carolina complete health™

Member Handbook

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Benefits

1-833-552-3876 (TTY 711)
carolinacompletehealth.com

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NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Benefits

NC MEDICAID MANAGED CARE MEMBER HANDBOOK

Carolina Complete Health

SEPTEMBER 2024

You can request free auxiliary aids and services, including this material and other plan information in large print. Call 1-833-552-3876 (TTY 711).

If English is not your first language, we can help. Call 1-833-552-3876 (TTY 711). We can give you, free of charge, the information in this material in your language orally or in writing, access to interpreter services, and can help answer your questions in your language. For help choosing a primary care provider and enrolling in a health plan, call 1-833-870-5500 (TTY/TDD: 711 or RelayNC.com).

Ayudas auxiliares y servicios de interpretación

Puede solicitar ayudas y servicios auxiliares gratuitos, incluido este material y otra información del plan en letra grande. Llame al 1-833-552-3876 (TTY 711).

Si el inglés no es su lengua nativa, podemos ayudarle. Llame al 1-833-552-3876 (TTY 711). Podemos ofrecerle, de forma gratuita, la información de este material en su idioma de forma oral o escrita, acceso a servicios de interpretación y podemos ayudarle a responder a sus preguntas en su idioma. Para obtener ayuda para elegir un proveedor de atención primaria e inscribirse en un plan de salud, llame al 1-833-870-5500 (TTY/TDD: 711 o RelayNC.com).

辅助工具和翻译服务

您可以申请免费的辅助工具和服务，包括本资料和其他计划信息的大字版。请致电 **1-833-552-3876 (TTY 711)**。

如果英语不是您的首选语言，我们能提供帮助。请致电 **1-833-552-3876 (TTY 711)**。**我**们可以通过口头或书面形式，用您使用的语言免费为您提供本资料中的信息，为您提供翻译服务，并且用您使用的语言帮助回答您的问题。需要帮助来选择一个初级保健提供者以及参加健康计划，请致电 **1-833-870-5500 (TTY/TDD: 711 或 RelayNC.com**）。

Dịch Vụ Phiên Dịch và Hỗ Trợ Bổ Sung

Quý vị có thể yêu cầu các dịch vụ và hỗ trợ bổ sung miễn phí, bao gồm tài liệu này và thông tin kế hoạch khác dưới dạng bản in chữ lớn. Gọi đến 1-833-552-3876 (TTY 711).

Nếu Tiếng Anh không phải là ngôn ngữ mẹ đẻ của quý vị, chúng tôi có thể giúp quý vị. Gọi đến 1-833-552-3876 (TTY 711). Chúng tôi có thể cung cấp miễn phí cho quý vị thông tin trong tài liệu này bằng ngôn ngữ của quý vị dưới dạng lời nói hoặc văn bản, quyền tiếp cận các dịch vụ phiên dịch, và có thể giúp trả lời các câu hỏi của quý vị bằng chính ngôn ngữ của quý vị. Để được trợ giúp chọn nhà cung cấp dịch vụ chăm sóc chính và ghi danh vào một chương trình sức khỏe, hãy gọi đến 1-833-870-5500 (TTY/TDD: 711 hoặc RelayNC.com).

보조 자료 및 통역사 서비스

귀하는 무료 보조 자료 및 서비스를 요청할 수 있으며, 여기에는 큰 활자체의 자료 및 기타 플랜 정보가 포함되어 있습니다. 1-833-552-3876(TTY 711)번으로 전화주시기 바랍니다.

영어가 모국어가 아닌 경우 저희가 도와드리겠습니다. 1-833-552-3876(TTY 711)번으로 전화주시기 바랍니다. 저희는 귀하께 구두로 또는 서면으로 귀하의 언어로 된 자료의 정보를, 그리고 통역 서비스의 사용을 무료 제공해 드리며 귀하의 언어로 질문에 대한 답변을 제공해 드리겠습니다. 일차 진료 제공자를 선택하고 건강 플랜에 가입하는 데에 도움이 필요하신 경우 1-833-870-5500번(TTY/TDD: 711 또는 RelayNC.com)으로 전화주시기 바랍니다.

Aides auxiliaires et services d'interprétation

Vous pouvez demander des aides et des services auxiliaires gratuits, y compris ce document et d'autres informations sur le plan en gros caractères. Composez le 1-833-552-3876 (TTY 711).

Si votre langue maternelle n'est pas l'anglais, nous pouvons vous aider. Composez le

1-833-552-3876 (TTY 711). Nous pouvons vous fournir gratuitement les informations contenues dans ce document dans votre langue, oralement ou par écrit, vous donner accès aux services d'un interprète et répondre à vos questions dans votre langue. Pour obtenir de l'aide dans le choix d'un prestataire de soins primaires et dans l'inscription à un plan de santé, composez le 1-833-870-5500 (TTY/TDD: 711 ou RelayNC.com).

Cov Khoom Pab Cuam thiab Kev Pab Cuam Txhais Lus

Koj tuaj yeem thov tau cov khoom pab cuam thiab cov kev pab cuam, suav nrog rau tej ntaub ntawv no thiab lwm lub phiaj xwm tej ntaub ntawv kom muab luam ua tus ntawv loj. Hu rau 1-833-552-3876 (TTY 711).

Yog tias Lus Askiv tsis yog koj thawj hom lus hais, peb tuaj yeem pab tau. Hu rau

1-833-552-3876 (TTY 711). Peb tuaj yeem muab tau rau koj yam tsis sau nqi txog ntawm tej ntaub ntawv muab txhais ua koj hom lus hais ntawm ncauj los sis sau ua ntawv, mus siv tau cov kev pab cuam txhais lus, thiab tuaj yeem pab teb koj cov lus nug hais ua koj hom lus. Rau kev pab xaiv tus kws pab kho mob xub thawj thiab kev tso npe nyob rau hauv lub phiaj xwm kho mob, hu rau 1-833-870-5500 (TTY/TDD: 711 los sis RelayNC.com).

يمكنك طلب الخدمات والمساعدات الإضافية المجانية بما في ذلك، هذا المستند ومعلومات أخرى حول الخطة بأحرف كبيرة. اتصل على الرق

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

إذا كانت اللغة الإنجليزية ليست لغتك الأولى، فيمكننا المساعدة. اتصل على الرقم

1-833-552-3876 (TTY 711). يمكننا أن نقدم لك المعلومات الواردة في هذا المستند بلغتك شفهيًا أو كتابيًا والوصول إلى خدمات الترجمة مجانًا ويمكننا مساعدتك في الحصول على إجابات لأسئلتك بلغتك. للمساعدة في اختيار موفر الرعاية الأولي والتسجيل في الخطة الصحية، اتصل على الرقم 1-833-870-5500 (TTY/TDD: 711 أو RelayNC.com).

Вспомогательные средства и языковая поддержка

Вы можете запросить бесплатные вспомогательные средства и услуги, включая этот справочный материал и другую информацию о плане, напечатанную крупным шрифтом. Позвоните по номеру

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

Если английский не является Вашим родным языком, мы можем Вам помочь. Позвоните по номеру 1-833-552-3876 (TTY 711). Мы бесплатно предоставим Вам более подробную информацию этого справочного материала в устной или письменной форме, а также доступ к языковой поддержке и ответим на все вопросы на Вашем родном языке. Если Вам нужна помощь в выборе поставщика первичных медицинских услуг и регистрации в плане медицинского обслуживания, позвоните по номеру 1-833-870-5500 (TTY / TDD: 711 или посетите сайт RelayNC.com).

Mga Auxiliary Aid at Serbisyo ng Interpreter

Maaari kang humiling ng libreng mga auxiliary aid at serbisyo, kabilang ang materyal na ito at iba pang impormasyon ng plan sa malaking print. Tumawag sa 1-833-552-3876 (TTY 711).

Kung hindi English ang iyong unang wika, makakatulong kami. Tumawag sa 1-833-552-3876 (TTY 711). Maaari ka naming bigyan, nang libre, ng impormasyon sa materyal na ito sa iyong wika nang pasalita o nang pasulat, access sa mga serbisyo ng interpreter, at matutulungang sagutin ang mga tanong sa iyong wika. Para sa tulong sa pagpili ng pangunahing provider ng pangangalaga at pag-enroll sa isang plan na pangkalusugan, tumawag sa 1-833-870-5500 (TTY/TDD: 711 o RelayNC.com).

સહાયક સહાય અને દુભાષિયા સેવાઓ

તમે મોટી પ્રિન્ટમાં આ સામગ્રી અને અન્ય પ્લાનની માહિતી સહિત મફત સહાયક સહાય અને સેવાઓની વિનંતી કરી શકો છો. **1-833-552-3876 (TTY 711).** પર કૉલ કરો

જો અંગ્રેજી તમારી પ્રથમ ભાષા ન હોય, તો અમે મદદ કરી શકીએ છીએ. **1-833-552-3876 (TTY 711).** પર કૉલ કરો તમારી ભાષામાં મૌખિક રીતે અથવા લેખિતમાં તમને આ સામગ્રીની માહિતી અમે વિના

મૂલ્યે આપી શકીએ છીએ, દુભાષિયા સેવાઓની સુલભતા આપી શકીએ છીએ અને તમારી ભાષામાં તમારા પ્રશ્નોના જવાબ આપવામાં અમે સહાયતા કરી શકીએ છીએ. પ્રાથમિક સંભાળ પ્રદાતા પસંદ કરવામાં અને આરોગ્ય યોજનામાં નોંધણી કરવામાં મદદ માટે, **1-833-870-5500 (TTY/TDD: 711 અથવા RelayNC.com).** પર કૉલ કરો.

