NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Benefits

NC MEDICAID MANAGED CARE MEMBER HANDBOOK

carolina complete health™

Carolina Complete Health

July 2021

You can get this handbook and other plan information in large print for free. To get materials in large print, call Member Services at 1-833-552-3876 (TTY 711).

If English is not your first language, we can help. Call 1-833-552-3876 (TTY 711). You can ask us for the information in this handbook in your language. We have access to interpreter services and can help answer your questions in your language.

Spanish:	Usted puede obtener este material y otra información del plan en letra grande de forma gratuita. Para obtener materiales en letra grande, llame a Servicios para Afiliados al 1-833-552-3876. Si el inglés no es su idioma principal, podemos ayudarle. Llame al 1-833-552-3876 (TTY: 711). Puede solicitarnos la información de este material en su idioma. Tenemos acceso a servicios de interpretación y podemos ayudarle a responder sus preguntas en su idioma.
Chinese:	您可以免费获得本资料和其他计划信息的大字体版本。如需大字体版本的资料，请致电会员服务部，电话号码是 1-833-552-3876。 如果您的母语并非英文，我们可以提供帮助。请致电 1-833-552-3876 (TTY: 711)。您可以索取本资料内信息的您的语言版本。我们可以安排口译服务，并且能够以您的语言帮助回答您的问题。
Vietnamese:	Bạn có thể nhận được tài liệu này và các thông tin khác dưới dạng chữ in khổ lớn miễn phí. Để có được tài liệu với chữ in khổ lớn, hãy gọi Dịch vụ Thành viên theo số 1-833-552-3876. Nếu tiếng Anh không phải là ngôn ngữ chính của bạn , chúng tôi có thể giúp đỡ. Gọi số 1-833-552-3876 (TTY: 711) Bạn có thể yêu cầu chúng tôi cung cấp thông tin trong tài liệu này bằng ngôn ngữ của bạn. Chúng tôi có các dịch vụ thông dịch và có thể giúp trả lời cho câu hỏi của bạn bằng ngôn ngữ của bạn.
Korean:	본 자료와 기타 플랜 정보를 대형 활자본으로 별도의 비용 없이 받으실 수 있습니다. 대형 활자본으로 자료를 받으시려면 가입자 서비스부에 1-833-552-3876 번으로 연락해 주십시오. 영어를 사용하지 않으시면, 저희가 도움을 드릴 수 있습니다. 1-833-552-3876(TTY: 711)번으로 연락해 주십시오. 본 자료의 정보를 귀하께서 쓰시는 언어로 요청하실 수 있습니다. 문의 사항에 대한 답변을 귀하의 언어로 받으실 수 있도록 통역 서비스를 제공해 드립니다.
French:	Ces documents, ainsi que d'autres informations en gros caractères sur le programme, sont mis gratuitement à votre disposition. Pour obtenir des documents en gros caractères, appelez le Service aux membres au 1-833-552-3876. Si l'anglais n'est pas votre langue maternelle, nous pouvons vous aider. Composez le 1-833-552-3876 (TTY: 711). Vous pouvez nous demander les informations contenues dans ces documents dans votre langue. Nous avons accès à des services d'interprétation et pouvons vous aider à répondre à vos questions dans votre langue.
Arabic:	يمكنك الحصول مجانًا على هذه المواد ومعلومات أخرى عن البرنامج بأحرف كبيرة. للحصول على مواد مطبوعة بأحرف كبيرة، اتصل بخدمات الأعضاء على الرقم 1-833-552-3876. إذا لم تكن اللغة الإنجليزية لغتك الأولى يمكننا مساعدتك. اتصل بالرقم 1-833-552-3876 (TTY: 711). يمكنك أن تطلب منا المعلومات الموجودة في هذه المواد بلغتك. تتوفر لدينا الإمكانية لوصلك بخدمات الترجمة الفورية للمساعدة في الإجابة عن أسئلتك بلغتك.
Hmong:	Koj yeej tau cov ntaub ntawv no thiab lwm cov ntaub ntawv sau loj loj pub dawb xwb. Yog xav tau cov ntaub ntawv sau loj loj, hu rau Chaw Pab Tswv Cuab ntawm 1-833-552-3876. Yog Lus Askiv tsis yog koj thawj hom lus hais, peb pab tau koj. Hu rau 1-833-552-3876 (TTY: 711). Koj hais tau kom peb muab cov ncauj lus hauv phau ntawv no sau ua koj hom lus. Peb muaj kev cuag tau cov kev pab txhais lus thiab yeej pab teb tau koj cov lus nug ua koj hom lus.
Russian:	Вы можете бесплатно получить эти материалы и другую информацию, касающуюся программы страхования, крупным шрифтом. Чтобы получить материалы крупным шрифтом, позвоните в отдел обслуживания участников программы по телефону 1-833-552-3876. Если английский язык не является для вас родным, мы можем помочь. Позвоните нам по телефону 1-833-552-3876 (TTY: 711). Вы можете попросить предоставить вам информацию, содержащуюся в этих материалах, на вашем родном языке. Мы имеем доступ к услугам устных переводчиков и сможем ответить на ваши вопросы на вашем языке.

Tagalog:	Ang material na ito at iba pang impormasyon sa plan ay maaari mong makuha nang libre sa large print. Upang makuha ang materials sa large print, tumawag sa Member Services sa 1-833-552-3876. Kung hindi mo pangunahing wika ang wikang Ingles, makakatulong kami. Tumawag sa 1-833-552-3876 (TTY: 711). Maaari mong hingin sa amin ang impormasyon sa material na ito sa iyong wika. May access kami sa interpreter services at masasagot namin ang iyong mga katanungan sa iyong wika.
Gujarati:	તમે આ સામ□ી અને અન્ય યોજનાની માહિતી મોટી િ□ન્ટમાં મફત મેળવી શકો છો. મોટી િ□ન્ટમાં સાહિત્ય મેળવવા માટે 1-833-552-3876 પર મેમ્બર સ□વર્સીઝને કૉલ કરો.જો અં□ે□ તમારી □થમ ભાષા ન હોય તો અમે મદદ કરી શકીએ છીએ. 1-833-552-3876 (TTY: 711) પર કૉલ કરો. તમે તમારી ભાષામાં આ સામ□ીની માહિતી માટે અમને િવનંતી કરી શકો છો. અમે દુભાષિયાની સેવાઓ ધરાવીએ છીએ અને તમારી ભાષામાં તમારા □□નોના જવાબ આપવામાં મદદ કરી શકીએ છીએ.
Mon-Khmer (Cambodian):	អ្នកអាចទទួលបានឯកសារនេះ និងព័ត៌មានអំពីគម្រោងផ្សេងទៀតជាឯកសារបោះពុម្ពអក្សរធំដោយឥតគិតថ្លៃ។ ដើម្បីទទួលបានសម្ភារៈបោះពុម្ពខ្នាតធំ សូមហៅទៅកាន់សេវាសមាជិកតាមរយៈលេខ ១-៨៣៣-៥៥២-៣៨៧៦។ បើភាសាអង់គ្លេសមិនមែនជាភាសាកំណើតរបស់អ្នក យើងខ្ញុំអាចជួយអ្នកបាន។ សូមហៅទៅកាន់ ១-៨៣៣-៥៥២-៣៨៧៦ (TTY: ៧១១)។ អ្នកអាចសាកសួរយើងខ្ញុំអំពីព័ត៌មាននៅក្នុងសៀវភៅនេះបានជាភាសាកំណើតរបស់អ្នក។ យើងខ្ញុំមានទំនាក់ទំនងជាមួយសេវាបកប្រែ និងអាចជួយឆ្លើយសំណួរអ្នកជាភាសាជាតិរបស់អ្នកបាន។
German:	Dieses Material sowie andere Planinformationen sind kostenlos in Großdruck erhältlich. Um Materialien in Großdruck anzufordern, wenden Sie sich telefonisch an Mitgliederdienstleistungen unter der Nummer 1-833-552-3876. Wenn Englisch nicht Ihre Muttersprache ist, können wir Ihnen helfen. Rufen Sie die Nummer 1-833-552-3876 (TTY: 711) an. Sie können die Informationen in diesem Material in Ihrer Sprache anfordern. Wir haben Zugang zu Dolmetscherdiensten und können Ihnen bei der Beantwortung von Fragen in Ihrer Sprache behilflich sein.
Hindi:	आप यह सामग्री और योजना से सम्बन्धित अन्य जानकारी बड़े प्रिंट में मुफ़्त प्राप्त कर सकते हैं। बड़े प्रिंट में सामग्रियां प्राप्त करने के लिए, सदस्य सेवाओं (Member Services) को 1-833-552-3876 पर फोन करें। यदि अंग्रेजी आपकी प्रथम भाषा नहीं है, तो हम मदद कर सकते हैं। 1-833-552-3876 (TTY: 711) पर फोन करके आप हमसे इस सामग्री में दी गयी जानकारी अपनी भाषा में मांग सकते हैं। हमारे पास दुभाषिया सेवाएँ उपलब्ध हैं और हम आपके सवालों के जवाब आपकी भाषा में देने में मदद कर सकते हैं।
Laotian:	ທ່ານສາມາດຮັບເອົາຂໍ້ຄວາມນີ້ ແລະຂໍ້ມູນຂ່າວສານອື່ນໆກ່ຽວກັບແຜນປະກັນເປັນໂຕພິມໃຫຍ່ໄດ້ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ໂທຫາພະແນກການບໍລິການສະມາຊິກທີ່ 1-833-552-3876 ເພື່ອຂໍຮັບຂໍ້ຄວາມຕ່າງໆເປັນໂຕພິມໃຫຍ່. ຖ້າຫາກວ່າພາສາແມ່ຂອງທ່ານບໍ່ແມ່ນພາສາອັງກິດ ພວກເຮົາຈະຊ່ວຍເຫຼືອໄດ້. ໂທຫາ 1-833-552-3876 (TTY ໂທຫາ 711). ທ່ານສາມາດຂໍໃຫ້ເຮົາຈັດໃຫ້ຂໍ້ມູນຂ່າວສານນີ້ເປັນພາສາຂອງທ່ານໄດ້. ພວກເຮົາຈະເຂົ້າຫາການບໍລິການນາຍພາສາໄດ້ ແລະຍັງສາມາດຊ່ວຍຕອບຄຳຖາມຂອງທ່ານເປັນພາສາຂອງທ່ານເອງໄດ້ອີກດ້ວຍ.
Japanese:	この内容物そして他のプラン情報の大きな活字版を無料でご提供しています。大きな活字版をご希望の方は、メンバーサービス（Member Services）にお電話ください。電話番号は1-833-552-3876です。 英語が母国語ではない場合には、お手伝いいたします。1-833-552-3876 (TTY: 711) にお電話ください。この内容物について、ご希望の言語による情報もご提供できます。また、通訳サービスを介することで、ご希望の言語でご質問に対応できます。

Notice of Non-Discrimination

Carolina Complete Health complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation. Carolina Complete Health does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation.

