NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Benefits

NC MEDICAID MANAGED CARE MEMBER HANDBOOK

Carolina Complete Health

February 1, 2020

carolina complete health™

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

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 material 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 1-833-552-3876번으로 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:	□□□ □ □□□□□□□□ □□□ □□□□ □□□□□□□ □□□□□□ □□□□ □□□□□□□□□□ □□□ □□□□□ □□□ □□. □□□□ □□□□□□□□□□ □□□□□□□ □□□□□□ □□□□ 1-833-552-3876 □□ □□□□□□ □□□□□□□□□□ □□□ □□□. □□ □□□□□□□□□ □□□□□ □□□□□ □□□□ □ □□□ □□ □□□ □□□ □□□ □□□□ □□□. 1-833-552-3876 (TTY: 711) □□ □□□ □□□. □□□ □□□□□ □□□□□□□ □ □□□□□□□□□ □□□□□□ □□□□ □□□□ □□□□□□ □□□ □□□ □□. □□□ □□□□□□□□□□ □□□□□ □□□□□□ □□□ □□□ □□□□□ □□□□□□□ □□□□□ □□□□□□□□□ □□□□ □□□□□□□ □□□ □□□ □□□□ □□□.
Mon-Khmer (Cambodian):	អ្នកអាចទទួលបានឯកសារនេះ និងព័ត៌មានអំពីគម្រោងផ្សេងទៀតជាឯកសារបោះពុម្ពអក្សរធំដោយឥតគិតថ្លៃ។ ដើម្បីទទួលបានសម្ភារៈបោះពុម្ពខ្លាតធំ 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।
Lao:	ທ່ານສາມາດຮັບເອົາຂໍ້ຄວາມນີ້ແລະຂໍ້ມູນຂ່າວສານອື່ນໆກ່ຽວກັບແຜນປະກັນເປັນໃຕ້ພິມໃຫຍ່ໄດ້ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ໂທຫາພະແນກການບໍລິການສະມາຊິກທີ່ 1-833-552-3876 ເພື່ອຈະໄດ້ຮັບຂໍ້ຄວາມຕ່າງໆເປັນໃຕ້ພິມໃຫຍ່. ຖ້າຫາກວ່າພາສາແມ່ຂອງທ່ານບໍ່ແມ່ນພາສາອັງກິດ ພວກເຮົາຈະຊ່ວຍເຫຼືອໄດ້. ໂທຫາ 1-833-552-3876 (TTY ໂທຫາ 711). ທ່ານສາມາດຂໍໃຫ້ເຮົາຈັດໃຫ້ຂໍ້ມູນຂ່າວສານນີ້ເປັນພາສາຂອງທ່ານໄດ້. ພວກເຮົາຈະເຂົ້າຫາການບໍລິການນາຍພາສາໄດ້ ແລະຍັງສາມາດຊ່ວຍຕອບຄຳຖາມຂອງທ່ານເປັນພາສາຂອງທ່ານຂອງໄດ້ອີກດ້ວຍ.
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 17.
Get help to deal with my stress or anxiety	Behavioral Health Crisis Line at 1-833-552-3876 (TTY:711), 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 Advice 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).
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 prepaid 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, and 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.

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 your Plan'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 supports 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 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 Department Care: Care you receive in a hospital if you are experiencing an emergency medical condition.

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

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

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.

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 website below for more information about Medicaid and your rights: https://medicaid.ncdhhs.gov/medicaid/your-rights

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.

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: 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 healthcare 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, 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 condition that is life-threatening, degenerative, or disabling and requires treatment over an extended period. This includes certain situations related to pregnancy, surgeries, organ transplants, inpatient stays 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 State Office of Administrative Hearings (OAH) will conduct your State Fair Hearing. The judge will carefully review the Plan'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.

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 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.** You will find a list of providers in our provider directory. This list will include the type or Specialty of the provider, the provider's qualifications (for example, if they are a physician or a psychologist), board certification, the address and telephone number, office hours, handicap-accessibility of sites/facilities, if the provider is accepting new patients, and any hospital affiliations.
    - 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 10 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. Member Services can also give you information about a provider's medical school and residency.

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 1 to 56 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, calls to Member Services will be answered by v 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.

Other Ways We Can Help

- If you have basic questions or concerns about your health, you can call our Nurse Advice 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 1-833-552-3876 (TTY: 711) 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.**

- 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 711 or 800-735-2962.
- 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.