សម្ភារៈជំនួយ និងសេវាអ្នកបកប្រែ

អ្នកអាចស្នើសុំសម្ភារៈនិងសេវាជំនួយដោយឥតគិតថ្លៃ រួមទាំងព័ត៌មានអំពីសម្ភារៈនេះ និងព័ត៌មានអំពីផែនការ ផ្សេងទៀតនៅជាអក្សរពុម្ពធំ។ ហៅទូរសព្ទទៅលេខ 1-833-552-3876 (TTY 711) ។

ប្រសិនបើភាសាអង់គ្លេសមិនមែនជាភាសាទីមួយរបស់អ្នក យើងអាចជួយអ្នកបាន។ ហៅទូរសព្ទទៅលេខ 1-833-552-3876 (TTY 711) ។
យើងអាចផ្តល់ជូនអ្នកដោយឥតគិតថ្លៃនូវព័ត៌មាននៅក្នុងឯកសារនេះជាភាសារបស់អ្នក ដោយផ្ទាល់មាត់ឬជាលាយលក្ខណ៍អក្សរ ទទួលបានសេវាអ្នកបកប្រែ និងអាចជួយឆ្លើយសំណួររបស់អ្នកជាភាសារបស់អ្នក ។
សម្រាប់ជំនួយក្នុងការជ្រើសរើសអ្នកផ្តល់សេវាថែទាំបឋម និងក្នុងការចុះឈ្មោះក្នុងគម្រោងសុខភាព សូមទូរសព្ទទៅលេខ1-833-870-5500 (TTY/TDD: 711 ឬ RelayNC.com) ។

Hilfsmittel und Dolmetscherdienste

Sie können kostenlose Hilfsmittel und Services anfordern, darunter diese Unterlagen und andere Versicherungsinformationen in Großdruck. Rufen Sie uns an unter

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

Sollte Englisch nicht Ihre Muttersprache sein, können wir Ihnen behilflich sein. Rufen Sie uns an unter 1-833-552-3876 (TTY 711). Wir können Ihnen die in diesen Unterlagen enthaltenen Informationen kostenlos mündlich oder schriftlich in Ihrer Sprache zur Verfügung stellen, Ihnen einen Dolmetscherdienst vermitteln und Ihre Fragen in Ihrer Sprache beantworten. Unterstützung bei der Auswahl eines medizinischen Erstversorgers und bei der Anmeldung zu einer Krankenversicherung erhalten Sie unter 1-833-870-5500 (TTY/TDD: 711 oder RelayNC.com).

अतिरिक्त सहायता और दुभाषिया सेवाएं

आप इस सामग्री और अन्य योजना की जानकारी बड़े प्रिंट में दिए जाने सहित मुफ्त अतिरिक्त सहायता और सेवाओं का अनुरोध कर सकते हैं। 1-833-552-3876 (TTY 711) पर कॉल करें।

अगर अंग्रेजी आपकी पहली भाषा नहीं है, तो हम मदद कर सकते हैं। 1-833-552-3876 (TTY 711) पर कॉल करें। हम आपको मुफ्त में इस सामग्री की जानकारी आपकी भाषा में जबानी या लिखित रूप

में दे सकते हैं, दुभाषिया सेवाओं तक पहुंच दे सकते हैं और आपकी भाषा में आपके सवालों के जवाब देने में मदद कर सकते हैं। प्राथमिक देखभाल प्रदाता चुनने और स्वास्थ्य योजना में नामांकन करने में मदद के लिए, 1-833-870-5500 (TTY/TDD: 711 या RelayNC.com) पर कॉल करें।

ການຊ່ວຍເຫຼືອເສີມ ແລະ ການບໍລິການນາຍແປພາສາ

ທ່ານສາມາດຂໍການຊ່ວຍເຫຼືອເສີມ ແລະ ການບໍລິການຕ່າງໆໄດ້ແບບຟຣີ, ລວມທັງເອກະສານນີ້ ແລະ ຂໍ້ມູນອື່ນໆຂອງແຜນ ເປັນຕົວພິມໃຫຍ່. ໂທຫາເບີ 1-833-552-3876 (TTY 711).

ຖ້າພາສາແມ່ຂອງທ່ານ ບໍ່ແມ່ນພາສາອັງກິດ, ພວກເຮົາສາມາດຊ່ວຍໄດ້. ໂທຫາເບີ 1-833-552-3876 (TTY 711). ພວກເຮົາສາມາດໃຫ້ຂໍ້ມູນໃນເອກະສານນີ້ ເປັນພາສາຂອງທ່ານທາງປາກເປົ່າ ຫຼື ເປັນລາຍລັກອັກສອນ, ການເຂົ້າເຖິງການບໍລິການນາຍແປພາສາ ໃຫ້ແກ່ທ່ານໂດຍບໍ່ເສຍຄ່າຫຍັງ ແລະ ສາມາດຊ່ວຍຕອບຄຳຖາມຂອງທ່ານເປັນພາສາຂອງທ່ານ. ສຳລັບຄວາມຊ່ວຍເຫຼືອໃນການເລືອກແຜນປະຈຳ ແລະ ການລົງທະບຽນໃນແຜນປະກັນສຸຂະພາບ, ກະລຸນາໂທຫາເບີ 1-833-870-5500 (TTY/TDD: 711 ຫຼື RelayNC.com).

補助具・通訳サービス

この資料やその他の計画情報を大きな文字で表示するなど、無料の補助支援やサービスを要請することができます。1-833-552-3876 (TTY 711)に電話してください。
英語が母国語でない方はご相談ください。1-833-552-3876 (TTY 711)に電話してください。この資料に記載されている情報を、お客様の言語で口頭または書面にて無料でお伝えするとともに、通訳サービスへのアクセスを提供し、お客様のご質問にもお客様の言語でお答えします。かかりつけ医の選択や健康保険プランへの登録については、1-833-870-5500（TTY/TDD: 711 またはRelayNC.com）にお問い合わせください。

Notice of Nondiscrimination

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 auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified American 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, call **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:

1557 Coordinator
P.O. Box 31384
Tampa, FL 33631
1-855-577-8234 (TTY: 711)
Fax: 1-866-388-1769
Email: SM_Section1557Coord@centene.com

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

- Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201
- By phone: **1-800-368-1019 (TDD: 1-800-537-7697)**

Complaint forms are available at 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 health plan:	Call toll free: 1-833-870-5500.
Get this handbook in another format or language	Member Services at 1-833-552-3876 (TTY 711).
Keep track of my appointments and health services	My PCP or Member Services at 1-833-552-3876 (TTY 711).
Get help with getting to and from my doctor's appointments	Member Services at 1-833-552-3876 (TTY 711). You can also find more information on Transportation Services in this handbook on page 18.
Get help to deal with thoughts of hurting myself or others, distress, severe stress or anxiety, or any other behavioral health crisis	Behavioral Health Crisis Line at 1-855-798-7093, at any time, 24 hours a day, 7 days a week. If you are in danger or need immediate medical attention, call 911.
Get answers to basic questions or concerns about my health, symptoms, or medicines	Nurse Line at 1-833-552-3876 (TTY 711)[Nurse Line Number] at any time, 24 hours a day, 7 days a week, or talk with your PCP.
• Understand a letter or notice I got in the mail from my health plan • File a complaint about my health plan • Get help with a recent change or denial of my health care services	Member Services at 1-833-552-3876 (TTY 711)or the NC Medicaid Ombudsman at 1-877-201-3750. You can also find more information about the NC Medicaid Ombudsman in this handbook on page 51.

I WANT TO:	I CAN CONTACT:
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 at dhhs.nc.gov/localdss. You can also use ePASS to update your address and information. epass.nc.gov is North Carolina's secure self-service website where you can apply for benefits and services. You can create a basic ePASS account, then choose to update to an Enhanced ePASS account. Sign up for ePASS at epass.nc.gov.
Find my health plan's health care provider directory or other general information about my health 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.

Added Services: Additional services from your health plan.

Adult Care Home: A licensed residential care setting with seven or more beds for elderly or disabled people who need some additional supports. These homes offer supervision and personal care appropriate to the person's age and disability.

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 written set of directions about how medical or mental health treatment decisions are to be made if you lose the ability to make them 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, you do not agree with, you can ask them to review it. This is called an "appeal." Ask for an **appeal** when you do not agree with your health care service being denied, reduced, stopped, or limited. When you ask your health plan for an appeal, you will get a new decision within 30 days. This decision is called a "resolution." **Appeals and grievances are different.**

Behavioral Health Care: Mental health and substance use disorder treatment and recovery services.

Beneficiary: A person who is receiving Medicaid.

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

Care Coordination: A service where a care coordinator or care manager helps organize your health goals and information to help you achieve safer and more effective care. These services may include, but are not limited to, identification of health service needs, determination of level of care, addressing additional support services and resources or monitoring treatment attendance.

Care Management: A service where a care manager can help you meet your health goals by coordinating your medical, social, and behavioral health services and help you find access to resources like transportation, healthy food, and safe housing.

Care Manager: A health professional who can help you meet your health goals by coordinating your medical, social, and behavioral health services and help you find access to sources like transportation, healthy food, and safe housing.

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

Complaint: Dissatisfaction about your health plan, provider, care, or services. Contact your health plan and tell them you have a "complaint" about your services. **Complaints and appeals are different.**

Copayment (Copay): An amount you pay when you get certain health care services or a prescription.