Carolina Complete Health provides free aids and services to people with disabilities to communicate effectively with us, such as:

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

Carolina Complete Health provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Member Services at **1-833-552-3876 (TTY 711).** If you believe that Carolina Complete Health has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

DHHS ADA/RA Complaints
Office of Legal Affairs
2001 Mail Service Center
Raleigh, NC 27699-2001

You can file an ADA/RA (American with Disabilities Act/Rehabilitation Act) complaint by mail. You can ask for the form to file an ADA and/or RA complaint from the DHHS Compliance Attorney at (919) 855-4800. It is also available online at: https://files.nc.gov/ncdhhs/DHHS%20ADA%20Grievance%20Procedure%20June%202019.pdf

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- **electronically** through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- **by mail** at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201; *or*
- **by phone** at **1-800–368–1019** (TDD: 1-800–537–7697)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Your Carolina Complete Health Quick Reference Guide

I WANT TO:	I CAN CONTACT:
Find a doctor, specialist or health care service	My Primary Care Provider (PCP). (If you need help with choosing your PCP, call Member Services at **1-833-552-3876 (TTY 711**).
Learn more about choosing or enrolling in a plan:	Call toll free: 1-833-870-5500.
Get this handbook in another format or language	Member Services at **1-833-552-3876 (TTY 711)**.
Keep track of my appointments and health services	My PCP or Member Services at **1-833-552-3876 (TTY 711)**.
Get help with getting to and from my doctor's appointments	Member Services at **1-833-552-3876 (TTY 711)**. You can also find more information on Transportation Services in this handbook on page 18.
Get help to deal with my stress or anxiety	Behavioral Health Crisis Line at **1-855-798-7093** at any time, 24 hours a day, 7 days a week. If you are in danger or need immediate medical attention, call 911.
Get answers to basic questions or concerns about my health, symptoms or medicines	Nurse Line at **1-833-552-3876 (TTY 711)** at any time, 24 hours a day, 7 days a week, or talk with your PCP.
• Understand a letter or notice I got in the mail from my health plan • File a complaint about my health plan • Get help with a recent change or denial of my health care services	Member Services at **1-833-552-3876 (TTY 711)** or the NC Medicaid Ombudsman at 1-877-201-3750. You can also find more information about the NC Medicaid Ombudsman in this handbook on page 46.
Update my address	Call your local Department of Social Services (DSS) office to report an address change. A list of DSS locations can be found here: www.ncdhhs.gov
Find my plan's health care provider directory or other general information about my plan	Visit our website at www.**carolinacompletehealth.com** or call Member Services at **1-833-552-3876 (TTY 711)**.

Key Words Used in This Handbook

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

Adult Preventive Care: Care consisting of wellness checkups, patient counseling and regular screenings to prevent adult illness, disease and other health-related issues.

Advance Directive: A set of directions about the medical and behavioral health care you want if you ever lose the ability to make decisions for yourself.

Adverse Benefit Determination: A decision your health plan can make to deny, reduce, stop or limit your health care services.

Appeal: If the health plan makes a decision that you do not agree with, you can ask them to review it. Ask for an **appeal** when you do not agree with your health care service being denied, reduced, stopped or limited. **Appeals and grievances are different.** When you ask your plan for an appeal, you will get a new decision within 30 days. This decision is called a "resolution."

Behavioral Health Care: Mental health (emotional, psychological and social well-being) and substance use (alcohol and drugs) disorder treatment and recovery services.

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

Care Management Services: The service provided by a health plan to work with you and your doctors in making sure you get the right care when and where you need it.

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

Children's Screening Services: A medical examination to monitor how a child is developing. Screening services can help identify concerns and problems early. The screenings assess social/emotional behavior, vision and hearing, motor skills and coordination, cognitive abilities, language and speech.

Copay: A fee you pay when you get certain health care services or a prescription. Federally recognized tribal members will not have a copay for any services.

Covered Services: Health care services that are provided by your health plan.

Crossover: The timeframe immediately before and after the start of North Carolina Medicaid Managed Care.

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

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): The Medicaid plan for members under 21 years of age is also called "EPSDT." Medicaid health coverage for children is different from Medicaid adult plans. Medicaid covers a complete plan of *wellness* visits for children. When children need medical care, services are not limited by Carolina Complete Health's coverage policies. Medicaid makes sure that members under 21 years old can get the medical care they need, when they need it.

Early Intervention: Services and support available to babies and young children with developmental delays and disabilities and their families. Services may include speech and physical therapy and other types of services.

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

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

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

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

Enrollment Broker: Unbiased, third party entity that provides Managed Care enrollment assistance and coordinates outreach and education to beneficiaries.

Enteral Formula: Balanced nutrition especially designed for the tube-feeding of children.

Fair Hearing: See "State Fair Hearing."

Grievance: A **complaint** about your health plan, provider, care, or services. Contact your plan and tell them you have a "grievance" about your services. **Grievances and appeals are different**.

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

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

Home Health Care: Certain services you receive outside a hospital or a nursing home to help with daily activities of life, like home health aide services, skilled nursing or physical therapy services.

Hospice Services: Special services for patients and their families during the final stages of terminal illness and after death. Hospice services include certain physical, psychological, social and spiritual services that support terminally ill individuals and their families or caregivers.

Hospitalization: Admission to a hospital for treatment that lasts more than 24 hours.

Local Management Entity/Managed Care Organization (LME-MCO): The organization providing behavioral health services to beneficiaries in the NC Medicaid Direct program.

Long-Term Services and Supports: A set of services to help individuals with certain health conditions or disabilities with day-to-day activities (like eating, bathing or getting dressed).

Managed Care: A health care program where providers work together to coordinate and manage the health needs of eligible members, creating a central home for members' health.

Medicaid: Medicaid is a health insurance plan. The program helps some families or individuals who have low income or serious medical problems. It pays for many medical and mental health services you might need. The program is funded by the federal and state government. You must apply through your county's Department of Social Services. When you qualify for Medicaid, you

are entitled to certain rights and protections. See the websites below for more information about Medicaid and your rights: https://medicaid.ncdhhs.gov/medicaid/your-rights

NC Medicaid Direct: Previously known as Medicaid Fee-For-Service, this category of care includes those who are not a part of Medicaid Managed Care.

Medically Necessary: Medical services, treatments or supplies that are needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Member: A person enrolled in and covered by a health plan.

NC Medicaid (State Medicaid Agency): Agency that manages the state's Medicaid and NC Health Choice health care programs, pharmacy benefits and behavioral health services.

NC Medicaid Ombudsman: A new Department program to be established to provide education, advocacy and issue resolution for Medicaid beneficiaries whether they are in Medicaid Managed Care or NC Medicaid Direct. This program is separate and distinct from the Long-Term Care Ombudsman Program.

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

Non-Covered Services: Health care services that are not covered by your health plan.

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

NC Health Choice: NC Health Choice offers health insurance coverage for children ages 6 through 18 years old when their families do not qualify for Medicaid. **Medicaid insurance and NC Health Choice health care insurance are different.** You must apply through your county's Department of Social Services. NC Health Choice benefits are not the same as Medicaid benefits, and the guarantees of Medicaid's "EPSDT benefit" do not apply.

Ongoing Course of Treatment: When a member, in the absence of continued services, reflected in a treatment or service plan or as otherwise clinically indicated, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

Ongoing Special Condition: A condition that is serious enough to require treatment to avoid possible death or permanent harm. A chronic illness or condition that is life-threatening, degenerative, or disabling and requires treatment over an extended period. This definition also includes pregnancy in its second or third trimester, scheduled surgeries, organ transplants, scheduled inpatient care or being terminally ill.

Palliative Care: Specialized care for a patient and family that begins at diagnosis and treatment of a serious or terminal illness.

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

Postnatal: Pregnancy health care for a mother who has just given birth to a child.

Preauthorization: The approval you must have from your plan before you can get or continue getting certain health care services or medicines.

Prenatal: Pregnancy health care for expectant mothers, prior to the birth of a child.

Prescription Drugs: A drug that, by law, requires a provider to order it.

Primary Care: The day-to-day health care given by a health care provider, to include health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings.

Primary Care Provider (PCP): The provider who takes care of and coordinates all your health needs. Your PCP is often the first person you should contact if you need care. Your PCP is your doctor, clinic or other health care provider.

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

Referrals: A written order from your primary care provider for you to see a specialist or receive certain medical services.

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

Skilled Nursing Care: Health care services that require the skill of a licensed nurse.

Specialist: A provider who is trained and practices in a specific area of medicine.

State Fair Hearing: When you do not agree with your plan's resolution, you can ask for the state to review it. The NC Office of Administrative Hearings (OAH) will conduct your State Fair Hearing. The judge will carefully review the Carolina Complete Health's resolution. The judge does not work for your health plan. You may give the judge more medical updates. You may also ask questions directly to a member of the team who worked on your resolution.

Substance Use Disorder: A medical disorder that includes the misuse or addiction to alcohol and/or legal or illegal drugs.

Telemedicine: The practice of caring for patients remotely when the provider and patient are not physically in the same room. It is usually accomplished using HIPAA-compliant videoconferencing tools.

Transition of Care: The process of assisting you to move between health plans or to another Medicaid program, such as NC Medicaid Direct. The term Transition of Care also applies to the assistance provided to you when your provider is not enrolled in the health plan.

Urgent Care: Care for a health condition that needs prompt medical attention but is not an emergency medical condition. You can get urgent care in a walk-in clinic for a non-life-threatening illness or injury (like the flu or sprained ankle).

Welcome to Carolina Complete Health's North Carolina Medicaid Managed Care Program

NC Medicaid Managed Care Program

This handbook will help you understand the Medicaid health care services available to you. You can also call Member Services with questions at **1-833-552-3876 (TTY 711)** or visit our website at www.carolinacompletehealth.com.

How Managed Care Works

You Have a Health Care Team

Managed Care works like a central home to coordinate your health care needs.

- Carolina Complete Health has a contract to meet the health care needs of people with North Carolina Medicaid. We partner with a group of health care providers (doctors, therapists, specialists, hospitals, home care providers and other health care facilities) who make up our **provider network.**
- When you join Carolina Complete Health, our provider network is here to support you. Most of the time, your main contact will be your Primary Care Provider (PCP). If you need to have a test, see a specialist or go into the hospital, your PCP can help arrange it. Your PCP is available to you day and night. If you need to speak to your PCP after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can go to certain doctors for some services without checking with your PCP. See page 5 for details.
- You can visit our website at www.carolinacompletehealth.com to find the provider directory online or call Member Services at **1-833-552-3876 (TTY 711)** to get a copy of the provider directory.

How to Use This Handbook

This handbook tells you how Carolina Complete Health works. It is your guide to health and wellness services.

Read pages 5-12 now. These pages have information that you need to start using your plan.

When you have questions about your health plan, you can:

- Use this handbook
- Ask your Primary Care Provider (PCP)
- Call Member Services at **1-833-552-3876 (TTY 711)**
- Visit our website at www.carolinacompletehealth.com

Help from Member Services

Member Services has people to help you. You can call Member Services at **1-833-552-3876 (TTY 711)**.

- For help with non-emergency issues and questions, call Member Services Monday – Saturday, 7 a.m. to 6 p.m. **After business hours, you may leave a voicemail for Member Services or speak to someone at the Nurse Advice Line.**
- In case of a medical emergency, call 911.
- **You can call Member Services to get help when you have a question.** You may call us to choose or change your Primary Care Provider (PCP), to ask about benefits and services, to get help with referrals, to replace a lost Medicaid card, to report the birth of a new baby or ask about any change that might affect you or your family's benefits.
- If you are or become pregnant, your child will become part of Carolina Complete Health on the day your child is born. Call us and your local Department of Social Services right away if you become pregnant. We can help you to choose a doctor for both you and your baby.
- **If English is not your first language, we can help.** Just call us and we will find a way to talk with you in your own language.
- For people with disabilities:
    - If you have difficulty hearing or need assistance communicating, please call us. If you are reading this on behalf of someone who is blind, deaf-blind or has difficulty seeing, we can help. We can tell you if a doctor's office is equipped with special communications devices. Also, we have services like:
    - TTY machine. Our TTY phone number is **1-833-552-3876 (TTY 711)**.
    - Information in large print
    - Help in making or getting to appointments
    - Names and addresses of providers who specialize in your condition

Other Ways We Can Help

- If you have basic questions or concerns about your health, you can call our Nurse Line at **1-833-552-3876 (TTY 711)** at any time, 24 hours a day, 7 days a week. This is a free call. You can get advice on when to go to your primary care provider or ask questions about symptoms or medications.
- If you are experiencing emotional or mental pain or distress, call the Behavioral Health Crisis Line at **1-855-798-7093** at any time, 24 hours a day, 7 days a week, to speak with someone who will listen and help. This is a free call. We are here to help you with problems like stress, depression or anxiety. We can get you the support you need to feel better. **If you are in danger or need immediate medical attention, call 911.**

- If you use a wheelchair, we can tell you if a doctor's office is wheelchair accessible and assist in making or getting to appointments.