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 711 or 800-735-2962.
- 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 aids or 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

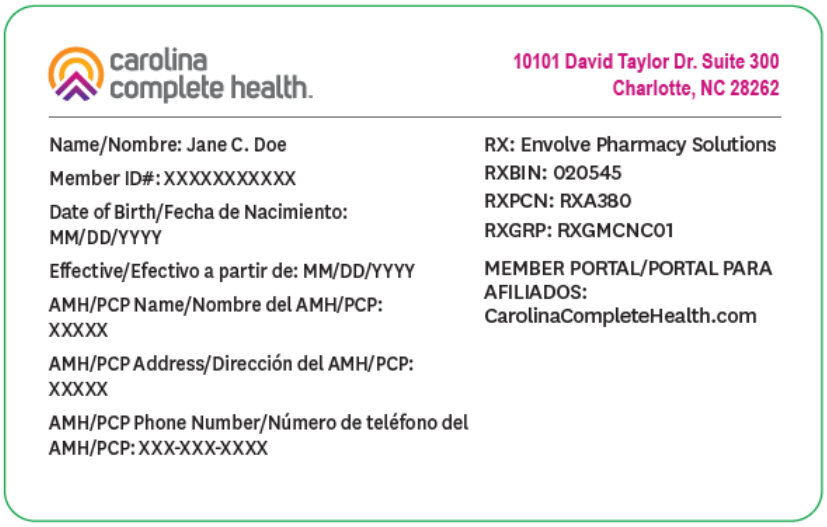
Your Medicaid card has been mailed to you with this welcome packet and member handbook. We used the mailing address on file at your local Department of Social Services. Your Medicaid card has:

- 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.

Members or their caretaker can create a secure account at www.member.carolinacompletehealth.com. Once the account is created, a temporary ID card can be printed.


carolina complete health.

10101 David Taylor Dr. Suite 300
Charlotte, NC 28262

Name/Nombre: Jane C. Doe

Member ID#: XXXXXXXXXX

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: 020545

RXPCN: RXA380

RXGRP: RXGMCNC01

MEMBER PORTAL/PORTAL PARA AFILIADOS: CarolinaCompleteHealth.com


IMPORTANT CONTACT INFORMATION / INFORMACIÓN IMPORTANTE DE CONTACTO

Members/Afiliados: Call **1-833-552-3876** (TTY: 711)
For **Member Services** / Servicios para afiliados
24/7 Nurse Advice Line / Línea de consejo de enfermería que atiende 24/7
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: 1-800-518-9072 **Pharmacy Prior Authorization:** 1-833-585-4309

Pharmacy Paper Claims: PO Box 419069, Rancho Cordova, CA 95741

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

contact Member Services at 1-833-552-3876 or register on the Carolina Complete Health Secure Member Portal to make this update.

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 contact you to help you choose another PCP within 7 days from when we know about this.
- If your provider leaves our network, we will 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 39 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) or visit the Secure Member Portal. 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 ever you 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 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 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. 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 page 35 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 page 35 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, call Member Services at 1-833-552-3876 (TTY: 711) or visit the Secure Member Portal. 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.

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.

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.
- **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).

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.

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

You can walk into an urgent care clinic to get care the same day or make an appointment for the next day. Whether you are at home or away, call your Primary Care Provider (PCP) any time, day or night. If you cannot 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.

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 26 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 20 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 and medically necessary lenses
- Specialist referrals for eye diseases or defects

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
- A list of preferred drugs can be found at www.CarolinaCompleteHealth.com

Pharmacy Lock-in Program

- The NC Medicaid Pharmacy Lock-In Program was established as mandated by legislation to restrict beneficiaries whose utilization of targeted medications with a significant potential for abuse and misuse (opioids and benzodiazepines) is documented as being excessive. Beneficiaries are "Locked-In" to one prescriber and one pharmacy for a two-year period in order to monitor and reduce unnecessary or inappropriate utilization of these targeted medications. This program is intended to prevent Medicaid beneficiaries from obtaining multiple prescriptions for and excessive quantities of these targeted medications through multiple visits to physicians and pharmacies.

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.
- If you need nursing care for more than 90 days, you may need to enroll in a different health plan. 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. If you choose a nursing home outside of Carolina Complete Health's network, and services are available in the plans' network, you may have to transfer to another plan. Call Member Services at 1-833-552-3876 (TTY: 711) for help with questions about nursing home providers and plan networks.
- Talk with your PCP or call Member Services at 1-833-552-3876 (TTY: 711) for help finding a nursing home in our network.

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. These services include:

- Mental Health Services
    - Services to help figure out if you have a mental health need (diagnostic assessment services)
    - Individual, group and family therapy
    - Mobile crisis management services
    - Facility-based crisis programs
    - Specialized behavioral health services for children with autism
    - Outpatient behavioral health services
    - Outpatient behavioral health emergency room services
    - Inpatient behavioral health services
    - Research-based intensive behavioral health treatment
    - Partial hospitalization
- Substance Use Disorder Services
    - Outpatient opioid treatment
    - Substance Abuse Comprehensive Outpatient Treatment program (SACOT)
    - Ambulatory detox
    - Non-hospital medical detox
    - Alcohol and drug abuse treatment center detox crisis stabilization

If you believe you need access to more intensive behavioral health services, like psychiatric residential treatment facilities or assertive community treatment, that your plan does not provide, talk with your PCP or call Member Services at 1-833-552-3876 (TTY: 711) . The following intensive behavior health services are not covered by this plan:

Also, SACOT and SAIOP were made Tailored Plan only by most recent legislation:

Medicaid BEHAVIORAL HEALTH SERVICES excluded from the Health Plan benefit. These services are only available in NC Medicaid Direct.