County Department of Social Services (DSS): The local (county) public agency that is responsible for determining eligibility for Medicaid and other assistance programs.

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

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

Durable Medical Equipment (DME): 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): A Medicaid benefit that provides comprehensive and preventive health care services for children under 21 who receive Medicaid. When children need medical care, services are not limited by Carolina Complete Health's coverage policies. Medicaid makes sure that members under age 21 can get the medical care they need, when they need it, including health care services to prevent future illnesses and medical conditions. **Early Intervention:** Services and support available to babies and young children with developmental delays and disabilities and their families. Services may include speech and physical therapy and other types of services.

Eastern Band of Cherokee Indians (EBCI) Tribal Option: The primary care case management entity (PCCME) created by the Cherokee Indian Hospital Authority (CIHA). It manages the primary care needs of federally recognized tribal members and others who qualify for services through Indian Health Service (I) and live in Cherokee, Haywood, Graham, Jackson, or Swain County or in a neighboring county of the 5-county regions.

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

Emergency Medical Condition: A situation in which your life could be threatened, or you could be hurt permanently if you do not get care right away.

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

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

Enrollment Broker: Unbiased, third-party entity that provides managed care choice counseling and enrollment assistance and coordinates outreach and education to beneficiaries.

Excluded Services: Services covered by the NC Medicaid Direct program, but not by your health plan. You can get these services from any provider who takes Medicaid.

Fair Hearing: See "State Fair Hearing."

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

Habilitation Services and Devices: Health care services that help you keep, learn, or improve skills and functioning for daily living.

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

Health Plan (or Plan): The organization providing you with health care services.

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.

Hospital Outpatient Care: Services you receive from a hospital or other medical setting that do not require hospitalization.

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

Institution: Health care facility or setting that that may provide physical and/or behavioral supports. Some examples include, but are not limited to, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), Skilled Nursing Facility (SNF) and Adult Care Home (ACH).

Legal Guardian or Legally Responsible Person: A person appointed by a court of law to make decisions for an individual who is unable to make decisions on their own behalf (most often a family member or friend unless there is no one available, in which case a public employee is appointed).

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

Long-Term Services and Supports (LTSS): Care provided in the home, in community-based settings or in facilities to help individuals with certain health conditions or disabilities with day-to-day activities. LTSS includes services like home health and personal care services. **Managed Care:** A health care program where North Carolina contracts with health plans, called managed care organizations (MCOs), to arrange for integrated and coordinated physical health, behavioral health, and other health services for Medicaid beneficiaries.

Medicaid: Medicaid is a health coverage program. The program helps certain families or individuals who have low income or serious medical problems. It is paid with federal, state and county dollars and covers many physical health, behavioral health, and I/DD services you might need. You must apply through your local Department of Social Services. When you qualify for Medicaid, you are entitled to certain rights and protections. See the websites below for more information about Medicaid and your rights:

www.carolinacompletehealth.com/members/medicaid/additional-benefits/member-rights.html and medicaid.ncdhhs.gov/medicaid/your-rights.

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.

Member Services: The phone number you can call to speak to someone and get help when you have a question. Carolina Complete Health's Toll-Free number is 1-833-552-3876 (TTY 711).

NC Department of Health and Human Services (NCDHHS): The stage agency that includes NC Medicaid (Division of Health Benefits), Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), Division of Social Services (DSS), Division of Aging and Adult Services (DAAS) and other health and human services agencies. The NCDHHS website is ncdhhs.gov.

NC Medicaid (State Medicaid Agency): Agency that manages Medicaid health care programs, pharmacy benefits and behavioral health services on behalf of NCDHHS.

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

NC Medicaid Ombudsman: A Department program that provides education and advocacy for Medicaid beneficiaries whether they are in NC Medicaid Managed Care or NC Medicaid Direct. The NC Medicaid Ombudsman provides issue resolution for NC Medicaid Managed Care members. A resource to be used when you have been unable to resolve issues with your health plan or PCP. The NC Medicaid Ombudsman is separate and distinct from the Long-Term Care Ombudsman Program.

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

Network Provider: A provider that is in your health plan's provider network.

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

Non-Emergency Medical Transportation (NEMT): Transportation your health 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.

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

Ongoing Special Condition: A condition that is serious enough to require treatment to avoid possible death or permanent harm. A chronic illness or condition that is life-threatening, degenerative, or disabling and requires treatment over an extended period. This definition also

includes pregnancy in its second or third trimester, scheduled surgeries, organ transplants, scheduled inpatient care or being terminally ill.

Out-of-Network Provider: A provider that is not in your health plan's provider network.

Palliative Care: Specialized care for a patient and family that begins at diagnosis and treatment of a serious or terminal illness. This type of care is focused on providing relief from symptoms and stress of the illness with the goal of improving quality of life for you and your family.

Physician: A person who is qualified to practice medicine.

Physician Services: Health care services you receive from a physician, nurse practitioner or physician assistant.

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

Premium: The amount you pay for your health insurance every month. Most Medicaid beneficiaries do not have a premium.

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

Prescription Drug Coverage: Refers to how the health plan helps pay for its members' prescription drugs and medications.

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

Primary Care: Services from a primary care provider that help you prevent illness (check-up, immunization) to manage a health condition you already have (like diabetes).

Primary Care Provider or Primary Care Physician (PCP): The doctor or clinic where you get your primary care (immunizations, well-visits, sick visits, visits to help you manage an illness like diabetes). Your PCP should also be available after hours and on weekends to give you medical advice. They also refer you to specialists (cardiologists, behavioral health providers) if you need it. Your PCP should be your first call for care before going to the emergency department.

Prior Authorization (or Preauthorization): Approval you must have from your health plan before you can get or continue getting certain health care services or medicines.

Provider Network (or 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.

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

Referrals: A documented order from your 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.

Service Limit: The maximum amount of a specific service that can be received.

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

Skilled Nursing Facility (SNF): A facility that provides skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation services for injured, disabled, or sick people.

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

Standard Plan: A North Carolina Medicaid health plan that offers physical health, pharmacy, and basic behavioral health services for members. Standard Plans offer added services for members who qualify. Carolina Complete Health is a Standard Plan.

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

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

Telehealth: Use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations.

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

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

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

Table of Contents

NC Medicaid Managed Care Program

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

How Managed Care Works

You Have a Health Care Team

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

- Carolina Complete Health has a contract to meet the health care needs of people with North Carolina Medicaid. We partner with a group of health care providers (doctors, therapists, specialists, hospitals, home care providers and other health care facilities) who make up our **provider network.**
- When you join Carolina Complete Health, our provider network is here to support you. Most of the time, your main contact will be your primary care provider (PCP). If you need to have a test, see a specialist, or go into the hospital, your PCP can help arrange it. Your PCP is available to you day and night. If you need to speak to your PCP after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can go to certain doctors for some services without checking with your PCP. See page 9 for details.
- You can visit our website at www.carolinacompletehealth.com/members/medicaid/resources/handbooks-forms.html to find the provider directory online or call Member Services at 1-833-552-3876 (TTY 711) to get a printed copy of the provider directory.

How to Use This Handbook

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

Read pages 1-25 now. These pages have information that you need to start using your health 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. For calls made during non-business hours, there is an option to leave a message and Carolina Complete Health will return the call the next business day. **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), ask about benefits and services, get help with referrals, replace a lost Medicaid ID card, 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.** Call us at 1-833-552-3876 (TTY 711) 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 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 PCP or ask questions about symptoms or medications.
- If you are experiencing emotional or mental pain or distress, call the Behavioral Health Crisis Line at 1-855-798-7093at 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 Hearing, Vision, or Speech Disabilities

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.

For People with Hearing Loss

If you are deaf, hard of hearing or feel that you have difficulty hearing and need help communicating, Carolina Complete Health has resources available to help you. These include but are not limited to:

- Qualified American Sign Language interpreters
- Certified deaf interpreters

- Communication Access Realtime Translation (CART) captioning
- Personal amplification listening devices (ALDs) for your use
- Staff trained to appropriately handle your relay service calls (videophone, captioned phone, or TTY)
- Carolina Complete Health's website allows members to access information and contact the health plan using a webform.

For People with Vision Loss

If you have vision loss, Carolina Complete Health has resources available to help you. These include but are not limited to:

- Information in large print
- Written materials in accessible formats (large print, Braille, audio, accessible electronic format)
- Carolina Complete Health's website pages can be accessed so that members can hear full pages read aloud.

For People with Speech Disabilities

If you have a speech disability, Carolina Complete Health has resources available to help you. These include but are not limited to:

- Speech-to-Speech Relay (STS)
- Artificial larynx

For People with Multiple Disabilities

Access needs for people with disabilities vary. Special aids and services are always provided free of charge.

Other Special Aids and Services for People with Disabilities

- Help in making or getting to appointments.
- Care managers who can help you get the care you need.
- 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 help you make or get to appointments.
- Easy access to any from services (like ADA accessible, ramps, handrails, and other services).

To ask for services, call Member Services at 1-833-552-3876 (TTY 711).

Carolina Complete Health complies with federal civil rights laws and does not leave out or treat people differently because of race, color, national origin, age, disability, or sex. If you believe that Carolina Complete Health failed to provide these services, you can file a complaint. To file a

complaint or to learn more, call Member Services at 1-833-552-3876 (TTY 711).

If you have issues that you have been unable to resolve with Carolina Complete Health, you may contact the NC Medicaid Ombudsman at 1-877-201-3750 or ncmedicaidombudsman.org.

