Kentucky Integrated Health Insurance Premium Payment Program Application Instructions

KI HIPP
Kentucky Integrated Health Insurance Premium Payment

KIHIPP-101

When should you use this application form?	Use this form if someone in your household is eligible for health insurance from a job, COBRA, Retiree Health Plan or United Mine Workers. The form refers to this person as the Employee. Health insurance from a job is called Employer Sponsored Insurance or ESI. ESI can include coverage for your spouse and dependents, but it does not have to. Complete this form if: ☐ You have a job that offers health insurance or have health coverage from COBRA, retiree Health Plan or United Mine Workers.
What do you need to apply?	☐ Completed and signed Health Coverage form. ☐ Summary of Benefits and Coverage (SBC) for your health insurance plan. ☐ Your most recent paystub, if available. ☐ Premium Payment proof from insurance company. ☐ Premium rate sheet.
How can you submit your application form?	1. **Self-Service Portal**: Log in to your account at benefind.ky.gov. 2. **Email**: KIHIPP.PROGRAM@KY.GOV 3. **Fax**: 502-564-3232 4. **Mail:** CHFS, KI-HIPP Unit, 275 E. Main St., 6C-A, Frankfort, KY 40621 You will need to provide both the information requested on this form and additional documentation as described below to be enrolled in Kentucky Integrated Health Insurance Premium Payment program. You do not need to submit this information the same way. For example, you can submit your information on the Self-Service Portal and email, fax, or mail copies of the documents.
When would you need to fill out more than one application form?	☐ If more than one person in your household has health insurance as primary policy holder, **each person** with a health insurance will need to fill out a form. ☐ If you have more than 4 dependents in your household, fill out **Appendix A** as many times as necessary. You need to show all dependents who can get health insurance through your health insurance. ☐ If you have more than one health insurance, fill out **Appendix B** for each additional health insurance.
Why do we ask you for this information?	• We only ask you for information to see if you are eligible for the Kentucky Integrated Health Insurance Premium Payment program. We need information **about you** to verify your identity and make sure you are eligible for the program. We need information **about your health insurance plan** to make sure it covers essential health services and is cheaper than the Medicaid plan. We are also making sure we are giving you the right amount of Premium reimbursement based on the cost of your plan.
What happens next?	• If you do not have all the information we ask for, submit your form anyway. We will contact you for the missing information if we cannot verify your eligibility based on the information you gave us. • If we decide you are eligible for Kentucky Integrated Health Insurance Premium Payment program, we will send you more information about the steps you need to take.

	• If you are **not already enrolled** in your health insurance (and you want to enroll), wait until you get a notice from us, telling you to enroll to avoid paying your full cost of premium. • If you are **already enrolled** in your health insurance, you will stay enrolled in your plan. • You will have an extra $1 per month surcharge added to the premium amount you pay if your plan covers a non-allowable service under Medicaid. You will want to submit a copy of supporting documentation, such as your Certificate of Coverage or Summary Plan Description, showing that your plan is not covering any such services. You can usually get the Certificate of Coverage or other supporting documentation from your employer or insurance company.
Where can you get help?	☐ **In this instruction form**: Look for the shaded boxes for tips on how to fill out the form. ☐ **Website**: benefind.ky.gov**.** ☐ **By phone**: 855-459-6328 ☐ **In person**: Find a list of DCBS offices near you by going to our website at https://prd.chfs.ky.gov/Office Phone/index.aspx or calling us. ☐ **TTY services**: <call number> ☐ Refer to the member handbook for additional information about the Kentucky Integrated Health Insurance Premium Payment program, including reimbursements, surcharges, and fees.