- 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 (ACT)

- Community support team
- Psychosocial rehabilitation
- Substance abuse non-medical community residential treatment
- Substance abuse medically monitored residential treatment
- Substance Abuse Intensive Outpatient (SAIOP)
- Substance Abuse Comprehensive Outpatient Treatment (SACOT)
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)
- Innovations Waiver services*
- Traumatic Brain Injury Waiver services*
- 1915(b)(3) services
- State-Funded Behavioral Health and Intellectual and Developmental Disability Services

Please note that Waiver services are only available to individuals enrolled in the waiver

1915(b)(3) SERVICES

- Respite
- Supported Employment/Employment Specialist
- Personal Care/Individual Support
- One-time Transitional Costs
- NC Innovations Waiver Services (funded by (b)(3))
- Community Guide
- In-home Skill Building
- Transitional Living Skills
- Intensive Recovery Support

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. 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) up to 2 days before your appointment to arrange transportation to and from your appointment. Non-emergency medical transportation is provided by LogistiCare | Circulation. 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 Member Services at 1-833-552-3876 (TTY:771) 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 Member Services at 1-833-552-3876 (TTY:771) 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 35 for more information on appeals. If you have questions about transportation, call Member Services at 1-833-552-3876 (TTY:771).

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 20.
- 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 20 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:771).

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:

- 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 to 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:771).

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:771) 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:771) 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:771).

Start Smart for Your Baby®

Start Smart for Your Baby® (Start Smart) is a program just for pregnant women and mothers with a newborn. It helps make sure you and your baby are healthy during your pregnancy and after you deliver. To sign up, fill out a Notification of Pregnancy (NOP) form on our website at www.CarolinaCompleteHealth.com.

When you sign up, we will give you information that can help you. We will talk to you on the phone and send you things in the mail. Our Start Smart staff can answer questions and give you support if you are having a problem. We can even arrange for a home visit if you need more help.

Start Smart offers a range of care management techniques, including health screenings, and educational literature designed to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease, which can result from high-risk pregnancies. The program provides educational materials as well as incentives for going to postpartum and well-child visits. Includes breast pump and gifts for qualified moms. Other services provided include:

Start Smart Mobile. An interactive and personalized application for new and expecting mothers. Start Smart Mobile will provide support for Carolina Complete Health's pregnant beneficiaries from the first positive pregnancy test through the post-partum and early newborn period. The mobile application helps families stay on track with key prevention milestones, set personalized reminders, proactively identify and take action on health issues, and tap into Carolina Complete Health's other programs, such as, telephonic Care Management and 24/7 nurse advice line. Start Smart Mobile provides personalized content, based on the expecting mother's due date and provides daily advice and informational photos and videos by weekly pregnancy stage. Start Smart Mobile features a broad range of interactive tracking tools, self-service functions, alerts, educational videos, and accessible resources. Using Start Smart Mobile, beneficiaries are able to access care and support quickly and efficiently, engage with self-service tools (i.e., gaps-in-care, set custom reminders and alerts), check their My Health Pays rewards balance, and interact with additional features (i.e., , local parenting classes, family planning tools and information to enroll their newborn in health coverage).

Start Smart Baby Shower Program. Baby Showers are conducted in a classroom environment in regions across the state and educate pregnant beneficiaries about prenatal and postpartum care for themselves and their newborn. The classes cover the basics of prenatal care, including nutrition, the risk of smoking and benefits of smoking cessation, the progress of a fetus throughout pregnancy, the importance of regular

follow-up with medical providers, common health issues that occur during pregnancy, and a review of the Start Smart programs.

We have many ways to help you have a healthy pregnancy. To help you, we need to know if you are pregnant. Please call Beneficiary Services as soon as you learn you are pregnant. The phone number is 1-833-552-3876 (TTY: 711). We will set up the special care you and your baby need.

SafeLink® Cell Phones

You may be eligible for free cell phone services through SafeLink®. This program provides up to 1,000 free minutes of service per month and unlimited texting. This program includes free calls to and from Carolina Complete Health. Call Beneficiary Services at 1-833-552-3876 (TTY: 711) to find out if you are eligible to receive the SafeLink® Cell Phone.