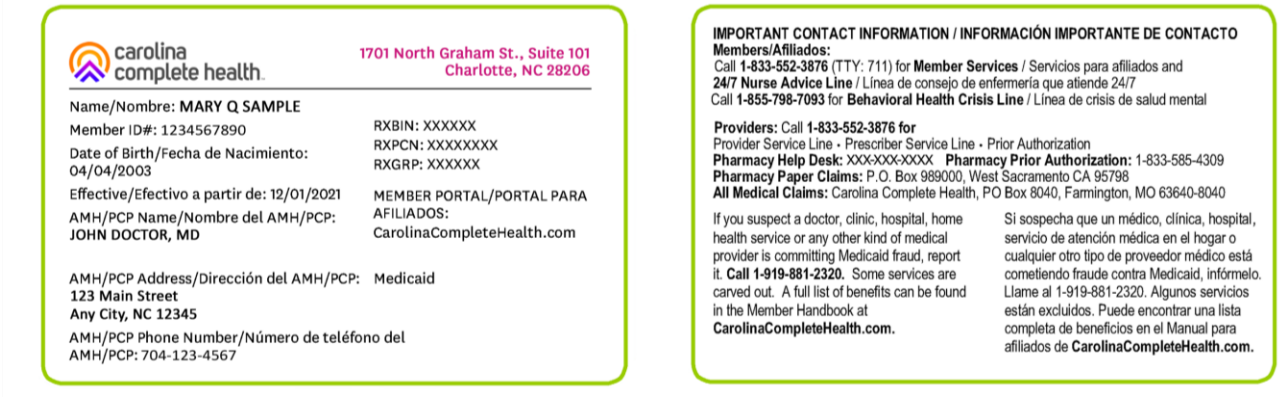
Your Medicaid ID Card

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

Members who require assistance or access to benefits before they receive their ID card in the mail can call Member Services at 1-833-552-3876 (TTY 711).



How to Choose Your PCP

- Your primary care provider (PCP) is a doctor, nurse practitioner, physician assistant or other 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 choose 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 ID card. If you would like to change your PCP, you have 30 days from the date you receive this packet to make the change. (See "How to Change Your PCP" on page 6 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 choosing a PCP that is right for you and your family.
- Carolina Complete Health's network is a group of doctors, hospitals, and other healthcare providers who have agree to provide you with your healthcare services.
- To find a provider in Carolina Complete Health's network, you can use the online Find a Provider tool at https://findaprovider.carolinacompletehealth.com/ location, This tool will have the most up-to-date information about the provider network, including name, address, telephone number, professional qualifications, languages spoken, gender, specialty and board certification status, and whether they are accepting new patients. For more information about a provider's medical school and residency, please call Member Services at 1-833-552-3876 (TTY 711).
- Women can choose an OB/GYN to serve as their PCP. Women do not need a PCP referral to see a health plan OB/GYN doctor or another provider who offers women's health care services. Women can get routine check-ups, follow-up care if needed and regular care during pregnancy.
- If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP. In order to select a specialist as your PCP, please register on the Carolina Complete Health Secure Member Portal or contact Member Services at 1-833-552-3876 (TTY 711). If you did not choose your PCP and have not visited a PCP within the last 12-18 months, Carolina Complete Health may assign you a different PCP based on medical history.

If Your Provider Leaves Our Provider Network

- If your provider leaves Carolina Complete Health, we will tell you within 15 days from when we know about this. If the provider who leaves Carolina Complete Health is your PCP, we will tell you within 7 days and help make sure you choose a new PCP.
- If your provider leaves our network, we can help you find a new one.
- Even if your provider leaves our network, you may be able to stay with your provider for a while longer in certain situations.
- Please read "Your Care When You Change Health Care Providers" on page 5 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 ID card. You can change your PCP within 30 days from the date you receive your Medicaid ID card. To change your PCP, call Member Services at 1-833-552-3876 (TTY 711). After that, you can only change your PCP once 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 patients are seen
    - 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 and address illness or other symptoms. It also includes giving you advice when you need it and referring you to the hospital or specialists when needed. You and

your primary care provider (PCP) work together to keep you well or to see that you get the care you need.

- Your PCP is always available. Call your PCP when you have a medical question or concern. If you call after hours or on weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how your health plan works.
- Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If you ever cannot keep an appointment, call to let your PCP know.
- **Making your first regular health care appointment.** As soon as you choose or are assigned a PCP, if it is a new provider, call to make a first appointment. There are several things you can do to help your PCP get to know you and your health care needs.
- How to prepare for your first visit with a new provider:
    - Request a transfer of medical records from your current provider to your new PCP.
    - Make a list of health concerns you have now, and be prepared to discuss your general health, past major illnesses, surgeries, etc.
    - Make a list of questions you want to ask your PCP.
    - Bring all medications and supplements you are taking to your first appointment.

  It is best to visit your PCP within three months of joining the health 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 Appointment Guide (below) 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 department 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 department 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 department immediately (available 24 hours a day, 365 days a year) or go to an urgent care clinic

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

How to Get Specialty Care – Referrals

- If you need specialized care that your primary care provider (PCP) cannot give, your PCP will refer you to a **specialist** who can. A specialist is a doctor who is trained and practices in a specific area of medicine (like a cardiologist or a surgeon). If your PCP refers you to a specialist, we will pay for your care if it is medically necessary. 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 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).

Out-of-Network Referral

- 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 health 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.
- To request care from specialists or providers outside of Carolina Complete Health's network, please call Member Services at 1-833-552-3876 (TTY 711) or fill out the Out-of-Network Referral Form at www.carolinacompletehealth.com/referral.
- 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 36 to find out how.
- Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is similar to what you can get from a Carolina Complete Health provider. If you do not agree with our decision, you can **appeal** our decision. See page 36 to find out how.

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

Out-of-Network Providers

If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan, or an **out-of-network**

provider. For more information about getting services from an out-of-network provider, talk to your primary care provider (PCP) or call Member Services at 1-833-552-3876 (TTY 711).

Get These Services from Carolina Complete Health Without a Referral

A referral is a documented order from your provider for you to see a specialist or receive certain medical services. You do not need a referral to get these services:

Primary Care

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

Women's Health Care

You do not need a referral from your PCP if:

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

Family Planning

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

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

Children's Screening

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

Local Health Department Services

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

Behavioral Health Services

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

Emergencies

You are always covered for emergencies. An emergency medical or behavioral 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 will not 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 breakup.

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

- You can go to any hospital or other setting to get emergency care.
- You **do not** need approval from your health plan or your PCP before getting emergency care, and you are not required to use our hospitals or doctors.
- **If you are 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 about community services you can get.
  - Tell you to go to the nearest urgent care emergency department.

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

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

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).

If you need help with a mental health or drug situation, feel stressed or worried, or need someone to talk to, you can call the Behavioral Health Crisis Line at 1-833-798-7093.

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 earache who wakes up in the middle of the night and will not stop crying
- The flu
- A cut that needs stitches
- A sprained ankle
- A bad splinter you cannot remove

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

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

Care Outside North Carolina and the United States

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

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

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

Your Benefits

NC Medicaid Managed Care provides **benefits** or health care services covered by your health 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.
- Added services that are available to Carolina Complete Health to help support holistic member health in areas such as education, food insecurity, employment, and more.

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 14.

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
- Vision/hearing exams
- Well-baby care
- Well-childcare
- Immunizations (shots) for children and adults
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for members under age 21 (see page 28 for more information about EPSDT services)
- Help with quitting tobacco

Maternity Care

- Prenatal, delivery and postpartum care
- Childbirth education classes
- Professional and hospital services related to maternal care and delivery
- One medically necessary postpartum 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 26 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 equipment and supplies

Personal Care Services

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

Hospice Care

- Hospice care will be arranged by Carolina Complete Health if medically necessary.
- Hospice helps patients and their families with the special needs that come during the final stages of illness and after death.
- Hospice provides medical, supportive, and palliative care to terminally ill individuals and their families or caregivers.
- You can get these services in your home, in a hospital or in a nursing home.

Vision Care

- Services provided by ophthalmologists and optometrists, including routine eye exams, medically necessary contact lenses and dispensing fees for eyeglasses. Opticians may also fit and dispense medically necessary contact lenses and eyeglasses.
- Specialist referrals for eye diseases or defects
- Fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses and ophthalmic frames, is provided to you through the NC Medicaid Direct program. Although these eyeglasses are covered through NC Medicaid Direct, Carolina Complete Health providers who work in an office that offers eye exams and eyeglasses must give you your eye exam and your NC Medicaid Direct eyeglasses (see page 30 for more information on benefits covered by Medicaid but not through your Health Plan).

Pharmacy

- Prescription drugs
- Some medicines sold without a prescription (also called “over the counter”), like allergy medicines
- Insulin and other diabetic supplies like syringes, test strips, lancets and pen needles
- Smoking cessation agents, including over the counter products
- Emergency contraception
- Medical and surgical supplies, available through DME pharmacies and suppliers
- We also provide a Pharmacy Lock-In Program that helps identify members that are at risk for possible overuse or improper use of pain medications (opioid analgesics) and nerve medications (benzodiazepines and certain anxiolytics). See page 27 for more information on our pharmacy lock-in program.

Carolina Complete Health adheres to the North Carolina Medicaid Formulary, or Preferred Drug List (PDL), which is a guide to available brand and generic drugs that are approved by the Food and Drug Administration (FDA) and covered through your prescription drug benefit.