Special Aids and Services

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

- A TTY machine. Our TTY phone number is **1-833-552-3876 (TTY 711)**.
- Qualified American Sign Language interpreters
- Closed captioning
- Written information in other formats (like large print, audio, accessible electronic format, and other formats)

These services are available for free. To ask for services, call Member Services at **1-833-552-3876 (TTY 711).**

Carolina Complete Health complies with federal civil rights laws and does not leave out or treat people differently because of race, color, national origin, age, disability or sex. If you believe that Carolina Complete Health failed to provide these services, you can file a complaint. To file a complaint or to learn more, call Member Services at **1-833-552-3876 (TTY 711).**

Your Medicaid Card

Your Medicaid card has been mailed to you with this welcome packet and member handbook. We used the mailing address on file at your local Department of Social Services. Your Medicaid card has:

- Your Primary Care Provider's (PCP's) name and phone number
- Your Medicaid Identification Number
- Information on how to contact us with questions

If anything is wrong on your Medicaid card, call us right away.

If you lose your card, call Member Services at **1-833-552-3876 (TTY 711).** Always carry your Medicaid card with you. You will need to show it each time you go for care.

If you need services prior to receiving your ID card in the mail, please call Members Services at 1-833-552-3876 (TTY 711).

carolina complete health

10101 David Taylor Dr. Suite 300
Charlotte, NC 28262

Name/Nombre: Jane C. Doe

Member ID#: XXXXXXXXXXX

Date of Birth/Fecha de Nacimiento: **MM/DD/YYYY**

Effective/Efectivo a partir de: **MM/DD/YYYY**

AMH/PCP Name/Nombre del **AMH/PCP:** XXXXX

AMH/PCP Address/Dirección del **AMH/PCP:** XXXXX

AMH/PCP Phone Number/Número de teléfono del **AMH/PCP: XXX-XXX-XXXX**

RX: Envolve Pharmacy Solutions

RXBIN: 004336

RXPCN: MCAIDADV

RXGRP: RX5480

MEMBER PORTAL/PORTAL PARA AFILIADOS: CarolinaCompleteHealth.com

NC Health Choice

IMPORTANT CONTACT INFORMATION / INFORMACIÓN IMPORTANTE DE CONTACTO

Members/Afiliados:

Call **1-833-552-3876** (TTY: 711) for **Member Services** / Servicios para afiliados and **24/7 Nurse Advice Line** / Línea de consejo de enfermería que atiende 24/7

Call **1-855-798-7093** for **Behavioral Health Crisis Line** / Línea de crisis de salud mental

Providers: Call **1-833-552-3876 for**

Provider Service Line • Prescriber Service Line • Prior Authorization

Pharmacy Help Desk: 1-833-992-2785 **Pharmacy Prior Authorization:** 1-833-585-4309

Pharmacy Paper Claims: P.O. Box 989000, West Sacramento, CA 95798

All Medical Claims: Carolina Complete Health, PO Box 8010, Farmington, MO 63640

If you suspect a doctor, clinic, hospital, home health service or any other kind of medical provider is committing Medicaid fraud, report it. **Call 1-919-881-2320.** Some services are carved out. A full list of benefits can be found in the Member Handbook at **CarolinaCompleteHealth.com.**

Si sospecha que un médico, clínica, hospital, servicio de atención médica en el hogar o cualquier otro tipo de proveedor médico está cometiendo fraude contra Medicaid, infórmelo. Llame al 1-919-881-2320. Algunos servicios están excluidos. Puede encontrar una lista completa de beneficios en el Manual para afiliados de **CarolinaCompleteHealth.com.**

PART I: First Things You Should Know

How to Choose Your PCP

- Your Primary Care Provider (PCP) is a doctor, nurse practitioner, physician assistant or another type of provider who will:
  - Care for your health
  - Coordinate your needs
  - Help you get referrals for specialized services if you need them
- As a Medicaid beneficiary, you had an opportunity to choose your own PCP. If you did not select a PCP, we chose one for you based on your past health care. You can find your PCP's name and contact information on your Medicaid card. If you would like to change your PCP, you have 30 days from the date of receiving this packet to make the change. (See "How to Change Your PCP" to learn how to make those changes).
- When deciding on a PCP, you may want to find a PCP who:
  - You have seen before
  - Understands your health history
  - Is taking new patients
  - Can serve you in your language
  - Is easy to get to
- Each family member enrolled in Carolina Complete Health can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Call Member Services at **1-833-552-3876 (TTY 711)** to get help with choosing a PCP that is right for you and your family.
- You can find the list of all the doctors, clinics, hospitals, labs and others who partner with Carolina Complete Health in our provider directory. You can visit our website at www.carolinacompletehealth.com to look at the provider directory online. You can also call Member Services at **1-833-552-3876 (TTY 711)** to get a copy of the provider directory.
- Women can choose an OB/GYN to serve as their PCP. Women do not need a PCP referral to see a plan OB/GYN doctor or another provider who offers women's health care services. Women can get routine check-ups, follow-up care if needed and regular care during pregnancy.
- If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP. In order to select a specialist as your PCP, please register on the Carolina Complete Health Secure Member Portal or contact Member Services at **1-833-552-3876 (TTY 711).**

If Your Provider Leaves Our Network

- If your provider leaves Carolina Complete Health, we will tell you within 15 days from when we know about this. If the provider who leaves Carolina Complete Health is your PCP, we will tell you within 7 days and help make sure you select a new PCP.
- If your provider leaves our network, we can help you find a new one.
- Even if your provider leaves our network, you may be able to stay with your provider for a while longer in certain situations.
- Please read "Your Care When You Change Health Care Providers" under Part III, Plan Procedures on page 38 for more information about how long you can stay with a provider who has left our network.
- If you have any questions about the information in this section, please visit our website www.carolinacompletehealth.com or call Member Services at **1-833-552-3876 (TTY 711).**

How to Change Your PCP

- You can find your Primary Care Provider's (PCP's) name and contact information on your Medicaid card. You can change your PCP within 30 days from the date you receive your Medicaid card. To change your PCP, call Member Services at **1-833-552-3876 (TTY 711)**. After that, you can change your PCP only one time each year. You do not have to give a reason for the change.
- To change your PCP more than once a year, you need to have a good reason (good cause). For example, you may have good cause if:
    - Your PCP does not provide accessible and proper care, services or supplies (e.g., does not set up hospital care or consults with specialists when required for treatment)
    - You disagree with your treatment plan
    - Your PCP moves to a different location that is not convenient for you
    - Your PCP changes the hours or days that he or she sees patients
    - You have trouble communicating with your PCP because of a language barrier or another issue
    - Your PCP is not able to accommodate your special needs
    - You and your PCP agree that a new PCP is what is best for your care

Call Member Services at **1-833-552-3876 (TTY 711)** to learn more about how you can change your PCP.

How to Get Regular Health Care

- "Regular health care" means exams, regular check-ups, shots or other treatments to keep you well. It also includes giving you advice when you need it and referring you to the hospital or specialists when needed. You and your Primary Care Provider (PCP) work together to keep you well or to see that you get the care you need.
- Your PCP is always available. Call your PCP when you have a medical question or concern. If you call after hours or on weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how your health plan works.
- Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If you ever cannot keep an appointment, call to let your PCP know.
- **Making your first regular health care appointment.** As soon as you choose or are assigned a PCP, if it is a new provider, call to make a first appointment. There are several things you can do to help your PCP get to know you and your health care needs.
- How to prepare for your first visit with a new provider:
    - Request a transfer of medical records from your current provider to your new PCP.
    - Make a list of problems you have now, as well as being prepared to discuss your general health, past major illnesses, surgeries, etc.
    - Make a list of questions you want to ask your PCP.
    - Bring medications and supplements you are taking to your first appointment.

  It's best to visit your PCP within three months of joining the plan.
- **If you need care before your first appointment,** call your PCP's office to explain your concern. Your PCP will give you an earlier appointment to address that particular health concern. You should still keep the first appointment to talk about your medical history and ask questions.
- It is important to Carolina Complete Health that you can visit a doctor within a reasonable amount of time. The table lets you know how long you may have to wait to be seen.

APPOINTMENT GUIDE	
IF YOU CALL FOR THIS TYPE OF SERVICE:	**YOUR APPOINTMENT SHOULD TAKE PLACE:**
Adult preventive care (services like routine health check-ups or immunizations)	within 30 days
Pediatric preventive care (services like well-child check-ups)	within 14 days for members younger than 6 months; within 30 days for members 6 months or older
Urgent care services (care for problems like sprains, flu symptoms or minor cuts and wounds)	within 24 hours
Emergency or urgent care requested after normal business office hours	Go to hospital emergency room immediately (available 24 hours a day, 365 days a year) or go to urgent care clinic
First prenatal visit (1st or 2nd trimester)	within 14 days
First prenatal visit (3rd trimester or high-risk pregnancy)	within 5 days
Mental Health	
Routine services	within 14 days
Urgent care services	within 24 hours
Emergency services (services to treat a life-threatening condition)	Go to hospital emergency room immediately (available 24 hours a day, 365 days a year) or go to urgent care clinic
Mobile crisis management services	within 30 minutes
Substance Use Disorders	
Routine services	within 14 days
Urgent care services	within 24 hours
Emergency services (services to treat a life-threatening condition)	Go to hospital emergency room immediately (available 24 hours a day, 365 days a year) or go to urgent care clinic

If you are not getting the care you need within the time limits described above, call Member Services at **1-833-552-3876 (TTY 711)**.

How to Get Specialty Care – Referrals

- If you need specialized care that your Primary Care Provider (PCP) cannot give, your PCP will refer you to a **specialist** who can. A specialist is a doctor who is trained and practices in a specific area of medicine (like a cardiologist or a surgeon). If your PCP refers you to a specialist, we will pay for your care. Most specialists are Carolina Complete Health

providers. Talk with your PCP to be sure you know how referrals work. See below for the process on referrals to a specialist who is not in our provider network.

- If you think a specialist does not meet your needs, talk with your PCP. Your PCP can help you find a different specialist.
- There are some treatments and services that your PCP must ask Carolina Complete Health to approve before you can get them. Your PCP will tell you what those services are.
- If you have trouble getting a referral you think you need, contact Member Services at **1-833-552-3876 (TTY 711)**.
- If Carolina Complete Health does not have a specialist in our provider network who can give you the care you need, we will refer you to a specialist outside our plan. This is called an **out-of-network referral**. Your PCP or another network provider must ask Carolina Complete Health for approval before you can get an out-of-network referral.
    - If you need to see an out-of-network provider, please contact Member Services at **1-833-552-3876 (TTY 711)**. Services from out-of-network providers need prior authorization.
    - **IMPORTANT:** You may have to pay for out-of-network services if you do not get prior authorization. If you have questions, call Member Services at **1-833-552-3876 (TTY 711)**.
- Sometimes we may not approve an out-of-network referral because we have a provider in Carolina Complete Health who can treat you. If you do not agree with our decision, you can **appeal** our decision. See pages 33 – 37 to find out how.
- Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is similar to what you can get from a Carolina Complete Health provider. If you do not agree with our decision, you can **appeal** our decision. See pages 33 – 37 to find out how.

If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP. If you would like to choose a specialist as your PCP, visit the Secure Member Portal at www.carolinacompletehealth.com or call Member Services at **1-833-552-3876 (TTY 711)**. After you tell us who your Specialist PCP is, we will send you a new Carolina Complete Health member ID card with your PCP's name and telephone number on it.

Out-of-Network Providers

If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan, or an **out-of-network provider**. For more information about getting services from an out-of-network provider, talk to your Primary Care Provider (PCP) or call Member Services at **1-833-552-3876 (TTY 711)**.

Get These Services from Carolina Complete Health without a Referral

You do not need a referral to get these services:

Primary Care

You do not need a referral to get primary care services. If you need a check-up or have a question about your health, call your Primary Care Provider (PCP) to make an appointment. Your assigned primary care provider's name and contact information are listed on your Medicaid card.