ConnectionsPlus®

Carolina Complete Health has implemented our ConnectionsPlus® Program, which provides pre-programmed cell phones to our eligible high-risk beneficiaries who lack reliable phone access, if you do not qualify for a SafeLink® phone. This innovative program provides 24-hour instant access for our beneficiaries, allowing them to make calls to and receive calls from their providers, case managers (including behavioral health case managers), peer supports (for beneficiaries with behavioral health conditions), health plan personnel, our nurse advice line, and 911. The overall objective of the program is a reduction in preventable events, such as inappropriate ER use or hospital admissions, through improved access to health care information and treating providers. High-risk beneficiaries receive a cell phone (at no expense to the beneficiary) that has pre-programmed direct dial to important phone numbers. Beneficiaries are educated on observing their health status and calling promptly for advice rather than waiting until the next appointment. In addition, the phones allow case managers to send the beneficiary a text message with health information targeted to the individual beneficiary's condition. In rural areas, increased telephonic communication helps overcome the barrier to care that travel distances sometimes pose for beneficiaries.

Health Education for You

Carolina Complete Health wants to help you stay healthy. We have several resources available to help you, including:

- An online health library with easy access to more than 4,000 topics relating to health and medication
- Educational books available for children, teens and adults

We will share information with you about:

- Preventive health services available to you
- Schedules for getting important health screenings, such as cancer, high blood pressure and diabetes

• Disease education on asthma, diabetes, and heart health

• Well-child services and screenings (EPSDT)

• Substance use risks (such as alcohol, tobacco and other substances) and counseling services available to help you

• How managed care works and health literacy

These resources are available on the Health and Wellness Topics webpage on our website at www.CarolinaCompleteHealth.com.

MyStrength.com

Carolina Complete Health offers online, beneficiary-directed behavioral health resources through www.myStrength.com, a website that offers a range of personalized e-Learning programs to help overcome depression, anxiety or overuse of drugs or alcohol supported by tools, weekly exercises and daily inspiration in a safe and confidential environment. The website offers beneficiaries the ability to take responsibility for their health care and learn more about their diagnoses, track their symptoms, and offers motivational ideas and information. We also encourage caregivers to enroll and utilize MyStrength for support for themselves, or to understand the behavioral health needs of the persons they care for. MyStrength is also accessible through a beneficiary's smart phone.

Healthy Rewards (My Health Pays)

Carolina Complete Health offers rewards for health behaviors. These rewards can be used at Walmart. They can also be used for:

- Utilities
- Transportation
- Child care
- Phone
- Education
- Rent

Additional Prevention and Population Health Management Programs

Carolina Complete Health encourages improved health and wellness for our beneficiaries through the programs identified above in addition to some of the following programs and services available:

- **Boys & Girls Club** available to beneficiaries ages 6-18 years old
- **YMCA** scholarships provided to beneficiaries that take part in YMCA Diabetes Prevention Program and the Blood Pressure Self-Monitoring (BPSM) Program
- **Weight Watchers** beneficiaries have a Weight Watchers benefit. Membership fee support is provided

- **Care Grants** requests for support and resources for beneficiaries. Caregivers, providers, and Carolina Complete Health staff make these requests. This could include items such as helmets for bike safety, personal care items, and air conditioners
- **GED Prep Testing** vouchers for official GED test practice materials available to beneficiaries
- **Live Great Healthy Food Program** can be provided to beneficiaries experiencing food insecurities who also experience a high-risk condition such as diabetes or high-risk pregnancy.
- **Room to Breathe** program to support beneficiaries with asthma. A Housing Specialist will come to the home to find asthma triggers. They will provide a kit with items that can help triggers. This includes items like air filters and mattress covers. Asthma management education is also available and to be provided by a clinical professional.
- **SUD Recovery App** to assist beneficiaries with substance abuse recovery. 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
- **Wellness Assessments** available through the Beneficiary Portal that offer self-care recommendations for important screenings, doctor visits, dietary and behavior/lifestyle changes
- **24/7 Online Resources** through our beneficiary website and portal including information on important programs and resources to improve health and wellness
- **Designated Health Coaches** to provide personalized lifestyle coaching support to eligible beneficiaries for conditions such as diabetes, ADHD, COPD, anxiety, asthma, depression that includes support for healthy eating and smoking cessation
- **Dedicated Specialists** to assist with housing, food access, emotional wellness, employment and transportation needs
- **Health Kiosks** located in the community to provide screenings, resource referrals, and tips for hypertension, diabetes, and other conditions
- **ADHD Support** for parents of children diagnosed with ADHD including tools and books to help parents understand and talk to their child about his or her behaviors and emotions
- **Depression Screenings** for pregnant beneficiaries or beneficiaries who have just given birth to provide appropriate resources as soon as possible
- **Partnerships with LME/MCOs** to make sure that our beneficiaries receive the right services to meet their medical and behavioral health needs
- **Beneficiary Healthy Rewards** incentives available for beneficiaries that meet certain requirements including specific doctor visits and screenings
- **Enhanced Pharmacy Benefit** in addition to covered pharmacy items, beneficiaries receive a $30 quarterly benefit through our mail order pharmacy for certain over-the-

counter non-formulary items such as cold medicine and pain relievers. This is per member household.