The PDL is available at www.carolinacompletehealth.com/forms. The PDL includes drugs available without Prior Authorization (PA) and those agents that have the restrictions of Step Therapy (ST). The PA list includes those drugs that require PA for coverage. Medication not listed on the PDL is covered unless otherwise excluded. The PDL applies to drugs you receive at retail pharmacies. The PDL is continually evaluated by the North Carolina Medicaid Pharmacy and Therapeutics (P&T) Committee to promote the appropriate and cost-effective use of medication. The Committee is composed of the North Carolina Medical Director, North Carolina Medicaid Pharmacy Director, and several primary care physicians, pharmacists, and specialists. Annual updates and major changes to drug coverage and pharmaceutical management edits are communicated to providers and members by mail, fax, and email as needed.

The PDL is not meant to be a complete list of the drugs covered under your prescription benefit. Not all dosage forms or strengths of a drug may be covered. This list is periodically reviewed and updated.

Pharmaceutical Management Procedures:

Carolina Complete Health covers needed drugs for Medicaid members. You may call a Member Services Representative for a list of drugs Carolina Complete Health covers.

How do you get your prescriptions?

- Visit the Primary Care Provider (PCP) assigned to you by Carolina Complete Health or another provider on the network to get a prescription.
- Get your prescription filled at a pharmacy that is in Carolina Complete Health’s network. You will need to show your member ID card at the pharmacy.

Please reference Carolina Complete Health's Provider Directory to find pharmacies near you. You can also call Member Services at 1-833-552-3876 (TTY 711) to help you find a pharmacy. You can also find a pharmacy by using the 'Find a Pharmacy' feature in Carolina Complete Health's online tool. Carolina Complete Health requires that you try at least two preferred drugs before you can get a non-preferred drug. Please ask your doctor to write a prescription for a preferred drug first.

Copays

In accordance with NC Medicaid, members will have a $4 copayment associated with each prescription medication, unless an exemption exists resulting in a $0 copay. Exemptions include, but are not limited to, members under 21 years of age; members residing in a nursing home facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), or a mental health hospital; pregnant members; and members of a federally recognized tribe. Some medications may also result in a copay exemption for specific products as designated by NC Medicaid, such as oral contraceptive medications and diabetic supplies that are covered on the preferred drug list. Additional products may be added at the State's discretion.

What is Prior Authorization?

Carolina Complete Health must approve certain prescription drugs before you get them. This is called Prior Authorization (PA). Ask your doctor if your prescription requires this. If it does, ask if there is another medicine that can be used that does not require a PA. Carolina Complete Health doctors have been notified in writing of:

- The drugs included in the Preferred Drug List (PDL)
- How to request a Prior Authorization
- Special procedures set up for urgent request

Your doctor can decide if it is necessary to have a non-preferred drug. If so, they must give Carolina Complete Health a request for a PA. If Carolina Complete Health does not approve the request, we will notify you. We will give you information about the appeal and administrative review process.

Dispensing Limits, Quantity Limits, and Age Limits

Drugs may be dispensed up to a maximum of 90-day supply for each new or refill non-controlled substance. A total of 75% of the days supplied must have elapsed before the prescription can be refilled. Dispensing outside the quantity limit (QL) or age limit (AL) requires Prior Authorization (PA). Carolina Complete Health may limit how much of a medication you can get at one time. If the physician/clinician feels you have a medical reason for getting a larger amount, he or she can ask for PA. If Carolina Complete Health does not grant PA, we will notify you and your physician/clinician and provide information regarding the appeal process. Some medications on the Carolina Complete Health PDL may have AL. These are set for certain drugs based on FDA approved labeling, for safety concerns, and quality standards of care. The AL aligns with current FDA alerts for the appropriate use of pharmaceuticals.

Medical Necessity Requests

If the member requires a medication that does not appear on the PDL or is not covered, the member's practitioner can make a medical necessity (MN) request for the medication. It is anticipated that such exceptions will be rare and that PDL medications will be appropriate to treat the vast majority of medical conditions. Carolina Complete Health requires:

- Documentation of failure of up to two PDL agents within the same therapeutic class (provided two agents exist in the therapeutic category with comparable labeled indications) for the same diagnosis (e.g., migraine, neuropathic pain); or
- Documented intolerance or contraindication to up to two PDL agents within the same therapeutic class (provided two agents exist in the therapeutic category with comparable labeled indications); or
- Documented clinical history or presentation where the patient is not a candidate for any of the PDL agents for the indication.

All reviews are performed by a licensed clinical pharmacist using the criteria established by the NC Medicaid P&T Committee. If the clinical information provided does not meet the coverage criteria for the requested medication, Carolina Complete Health will notify the member and their practitioner of alternatives and provide information regarding the appeal process.

Generic Substitution

Generic drugs have the same active ingredients as their brand name counterparts and should be considered the first line of treatment. The FDA requires generics to be safe and work the same as brand name drugs. If there is no generic available, there may be more than one brand name drug to treat a condition. Preferred brand name drugs are listed on Tier 2 to help identify brand drugs that are clinically appropriate, safe, and cost-effective treatment options, if a generic medication on the formulary is not suitable for your condition.

Step Therapy

Some medications listed on the NC Medicaid PDL may require specific medications to be used before you can receive the step therapy medication. If Carolina Complete Health has a record that the required medication was tried first the ST medications are automatically covered. If Carolina Complete Health does not have a record that the required medication was tried, you or your physician/clinician may be required to provide additional information. If Carolina Complete Health does not grant PA we will notify you and your physician/clinician and provide information regarding the appeal process.

Emergency Care

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.
- After you have received emergency care, you may need other care to make sure you remain in stable condition.

- Depending on the need, you may be treated in the emergency department, in an inpatient hospital room or in another setting.
- For more about emergency services, see page 11.

Specialty Care

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

Nursing Home Services

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

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

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

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

- Ambulatory detoxification services
- Diagnostic assessment services
- Early and periodic screening, diagnostic and treatment services (EPSDT) for members under age 21
- Facility-based crisis services for children and adolescents
- Inpatient behavioral health services
- Medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization

- Mobile crisis management services
- Non-hospital medical detoxification services
- Outpatient behavioral health emergency department services
- Outpatient behavioral health services provided by direct-enrolled providers
- Outpatient opioid treatment services
- Partial hospitalization
- Peer support services
- Professional treatment services in a facility-based crisis program
- Research-based intensive behavioral health treatment

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

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

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

Transportation Services

- **Emergency:** If you need emergency transportation (an ambulance), call 911.
- **Non-Emergency:** Carolina Complete Health can arrange and pay for your transportation to help you get to and from your appointments for Medicaid-covered care. This service is free to you. If you need an attendant to go with you to your doctor's appointment, or if your child (age 18 or younger) is a member of the plan, transportation is also covered for the attendant, parent, or guardian. Non-emergency medical transportation includes personal vehicles, taxis, vans, mini-buses, mountain area transports and public transportation.

How to Get Non-Emergency Medical Transportation (NEMT). Members should arrange for transportation as far in advance as possible, but no less than two business days before their appointment.

Call 1-833-552-3876 (TTY 711) to schedule transportation.

Non-Emergency Medical Transportation is provided by ModivCare. After hours you may obtain medical transportation to appointments by dialing the same toll-free number used during normal business hours. ModivCare's reservation hours are Monday - Saturday, 7:00 am - 6:00 pm. ModivCare is closed Sundays and national holidays (New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving, day after Thanksgiving, and Christmas Day).

Modivcare, has added Lyft to their network as of 11/7/23. You may find that your future trip is provided by a Lyft vehicle. Please note that you will need to still make reservations for transportation directly through Modivcare. Reservations can NOT be made via the Lyft app.

Non-Emergency Medical Transportation is covered for medically necessary, covered services, such as doctor appointments, dialysis, and counseling appointments. If you need to change or cancel your transportation appointment, please call Transportation Services at 1-833-552-3876 (TTY 711) as soon as you are aware of the need to change or cancel your pickup time. If the transportation does not arrive at the appointment time, please contact Member Services at 1-833-552-3876 (TTY 711) to determine the location of the driver or make alternative arrangements.

Urgent transportation services, including hospital discharges, are exempt from any advance notice requirement. An urgent transportation need is transportation to a medical service which does not warrant ambulance transport but cannot be postponed to another time. Examples include hospital discharge, acute illnesses, trip modification/transfer request, and non-emergent injuries, as well as necessary medical care that cannot be rescheduled to another time. To schedule an urgent transportation services, please call Member Services at 1-833-552-3876 (TTY 711).

If transportation services are denied, you have the right to appeal our decision. See page 36 for more information on appeals. If you have questions about transportation, visit www.carolinacompletehealth.com or call Member Services at 1-833-552-3876 (TTY 711).

For certain types of trips, Carolina Complete Health may need to review the request or require additional information before we can schedule the trip. This is called **preauthorization** (see page 19 for more information on service authorization). The following types of trips must be reviewed by us and/or require additional information before we can schedule the trip:

Preauthorization Required
• Out-of-network providers/facilities • One-way trip exceeding 100 miles • Out-of-state providers/facilities • One-way trip exceeding $200 (excluding costs associated with surcharges) • Trips for services not covered by Carolina Complete Health (excluding dental services)

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

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

Under certain circumstances, such as overnight stays, very early travel, or late returns, you may be eligible for meal or lodging reimbursement. To find out more and to request a prior authorization for reimbursement, please contact Transportation Services at 1-833-552-3876 (TTY 711). You can get additional information on our Non-Emergency Medical Transportation policy by calling Member Services at 1-833-552-3876 (TTY 711) or by visiting our website at www.carolinacompletehealth.com. You can get additional information on our Non-Emergency Medical Transportation policy by calling Member Services at 1-833-552-3876 (TTY 711) or by visiting our website at www.carolinacompletehealth.com/members/medicaid/resources/benefits-services/transportation.html.