Women's Health Care

You do not need a referral from your PCP if:

- You are pregnant and need pregnancy-related services
- You need OB/GYN services
- You need family planning services
- You need to have a breast or pelvic exam

Family Planning

You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can also visit one of our family planning providers. You do not need a referral from your PCP for family planning services. Family planning services include:

- Birth control
- Birth control devices such as IUDs, implantable contraceptive devices, and others that are available with a prescription
- Emergency contraception
- Sterilization services
- HIV and sexually transmitted infection (STI) testing, treatment and counseling
- Screenings for cancer and other related conditions

Children's Screening

You do not need a referral to get children's screening services or school-based services.

Local Health Department Services

You do not need a referral to get services from your local health department.

Behavioral Health Services

You do not need a referral for your first behavioral health or substance use disorder assessment completed in a 12-month period. Ask your PCP or call Member Services at **1-833-552-3876 (TTY 711)** for a list of mental health providers and substance use disorder providers. You can also find a list of our behavioral health providers online at www.carolinacompletehealth.com.

Emergencies

You are always covered for emergencies. An emergency medical condition is a situation in which your life could be threatened, or you could be hurt permanently if you don't get care right away. Some examples of an emergency are:

- A heart attack or severe chest pain
- Bleeding that won't stop or a bad burn
- Broken bones
- Trouble breathing, convulsions or loss of consciousness
- When you feel you might hurt yourself or others
- If you are pregnant and have signs like pain, bleeding, fever or vomiting
- Drug overdose

Some examples of **non-emergencies** are colds, upset stomach or minor cuts and bruises. Non-emergencies may also be family issues or a break up.

If you believe you have an emergency, call 911 or go to the nearest emergency room.

- You **do not** need approval from your plan or your PCP before getting emergency care, and you are not required to use our hospitals or doctors.
- **If you're not sure, call your PCP at any time, day or night.** Tell the person you speak with what is happening. Your PCP's team will:
    - Tell you what to do at home
    - Tell you to come to the PCP's office
    - Tell you to go to the nearest urgent care emergency room.

Remember: If you need to speak to your PCP after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible.

- **If you are out of the area when you have an emergency:**
    - Go to the nearest emergency room.

Remember: Use the Emergency Department only if you have an emergency. If you have questions, call your PCP or Carolina Complete Health Member Services at **1-833-552-3876 (TTY 711)**.

Urgent Care

You may have an injury or an illness that is not an emergency but still needs prompt care and attention. This could be:

- A child with an ear ache who wakes up in the middle of the night and won't stop crying
- The flu
- A cut that needs stitches
- A sprained ankle
- A bad splinter you cannot remove

Whether you are at home or away, you can walk into an urgent care clinic to get care the same day or make an appointment for the next day. If you would like assistance making an appointment:

- Call your PCP any time day or night.
- If you are unable to reach your PCP, call Member Services at **1-833-552-3876 (TTY 711)**. Tell the person who answers what is happening. They will tell you what to do.

Care Outside North Carolina and the United States

In some cases, Carolina Complete Health may pay for health care services you get from a provider located along the North Carolina border or in another state. Your PCP and Carolina Complete Health can give you more information about which providers and services are covered outside of North Carolina by your health plan and how you can get them if needed.

- If you need medically necessary emergency care while traveling anywhere **within** the United States and its territories**,** Carolina Complete Health will pay for your care.
- Your health plan will not pay for care received **outside** of the United States and its territories.

If you have any questions about getting care outside of North Carolina or the United States, talk with your PCP or call Member Services at **1-833-552-3876 (TTY 711)**.

Part II: Your Benefits

NC Medicaid Managed Care provides **benefits** or health care services covered by your plan.

This section describes:

- Covered and non-covered services. “Covered services” means Carolina Complete Health will pay for the services. These are also called benefits. “Non-covered services” means Carolina Complete Health will not pay for the services.
- What to do if you are having a problem with your health plan.

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

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

The section below describes the specific services covered by Carolina Complete Health. Ask your Primary Care Provider (PCP) or call Member Services at **1-833-552-3876 (TTY 711)** if you have any questions about your benefits.

You can get some services without going through your PCP. These include primary care, emergency care, women’s health services, family planning services, children’s screening services, services provided at local health departments, school-based services and some behavioral health services. You can find more information about these services on page 10.

Services Covered by Carolina Complete Health’s Network

You must get the services below from the providers who are in Carolina Complete Health’s network. Services must be medically necessary, and provided, coordinated or referred by your PCP. Talk with your PCP or call Member Services at **1-833-552-3876 (TTY 711)** if you have questions or need help.

Regular Health Care

- Office visits with your PCP, including regular check-ups, routine labs and tests
- Referrals to specialists
- Eye/hearing exams
- Well-baby care
- Well-child care
- Immunizations (shots) for children and adults

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for members under age 21 (see page 25 for more information about EPSDT services)
- Help with quitting smoking or other tobacco use

Maternity Care

- Pregnancy care
- Childbirth education classes
- OB/GYN and hospital services
- One medically necessary post-partum home visit for newborn care and assessment following discharge, but no later than 60 days after delivery
- Care management services for high-risk pregnancies during pregnancy and for two months after delivery (see page 23 for more information)

Hospital Care

- Inpatient care
- Outpatient care
- Labs, X-rays and other tests

Home Health Services

- Must be medically necessary and arranged by Carolina Complete Health
- Time-limited skilled nursing services
- Specialized therapies, including physical therapy, speech-language pathology and occupational therapy
- Home health aide services for help with activities such as bathing, dressing, preparing meals and housekeeping
- Medical supplies

Personal Care Services (Adults only)

- Must be medically necessary and arranged by Carolina Complete Health
- Help with common activities of daily living, including eating, dressing and bathing, for individuals with disabilities and ongoing health conditions

Hospice Care

- Hospice care will be arranged by Carolina Complete Health if medically necessary.
- Hospice helps patients and their families with the special needs that come during the final stages of illness and after death.
- Hospice provides medical, supportive and palliative care to terminally ill individuals and their families or caregivers.

- You can get these services in your home, in a hospital or in a nursing home.

Vision Care

- Services provided by ophthalmologists and optometrists, including routine eye exams, medically necessary contact lenses, and dispensing fees for eyeglasses. Opticians may also fit and dispense medically necessary contact lenses and eyeglasses.
- Specialist referrals for eye diseases or defects
- The fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses and ophthalmic frames, is provided to you through the NC Medicaid Direct program. Although these eyeglasses are covered through NC Medicaid Direct, Carolina Complete Health providers who work in an office that offers eye exams and eyeglasses must give you your eye exam and your NC Medicaid Direct eyeglasses (see page 26 for more information on benefits covered by Medicaid but not through your Health Plan).

Pharmacy

- Prescription drugs
- Some medicines sold without a prescription (also called “over-the-counter”), like allergy medicines
- Insulin and other diabetic supplies like syringes, test strips, lancets and pen needles
- Smoking cessation agents, including over-the-counter products
- Enteral formula (balanced nutrition designed for the tube-feeding of children)
- Emergency contraception
- Medical and surgical supplies
- We also provide a **Pharmacy Lock-in Program** that helps identify Members that are at risk for possible overuse or improper use of pain medications (opioid analgesics) and nerve medications (benzodiazepines and certain anxiolytics). See page 22 for more information on our pharmacy lock-in program.

Emergency Care

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.
- After you have received emergency care, you may need other care to make sure you remain in stable condition.
- Depending on the need, you may be treated in the Emergency Department, in an inpatient hospital room or in another setting.
- For more about emergency services, see page 11.

Specialty Care

- Respiratory care services

- Podiatry services
- Chiropractic services
- Cardiac care services
- Surgical services

Nursing Home Services

- Must be ordered by a physician and authorized by Carolina Complete Health
- Includes short-term or rehabilitation stays and long-term care for up to 90 days in a row. After the 90th day, your nursing services will be covered by NC Medicaid Direct and not Carolina Complete Health. Talk with your PCP or call Member Services at **1-833-552-3876 (TTY 711)** if you have questions.
- Covered nursing home services include medical supervision, 24-hour nursing care, assistance with daily living, physical therapy, occupational therapy and speech-language pathology.
- Nursing home services must come from a nursing home that is in Carolina Complete Health's provider network. Call Member Services at **1-833-552-3876 (TTY 711)** for help with questions about nursing home providers and plan networks.

Behavioral Health Services (Mental Health and Substance Use Disorder Services)

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

The behavioral health services **covered** by Carolina Complete Health include the following:

- Ambulatory detoxification services
- Diagnostic assessment services
- Early and periodic screening, diagnostic and treatment services (EPSDT) for members under age 21
- Facility-based crisis services for children and adolescents
- Inpatient behavioral health services
- Medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization
- Mobile crisis management services
- Non-hospital medical detoxification services
- Outpatient behavioral health emergency room services
- Outpatient behavioral health services provided by direct-enrolled providers

- Outpatient opioid treatment services
- Partial hospitalization
- Peer support services
- Professional treatment services in a facility-based crisis program
- Research-based intensive behavioral health treatment

Some behavioral health services for people with an intellectual or developmental disability, mental illness, traumatic brain injury or substance use disorder are only available through the LME-MCOs and in NC Medicaid Direct. The following behavioral health services are not covered by Carolina Complete Health but, if needed, members may access these services through the LME-MCOs and NC Medicaid Direct programs:

- Residential treatment facility services for children and adolescents
- Child and adolescent day treatment services
- Intensive in-home services
- Multi-systemic therapy services
- Psychiatric residential treatment facilities
- Assertive community treatment
- Community support team
- Psychosocial rehabilitation
- Substance Abuse Comprehensive Outpatient Treatments (SACOT)
- Substance abuse non-medical community residential treatment
- Substance abuse medically monitored residential treatment
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)
- Innovations waiver services
- Traumatic brain injury waiver services (only available in counties served by the LME-MCO Alliance Health)
- 1915(b)(3) services

If you believe you need access to any of the behavioral health services that Carolina Complete Health does not provide, call Member Services at 1-833-552-3876 (TTY 711).

Transportation Services

- **Emergency:** If you need emergency transportation (an ambulance), call 911.
- **Non-Emergency:** Carolina Complete Health can arrange and pay for your transportation to help you get to and from your appointments for Medicaid-covered care. This service is free to you. If you need an attendant to go with you to your doctor's appointment, or if your child (18 years old or younger) is a member of the plan, transportation is also covered for the attendant, parent or guardian. Non-emergency transportation includes personal vehicles, taxis, vans, mini-buses, mountain area transports and public transportation. **NC Health Choice members are not eligible to receive non-emergency transportation services.**

  How to Get Non-Emergency Transportation. Call **1-833-552-3876 (TTY 711) 24 hours, 7 days a week, 365 days a year,** up to 2 days before your appointment to arrange transportation to and from your appointment. Non-emergency medical transportation is provided by **ModivCare**. After hours you may obtain medical transportation to appointments by dialing the same toll-free number used during normal business hours. Non-emergency transportation is covered for medically necessary, covered services, such as doctor appointments, dialysis, and counseling appointments. If you need to change or cancel your transportation appointment, please call Transportation Services at **1-833-552-3876 (TTY 711)** as soon as you are aware of the need to change or cancel your pickup time. If the transportation does not show at the appointment time, please contact Transportation Services at **1-833-552-3876 (TTY 711)** to determine the location of the driver or make alternative arrangements.

  If transportation services are denied, you have the right to appeal our decision. See page 33 for more information on appeals. If you have questions about transportation, visit carolinacompletehealth.com or call Member Services at **1-833-552-3876 (TTY 711).**

For certain types of trips, Carolina Complete Health may need to review the request or require additional information before we can schedule the trip. This is called **preauthorization**. The following types of trips must be reviewed by us and/or require additional information before we can schedule the trip:

Preauthorization Required	No Preauthorization Required
• Out-of-network providers/facilities • One-way trip exceeding 100 miles • Out-of-state providers/facilities • One-way trip exceeding $200 (excluding costs associated with surcharges) • Trips for services not covered by Carolina Complete Health (excluding dental services)	• If Carolina Complete Health is not the primary insurer (unless member is traveling out-of-state for over 100 miles one way • Urgent appointments

• Pick-up or drop off address differs from the address on file (excluding provider's offices/hospitals).	

