A measure of income issued every year by the Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on **kynect health coverage**, Medicaid, and KCHIP.

FQHC: Federally Qualified Health Center is a federally funded nonprofit health center or clinic that serves medically under served areas and populations. Federally qualified health centers provide primary care services regardless of your ability to pay.

Grievance: A complaint about a decision about your coverage or quality of care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

Household: kynect generally considers your household to be you, your spouse if you're married, and your tax dependents. Basically, the people on your tax return each year.

MCO: Commercial organizations that manage health care for Medicaid enrollees. You may often know your Medicaid coverage by the name of the coverage provider.

Medical Records: A medical record or medical chart is a file with information about your current and past medical conditions and treatments. This helps your provider keep track of your medical background. This helps providers spot trends and track improvements.

Network: The facilities, providers, and suppliers your health insurer has contracted with to provide health care services.

New Patient: You are considered a new patient when you have not visited the provider or office before. Some providers do not take new patients, so it is best to call and ask first.

Nonphysician Provider: A nonphysician specialist is a provider – such as a Nurse Practitioner (NP) or Physician Assistant (PA) – who has more training in a specific area of health care.

OOAR: Ombudsman and Administrative Review is an advocate for citizens and works to ensure those seeking public services are treated fairly.

Open Enrollment: The yearly period when people can enroll in a plan through **kynect health coverage**.

- **QHP:** Yearly Open Enrollment when individuals may enroll in a Qualified Health Plan. This is the only time enrollment is open unless there is a Special Enrollment Period.
- **Medicaid:** You may apply and enroll in a Medicaid MCO anytime during the year. The yearly Open Enrollment Period is when individuals may choose a new MCO.

Out-of-Pocket Maximum: The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit includes deductibles, co-insurance, copayments, or similar charges and any other expenditure required of an individual for a qualified medical expense.

Prescription: This is a direction to dispense medication for a prescribed amount, duration, or strength. If you are on medication for chronic conditions, you may need to get refills on your prescription on a regular basis.

Preventive Services: Routine health care that includes screenings, checkups, and patient counseling to prevent illnesses, disease, or other health problems or to detect illness at an early stage, when treatment is likely to work best. (This can include services like flu and pneumonia shots and vaccines as well as screenings like mammograms or depression/behavioral-health screenings.)

Primary Care: Routine health care that includes screenings, checkups, and patient counseling to prevent illnesses, disease, or other health problems or to detect illness at an early stage, when treatment is likely to work best. (This can include services like flu and pneumonia shots and vaccines as well as screenings like mammograms or depression/behavioral-health screenings.)

Primary Care Provider: The doctor you see for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many health plans, you must see your Primary Care Provider before you see any other health care provider.

Provider: A provider can be a doctor, nurse practitioner, behavioral-health professional, or other health care provider you see.

Qualified Health Plan: A health insurance plan that is certified by **kynect** and meets requirements under the Affordable Care Act.

Referral: A referral is a letter from a doctor asking a specialist or other health professional for a diagnosis or treatment. If you see the specialist without a referral, your plan may not cover your costs.

RHC: A Rural Health Clinic serves rural communities to increase access to primary care services. RHCs can be public, nonprofit, or for-profit health care facilities.

Self Diagnose: This is when a person assumes they have an illness or condition without talking to a professional provider. Most assumptions are not correct. It is important to get a diagnosis from your provider to determine the level or severity of an illness and to get appropriate treatment.

Special Enrollment Period (SEP): A period of enrollment that is granted due to specific reported changes. There is a time limit for reporting changes and a limit to the number of days allowed to enroll.

Specialist: Physician specialists focus on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Statement of Benefits and Coverage (SBC): A summary of a health plan's benefits and coverage. This summary helps you compare plans. The SBC details coverage, covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

Termination Date: The date your health coverage ends.

Treatment: Treatment is the method used to make your illness or condition better. This may include daily or regular medication, therapy, or diet and exercise changes.

Urgent Care: Urgent Treatment Centers – for medical problems, not emergencies.

Vital Signs: These measure your body temperature, weight, pulse rate, respiration rate, and blood pressure. They help show how your body is functioning and help detect early signs of health problems.

Walk-in Clinic: A walk-in clinic is a medical facility that accepts patients on a walk-in basis with no appointment required.

Yearly Exam or Wellness Visit: This is typically a once-a-year visit with your doctor to check your overall health and fitness. This helps you and the doctor understand your overall health needs and plan the ongoing maintenance of any health goals. This also helps the doctor identify any new health issues that may have changed since your last visit.

Whatever Your Situation or Need, There's a Way to kynect

kynect is here as your one-stop shop for the programs and assistance you need no matter who you are or where you are in life. Visit **kynect.ky.gov** to see all that is available to you.

Health Coverage

Programs covering Qualified Health Plans (QHP) and Advance Premium Tax Credit (APTC), also known as Payment Assistance and Cost Sharing Reductions, to help your family get health coverage.

Call 855-4kynect (855-459-6328)
kynect.ky.gov/healthcoverage

Benefits

Programs covering food assistance (SNAP), Medicaid, child-care assistance, financial aid for children and caregivers (KTAP), and many more state assistance programs.

Call 855-306-8959
kynect.ky.gov/benefits

Resources

Find local help with:

- Housing
- Food
- Employment
- Transportation
- Health
- Finances
- Education
- Mental health and addiction
- Legal issues

For additional help, call 2-1-1
kynect.ky.gov/resources

kynect to care

kynect.ky.gov

Department for Aging and Independent Living (DAIL)
Phone: (502) 564-6930

Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID)
Phone: (502) 564-4527

Office for Children with Special Health Care Needs (OCSHCN)
Phone: (502) 429-4430

Department for Community Based Services (DCBS)
Phone: (502) 564-3703

Department for Family Resource Centers and Volunteer Services (DFRCVS)
Phone: (502) 564-4986

Department for Income Support (DIS)
Phone: (502) 564-7941

Department for Medicaid Services (DMS)
Phone: (502) 564-4321

Department for Public Health (DPH)
Phone: (502) 564-3970

Department of Insurance (DOI)
Phone: (800) 595-6053

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health coverage

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