Member Services can provide information such as:

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

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

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

If you disagree with a decision made about your transportation services, you have the right to appeal our decision. See page 36 for more information on appeals. If you are dissatisfied with your transportation service, you may file a grievance. See page 40 for more information on grievances.

Long-Term Services and Supports (LTSS)

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

- If you need LTSS, you may have a care manager on your care team. A care manager is a specially trained health professional who works with you, 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 (Care Management)" on page 26.
- 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
- Telehealth
- Extra support to manage your health (see page 26 for more information)
- Home infusion therapy
- Rural Health Clinic (RHC) services
- Local health department services
- Federally Qualified Health Center (FQHC) services
- Free clinic services

Added Services

Carolina Complete Health offers extra benefits at no cost to you. These are called added services. Some added services may only be available for members who qualify. To learn more about added services, members should visit www.carolinacompletehealth.com/vas or call Member Services at 1-833-552-3876 (TTY 711).

Carolina Complete Health offers the following added services:

Added Service	Description and Eligibility	How to Get Added Service
My Health Pays® Rewards Card	All members can earn dollar rewards for completing healthy activities such as completing an annual Carolina Complete Health Care Needs Screening, getting a flu shot, or getting an annual wellness visit.	All members receive a personalized Visa® debit card within two weeks of enrollment with information on how to earn rewards. Dollar rewards are loaded on the card after the member completes the activity.
My Healthy Balance® Food Rewards	Members who complete a Carolina Complete Health Care Needs Screening and are determined to have food insecurity are eligible for this program.	Members who are eligible for this program will receive a Visa® debit card. $20 will be loaded on the card every month for six months up to $120 per year per member.
New Parent's Package	Members who are expecting a baby or who have delivered a baby in the previous 12 months are eligible to receive a choice of a car seat and a box of diapers or an electronic breast pump and a box of diapers.	Visit Carolina Complete Health's website to complete a web form or call Member Services.
School Supplies	Members enrolled in pre-kindergarten through 12th grade are eligible to receive a backpack with school supplies valued at $50.	Visit Carolina Complete Health's website to complete a web form or call Member Services.

Added Service	Description and Eligibility	How to Get Added Service
Online Tutoring	Members enrolled in kindergarten through 6th grade are eligible to receive 24 hours of online math and/or reading tutoring.	Visit Carolina Complete Health's website to complete a web form or call Member Services.
GED Exam Voucher	Members age 16+ and not enrolled in high school can receive a voucher.	Visit Carolina Complete Health's website to complete a web form or call Member Services.
Youth and Afterschool Development Voucher	Members aged 6-18 are eligible to receive a $75 voucher that can be presented at any participating organization.	Visit Carolina Complete Health's website to complete a web form or call Member Services.
Room to Breathe Asthma Support Program	Members under the age of 18 and diagnosed by their PCP with asthma are eligible to receive up to $300 in support to help reduce or eliminate triggers of asthma. This includes portable air conditioner, air purifier, HEPA vacuum, hypoallergenic bedding, green cleaning supplies, and more.	Visit Carolina Complete Health's website to complete a web form or call Member Services. Upon receipt of the request, a CCH Care Manager will reach out to the parent/guardian of the member to determine which items could help support the member.
YMCA Pre-Diabetes Health Management Program	Members age 18+ who are diagnosed with pre-diabetes by their PCP are eligible for this online program.	Visit Carolina Complete Health's website to complete a web form or call Member Services. Upon receipt of the request, a CCH Care Manager will reach out to the member to confirm eligibility.

Added Service	Description and Eligibility	How to Get Added Service
YMCA High Blood Pressure Monitoring Program	Members age 18+ who are diagnosed with high blood pressure by their PCP are eligible for this online program.	Visit Carolina Complete Health's website to complete a web form or call Member Services. Upon receipt of the request, a CCH Care Manager will reach out to the member to confirm eligibility.
Weight Watchers® Program	Members who meet Body Mass Index requirements are eligible for this online program.	Visit Carolina Complete Health's website to complete a web form or call Member Services. Upon receipt of the request, a CCH Care Manager will reach out to the member to confirm eligibility.
Over the Counter (Pharmacy) Allowance	All members are eligible to receive $30 per month (up to $120 per year) to order select items from CVS (online or in-person).	Visit Carolina Complete Health's website to learn more and view a catalog of available items. To order by phone, call 1-888-262-6298 Monday through Friday from 9 a.m. to 8 p.m.
Vision Allowance	Members aged 21+ are eligible to receive extra vision benefits, including a $125 retail allowance toward select prescription eyeglass frames and lenses, once every 2 years (730 days).	Visit an Envolve vision provider or call Member Services.
myStrength Mobile App	All members are eligible to access the myStrength app to help manage stress, anxiety, chronic pain, and more.	Visit Carolina Complete Health's website for link to download the app or call Member Services.

Added Service	Description and Eligibility	How to Get Added Service
Tribal Talking Circles	Native American members are eligible to earn $100 on their My Health Pays® Rewards card when they complete two Tribal Talking Circles.	Visit Carolina Complete Health's website to complete a web form or call Member Services.
Cell Phone Support	Members aged 18+ who do not qualify for the Federal SafeLink phone program can get a cell phone through our ConnectionsPlus program. To be eligible for this program, you must be enrolled in Carolina Complete Health Care Management. Please call Carolina Complete Health at 1-833-552-3876 (TTY 711) to be transferred to our Care Management team.	Call Member Services.

In Lieu of Services

Carolina Complete Health offers services or settings that are medically appropriate, cost-effective substitutions for services covered by NC Medicaid. These are called in lieu of services. Carolina Complete Health offers the following in lieu of services:

- Massage therapy in lieu of opioid pain management: Massage therapy as a method of managing a pain instead of opioid medicine management for a chronic pain condition/diagnosis.
- Behavioral Health Urgent Care (BHUC) in lieu of emergency room care: BHUC offers a safe alternative to hospital emergency departments for behavioral health crises. A BHUC is designed to triage, assess, evaluate, and stabilize members in crisis. A BHUC is an alternative, but not a replacement for, a community hospital Emergency Department (ED).
- Institute of Mental Disease (IMD) in lieu of emergency department stays and medical stays for behavioral health needs: This service offers psychiatric and therapeutic interventions including medication management, group therapy, and room and board.

The goal of this service is stabilization of psychiatric symptoms to allow for treatment in a less restrictive setting.

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

Extra Support to Manage Your Health (Care Management)

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 care professional who works with you and your doctors to make sure you get the right care when and where you need it.

Your care manager can:

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

Carolina Complete Health can also connect 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 tobacco
- Children from birth to age 5 who may live in stressful situations or have certain health conditions or disabilities

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

Help with Problems beyond Medical Care (Healthy Opportunities)

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

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

- Worry about your housing or living conditions

- Have trouble getting enough food to feed yourself or your family
- Find it hard to get to appointments, work, or school because of transportation issues
- Feel unsafe or are experiencing domestic or community violence. If you are in immediate danger, call 911.

These services may be covered by Carolina Complete Health based on where you live and other reasons, such as if you have a physical or behavioral health condition. To learn more about these services or see if you qualify, contact your care manager, or call Member Services at 1-833-552-3876 (TTY 711).

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 tobacco or are a new mom who wants to learn more about how to best feed your baby, we can connect you with the right program for support.

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

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

Opioid Misuse Prevention Program

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

Pharmacy Lock-in Program

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

- One prescriber orders your medications. You will be given a chance to pick a prescriber in the Carolina Complete Health's network.
- You have these prescriptions filled from one pharmacy. You will be given a chance to pick a pharmacy in Carolina Complete Health's network.

If you qualify for the Pharmacy Lock-In Program, you will be in the program for a two-year period. If you do not agree with our decision that you should be in the program, you can appeal our decision before you are placed in the program (see page 36 for more information on appeals).

Carolina Complete Health will provide additional prevention and population health management programs to encourage improved health and wellness among members including but not limited to:

- Pregnancy and postpartum support (Start Smart for baby, Notice of Pregnancy, OB engagement, Women's health, POM Calls, Baby Steps Care Management program etc.)
- Obesity management (Weight Watchers, Member rewards, Dietician/Nutrition services etc.)
- Depression (Counseling, Medication Management, Psychotropic Medication Utilization review, Provider education etc.)
- Tobacco Cessation (Optum/Quit for Life®)
- Hypertension Prevention and Management
- Diabetes Prevention and Management
- Early Childhood Intervention Support (i.e., referrals to CSDA)
- Pregnancy Risk Screening and care management follow up

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

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

HIV and STI Screening

You can get human immunodeficiency virus (HIV) and sexually transmitted infection (STI) testing, treatment, and counseling services 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 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 Age 21

Members under the age of 21 have access to a broad menu of federal health care benefits referred to as "Early and Periodic Screening, Diagnosis and Treatment Services." The "EPSDT guarantee" covers wellness visits and treatment services.