Please call Transportation Services at **1-833-552-3876 (TTY 711)** to initiate a prior authorization. Transportation Services will contact you when a trip requiring prior authorization is approved. For all trip denials, Transportation Services will notify you by phone and in writing. You may receive verbal approval at the time of the call if it is available when you call.

Members using Transportation Services must comply with the conduct policies of the transportation providers. Any conduct that jeopardizes the safety of other passengers or the driver may result in suspension of transportation services. Depending on the circumstances, not canceling a trip or canceling less than 24 hours in advance may result in a no-show. Repeated no-shows may result in a suspension from transportation services.

Under certain circumstances, such as overnight stays, very early travel, or late returns, you may be eligible for meal or lodging reimbursement. To find out more and to request a prior authorization for reimbursement, please contact Transportation Services at **1-833-552-3876 (TTY 711)**.

You can get additional information on our Non-Emergency Medical Transportation policy by calling Member Services at **1-833-552-3876 (TTY 711**) or by visiting our website at www.carolinacompletehealth.com.

Member Services can provide information such as:

- How to request, schedule or cancel a trip
- Any limitations on Non-Emergency Medical Transportation services
- Expected member conduct and procedures for no-shows
- How to get mileage reimbursement if you use your own car

When taking a ride to your appointment, you can expect to:

- Be able to arrive at your appointment on time and no sooner than one hour before the appointment
- Not to have to wait more than one hour after the appointment for a ride home
- Not to have to leave the appointment early

If you disagree with a decision made about your transportation services, you have the right to appeal our decision. See pages 33 – 37 for more information on appeals. If you are dissatisfied with your transportation service, you may file a grievance. See page 36 for more information on grievances.

Long-Term Services and Supports (LTSS)

If you have a certain health condition or disability, you may need help with day-to-day activities like eating, bathing or doing household chores. You can get help through a Carolina Complete Health benefit known as **"**Long-Term Services and Supports" (LTSS). LTSS includes services like home health and personal care services. You may get LTSS in your home, community or in a nursing home.

- If you need LTSS, you may have a Care Manager on your care team. A Care Manager is a specially trained health professional who works with you and your doctors and other providers of your choice to make sure you get the right care when and where you need it. For more information about what a Care Manager can do for you, see "Extra Support to Manage Your Health" on page 21.
- If you are leaving a nursing home and are worried about your living situation, we can help. Our Housing Specialist can connect you to housing options. Call Member Services at **1-833-552-3876 (TTY 711)** to learn more.

If you have questions about using LTSS benefits, talk with your PCP, a member of your care team or call Member Services at **1-833-552-3876 (TTY 711).**

Family Planning

You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can also visit one of our family planning providers. You do not need a referral from your PCP for family planning services. Family planning services include:

- Birth control
- Birth control devices such as IUDs, implantable contraceptive devices, and others that are available with a prescription
- Emergency contraception
- Sterilization services
- HIV and sexually transmitted infection (STI) testing, treatment and counseling
- Screenings for cancer and other related conditions

Other Covered Services

- Durable medical equipment/prosthetics/orthotics
- Hearing aid products and services
- Telemedicine
- Extra support to manage your health (see page 21 for more information)
- Home infusion therapy
- Rural Health Clinic (RHC) services
- Federally Qualified Health Center (FQHC) services

- Free Clinic services

If you have any questions about any of the benefits above, talk to your PCP or call Member Services at **1-833-552-3876 (TTY 711).**

Extra Support to Manage Your Health

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

Your Care Manager can:

- Help coordinate your appointments and help arrange for transportation to and from your doctor
- Support you in reaching your goals to better manage your ongoing health conditions
- Answer questions about what your medicines do and how to take them
- Follow up with your doctors or specialists about your care
- Connect you to helpful resources in your community
- Help you continue to receive the care you need if you switch health plans or doctors

Carolina Complete Health can also connect you to a Care Manager who specializes in supporting:

- People who need access to services like nursing home care or personal care services to help manage daily activities of living like eating or bathing and household tasks
- Pregnant women with certain health issues such as diabetes or other concerns such as wanting help to quit smoking
- Children from birth to age 5 who may live in stressful situations or have certain health conditions or disabilities

At times, a member of your Primary Care Provider's (PCP's) team will be your Care Manager. To learn more about how you get can extra support to manage your health, talk to your PCP or call Member Services at **1-833-552-3876 (TTY 711)**.

Help with Problems beyond Medical Care

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

Call Member Services at **1-833-552-3876 (TTY 711)** if you:

- Worry about your housing or living conditions
- Have trouble getting enough food to feed you or your family

- Find it hard to get to appointments, work or school because of transportation issues
- Feel unsafe or are experiencing domestic violence. If you are in immediate danger, call 911.

Other Programs to Help You Stay Healthy

Carolina Complete Health wants to help you and your family get and stay healthy. If you want to quit smoking or are a new mom who wants to learn more about how to best feed your baby, we can connect you with the right program for support.

Call Member Services at **1-833-552-3876 (TTY 711)** to learn more about:

- Tobacco cessations services to help you stop smoking or using other tobacco products
- Women, Infants and Children (WIC) special supplemental nutrition program
- Newborn screening program
- Hearing screening program
- Early intervention program

Opioid Misuse Prevention Program

Opioids are powerful prescription medications that can be the right choice for treating severe pain. However, opioids may also have serious side effects, such as addiction and overdose. Carolina Complete Health supports safe and appropriate opioid use through our Opioid Misuse Prevention Program. If you have any questions about our program, call Member Services at **1-833-552-3876 (TTY 711)**.

Pharmacy Lock-in Program

The **Pharmacy Lock-in Program** helps identify members that are at risk for possible overuse or improper use of pain medications (opioid analgesics) and nerve medications (benzodiazepines and certain anxiolytics). The **Pharmacy Lock-in Program** also helps identify members who get the medications from more than one prescriber (doctor, nurse practitioner or physician's assistant). If you qualify for this program, Carolina Complete Health will only pay for your pain medications and nerve medications when:

- Your medications are ordered by one prescriber. You will be given a chance to pick a prescriber in Carolina Complete Health's network.
- You have these prescriptions filled from one pharmacy. You will be given a chance to pick a pharmacy in Carolina Complete Health's network.

If Carolina Complete Health decides that you should be in the **Pharmacy Lock-in Program**, you will be in the program for a two-year period. If you do not agree with our decision that you should be in the program, you can appeal our decision before you are placed in the program (see pages 33 - 37 for more information on Appeals).

Additional health management programs provided by Carolina Complete Health.

Personal Coaching	• Health coaching for adults, teens, and children to support conditions such as diabetes, ADHD, COPD, anxiety, asthma, depression, nutrition, and smoking cessation. • Dedicated specialists to assist individuals and families with housing, food access, employment, and transportation needs.
Health Education Resources	• Online library with over 4,000 pieces of information on a wide-range of health topics. • Series of award-winning educational books for adults, teens, and children.
Child Education Support	• $75 per year for child education support including school supplies and online tutoring for covered children enrolled in grades Pre-K through 12.
Adult Education Support	• GED support including study materials and exam voucher.
Youth Support	• $75 per year for child after school sports/activities or youth club memberships (Boys & Girls Club or similar membership) for covered children, age 6-18.
Maternity Care – Prenatal and Infant Support	Programs and care management services including high-risk pregnancies during pregnancy and for two months after delivery. • Health screenings to reduce the pregnancy complications, premature delivery, and infant disease. • Education support for new mothers including infant care, safety, nutrition, and more. • Practical resources for new mothers and infants including diapers, diaper bags, breast pumps, and car seats.
Cell Phone	• Cell phone and service to help eligible members stay in touch with their doctors. • ConnectionsPlus® Program, provides pre-programmed cell phones with 24-hour instant access to providers, case managers (including behavioral health case managers), nurse advice line, and 911. In addition, the phones allow case managers to send you a text message with health information specific to your condition.
My Health Pays	• $75 per year healthy rewards gift card for healthy behaviors. Rewards can be used at Walmart® and/or for utilities, transportation, child care, phone, education, and rent.

Nutrition Support	• $120 per year for approved healthy foods at Walmart® • Up to 14 weeks of Weight Watchers® including online tools
Diabetes Prevention and Management	• YMCA membership for diabetic and high blood pressure
Vision	• An additional routine eye exam and up to a $125 allowance for adult vision Value Added Service (VAS) eyeglasses every 730 days for members ages 21 and older.
Asthma Management	• The Room to Breathe program supports members with asthma. A Carolina Complete Health Housing Specialist is available to visit your home to find asthma triggers and provide a kit that includes items such as air filters and mattress covers.
MyStrength.com Online Resource for Mental Health	• This website provides personalized e-Learning programs in a safe and confidential environment. • The online resources support members struggling with depression, anxiety, or drug/alcohol misuse with weekly exercises and daily inspiration.
Substance Abuse Recovery Application	• Website/mobile app helps build 24/7 social support network made up of peers and caregivers. • Features include creating and tracking personal goals, setting medication reminders and support locator
Other	• $120 per year per household for over-the-counter products such as Tylenol, first-aid supplies, and cold medicine

Benefits You Can Get from Carolina Complete Health OR a NC Medicaid Direct Provider

You can choose where to get some services. You can get these services from providers in the Carolina Complete Health network or from another Medicaid provider. You do not need a referral from your Primary Care Provider (PCP) to get these services. If you have any questions, talk to your PCP or call Member Services at **1-833-552-3876 (TTY 711)**.

HIV and STI Screening

You can get human immunodeficiency virus (HIV) and sexually transmitted infection (STI) testing and treatment and counseling service any time from your PCP or Carolina Complete Health doctors. When you get this service as part of a family planning visit, you can go to any

doctor or clinic that takes Medicaid and offers family planning services. You do not need a referral when you get this service as part of a family planning visit.

You can choose to go either to your PCP or to the local health department for diagnosis and/or treatment. You do not need a referral to go to the local health department.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): The Medicaid Health Benefit for Members Under 21 Years Old

Members under 21 years old (excluding NC Health Choice members) have access to a broad menu of federal health care benefits referred to as "Early and Periodic Screening, Diagnosis and Treatment Services." The "EPSDT guarantee" covers wellness visits and treatment services.

Early and Periodic Screening and Diagnosis

These "screening" visits are wellness care. They are free for members under age 21. These visits include a complete exam, free vaccines and vision, and hearing tests. Your provider will also watch your child's physical and emotional growth and well-being at every visit and "diagnose" any conditions that may exist. At these visits, you will get referrals to any treatment services your child needs to get well and to stay healthy.

The "T" in EPSDT: Treatment for Members under 21 years old

Sometimes children need medical treatment for a health problem. Carolina Complete Health may not offer every service covered by the federal Medicaid program. When a child needs treatment, we will pay for any service that the federal government's Medicaid plan covers. We must use a set of special rules that apply only to children to determine if the service is covered. These rules are called EPSDT "medical necessity criteria." Carolina Complete Health cannot deny your child's service just because of a policy limit. Also, we cannot deny a service just because that service is not included in our coverage policies. We must complete a special "EPSDT review" in these cases.

When Carolina Complete Health approves services for children, important rules apply:

- There are no copays for Medicaid covered services to members under 21 years old.
- There are no limits on how often a service or treatment is given.
- There is no limit on how many services the member can get on the same day.
- Services may be delivered in the best setting for the child's health. This might include a school or a community setting.

You will find the entire menu of Medicaid-covered services in the Social Security Act. The federal Medicaid program covers a broad menu of medical care, including:

- Dental services
- Comprehensive health screening services (well-child checks, developmental screenings and immunizations)
- Health education

- Hearing services
- Home health services
- Hospice services
- Inpatient and outpatient hospital services
- Lab and X-ray services
- Mental health services
- Personal care services
- Physical and occupational therapy
- Prescription drugs
- Prosthetics
- Rehabilitative and therapy services for speech, hearing and language disorders
- Transportation to and from medical appointments
- Vision services
- Any other necessary health services to treat, fix or improve a health problem

If you have questions about EPSDT services, talk with your child's PCP. You can also find out more about the federal EPSDT guarantee online. Just visit our website at www.carolinacompletehealth.com or go to the NC Medicaid EPSDT webpage at https://medicaid.ncdhhs.gov/medicaid/get-started/find-programs-and-services-right-you/medicaids-benefit-children-and-adolescents.