- **Enhanced Vision** in addition to covered vision services, beneficiaries receive added vision benefits. Beneficiaries receive contacts or glasses up to $125 each year. Includes a glasses fitting.
- For more information on these and other programs available, please call Beneficiary Services at 1-833-552-3876 (TTY: 711). They can talk to you about eligibility, and how to "opt in" and "opt out."

Carolina Complete Health can notify your PCP of your participation in a Preventative and Population Health Program. If you do not want your provider to be notified, please call Beneficiary Services at 1-833-552-3876 (TTY: 711).

Benefits You Can Get from Carolina Complete Health OR a Medicaid 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:771).

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 a broad menu of healthcare benefits. Medicaid calls this benefit "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 Plan 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. Your Plan may not offer every service covered by the federal Medicaid program. When a child needs treatment, your Plan will pay for any service that the federal government's Medicaid plan covers. The Plan must use a set of special rules that apply only to children. These rules are called EPSDT "medical necessity criteria." A Plan cannot deny your child's service just because of a policy limit. Also, a Plan cannot deny a service just because that service is not covered in the Plan's policies. Your Plan must complete a special "EPSDT review" in these cases.

When your Plan 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.

Primary Care Providers (PCP) should include all of the following components in your child's medical screening:

- Routine physical check-ups as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents".
- Screening for developmental delay at each visit through your child's 5th birthday; and
- Screening for Autistic Spectrum Disorders per AAP guidelines.

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 You Can Get ONLY from a Medicaid Provider

There are some services Carolina Complete Health does not provide. You can get these services from a provider outside of our health plan's provider network who takes Medicaid:

- Dental services
- Services provided through the Program of All-Inclusive Care for the Elderly (PACE). Details about PACE maybe found on the DHHS Medicaid webpage.
- Services provided by Local Education Agencies
- Services provided 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

If you have questions or need help with accessing benefits you can only get through Medicaid, talk with your Primary Care Provider (PCP) or call Member Services at 1-833-552-3876 (TTY:771).

Services NOT Covered

Below are some examples of services that are **not available** from Carolina Complete Health **or** Medicaid. 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.

New Technology

Options for medical care may change over time. New medicines, tests and surgeries come out every year. We watch for the latest in medical care. We also make sure new treatments are safe. A team of doctors reviews new medical care for people with some illnesses. The team checks with other doctors. It checks with scientific groups. New medical care that is covered by Medicaid is then shared with our doctors. This allows our doctors to give you the most fitting types of care. Not all care is covered for every patient. Some patients may benefit more from some treatments. We cover care that is medically necessary. Call us for more information if you have questions.

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 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 have the right to ask for a State Fair Hearing if you think you are being asked to pay for something Medicaid or Carolina Complete Health should cover. A State Fair Hearing allows you or your representative to make your case before an administrative law judge. See the State Fair Hearing section on page 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 <u>do</u> 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**. You can ask for this. All services offered by the State Plan are covered under Carolina Complete Health. Some services require your doctor to submit a prior authorization request to receive the service.

To learn more about which services require preauthorization, visit our website at www.CarolinaCompleteHealth.com or contact Member Services at 1-833-552-3876 (TTY: 711).

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:

You or your doctor may call Member Services at 1-833-552-3876 (TTY: 711) or send your request in writing to 10101 David Taylor Dr., Suite 300, Charlotte, NC 28262. Your doctor can also submit a service request using the online provider portal, which can be accessed on our website at www.CarolinaCompleteHealth.com.

Service Authorization Requests for Children Under Age 21

Special rules apply to decisions to approve medical services for children under age 21 receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. To learn more about EPSDT services, see page 26 or visit our website at www.carolinacompletehealth.com.

What happens after we get your service authorization request?

Your Plan 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 your plan and that it will help with your medical condition. Your Plan's nurses, doctors and behavioral health clinicians will review your provider's request. We do not make choices based on financial reasons. We do not reward doctors or staff for saying no to care. We want you to get the care you need, when you need it.

The Plan team uses policies and guidelines approved by the North Carolina Department of Health and Human Services to see if the service is medically necessary.

Sometimes your Plan 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 the team used to decide on your request.

If the request is approved, we will let you and your health care provider know it was approved. If the request is not approved, a letter will be sent to you and your health care provider giving the reason for the decision.