STEP 1	**Tell us about You** Each member of your household who has an offer of health insurance through his or her job, COBRA, Retiree Health Plan or United Mine Worker should fill out this form. For example, if you are married and you have an offer of insurance through your job and your spouse has an offer of insurance through his or her job, each of you should fill out a copy of this form. When you fill out the form about your offer of health insurance, you will enter your information as the Employee. When your spouse fills out the form, your spouse will enter his or her information as the Employee. If you have more than one source offering you health insurance, you will need to fill out Appendix B to provide information about each health insurance offer. For example, if you are working two jobs and both offer health insurance, you will give the information for the job that is your primary health insurance on the main form. Then you will give the information about the other job's health insurance as the secondary coverage on **Appendix B**.

We need your Social Security Number (SSN) if you want coverage & have an SSN. We use SSNs to check income and other information to see if you are eligible for KI-HIPP

Step 1: Tell us about you: Policy Holder Information

1. First Name	Middle Name	Last Name
2. Social Security Number	3. Date of Birth (MM/DD/YYYY) _____/_____/_____	4. Medicaid ID (if known)
5. Home Address		
6. City	7. State	8. Zip Code
9. Email	10. Phone Number	

List your Medicaid ID number, if you have one. You can find this number on your Medicaid card.

You can give your work or personal email address.

List your home mailing address. We will send any notices about your eligibility to this address.

You can give your work or personal phone number.

STEP 2	**Tell us about your health insurance plan or COBRA Benefits** We will need to know how much your plan costs to see if coverage is cheaper through your health insurance or Medicaid plan. Your health insurance plan may cover just you, or it may be available to cover other people in your household.

Provide as much information as you can about the health insurance you are already enrolled in. You can find this information on your health insurance card.

Make sure to tell us the dates your coverage starts & stops for the current year, if already enrolled for health insurance. If you are not enrolled, provide the anticipated or future dates. Many employers have their employees enroll in the fall during their open enrollment period, but coverage does not start until January

Step 2: Tell us about the health insurance or COBRA benefits the person in Step 1 can get

11. Health Insurance Company Name	12. Plan name
13. Policy ID	14. Group ID (If known)
15. What is the Coverage start date? (MM/DD/YYYY) _____/_____/_____	16. What is the Coverage End date? (MM/DD/YYYY) _____/_____/_____ (if known)
17. Is this COBRA Insurance? ☐ Yes ☐ No	18. Do you use tobacco? (this question does not impact your Medicaid coverage)? ☐ Yes ☐ No

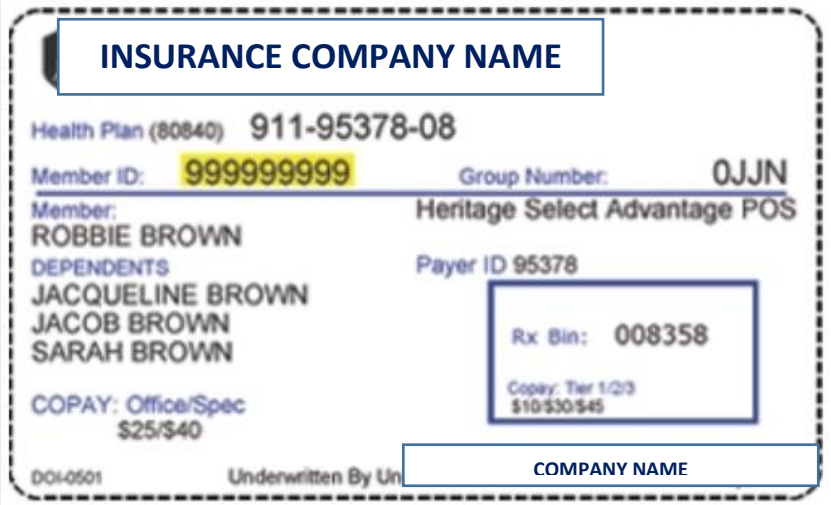
STEP 2

If you are already enrolled, tell us about your health insurance plan

You can find the information on your health plan ID or insurance card.