Benefits Covered by NC Medicaid Direct but Not by Your Health Plan

There are some Medicaid and NC Health Choice services that Carolina Complete Health does not cover, but if you need them, the services are covered for you by the NC Medicaid Direct program. You can get these services from any provider who takes Medicaid:

- Dental services
- Services provided or billed by Local Education Agencies that are included in your child's Individualized Education Program, Individual Family Service Plan, a section 504 Accommodation Plan, an Individual Health Plan, or a Behavior Intervention Plan
- Services provided and billed by Children's Developmental Agencies that are included in your child's Individualized Family Service Plan
- Fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses and ophthalmic frames (see page 15 for more information on vision services)

If you have questions or need help with accessing benefits you can only get through NC Medicaid Direct, talk with your Primary Care Provider (PCP) or call Member Services at **1-833-552-3876 (TTY 711)**.

Services NOT Covered

Below are some examples of services that are **not available** from Carolina Complete Health **or NC** Medicaid Direct. If you get any of these services, you may have to pay the bill:

- Cosmetic surgery if not medically necessary
- Personal comfort items such as cosmetics, novelties, tobacco or beauty aids
- Routine foot care, except for beneficiaries with diabetes or a vascular disease
- Routine newborn circumcision
- Experimental drugs, procedures or diagnostic tests
- Infertility treatments
- Sterilization reversal
- Sterilization under age 21
- Medical photography
- Biofeedback
- Hypnosis
- Blood tests to determine paternity (contact your local child support enforcement agency)
- Chiropractic treatment unrelated to the treatment of an incomplete or partial dislocation of a joint in the spine.
- Erectile dysfunction drugs
- Weight loss or weight gain drugs
- Liposuction
- Tummy tuck
- Ultrasound to determine sex of child
- Hearing aids for beneficiaries age 21 and older
- Services from a provider who is not part of Carolina Complete Health, unless it is a provider you are allowed to see as described elsewhere in this handbook or Carolina Complete Health, or your Primary Care Provider (PCP) sent you to that provider
- Services for which you need a referral (approval) in advance, and you did not get it
- Services for which you need prior authorization in advance, and you did not get it
- Medical services provided out of the United States
- Tattoo removal
- Payment for copies of medical records

This list does not include all services that are not covered. To determine if a service is not covered, call Member Services at **1-833-552-3876 (TTY 711)**.

A provider who agrees to accept Medicaid generally cannot bill you. You may have to pay for any service that your PCP or Carolina Complete Health does not approve. Or, if before you get a service, you agree to be a "private pay" or "self-pay" patient, you will have to pay for the service. This includes:

- Services not covered (including those listed above)
- Unauthorized services
- Services provided by providers who are not part of Carolina Complete Health

If You Get a Bill

If you get a bill for a treatment or service you do not think you owe, do not ignore it. Call Member Services at **1-833-552-3876 (TTY 711)** right away. We can help you understand why you may have gotten a bill. If you are not responsible for payment, Carolina Complete Health will contact the provider and help fix the problem for you. You will not be held accountable for payment of items any items identified within 42 C.F.R. § 438.106; 42 CFR 438.3(k); 42 CFR 438.230, including, covered services you receive which the state does not pay for or are provided by and individual or provider under contractual referral such as out of network providers.

You have the right to ask for an appeal and a State Fair Hearing if you think you are being asked to pay for something Medicaid or Carolina Complete Health should cover. See the Appeals section on pages 33 – 37 in this handbook for more information. If you have any questions, call Member Services at **1-833-552-3876 (TTY 711)**.

Plan Member Copays

Some members may be required to pay a copay. A "copay" is a fee you pay when you get certain health care services from a provider or pick up a prescription from a pharmacy.

Copays if You Have Medicaid*

Service	Your Copay
Physicians Outpatient services Podiatrists	$3 per visit
Generic and brand prescriptions	$3 for each prescription
Chiropractic Optical services/supplies	$2 per visit

Optometrists Non-emergency Emergency Department visits	$3 per visit

**There are NO copays for the following members or services:*

- Members under age 21
- Members who are pregnant
- Members receiving hospice care
- Federally recognized tribal members
- North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) beneficiaries
- Children in foster care
- People living in an institution who are receiving coverage for cost of care

A provider cannot refuse to provide services if you cannot pay. If you have any questions about Medicaid copays, please call Member Services at **1-833-552-3876 (TTY 711)**.

Copays if Your Child Has NC Health Choice

Service	Your Copay
If you <u>do not</u> pay an annual enrollment fee for your child or children:	
Office visit	$0 per visit
Generic prescription Brand prescription when no generic is available Over-the-counter medications	$1 for each prescription
Brand prescription when generic is available	$3 for each prescription
Non-emergency Emergency Department visits	$10 per visit
If you do pay an annual enrollment fee for your child or children:	
Office visit Outpatient hospital	$5 per visit
Generic prescription Brand prescription when no generic is available Over-the-counter medications	$1 for each prescription
Brand prescription when generic is available	$10 for each prescription
Non-emergency Emergency Department visits	$25 per visit

If you have any questions about NC Health Choice copays, call Member Services at **1-833-552-3876 (TTY 711)**.

If your PCP is not able to accommodate your special needs, call Member Services at **1-833-552-3876 (TTY 711)** to learn more about how you can change your PCP.

Service Authorization and Actions

Carolina Complete Health will need to approve some treatments and services **before** you receive them. Carolina Complete Health may also need to approve some treatments or services for you to **continue** receiving them. This is called **preauthorization**. The following treatments and services must be approved before you get them:

Inpatient Benefits		Outpatient Benefits		Prescription Drugs
In-Network	Out-of-Network*	In-Network	Out-of-Network*	
Non-emergent inpatient acute care Partial hospitalization Medically-supervised detoxification Rehabilitation admission Skilled nursing facilities Long-term acute care Intensive outpatient services	Non-emergent inpatient acute care Partial hospitalization Medically-supervised detoxification Rehabilitation admission Skilled nursing facilities Long-term acute care Intensive outpatient services	Home health services Nutritionist services Surgical services per DHHS Imaging Durable medical equipment (DME) Hospice and palliative care OP office visits to specialists	Outpatient services provided by direct-enrolled providers Outpatient opioid treatment Ambulatory detoxification Home health services Nutritional services Surgical services per DHHS	Per State guidelines State Outpatient Pharmacy Non-Preferred Drug Prior Authorization Policies State Prior Approval Drugs and Criteria for Outpatient Pharmacy Clinical Policies Non-Formulary Drugs

*Out-of-Network Care treatments and services require prior authorization unless urgent/emergent.

Asking for approval of a treatment or service is called a **service authorization request**. To get approval for these treatments or services you need to: call Member Services at **1-833-552-3876 (TTY 711)** or send your request in writing to: Service Authorizations, Carolina Complete Health, 10101 David Taylor Drive, Suite 300, Charlotte, NC 28262.

What happens after we get your service authorization request?

Carolina Complete Health uses a group of qualified health care professionals for reviews. Their job is to be sure that the treatment or service you asked for is covered by our plan and that it will help with your medical condition. Carolina Complete Health's nurses, doctors and behavioral health clinicians will review your provider's request.

Carolina Complete Health uses policies and guidelines approved by the North Carolina Department of Health and Human Services (NCDHHS) to see if the service is medically necessary.

Sometimes Carolina Complete Health may deny or limit a request your provider makes. This decision is called an adverse benefit determination. When this happens, you can request any records, standards and policies we used to decide on your request.

If you receive a denial and you do not agree with our decision, you may ask for an "appeal." You can call or send in the appeal form you will find with your decision notice. See pages 33 – 37 for more information on appeals.

Prior Authorization Requests for Children Under Age 21 (applies to Medicaid members only)

Special rules apply to decisions to approve medical services for children under age 21. Carolina Complete Health cannot say no to a request for children under 21 years old just because of our plan policies, policy limits or rules. We must complete another review to help approve needed care. Carolina Complete Health will use federal EPSDT rules for this review. These rules help Carolina Complete Health take a careful look at:

- Your child's health problem
- The service or treatment your provider asked for

Carolina Complete Health must approve services that are not included in our coverage policies when our review team finds that your child needs them to get well or to stay healthy. This means that the Carolina Complete Health review team must agree with your provider that the service will:

- Correct or improve a health problem
- Keep the health problem from getting worse
- Prevent the development of other health problems

Important Details about Services Coverable by the Federal EPSDT Guarantee:

- Your provider must ask Carolina Complete Health for the service.
- Your provider must ask us to approve services that are not covered by Carolina Complete Health.
- Your provider must explain clearly why the service is needed to help treat your child's health problem. Carolina Complete Health's EPSDT reviewer must agree. We will work with your provider to get any information our team needs to make a decision. Carolina Complete Health will apply EPSDT rules to your child's health condition. Your provider must tell us how the service will help improve your child's health problem or to keep it from getting worse.

Carolina Complete Health must approve these services with an "EPSDT review" *before* your provider gives them.

To learn more about the Medicaid health plan for children (EPSDT), see page 25, visit our

website at www.carolinacompletehealth.com and visit the state of North Carolina website for the EPSDT guarantee at https://medicaid.ncdhhs.gov/medicaid/get-started/find-programs-and-services-right-you/medicaids-benefit-children-and-adolescents.

Preauthorization and Timeframes

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

- **Standard review:** A decision will be made within 14 days after we receive your request.
- **Expedited (fast track) review:** A decision will be made, and you will hear from us within 3 days of your request.
- In most cases, you will be given at least 10 days' notice if any change (to reduce, stop or restrict services) is being made to current services. **If we approve a service and you have started to receive that service, we will not reduce, stop or restrict the service during the approval period unless we determine the approval was based on information that was known to be false or wrong.**
- If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills. **You will not have to pay for any care you received that was covered by Carolina Complete Health or by Medicaid, even if we later deny payment to the provider.**

Information from Member Services

You can call Member Services at **1-833-552-3876 (TTY 711)** to get a PCP, to ask about benefits and services, to get help with referrals, to replace a lost Medicaid card, to report the birth of a new baby, or ask about any change that might affect you or your family's benefits. We can answer any questions about the information in this handbook.

- If English is not your first language, we can help. Just call us and we will find a way to talk with you in your own language.
- **For people with disabilities:** If you have difficulty hearing or need assistance communicating, please call us. If you are reading this on behalf of someone who is blind, deaf-blind or has difficulty seeing, we can help. We can tell you if a doctor's office is equipped with special communications devices. Also, we have services like:
    - TTY machine. Our TTY phone number is **1-833-552-3876 (TTY 711)**
    - Information in large print
    - Help in making or getting to appointments
    - Names and addresses of providers who specialize in your condition

If you use a wheelchair, we can tell you if a doctor's office is wheelchair accessible and assist in making or getting to appointments.

You Can Help with Plan Policies

We value your ideas. You can help us develop policies that best serve our members. We have several member committees in our health plan or with NCDHHS, like:

- Carolina Complete Health Member Advisory Committee (MAC) – a group that meets at least quarterly where you can give input on our programs and policies.
- Carolina Complete Health Long-Term Services and Supports (LTSS) Advisory Committee – a group that meets at least quarterly where you can give input on our Long-Term Services and Supports programs and policies.
- Medical Care Advisory Committee (MCAC) – a statewide group that gives advice to NC Medicaid about Medicaid and Health Choice medical care policies and quality of care.
- State Consumer and Family Advisory Committee (CFAC) – a statewide group that gives advice to NC Medicaid and lawmakers to help them plan and manage the state's behavioral health program.

Call Member Services at **1-833-552-3876 (TTY 711)** to learn more about how you can help.