If you receive a denial and you do not agree with our decision, you may ask your Plan for an "appeal." You can call your Plan, make your request online or send in the appeal form you will find with your decision notice. See page 35 for more information on appeals.

Prior Authorization Requests for Children Under Age 21

Special rules apply to decisions to approve medical services for children under age 21. The Plan cannot say no to a request for children under 21 years old just because of Plan policies, policy limits or rules. They must complete another review to help them approve needed care. They will use federal EPSDT rules. These rules help the Plan team to take a careful look at:

- the child's health problem, and;
- the service or treatment your provider asked for.

Your Plan must approve services that are not included in Plan policies when the Plan's review team finds that a child needs them to get well or to stay healthy. This means that the Plan's review team must agree with your provider that the service will:

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

Important Details about Services Coverable by the federal EPSDT Guarantee:

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

The Plan 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 33 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 <u>that was covered</u> by your plan or by Medicaid, even if your plan later denies payment to the provider.**

Information from Member Services

You can call Member Services at 1-833-552-3876 (TTY: 711) to get a 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. 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 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 North Carolina, like:

- Carolina Complete Health Member Advisory Committee (MAC)

- Carolina Complete Long-Term Services and Supports (LTSS) Advisory Committee
- Medical Care Advisory Committee (MCAC)
- State Consumer and Family Advisory Committee (CFAC)

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

Appeals

Medicaid and NC Health Choice members have a right to appeal Plan decisions to the Plan. When members do not agree with Plan decisions on an appeal, they can ask the State Medicaid agency for a State Fair Hearing.

When you ask for an appeal, your Plan 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 the Plan 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 Member Services 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 your Plan 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 addresses listed on the form. We must receive your form no later than 60 days after the date on this 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.
- **BY PHONE:** Call 1-833-552-3876 (TTY: 711) and ask for an appeal. You will get help with your form during this call. You will still need to send us your appeal request form after you call. There are instructions on the form that tell you what to do.

When you appeal, you and any person you have chosen to help you can see the health records and criteria your Plan 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 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 3 days from your appeal.

Member Requests for Expedited Appeals

Carolina Complete Health will review all member requests for expedited (faster) appeals. If a member's request for an expedited appeal is denied, we will call right away. We will usually call within 2 hours of the decision. We also will tell the member and the provider in writing if the member's request for an expedited appeal is denied. We will tell you the reason for the decision. The Plan will mail you a written notice within two calendar days.

When the member does not agree with the Plan's decision to deny an expedited appeal request, he or she may call and file a grievance with the Plan.

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, you will have a decision in writing within 30 days from your appeal. 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, 10101 David Taylor Dr. 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 day you get your Notice of Decision from your Plan.

State Fair Hearings

If you do not agree with your Plan'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. 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 your Plan'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 North Carolina Office of Administrative Hearings (OAH). An administrative law judge will give you a decision. 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 Carolina Complete Health's decision. The judge in your State Fair Hearing is not a part of your health plan 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
- **FAX:** Fill out, sign and fax the State Fair Hearing Request Form that comes with your notice.
- **BY PHONE:** There are instructions in your letter that will tell you who to call. You will get help with your form during this call.

If you are unhappy with your State Fair Hearing decision, you can appeal to the North Carolina Superior Court.

State Fair Hearings for Disenrollment Decisions

You can also ask for a State Fair Hearing for decisions that you disagree with about changing your health plan (see page 42 for more information about Disenrollment Options).

You, or your authorized representative, may ask for a State Fair Hearing if you disagree with a decision to:

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

You can ask for a State Fair Hearing within 30 days from the day you receive a notice informing you of the decision about your request to change plans or Carolina Complete Health's request for you to leave the health plan.

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.

- **FAX:** Fill out, sign and fax the State Fair Hearing Request Form that comes with your notice.
- **BY PHONE:** There are instructions in your letter that will tell you who to call. You will get help with your form during this call.

Continuation of Benefits During an Appeal

Sometimes a Plan's decision reduces or stops a healthcare 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.

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, [PHP] 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 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 the Plan to bill you for services they paid for during your appeal.

Sometimes your provider makes a new request for less of your service than you were getting. When you appeal and ask for your service to continue, you will get the level of services that your provider asked for in the new request. You will not get your old approval extended.

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 Dr. Suite 300, Charlotte, NC 28262.

For Medicaid members, a grievance and a complaint are the same thing. Contacting us with a grievance means that you are 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 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 Dr. 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 let you know quickly and in writing that we got your grievance. We will reply in writing within 24 hours after we get 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 5 days of getting your complaint.

These issues will be handled according to our Grievance Procedures. You can find them online at www.carolinacompletehealth.com.