If you are already enrolled in your health insurance, you should have a card for each insurance plan you have. **For example**, if you have medical insurance and a separate dental plan, you will probably have two separate insurance cards. You will need those cards to provide the information needed on questions #11-18, #29-34, and #35-40.

Sometimes health insurance cards will call the numbers something different from what you see on the form. In that case, you can look for the matching key words and fill those in. **For example**, if you had a card that looked like this:



You would fill out the questions in Step 2 this way:

11. Health Insurance Company Name: Insurance Company Name
12. Health Plan name: Heritage Select Advantage POS
13. Health Plan Group # or ID #: OJJN
14. Health Plan Policy #: 911-95387-08

You will use this same process to fill out #29-34 and #35-40 if you are getting dental and/or vision insurance as a separate plan. You should have a different card with different plan and policy numbers. If you do not have dental or vision insurance leave these questions blank

STEP 3	**Tell us about your employer or other place that offers the health insurance or COBRA** We will need information about your employer or other place that offers the health insurance or COBRA benefits. If you have insurance from a job, you may need to ask your employer for some of this information if you do not have it. If your job has a human resources department or person, that may be the best place to get the information you need. The requested information may also be listed on tax form (W2) that you may have received from your current employer. Also, you may have more than one job or have insurance from more than one source that offers health insurance. If that is the case, we need to know about your other health insurance. **Use Appendix B to give us information about any other jobs or sources that are offering you health insurance.**

Step 3: Tell us about the employer or other place that offers the health insurance or COBRA

19. Name	20. Employer Identification Number (EIN) (if known)	
21. Other Name (if applicable)		
22. Address		
23. City	24. State	25. Zip Code
26. Employer/Business Type Contact Name	27. Employer/Business Type Contact Phone Number	
28. Employer/Business Type Contact Email		

List the company name of your current job or other place offering health insurance.

List other names the employer or company may use.

Ask your employer for this number, or look for it on your W2 tax form, if you have one.

STEP 4	**Tell us about your dental or vision insurance plan** Your health insurance plan may cover just you, or it may be available to cover other people in your household.

Provide as much information as you can about the health insurance you are already enrolled in. You can find this information on your health insurance card.

Step 4: Additionally, Tell us about your Dental or Vision insurance details , only if you are enrolled

29. Dental Insurance Company Name	30. Plan name
31. Policy ID	32. Group Number (If known)

33. What is the Coverage start date? (MM/DD/YYYY) _____/_____/_____	34. What is the Coverage End date? (MM/DD/YYYY) _____/_____/_____ (if known)

35. Vision Insurance Company Name	36. Plan name
37. Policy ID	38. Group Number (If known)
39. What is the Coverage start date? (MM/DD/YYYY) _____/_____/_____	40. What is the Coverage End date? (MM/DD/YYYY) _____/_____/_____ (if known)

Leave #29 to 34 blank if you are not enrolled in a dental plan.
Leave #35 to 40 blank if you are not enrolled in a vision plan.

STEP 5	**Who else has coverage on your insurance?** In this section, You will tell us **who else in your household can get health insurance coverage under your health insurance**. **For example**, if you are married and have three children, and your job offers to cover everyone in the household, you will fill out the information for your spouse in the Spouse box, and you will put the information for your children in the Dependent boxes. For three children, you will fill out Dependent 1, Dependent 2, and Dependent 3 on the form and you will leave Dependent 4 blank. Each child will have a separate box. If there are people in your household who **cannot** get health insurance through you, do not list them on the tables below. **For example**, if you are married and have three children, but your job will only offer to cover you, you will not fill this section.

Step 5: Who else is offered coverage by this employer?

Spouse	
a. Name (First, Middle, Last)	b. Social Security Number (SSN)
c. Date of Birth (MM/DD/YYYY) _____/____/_____	d. Medicaid ID (if known)
e. Coverage start date (if known) _____/____/_____	f. Coverage end date (if known) _____/____/_____
g. Do you use tobacco? (This question does not impact your Medicaid coverage)? ☐ Yes ☐ No	

Make sure to include the dates the coverage for your family member(s) will start and stop. Many employers have their employees enroll in the fall, but often the coverage does not start until January 1.