Appeals

Sometimes Carolina Complete Health may decide to deny or limit a request your provider makes for you for benefits or services offered by our plan. This decision is called an adverse benefit determination. You will receive a letter from Carolina Complete Health notifying you of any adverse benefit determination. Medicaid and NC Health Choice members have a right to appeal adverse benefit determinations to Carolina Complete Health. You have 60 days from the date on your letter to ask for an appeal. When members do not agree with our decisions on an appeal, they can ask the NC Office of Administrative Hearings for a State Fair Hearing.

When you ask for an appeal, Carolina Complete Health has 30 days to give you an answer. You can ask questions and give any updates (including new medical documents from your providers) that you think will help us approve your request. You may do that in person, in writing or by phone.

You can ask for an appeal yourself. You may also ask a friend, a family member, your provider or a lawyer to help you. You can call Carolina Complete Health at **1-833-552-3876 (TTY 711)** or visit our website at www.carolinacompletehealth.com if you need help with your appeal request. It's easy to ask for an appeal by using one of the options below:

- **MAIL:** Fill out and sign the Appeal Request Form in the notice you receive about our decision. Mail it to the address listed on the form. We must receive your form no later than 60 days after the date on the notice.
- **FAX:** Fill out, sign and fax the Appeal Request Form in the notice you receive about our decision. You will find the fax number listed on the form. We must receive your form no later than 60 days after the date on the notice.

BY PHONE: Call **1-833-552-3876 (TTY 711)** and ask for an appeal. When you appeal, you and any person you have chosen to help you can see the health records and criteria Carolina Complete Health used to make the decision. If you choose to have someone help you, you must give them written permission.

Expedited (faster) Appeals

You or your provider can ask for a faster review of your appeal when a delay will cause serious harm to your health or to your ability to attain, maintain or regain your good health. This faster review is called an expedited appeal.

Your provider can ask for an expedited appeal by calling us at **1-833-552-3876 (TTY 711)**.

You can ask for an expedited appeal by phone, by mail, or by fax. There are instructions on your Appeal Request Form that will tell you how to ask for an expedited appeal.

Provider Requests for Expedited Appeals

If your provider asks us for an expedited appeal, we will give a decision no later than 72 hours after we get the request for an expedited appeal. We will call you and your provider as soon as there is a decision. We will send you and your provider a written notice of our decision within 72 hours from the day we received the expedited appeal request.

Member Requests for Expedited Appeals

Carolina Complete Health will review all member requests for expedited appeals. If your request for an expedited appeal is denied, we will call you during our business hours promptly following our decision. We also will tell you and the provider in writing if your request for an expedited appeal is denied. We will tell you the reason for the decision. Carolina Complete Health will mail you a written notice within two calendar days.

If you do not agree with our decision to deny an expedited appeal request, you may file a grievance with us (see page 37 for more information on grievances).

When we deny a member's request for an expedited appeal, there is no need to make another appeal request. The appeal will be decided within 30 days of your request. In all cases, we will review appeals as fast as a member's medical condition requires.

Timelines for Standard Appeals

If we have all the information we need, we will make a decision on your appeal within 30 days from the day we get your appeal request. We will mail you a letter to tell you about our decision. If we need more information to decide about your appeal, we will:

- Write to you and tell you what information is needed
- Explain why the delay is in your best interest
- Decide no later than 14 days from the day we asked for more information

If you need more time to gather records and updates from your provider, just ask. You or a helper you name may ask us to delay your case until you are ready. Ask for an extension by calling Member Services at **1-833-552-3876 (TTY 711)** or writing to Carolina Complete Health, Attn: Grievance and Appeals, 10101 David Taylor Drive, Suite 300, Charlotte, NC 28262.

Decisions on Appeals

When we decide your appeal, we will send you a letter. This letter is called a Notice of Decision. If you do not agree with our decision, you can ask for a State Fair Hearing. You can ask for a State Fair Hearing within 120 days from the date on the Notice of Decision.

State Fair Hearings

If you do not agree with Carolina Complete Health's decision on your appeal, you can ask for a State Fair Hearing. In North Carolina, State Fair Hearings include an offer of a free and voluntary mediation session. This meeting is held before your State Fair Hearing date.

Free and Voluntary Mediations

When you ask for a State Fair Hearing, you will get a phone call from The Mediation Network of North Carolina. The Mediation Network will call you within 5 business days after you request a State Fair Hearing. During this call you will be offered a mediation meeting. The state offers this free meeting to help resolve your disagreement quickly. These meetings are held by phone.

You do not have to accept this meeting. You can ask to schedule just your State Fair Hearing. When you do accept, a Mediation Network counselor will lead your meeting. This person does not take sides. A member of Carolina Complete Health's review team will also attend. If the meeting does not help with your disagreement, you will have a State Fair Hearing.

State Fair Hearings

State Fair Hearings are held by the NC Office of Administrative Hearings (OAH). An administrative law judge will review your request along with new information you may have. The judge will make a decision on your service request. You can give any updates and facts you need to at this hearing. A member of Carolina Complete Health's review team will attend. You may ask questions about the Carolina Complete Health's decision. The judge in your State Fair Hearing is not a part of Carolina Complete Health in any way.

It is easy to ask for a State Fair Hearing. Use one of the options below:

- **MAIL:** Fill out and sign the State Fair Hearing Request Form that comes with your notice. Mail it to the addresses listed on the form.
- **FAX:** Fill out, sign and fax the State Fair Hearing Request Form that comes with your notice. You will find the fax numbers you need listed on the form.
- **BY PHONE:** Call the Office of Administrative Hearings (OAH) at 1-984-236-1860 and ask for a State Fair Hearing. You will get help with your request during this call.

If you are unhappy with your State Fair Hearing decision, you can appeal to the North Carolina Superior Court in the county where you live. You have **30 days** from the day you get your decision from your State Fair Hearing to appeal to the Superior Court. You can also contact the **NC Medicaid Ombudsman** to get more information about your options. See page 46 for more information about the NC Medicaid Ombudsman.

State Fair Hearings and Disenrollment Decisions

If you disagree about a decision to change your health plan, you can ask for a State Fair Hearing. The process to ask for a State Fair Hearing for disenrollment decisions is different than the process to ask for a State Fair Hearing when Carolina Complete Health limits or denies a service that you requested. For more information about requesting a State Fair Hearing for disenrollment decisions see page 41.

Continuation of Benefits During an Appeal

Sometimes Carolina Complete Health's decision reduces or stops a health care service you are already getting. You can ask to continue this service without changes until your appeal is finished. You can also ask the person helping you with your appeal to make that request for you. Your provider cannot ask for your services to continue during an appeal.

The rules in the section are the same for Appeals and State Fair Hearings.

There are special rules about continuing your service during your appeal. Please read this section carefully!

You will get a notice if Carolina Complete Health is going to reduce or stop a service you are receiving. You have 10 days from the date we send the letter to ask for your services to continue. The notice you get will tell you the exact date. The notice will also tell you how to ask for your services to continue while you appeal.

If you ask for your services to continue, Carolina Complete Health will continue your services from the day you ask for them to continue until you the day get your appeal decision. You or your authorized representative may contact Member Services at **1-833-552-3876 (TTY 711)** or contact the Appeals Coordinator on your adverse benefit determination letter to ask for your service to continue until you get a decision on your appeal.

Your appeal might not change the decision the health plan made about your services. When this happens, Medicaid allows Carolina Complete Health to bill you for services we paid for during your appeal. We must get approval from NC Medicaid before we can bill you for services we paid for during your appeal.

Appeals During Your Transition Out of Carolina Complete Health

If you decide to leave Carolina Complete Health, your appeal may be impacted by this transition. Please see below for additional information for how we will process appeals at transition. If you will be transitioning out of our plan soon and have an appeal with us, please contact Member Services at **1-833-552-3876 (TTY 711)** for additional information.

Member appeals will be transitioned in accordance with established DHHS guidance for all participating health plans when a member transitions from one plan to another during an active appeal.

If You Have Problems with Your Health Plan You Can File a Grievance

We hope our health plan serves you well. If you are unhappy or have a complaint, you may talk with your primary care provider, and you may call Member Services at **1-833-552-3876 (TTY 711)** or write to Carolina Complete Health: 10101 David Taylor Drive, Suite 300, Charlotte, NC 28262.

A grievance and a complaint are the same thing. Contacting us with a grievance means that you are unhappy with your health plan, provider or your health services. Most problems like this can be solved right away. Whether we solve your problem right away or need to do some work, we will record your call, your problem and our solution. We will inform you that we have received your grievance in writing. We will also send you a written notice when we have finished working on your grievance.

You can ask a family member, a friend, your provider or a legal representative to help you with your complaint. If you need our help because of a hearing or vision impairment, or if you need translation services, or help filing out any forms, we can help you.

You can contact us by phone or in writing:

- By phone, call Member Services at **1-833-552-3876 (TTY 711)**, 24 hours a day, 7 days a week. After business hours, you may leave a message, and we will contact you during the next business day.
- You can write us with your complaint to Carolina Complete Health: 10101 David Taylor Drive, Suite 300, Charlotte, NC 28262.

Resolving Your Grievance

We will let you know in writing that we got your grievance within 5 days of receiving it.

- We will review your complaint and tell you how we resolved it in writing within 30 days from receiving your complaint.
- If your grievance is about your request for an expedited (faster) appeal, we will tell you how we resolved it in writing within 5 days of getting your complaint.
- If your grievance is about your request for an expedited (faster) appeal, we will let you know quickly and in writing that we got your grievance. We will review your complaint about the denial of an expedited appeal quickly. We will tell you how we resolved it in writing within five calendar days of getting your complaint. These issues will be handled according to our Grievance Procedures. You can find them online at www.carolinacompletehealth.com.

Transition of Care

Your Care When You Change Health Plans or Providers

- If you join Carolina Complete Health from another health plan, we will work with your previous health plan to get your health information, like your service history, service authorizations and other information about your current care into our records.
- You can finish receiving any services that have already been authorized by your previous health plan. After that, if necessary, we will help you find a provider in our network to get any additional services if you need them.
- In almost all cases, your providers under your former plan will also be Carolina Complete Health providers. If your provider is not part of our network, there are some instances when you can still see the provider that you had before you joined Carolina Complete Health. You can continue to see your provider if:
    - At the time you join Carolina Complete Health, you are receiving an ongoing course of treatment or have an ongoing special condition. In that case, you can ask to keep your provider for up to 90 days.
    - You are more than 3 months pregnant when you join Carolina Complete Health and you are getting prenatal care. In that case, you can keep your provider until after your delivery and for up to 60 days of post-partum care.
    - You are pregnant when you join Carolina Complete Health and you are receiving services from a behavioral health treatment provider. In that case, you can keep your provider until after your delivery.
    - You have a surgery, organ transplant or inpatient stay already scheduled that your provider is doing. In these cases, you may be able to stay with your provider through the scheduled procedure, discharge from the hospital and for up to 90 days of follow-up care.
    - You are terminally ill, and the provider is supporting you in your care. You are considered terminally ill if you have been told by your provider that he or she expects you have six months or less to live. In that case, you can keep your provider for the remainder of your life.
- If your provider leaves Carolina Complete Health, we will tell you in writing within 15 days from when we know this will happen. If the provider who leaves Carolina Complete Health is your Primary Care Provider (PCP), we will tell you in writing within 7 days from when we know this will happen. We will tell you how you can choose a new PCP or how we will choose one for you if you do not make a choice within 30 days.
- If you want to continue receiving care from a provider who is not in our network:
    - Continuation of care with a terminated provider is allowed under certain circumstances for a period of up to 90 days, if the provider is not termed due to a quality issue. If it is determined that a provider could cause harm to members,

members will be removed immediately and provided with a written notification of the change, their newly assigned PCP, and their right to change PCP's. A terminating provider may also request that a member receive continued treatment. In these cases, the request is reviewed to evaluate whether it qualifies for continuation of care. Services that qualify for continuation of care are determined by Carolina Complete Health's Medical Director. If the request is approved, outreach to the member will be made.