Early and Periodic Screening and Diagnosis

These "screening" visits are wellness care. They are free for members under age 21. These visits include a complete exam, free vaccines, 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 Age 21

Sometimes children need medical treatment for a health problem. Carolina Complete Health may not offer every service covered by the Federal Medicaid program. When a child needs treatment, we will pay for any service listed within 1905(a) of the Social Security Act. The proposed treatment must be evaluated on its ability to treat, fix, or improve your child's health problem or condition. This decision is made specifically for your child. Carolina Complete Health cannot deny your child's service just because of a policy limit. Also, we cannot deny a service just because that service is not included in our coverage policies. We must complete a special EPSDT review in these cases.

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

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

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

- Dental services
- Comprehensive health screening services (well-child checks, developmental screenings, and immunizations)
- Health education
- Hearing services
- Home health services
- Hospice services
- Inpatient and outpatient hospital services
- Lab and X-ray services
- Mental health services
- Personal care services

- Physical and occupational therapy
- Prescription drugs
- Prosthetics
- Rehabilitative and therapy services for speech, hearing and language disorders
- Transportation to and from medical appointments
- Vision services
- Any other necessary health services to treat, fix or improve a health problem

If you have questions about EPSDT services, talk with your child's PCP. You can also find out more about the Federal EPSDT guarantee online. Visit our website at www.carolinacompletehealth.com or go to the NC Medicaid EPSDT webpage at medicaid.ncdhhs.gov/epsdt.

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

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

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

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

Services NOT Covered

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

- Cosmetic surgery if not medically necessary
- Personal comfort items such as cosmetics, novelties, tobacco, or beauty aids
- Routine foot care, except for beneficiaries with diabetes or a vascular disease
- Routine newborn circumcision (medically necessary circumcision is covered for all ages)
- Experimental drugs, procedures, or diagnostic tests

- Infertility treatments
- Sterilization reversal
- Sterilization for patients 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 aid products and services for beneficiaries aged 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

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

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

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

If You Get a Bill

If you get a bill for a treatment or service you do not think you owe, **do not ignore it**. Call Member Services at 1-833-552-3876 (TTY 711) right away. We can help you understand why you may have gotten a bill. If you are not responsible for payment, Carolina Complete Health will contact the provider and help fix the problem for you.

You have the right to ask for an appeal and a State Fair Hearing if you think you are being asked to pay for something Medicaid or Carolina Complete Health should cover. See the Appeals section on page 36 in this handbook for more information. If you have any questions, call Member Services at 1-833-552-3876 (TTY 711)

Health 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
• Chiropractic visits • Doctor visits • Non-emergency visits • Optometrist and optical visits • Outpatient visits • Podiatrist visits	$4 per visit
• Generic and brand prescriptions	$4 for each prescription

**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
- Behavioral health services
- Intellectual/developmental disability (I/DD) services
- Traumatic brain injury (TBI) services

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

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

Service Authorization and Actions

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

Inpatient Benefits		Outpatient Benefits		Prescription Drugs
In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***	
Non-emergent inpatient acute care Partial hospitalization Medically supervised detoxification Rehabilitation admission Skilled nursing facilities Long-term acute care Intensive outpatient services	Non-emergent inpatient acute care Partial hospitalization Medically supervised detoxification Rehabilitation admission Skilled nursing facilities Long-term acute care Intensive outpatient services	Home health services Nutritional services Surgical services per DHHS Imaging Durable medical equipment (DME) Hospice and palliative care OP office visits to specialists	Outpatient services provided by direct-enrolled providers Outpatient opioid treatment Ambulatory detoxification Home health services Nutritional services Surgical services per DHHS	Medications which have specific usage criteria as defined by the State.

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

For more information about preauthorization and process, please visit our website at www.carolinacompletehealth.com/providers/preauth-check/medicaid-pre-auth.html.

Asking for approval of a treatment or service is called a **service authorization request**. To get approval for these treatments or services you need to call Member Services at **1-833-552-3876 (TTY 711)** or send your request in writing to: Service Authorizations, Carolina Complete Health: 1701 North Graham Street, Suite 101, Charlotte, NC 28206.

You or your doctor may call Member Services at 1-833-552-3876 (TTY 711) or send your request in writing to Carolina Complete Health: 1701 North Graham Street, Suite 101, Charlotte, NC 28206.

What happens after we get your service authorization request?

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

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

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

If you receive a denial and you do not agree with our decision, you may ask for an "appeal." You can call or send in the appeal form you will find with your decision notice. See page 36 for more information on appeals.

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

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

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

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

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

Important Details about Services Coverable by the Federal EPSDT Guarantee:

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

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

To learn more about the Medicaid health plan for children (EPSDT), see page 28, visit our website at www.carolinacompletehealth.com and visit the state of North Carolina website for the EPSDT guarantee at medicaid.ncdhhs.gov/epsdt.

Preauthorization and Timeframes

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

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

Information from Member Services

You can call Member Services at 1-833-552-3876 (TTY 711) to get a PCP, to ask about benefits and services, to get help with referrals, to replace a lost Medicaid ID 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, deafblind or has difficulty seeing, we can help. We can tell you if a doctor's office is equipped with special communications devices. Also, we have services like:
    - TTY machine. Our TTY phone number is 1-833-552-3876 (TTY 711)
    - Information in large print
    - Help in making or getting to appointments
    - Names and addresses of providers who specialize in your condition

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

You Can Help with Health Plan Policies

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

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

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

Appeals

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

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

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

- **MAIL:** Fill out and sign the Appeal Request Form in the notice you receive about our decision. Mail it to the address listed on the form. We must receive your form no later than 60 days after the date on the notice.
- **FAX:** Fill out, sign, and fax the Appeal Request Form in the notice you receive about our decision. You will find the fax number listed on the form. We must receive your form no later than 60 days after the date on the notice.
- **BY PHONE:** Call 1-833-552-3876 (TTY 711) and ask for an appeal. When you appeal, you and any person you have chosen to help you can see the health records and criteria Carolina Complete Health used to make the decision. If you choose to have someone help you, you must give them permission.

You can also contact the NC Medicaid Ombudsman to get more information about your options. See page 51 for more information about the NC Medicaid Ombudsman.

Expedited (faster) Appeals

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

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

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

Provider Requests for Expedited Appeals

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

Member Requests for Expedited Appeals

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

If you do not agree with our decision to deny an expedited appeal request, you may file a grievance with us (see page 40 for more information on grievances).

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

Timelines for Standard Appeals

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

- Will write to you and tell you what information is needed
- Will explain why the delay is in your best interest
- May take an additional 14 days to make a decision on your appeal if you request it or if there is a need for additional information, and the delay is in your best interest

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: 1701 North Graham Street, Suite 101, Charlotte, NC 28206.

Decisions on Appeals

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

State Fair Hearings

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

Free and Voluntary Mediations

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

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

State Fair Hearings

State Fair Hearings are held by the NC Office of Administrative Hearings (OAH). An administrative law judge will review your request along with new information you may have. The judge will make a decision on your service request. You can give any updates and facts you need to at this hearing. A member of Carolina Complete Health's review team will attend. You

may ask questions about the Carolina Complete Health's decision. The judge in your State Fair Hearing is not a part of Carolina Complete Health in any way.

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

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

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

State Fair Hearings and Disenrollment Decisions

If you disagree about a decision to change your health plan, you can ask for a State Fair Hearing. The process to ask for a State Fair Hearing for disenrollment decisions is different than the process to ask for a State Fair Hearing when Carolina Complete Health limits or denies a service that you requested. For more information about requesting a State Fair Hearing for disenrollment decisions see page 38.

Continuation of Benefits During an Appeal

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

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

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

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

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

Your appeal might not change the decision the health plan made about your services. When this happens, Medicaid allows Carolina Complete Health to bill you for services we paid for

during your appeal. We must get approval from NC Medicaid before we can bill you for services we paid for during your appeal.

Appeals During Your Transition Out of Carolina Complete Health

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

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

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

We hope our health plan serves you well. If you are unhappy or have a complaint, you may talk with your primary care provider, and you may call Member Services at 1-833-552-3876 (TTY 711) or write to Carolina Compete Health: 1701 North Graham Street, Suite 101, Charlotte, NC 28206 at any time.

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

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

You can contact us by phone or in writing at any time:

- 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 to us with your complaint to Carolina Complete Health: 1701 North Graham Street, Suite 101, Charlotte, NC 28206.

Resolving Your Grievance

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

- We will review your complaint and tell you how we resolved it in writing within 30 days from receiving your complaint.
- If your grievance is about your request for an expedited (faster) appeal, we will tell you how we resolved it in writing within 5 days of getting your complaint.

- If your grievance is about your request for an expedited (faster) appeal, we will let you know quickly and in writing that we received 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 calendar days of receiving your complaint. These issues will be handled according to our Grievance Procedures. You can find them online at www.carolinacompletehealth.com.

Transition of Care

Your Care When You Change Health Plans or Providers

- If you join Carolina Complete Health from another health plan, we will work with your previous health plan to get your health information, like your service history, service authorizations and other information about your current care into our records.
- You can finish receiving any services that have already been authorized by your previous health plan. After that, if necessary, we will help you find a provider in our network to get any additional services if you need them.
- In almost all cases, your providers under your former health 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 Carolina Complete Health

is your primary care provider (PCP), we will tell you in writing within 7 days from when we know this will happen. We will tell you how you can choose a new PCP or how we will choose one for you if you do not make a choice within 30 days.