Your Care When You Change Health Plans or Providers

- If you join Carolina Complete Health from another health plan, we will contact you at least 5 business days before your expected enrollment date with us. We will confirm the name of your previous plan, so we can add your health information, like your medical records and prescheduled appointments, into our records.
- You can finish receiving any services that have already been authorized by your previous health plan. After that, 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 contact you 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.
    - 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 beneficiaries 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 1-833-552-3876 (TTY: 711).

Member Rights and Responsibilities

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.
- 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

Your Responsibilities

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

- Work with your PCP to protect and improve your health
- Give your providers and Carolina Complete Health information we need to provide care
- 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 the respect
- Tell us if you have problems with any health care staff by calling Member Services at 1-833-552-3876 (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

Disenrollment Options

1. If YOU Want to Leave the Plan

- You can try us out for 90 days. You may leave Carolina Complete Health and join another health plan at any time during the 90 days.
- You can switch health plans once every 12 months.
- If you want to leave Carolina Complete Health at any other time, you can do so **only** with a good reason (good cause). Some examples of good cause include:
    - You move out of our service area
    - We do not offer a Medicaid Managed Care service that you can get from another health plan in your area
    - You need a service that is related to a benefit we have chosen not to cover and getting the service separately would put your health at risk
    - You have a complex medical condition and another health plan or Medicaid program (e.g., Medicaid Direct, LME/MCO) can better meet your needs
    - We have not been able to provide services to you as we are required to under our contract with the North Carolina Department of Health and Human Services.

2. How to Change Plans

You can ask to change plans by phone, mail, in-person or electronically. You will receive help and information to choose a new plan. To change plans, contact:

NC Medicaid Enrollment Broker: Monday – Saturday, 7:00a.m.-5:00p.m.

Toll Free at 1-833-870-5500 (TTY: 1-833-870-5588)

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.

You Could Become Ineligible for Medicaid Managed Care

You may have to leave Carolina Complete Health if you:

- Are no longer eligible for Medicaid Managed Care
- If you stay in a nursing home for more than 90 days in a row
- If 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
- If you begin receiving Medicare

If you become ineligible for Medicaid, all services may stop. If this happens, call North Carolina Medicaid Contact Center at 1-888-245-0179.

3. We Can Ask You to Leave Carolina Complete Health

You can lose your Carolina Complete Health membership, if you:

- Abuse or harm plan members, providers or staff
- Do not fill out forms honestly or do not give true information (commit fraud)

4. You can appeal a disenrollment decision

You, or your authorized representative, may ask for a State Fair Hearing if you disagree with a decision to:

- deny your request to change plans; or
- approve a request made by Carolina Complete Health for you to leave the plan.

A State Fair Hearing is your opportunity to give more information and facts, and to ask questions about the decision before an administrative law judge. The judge in your State Fair Hearing is not a part of your health plan in any way.

You have 30 days from the time you receive a notice to ask for a State Fair Hearing if:

- We deny your request to change plans or
- Carolina Complete Health's request for you to leave the health plan.

When you request a State Fair Hearing, you will receive an opportunity to mediate your disagreement. Mediation is an informal voluntary process to see if an agreement can be made on your case. Mediation is guided by a professional mediator who does not take sides. If you do not reach an agreement at mediation, you can still have a State Fair Hearing. You can also decide not to go through mediation and just ask for a State Fair Hearing.

Requests for a Fair Hearing must be made with both the Department of Health and Human Services and Office of Administrative Hearings:

- Department of Health and Human Services (DHHS)
  Attention: Appeals Section

2501 Mail Service Center

Raleigh, NC 27699-2501

Fax: 919-715-7679

- Office of Administrative Hearings (OAH)
  Attention: Clerk of Court

  6714 Mail Service Center

  Raleigh, NC 27699-6700

  Fax: 919-431-3100

State Fair Hearings for disenrollment decisions

You have the right to ask for a State Fair Hearing if you disagree with a decision on disenrollment that changed your health plan. A State Fair Hearing allows you or your representative to make your case before a judge who rules on laws that regulate government agencies. If you have any questions, call Member Services at 1-833-552-3876 (TTY: 711).

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; or

- Are unconscious and your doctor determines that it is highly unlikely that you will regain consciousness; or
- 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.

Quality Improvement Program

Carolina Complete Health is committed to providing quality health care for you and your family. Our goal is to improve your health. We want to help you with any illness or disability. We want to help members get safe, reliable, and quality health care from our programs. Our programs include:

- Reviewing of doctors and providers before they become part of our network.
- Making sure members have access to all types of health care services.
- Giving members support and education about general health care and specific diseases.
- Sending members reminders to get tests once a year like adult physicals or breast cancer screenings.
- Looking into any member concerns regarding care received.

Carolina Complete Health believes your ideas can help make services better. We send out a member survey each year. The survey asks questions about your experience with the health care and services. We hope you will take the time to send us your answers.