Dependent 1	
a. Name (First, Middle, Last)	b. Social Security Number (SSN)
c. Date of Birth (MM/DD/YYYY) _____/____/_____	d. Medicaid ID (if known)
e. Relationship with the Employee Son ☐ Daughter ☐ Other	
f. Coverage start date (if known) _____/____/_____	g. Coverage end date (if known) _____/____/_____
h. Do you use tobacco? (This question does not impact your Medicaid coverage)? ☐ Yes ☐ No	

Dependent 2	
a. Name (First, Middle, Last)	b. Social Security Number (SSN)
c. Date of Birth (MM/DD/YYYY) _____/____/_____	d. Medicaid ID (if known)
e. Relationship with the Employee Son ☐ Daughter ☐ Other	
f. Coverage start date (if known) _____/____/_____	g. Coverage end date (if known) _____/____/_____
h. Do you use tobacco? (This question does not impact your Medicaid coverage)? ☐ Yes ☐ No	

Dependent 3	
a. Name (First, Middle, Last)	b. Social Security Number (SSN)
c. Date of Birth (MM/DD/YYYY) _____/____/_____	d. Medicaid ID (if known)
e. Relationship with the Employee Son ☐ Daughter ☐ Other	
f. Coverage start date (if known) _____/____/_____	g. Coverage end date (if known) _____/____/_____
h. Do you use tobacco? (This question does not impact your Medicaid coverage)? ☐ Yes ☐ No	

Dependent 4	
a. Name (First, Middle, Last)	b. Social Security Number (SSN)
c. Date of Birth (MM/DD/YYYY) _____/____/_____	d. Medicaid ID (if known)
e. Relationship with the Employee Son ☐ Daughter ☐ Other	
f. Coverage start date (if known) _____/____/_____	g. Coverage end date (if known) _____/____/_____
h. Do you use tobacco? (This question does not impact your Medicaid coverage)? ☐ Yes ☐ No	

NOTE: The form has spaces to include 4 dependents. If you have more than 4 dependents with offers of coverage and need more space, use **Appendix A** at the end of the form.

STEP 6

Authorization

Be sure to sign and date the form before you submit it.

After you complete and submit your form, there are some things that you can expect us to do to verify your eligibility. There are also things that we expect you to do – like letting us know if you experience any changes in your situation. Read the statements below to make sure you are aware of our responsibilities and yours.

Authorization

26. Member Signature and Date

- I am signing this form under penalty of perjury, which means I have given true answers to all the questions on this form to the best of my knowledge and belief. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell the Department for Medicaid Services (DMS) if anything changes from what I wrote on this form within 30 days of the change. I can visit benefind.ky.gov or call 855-459-6328 to report any changes.
- If I think DMS has made a mistake, I can appeal its decision. To appeal means to tell someone at DMS that I think the action is wrong, and ask for a fair review of the action. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I understand that DMS will check my answers using information in databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or any other trusted source. If the information does not match, I may be asked to send proof.
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If I am eligible for Kentucky Integrated Health Insurance Premium Payment:

- I understand that if Kentucky Integrated Health Insurance Premium Payment pays for a medical expense, any other health insurance or legal settlement payments will go to Medicaid, as applicable, to reimburse it for the expense.
- I understand that my Health Coverage form may be reviewed to make sure that eligibility was determined correctly. If my form is reviewed, I must cooperate with the review.