- If you want to continue receiving care from a provider who is not in our network:
    - Continuation of care with a terminated provider is allowed under certain circumstances for a period of up to 90 days if the provider is not termed due to a quality issue. If it is determined that a provider could cause harm to members, members will be removed immediately and provided with a written notification of the change, their newly assigned PCP, and their right to change PCPs.
    - A terminated provider may also request that a member receive continued treatment. In these cases, the request is reviewed to evaluate whether it qualifies for continuation of care. Services that qualify for continuation of care are determined by Carolina Complete Health's Medical Director. If the request is approved, outreach to the member will be made.
    - Upon receipt of a PCP Notice of Termination, Carolina Complete Health will work with the provider leaving the network to get a list of affected patients or use PCP assignment information or eligibility services to get the contact information for impacted members such as member name, ID number, or address. Patients seen on a "regular" basis means they have seen that provider at least four times or more in the last 12 months.

For more information, please call Member Services at 1-833-552-3876 (TTY 711) or 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).

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Member Rights and Responsibilities

As a member of Carolina Complete Health, you have certain rights and responsibilities. Carolina Complete Health will respect your rights and make sure that no one working for our health plan, or any of our providers, will prevent you from using your rights. Also, we will make sure that you are aware of your responsibilities as a member of our health plan. For a full list of your rights and responsibilities as a member of Carolina Complete Health visit our website at www.carolinacompletehealth.com/members/medicaid/additional-benefits/member-rights.html or call Member and Recipient Services at 1-833-552-3876 (TTY 711) to get a copy.

Your Rights

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

- Be cared for with respect and with consideration for your dignity and privacy without regard for health status, sex, race, color, religion, national origin, age, marital status, sexual orientation or gender identity
- Be told what services are available to you

- Be told where, when, and how to get the services, you need from Carolina Complete Health
- Be told by your primary care provider (PCP) what your options are when getting services so you or your guardian can make an informed choice
- 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 a way you understand. This includes additional languages.
- 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 information about your health care
- Get a copy of your medical record and talk about it with your PCP
- Ask, if needed, that your medical record be amended or corrected
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract or with your approval
- Use the Carolina Complete Health complaint process to settle complaints. You can also contact the **NC Medicaid Ombudsman** any time you feel you were not fairly treated (see page 51 for more information about the NC Medicaid Ombudsman).
- Use the State Fair Hearing system
- Appoint someone you trust (relative, friend or lawyer) to speak for you if you are unable to speak for yourself about your care and treatment
- Receive considerate and respectful care in a clean and safe environment, free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Make recommendations about your rights and responsibilities

Your Rights if You Are a Minor

- Minors have the right to agree to some treatments and services without the consent of a parent or guardian:
- Treatment for sexually transmitted diseases
- Services related to pregnancy
- Services to help with alcohol and/or other substance use disorders
- Services to help with emotional conditions

Your Responsibilities

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

- Supply the accurate and complete medical information that Carolina Complete Health and its providers need to provide healthcare.
- Work with your PCP to protect and improve your health
- Find out how your health plan coverage works
- Listen to your PCP's advice and ask questions
- Call or go back to your PCP if you do not get better or ask for a second opinion
- Treat health care staff with respect
- Tell us if you have problems with any health care staff by calling Member Services at 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

How to Change Your Health Plan (Disenrollment)

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

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

- At least once every 12 months. This usually happens at the same time that your eligibility for Medicaid is being recertified.
- During the first 90 days that Carolina Complete Health starts managing your care (you may hear this called your choice period). You may leave Carolina Complete Health and join another health plan at any time during the 90 days.

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

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

- You move out of our service area
- You have a family member in another health plan
- Your requested related services are not available in our provider network, and there is risk to getting the services separately

- Your medical condition requires treatment that you are unable to receive in our health plan
- Your Long-Term Services and Supports (LTSS) provider is no longer with our health plan
- Other reasons (poor quality of care, lack of access to covered services, lack of access to providers experienced in dealing with your health care needs)

If you need certain services to address needs related to a mental health disorder, substance use disorder, intellectual/developmental disability (I/DD) or traumatic brain injury (TBI), you may have other choices. Call **1-833-870-5500** (TTY711 or RelayNC.com).

How to Request to Change Health Plans

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

- Go to ncmedicaidplans.gov
- Use the NC Medicaid Managed Care mobile app
- Call 1-833-870-5500 (TTY 711 or RelayNC.com)

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

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

Reasons Why You May Have to Leave Carolina Complete Health

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

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

plan is going to take over your care. If you do not like the new health plan who takes over your care, you will be given the option to choose a different health plan.

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

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

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

State Fair Hearings for Disenrollment Decisions

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

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

State Fair Hearings are held by OAH. You will have a chance to give more information and facts, and to ask questions about the decision for you to change health plans before an administrative law judge. The judge in your State Fair Hearing is not a part of Carolina Complete Health in any way. In North Carolina, State Fair Hearings include an offer of a free and voluntary mediation session that is held before your Hearing date (see page 38 for more information on mediations).

Requesting a State Fair Hearing for Disenrollment Decisions

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

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

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

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

Advance Directives

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

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

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

Living Will

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

- Become incurably sick with an irreversible condition that will result in your death within a short period of time
- Are unconscious and your doctor determines that it is highly unlikely that you will regain consciousness

- Have advanced dementia or a similar condition which results in a substantial loss of attention span, memory, reasoning and other brain functions, and it is highly unlikely the condition will be reversed

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

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

Health Care Power of Attorney

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

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

Advance Instruction for Mental Health Treatment

An **advance instruction for mental health treatment** is a legal document that tells doctors and mental health providers what mental health treatments you would want and what treatments you would not want if you later became 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.

Evaluation of New Technology

Carolina Complete Health wants to make sure that you have access to the most up-to-date medical care. When new tests, medicines, surgeries, or other treatments are developed, the NC Medicaid Agency and Carolina Complete Health carefully review them. Carolina Complete Health has a team of doctors who check to make sure treatments are safe and effective. They help decide if these new treatments are best for our members. Carolina Complete Health will inform you and your doctor when new services that are covered under your benefits become available.

Concerns About Abuse, Neglect and Exploitation

Your health and safety are very important. You should be able to lead your life without fear of abuse or neglect by others or someone taking advantage of them (exploitation). Anyone who suspects any allegations of abuse, neglect, or exploitation of a child (age 17 or under) or disabled adult **must** report these concerns to the local Department of Social Services (DSS). A list of DSS locations can be found at dhhs.nc.gov/localdss. There are also rules that no one will be punished for making a report when the reporter is concerned about the health and safety of an individual.

Providers are required to report any concerns of abuse, neglect or exploitation of a child or disabled adult receiving mental health, substance use disorder, intellectual/developmental disability services (I/DD) or traumatic brain injury (TBI) services from an unlicensed staff to the local DSS and the Healthcare Personnel Registry Section of the North Carolina Division of Health Service Regulation for a possible investigation. The link to the Healthcare Personnel Registry Section is ncnar.org/verify_listings1.jsp. The provider will also take steps to ensure the health and safety of individuals receiving services.

For additional information on how to report concerns, call Member Services at 1-833-552-3876 (TTY 711).

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 bill for services that were not provided or were not medically necessary

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

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

Important Phone Numbers

	Number	Hours of Operation*
Member Services Line	1-833-552-3876 (TTY: 711)	7 a.m. to 6 p.m., Monday through Saturday
Behavioral Health Crisis Line	1-855-798-7093	24 hours a day, seven days a week
Nurse Line	1-833-552-3876 (TTY: 711)	24 hours a day, seven days a week.
Enrollment Broker	1-833-870-5500 (TTY: 1-833-870-5588)	7 a.m. to 5 p.m., Monday through Saturday
NC Medicaid Ombudsman	1-877-201-3750	8 a.m. to 5 p.m., Monday through Friday
NC Medicaid Contact Center	1-888-245-0179	8 a.m. to 5 p.m., Monday through Friday
Provider Service Line	1-833-552-3876 (TTY: 711)	7 a.m. to 6 p.m., Monday through Saturday
Prescriber Service Line	1-833-552-3876 (TTY: 711)	7 a.m. to 6 p.m., Monday through Saturday
NC Mediation Network	1-336-461-3300	8 a.m. to 5 p.m., Monday through Friday
Free Legal Services Line	1-866-219-LANC (5262)	8:30 a.m. to 4:15 p.m., Monday through Friday
Advance Health Care Directive Registry	1-919-814-5400	8 a.m. to 5 p.m., Monday through Friday
NC Medicaid Fraud, Waste, and Abuse Tip Line	1-877-DMA-TIP1 (877-362-8471)	8 a.m. to 5 p.m., Monday through Friday
State Auditor Waste Line	1-800-730-TIPS (1-800-730-8477)	8 a.m. to 5 p.m., Monday through Friday
U.S. Office of Inspector General Fraud Line	1-800-HHS-TIPS (1-800-447-8477)	8 a.m. to 5:30 p.m., Monday through Friday

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.

NC Medicaid Ombudsman

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

The NC Medicaid Ombudsman can:

- Answer your questions about benefits
- Help you understand your rights and responsibilities
- Provide information about NC Medicaid Managed Care
- Answer your questions about enrolling with or disenrolling from a health plan
- Help you understand a notice you have received
- Refer you to other agencies that may be able to assist you with your health care needs
- Help with issues you have been unable to resolve with your health care provider or health plan
- Be an advocate for you if you are dealing with an issue or a complaint affecting access to health care
- Provide information to assist you with your appeal, grievance, mediation or fair hearing
- Connect you to legal help if you need it to help resolve a problem with your health care

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