Do you have questions about our Quality Improvement Program or would you like more information? Please contact Member Services or visit our website at www.carolinacompletehealth.com.

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)

Carolina Complete Health

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

***PLEASE REVIEW IT CAREFULLY*.**

Effective 03.01.2018

For help to translate or understand this, please call 1-833-552-3876 (TTY: 711).

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono.

1-833-552-3876. (TTY: 711).

Covered Entities Duties:

Carolina Complete Health is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Carolina Complete Health is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Carolina Complete Health reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Carolina Complete Health will promptly revise and distribute this Notice whenever there is a material change to the following:

- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice.

We will make any revised Notices available on our website, www.carolinacompletehealth.com.

Internal Protections of Oral, Written and Electronic PHI:

Carolina Complete Health protects your PHI. We have privacy and security processes to help.

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- ***Treatment*** - We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.
- ***Payment*** - We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include

    - processing claims
    - determining eligibility or coverage for claims
    - issuing premium billings
    - reviewing services for medical necessity
    - performing utilization review of claims

- ***HealthCare Operations*** - We may use and disclose your PHI to perform our healthcare operations. These activities may include:
    - providing customer services
    - responding to complaints and appeals
    - providing case management and care coordination
    - conducting medical review of claims and other quality assessment
    - improvement activities

    In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:

- quality assessment and improvement activities
- reviewing the competence or qualifications of healthcare professionals
- case management and care coordination
- detecting or preventing healthcare fraud and abuse.

- ***Group Health Plan/Plan Sponsor Disclosures*** – We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** – We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- ***Underwriting Purposes*** – We may use or disclosure your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.

- ***Appointment Reminders/Treatment Alternatives*** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose.

- ***As Required by Law*** - If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.

- ***Public Health Activities*** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclosure your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness products or services under the jurisdiction of the FDA.

- ***Victims of Abuse and Neglect*** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency

authorized by law authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.

- ***Judicial and Administrative Proceedings*** - We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:

    - an order of a court
    - administrative tribunal
    - subpoena
    - summons
    - warrant
    - discovery request
    - similar legal request.

- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:

    - court order
    - court-ordered warrant
    - subpoena
    - summons issued by a judicial officer
    - grand jury subpoena

  We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.

- ***Coroners, Medical Examiners and Funeral Directors*** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.

- ***Organ, Eye and Tissue Donation*** - may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:

    - cadaveric organs
    - eyes
    - tissues

- ***Threats to Health and Safety*** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

- ***Specialized Government Functions*** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:

- to authorized federal officials for national security
- to intelligence activities
- the Department of State for medical suitability determinations
- for protective services of the President or other authorized persons

- ***Workers' Compensation*** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

- ***Emergency Situations*** – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.

- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.

- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

Sale of PHI – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing – We will request your written authorization to use or disclose your PHI for marketing purposed with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes – We will request your written authorization to use or disclose any of you psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

- ***Right to Revoke an Authorization*** - You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.

- ***Right to Request Restrictions -*** You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

- ***Right to Request Confidential Communications -*** You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason is for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you PHI should be delivered.

- ***Right to Access and Received Copy of your PHI -*** You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so**.** You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

- ***Right to Amend your PHI*** **-** You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

- ***Right to Receive an Accounting of Disclosures*** **-** You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.

- ***Right to File a Complaint*** **-** If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-866-788-4989) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

  WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

- ***Right to Receive a Copy of this Notice*** **-** You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Contact Information

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed below.

Carolina Complete Health

Attn: Privacy Official

10101 David Taylor Dr., Suite 300

Charlotte, NC 28262

1-833-552-3876 (TTY: 711)

Important Phone Numbers

- Member Services, Monday – Saturday, 7:00a.m.-6:00p.m. at 1-833-552-3876 (TTY: 711)
- Behavioral Health Crisis Line, Monday – Saturday, 7:00a.m.-6:00p.m. at 1-833-552-3876 (TTY: 711)
- Nurse Line, Monday – Saturday, 7:00a.m.-6:00p.m. at 1-833-552-3876 (TTY: 711)
- NC Medicaid Enrollment Broker at 1-833-870-5500 (TTY:1-833-870-5588)
- NC Medicaid Contact Center at 1-888-245-0179
- Provider Service Line, Monday – Saturday, 7:00a.m.-6:00p.m. at 1-833-552-3876 (TTY: 711)
- Prescriber Service Line, Monday – Saturday, 7:00a.m.-6:00p.m. at 1-833-552-3876 (TTY: 711)
- 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 1-919-814-0181
- State Auditor Waste Line at 1-800-730-8477
- U.S. Office of Inspector General Fraud Line at 1-800-424-9071

Keep Us Informed

Call Member Services at 1-833-552-3876 (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.