Signature	Date (MM/DD/YYYY)

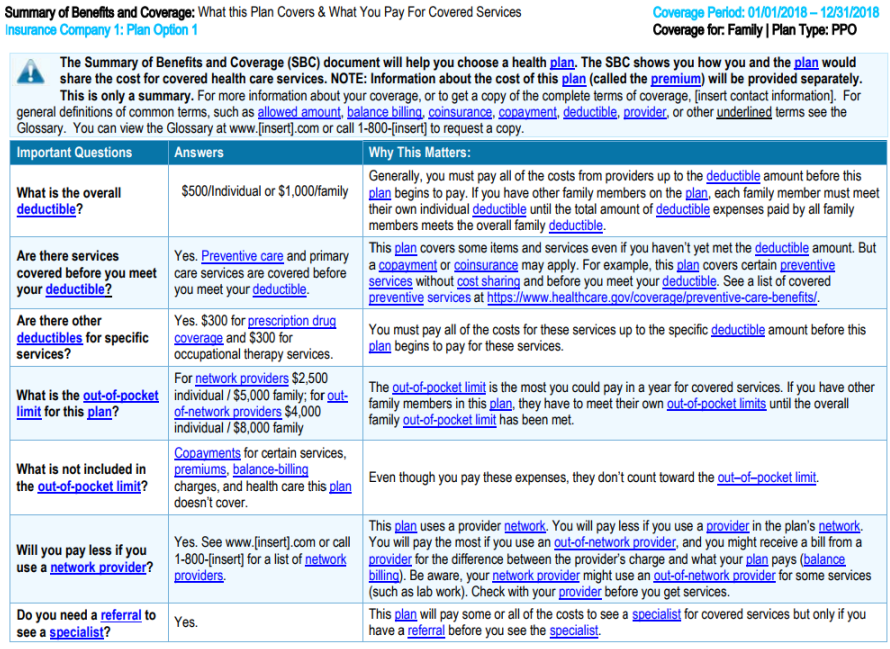
If you need help with your form or to complete faster online, go to benefind.ky.gov or call 855-459-6328.

STEP 7

Submit the required documents for each offer of health insurance

We need more information about your health insurance plan to verify if this coverage is eligible for KI-HIPP. You can submit this information electronically by **uploading** it or **emailing** it. You can also **fax** or **mail** your documents.

What we need	More information
☐ Summary of Benefits and Coverage (SBC)	Your SBC lists the services that are covered by your health plan, and any out-of-pocket costs you may have to pay. This is an **example** of what the first page of your SBC may look like. You generally get a copy of your SBC from your employer or the insurance company **in the mail** after you enroll in your plan. You may also look it up **online** by going to your health insurance company's website.
☐ Your most recent paystub	Your paystub gives us important information: • We can verify where you work. • We can see how much you are paying for your premium if you are already enrolled in your job's health insurance.
☐ Premium Payment proof from Insurance Company	If you have health insurance coverage offered by a source other than a job, please provide us a premium payment proof from insurance company. This should be a signed letter from your insurance company on their letterhead stating your current payment and how often you pay.



Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Insurance Company 1: Plan Option 1

Coverage Period: 01/01/2018 – 12/31/2018
Coverage for: Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500/Individual or $1,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 for prescription drug coverage and $300 for occupational therapy services.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual / $5,000 family; for out-of-network providers $4,000 individual / $8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.[insert].com or call 1-800-[insert] for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

STEP 8	**Appendix A: Provide extra information if you have more than four dependents in your household** You may have more than four dependents in your household. We need to get information about all the people in your household. Fill out Appendix A the same way you filled out the above information. Make as many copies of Appendix A as needed to provide information for all members of your household.

STEP 9	**Appendix B: Provide extra information if you have more than one job that offers you health insurance** Lots of people have more than one job, and some have more than one job offering them health insurance or have health insurance from multiple sources. If you have more than one health insurance, we need to get information about all the health insurance plans you are offered. Fill out Appendix B the same way you did the rest of the form, but this time give the information for your other job(s) and sources that are offering you health insurance. Make as many copies of Appendix B as needed to provide information for all of the offers of health coverage you have from your job(s). **Remember**, if someone else in your family has an offer of health coverage from his or her job, that person will need to fill out a separate form.