- Upon receipt of a PCP Notice of Termination, Carolina Complete Health will work with the provider leaving the network to get a list of affected patients or use PCP assignment information or eligibility services to get the contact information for impacted members such as member name, ID number, or address. Patients seen on a 'regular' basis means they have seen that provider at least four times or more in the last twelve months. For more information, please visit Carolina Complete Health's website at www.carolinacompletehealth.com.

If you have any questions, call Member Services at **833-552-3876 (TTY 711)**.

Member Rights and Responsibilities

As a member of Carolina Complete Health, you have certain rights and responsibilities. Carolina Complete Health will respect your rights and make sure that no one working for our plan, or any of our providers, will prevent you from using your rights. Also, we will make sure that you are aware of your responsibilities as a member of our plan.

Your Rights

As a member of **Carolina Complete Health**, you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, sexual orientation or gender identity
- Be told where, when and how to get the services you need from Carolina Complete Health
- Be told by your PCP what health issues you may have, what can be done for you and what will likely be the result, in language you understand
- Get a second opinion about your care
- Give your approval of any treatment
- Give your approval of any plan for your care after that plan has been fully explained to you
- Refuse care and be told what you may risk if you do
- Get a copy of your medical record and talk about it with your PCP
- Ask, if needed, that your medical record be amended or corrected

- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract or with your approval
- Use the Carolina Complete Health complaint process to settle complaints. You can also contact the **NC Medicaid Ombudsman** any time you feel you were not fairly treated (see page 46 for more information about the NC Medicaid Ombudsman.
- Use the State Fair Hearing system
- Appoint someone you trust (relative, friend or lawyer) to speak for you if you are unable to speak for yourself about your care and treatment
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints
- Make recommendations about your rights and responsibilities

Additionally, if you are a NC Health Choice Member, Carolina Complete Health will also make sure that costs for covered benefits and services are not avoided by us by referring you to publicly supported health care resources.

Your Responsibilities

As a member of Carolina Complete Health, you agree to:

- Work with your PCP to protect and improve your health
- Find out how your health plan coverage works
- Listen to your PCP's advice and ask questions
- Call or go back to your PCP if you do not get better or ask for a second opinion
- Treat health care staff with respect
- Tell us if you have problems with any health care staff by calling Member Services at **833-552-3876 (TTY 711)**
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the Emergency Department only for emergencies
- Call your PCP when you need medical care, even if it is after hours

How to Change Your Health Plan (Disenrollment)

At set times during your benefit year, you will be given a chance to pick a different health plan without needing a good reason (without cause). You can always ask to change health plans if you have a good reason (with cause).

The set times where you **do not** need a good reason to change plans include:

- At least once every 12 months. This usually happens at the same time that your eligibility for Medicaid or NC Health Choice is being reviewed.

- During the first 90 days that Carolina Complete Health starts managing your care (you may hear this called your choice period). You may leave Carolina Complete Health and join another health plan at any time during the 90 days.

You will receive a letter letting you know when you can change health plans without a good reason. During those set times, you may choose to stay a member of Carolina Complete Health or pick a different plan that offers benefits and services where you live.

If you want to leave Carolina Complete Health at any other time, you can do so **only** with a good reason (with cause). Some examples of a good reason to change plans include:

- You move out of our service area
- You have a family member in another plan
- Your requested related services are not available in our provider network
- We cannot provide related services that you need at the same time
- Your medical condition requires treatment that you are unable to receive in our plan
- You cannot access available providers in our provider network
- You received poor quality of care from our plan
- Your Long Term Services and Supports (LTSS) provider is no longer available with our plan

How to Request to Change Plans

You can ask to change plans by phone, mail or electronically. You will receive help and information to choose a new plan from the Enrollment Broker. If you want to change your plan, you can change in one of these ways:

- Go to ncmedicaidplans.gov
- Use the NC Medicaid Managed Care mobile app
- Call 1-833-870-5500 (TTY: 1-833-870-5588)

You can also ask for a form when you call so that you can mail or fax your request to change plans. If your request is approved, you will get a notice that the change will take place by a certain date. Carolina Complete Health will provide the care you need until then.

You can ask for faster action if you believe the timing of the regular process will cause risk to your health. In that case, you will get a notice about your request to leave the plan within 3 days of making the request.

Reasons Why You May have to Leave Carolina Complete Health

There are also some reasons why you may have to leave Carolina Complete Health, even when you did not ask to leave our plan. The following are reasons why you may have to leave Carolina Complete Health when you did not ask to leave:

- If Carolina Compete Health's request for you to leave our plan is approved

- We may request that you leave our plan only if your actions or behavior seriously limits our ability to care for you or other members of our plan. Carolina Complete Health is **not allowed** to request that you leave our plan because of a change in your health status, your use of benefits and services, your mental capacity diminishes, or for any disruptive behavior due to your health needs.
- Before Carolina Complete Health would make a request for you to leave our plan, we would try our best to work with you to address any concerns that we may have in providing your care.
- If Carolina Complete Health request for you to leave our plan is approved, you will get a letter letting you that our request was approved and what new plan is going to take over your care. If you do not like the new plan who takes over your care, you will be given the option to select a different plan.

- If you lose your Medicaid Managed Care program eligibility
  - You may lose your eligibility for the Medicaid Managed Care program if any of the following happen:
    - You stay in a nursing home for more than 90 days in a row (see page 16 for more information on nursing services)
    - You become eligible for and are transferred for treatment to a state-owned Neuro-Medical Center or a Department of Military & Veteran Affairs-operated Veterans Home
    - You change in Medicaid eligibility category
    - You begin receiving Medicare

If you are no longer eligible for Medicaid Managed Care, you will receive a letter letting you know that you will continue to receive your benefits and services through NC Medicaid Direct instead of through Carolina Complete Health. If this happens, you can call the NC Medicaid Contact Center at 1-888-245-0179 for help.

- If you lose your Medicaid or NC Health Choice eligibility
  - You may have to leave our plan if you are notified that you are no longer eligible to receive benefits and services through the Medicaid or NC Health Choice programs. **If you are no longer eligible for Medicaid or NC Health Choice, you will receive a letter letting you know that all benefits and services that you may be receiving under the program will stop**. If this happens, call your local Department of Social Services.

State Fair Hearings for Disenrollment Decisions

You have a right to ask for a State Fair Hearing if you disagree with a decision to:

- Deny your request to change plans
- Approve a request made by Carolina Complete Health for you to leave the plan

State Fair Hearings are held by OAH. You will have a chance to give more information and facts, and to ask questions about the decision for you to change plans before an administrative law judge. The judge in your State Fair Hearing is not a part of Carolina Complete Health in any way. In North Carolina, State Fair Hearings include an offer of a free and voluntary mediation session that is held before your Hearing date (see page 35 for more information on mediations).

Requesting a State Fair Hearing for Disenrollment Decisions

If you disagree with a decision for you to change plans, you have **30 days** from the date on the letter notifying you of the decision to ask for a State Fair Hearing. You can ask for a State Fair Hearing yourself. You may also ask a friend, a family member, your provider or a lawyer to help you. You can call the Enrollment Broker at **1-833-870-5500** if you need help with your State Fair Hearing request.

You can use one of the following ways to request a State Fair Hearing:

- **MAIL:** Fill out and sign the State Fair Hearing Request Form that comes with your notice. Mail it to the addresses listed on the form.
- **FAX:** Fill out, sign and fax the State Fair Hearing Request Form that comes with your notice. The fax numbers you need are listed on the form.
- **BY PHONE:** Call the Office of Administrative Hearings (OAH) at **1-984-236-1860** and ask for a State Fair Hearing. You will get help with your request during this call. When you ask for a State Fair Hearing, you and any person you have chosen to help you can see the records and criteria used to make the decision. If you choose to have someone help you, you must give them written permission. Include their name and contact information on the State Fair Hearing Request Form.

If you are unhappy with your State Fair Hearing decision, you can appeal to the North Carolina Superior Court in the county where you live. You have **30 days** from the day you get your decision from your State Fair Hearing Final Decision to appeal to the Superior Court.

Advance Directives

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

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

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

Living Will

In North Carolina, a **living will** is a legal document that tells others that you want to die a natural death if you:

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

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

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

Health Care Power of Attorney

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

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

Advance Instruction for Mental Health Treatment

An **advance instruction for mental health treatment** is a legal document that tells doctors and mental health providers what mental health treatments you would want and what treatments you would not want if you later become unable to decide for yourself. It can also be used to nominate a person to serve as guardian if guardianship proceedings are started. Your advance instruction for behavioral health treatment can be a separate document or combined with a health care power of attorney or a general power of attorney. An advance instruction for

behavioral health may be followed by a doctor or behavioral health provider when your doctor or an eligible psychologist determines in writing that you are no longer able to make or communicate behavioral health decisions.

Forms You Can Use to Make an Advance Directive

You can find the advance directive forms at www.sosnc.gov/ahcdr. The forms meet all the rules for a formal advance directive. For more information, you can also call 919-807-2167 or write to:

Advance Health Care Directive Registry
Department of the Secretary of State
P.O. Box 29622
Raleigh, NC 27626-0622

You can change your mind and update these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you cannot speak for yourself. Talk to your Primary Care Provider (PCP) or call Member Services at **1-833-552-3876 (TTY 711)** if you have any questions about advance directives.

Fraud, Waste and Abuse

If you suspect that someone is committing Medicaid fraud, report it. Examples of Medicaid fraud include:

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

You can report suspected fraud and abuse in any of the following ways:

- Call the Medicaid Fraud, Waste and Program Abuse Tip Line at 1-877-DMA-TIP1 (1-877-362-8471)
- Call the State Auditor's Waste Line at 1-800-730-TIPS (1-800-730-8477)
- Call the U.S. Office of Inspector General's Fraud Line at 1-800-HHS-TIPS (1-800-447-8477)

Important Phone Numbers

- Member Services, Monday – Saturday, including state holidays, 7:00 a.m.-6:00 p.m. at 1-833-552-3876 (TTY: 711)
- Behavioral Health Crisis Line – 24/ 7/365 at 1-855-798-7093
- Nurse Line - 24/7/365 at 1-833-552-3876 (TTY: 711)

- Enrollment Broker at 1-833-870-5500 (TTY:1-833-870-5588)
- NC Medicaid Contact Center at 1-888-245-0179
- Provider Services Line, Monday – Saturday, including state holidays, 7:00 a.m.-6:00 p.m. at 1-833-552-3876 (TTY: 711)
- Prescriber Service Line, Monday – Saturday, 7:00 a.m.-6:00 p.m. at 1-833-552-3876 (TTY: 711)
- The NC Mediation Network at 1-336-461-3300
- Free Legal Services Line at 1-919-856-2121
- Advance Health Care Directive Registry at 1-919-814-5400
- NC Medicaid Fraud, Waste and Abuse Tip Line at 877-DMA-TIP1 (877-362-8471)
- State Auditor Waste Line at 1-800-730-TIPS (1-800-730-8477)
- U.S. Office of Inspector General Fraud Line at 1-800-HHS-TIPS (1-800-447-8477)

Keep Us Informed

Call Member Services at **833-552-3876 (TTY 711)** whenever these changes happen in your life:

- You have a change in Medicaid eligibility
- You give birth
- There is a change in Medicaid coverage for you or your children

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

NC Medicaid Ombudsman

The NC Medicaid Ombudsman is a resource you can contact if you need help with your health care needs. The NC Medicaid Ombudsman is an independently operated, nonprofit organization whose only job is to ensure that individuals and families who receive North Carolina Medicaid and NC Health Choice get access to the care that they need.

The NC Medicaid Ombudsman can:

- Answer your questions about benefits
- Help you understand your rights and responsibilities
- Provide information about Medicaid and Medicaid Managed Care
- Answer your questions about enrolling with or disenrolling from a health plan
- Help you understand a notice you have received
- Refer you to other agencies that may be able to assist you with your health care needs

- Help to resolve issues you are having with your health care provider or health plan
- Be an advocate for members dealing with an issue or a complaint affecting access to health care
- Provide information to assist you with your appeal, grievance, mediation or fair hearing
- Connect you to legal help if you need it to help resolve a problem with your health care

You can contact the NC Medicaid Ombudsman at **1-877-201-3750**.