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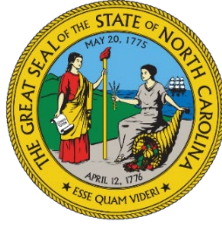

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Benefits

NC MEDICAID MANAGED CARE MEMBER HANDBOOK

[Insert Plan Name]

[Insert MONTH] [Insert YEAR]

[**Plans must insert the following inside front cover of handbook**]

[Plans must include the following statement in a font no smaller than 18 points]:

You can get this handbook and other plan information in large print for free. To get materials in large print, call Member Services at [insert Member Services Toll-Free Number].

If English is not your first language (or if you are reading this on behalf of someone who doesn't read English), we can help. Call [insert Member Services Toll-Free Number and the TTY Number.] You can ask us for the information in this handbook in your language. We have access to interpreter services and can help answer your questions in your language.

Per the RFP, translate the language statement above into the 15 prevalent non-English languages in North Carolina and insert the translated statements here.

Spanish:
Chinese:
Vietnamese:
Korean:
French:
Arabic:
Hmong:
Russian:
Tagalog:
Gujarati:
Mon-Khmer (Cambodia):
German:
Hindi:
Laotian:
Japanese:

Your [Insert Plan Name] 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 [insert Member Services Toll-Free Number].)
Get the information in this handbook in another format or language	Member Services at [insert Member Services Toll-Free Number and TTY number].
Keep better track of my appointments and health services	My PCP or Member Services at [insert Member Services Toll-Free Number].
Get help with getting to and from my doctor's appointments	Member Services at [insert Member Services Toll-Free Number]. You can also find more information on Transportation Services in this handbook on page [insert appropriate page number here].
Get help to deal with my stress or anxiety	Behavioral Health Crisis Line at [insert Behavioral Health Crisis Line], 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 [insert 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 [insert Member Services Toll-Free Number] or the Medicaid Managed Care Ombudsman Program at [insert appropriate phone number]. You can also find more information about the Ombudsman Program in this handbook on page [insert appropriate page number] or go to [insert hyperlinked web page].
Update my address	Call your local Department of Social Services (DSS) office to report an address change. A list of DSS locations can be found here: [insert hyperlinked web page]
Find my plan's provider directory or other general information about my plan	Visit our website at [insert hyperlinked web page] or call Member Services at [insert Member Services Toll-Free Number].

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.

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

Adverse Action: A decision your plan can make to reduce, stop or restrict your health care services.

Appeal: A request to the plan to review a decision the plan made about reducing, stopping or restricting your health care services.

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

Benefits: A set of health care services covered by your health plan.
Care Manager: A specially trained health professional who works with you and your doctors to make sure you get the right care when and where you need it.

Copay: A fee you pay when you get certain health care services or a prescription.

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

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

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

Emergency Services: Services you receive to treat your emergency medical condition.
Emergency Medical Transportation: Ambulance transportation to the nearest hospital or medical facility for an emergency medical condition.
Fair Hearing: A way you can make your case before an administrative law judge if you are not happy about a decision your plan made that reduced, stopped or restricted your services after your appeal.

Grievance: A complaint you can file if you have a problem with your health plan, provider, care, or services.

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

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

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

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

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

Managed Care: An organized way for providers to work together to coordinate and manage all your health needs. You can think of it a central home for your health.
Medicaid: A health plan that helps some individuals pay for health care. For example, the NC Health Choice plan is a Medicaid health program that pays for health coverage for children.

Medically Necessary: Medical services or treatments that you need to get and stay healthy.

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

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

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

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

Preauthorization: The approval needed from your plan before you can get certain health care services or medicines.

Prescription Drugs: A drug that, by law, requires a prescription by a doctor.

Primary Care Provider (PCP): The provider who takes care of and coordinates all your health needs. Your PCP is often the first person you should contact if you need care. Your PCP can be physician, including an OB/GYN, a nurse practitioner, a physician assistant or a certified nurse midwife.

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

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

Skilled Nursing Care: Care that requires the skill of a licensed nurse.

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

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

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

Welcome to [insert plan name]'s North Carolina Medicaid Managed Care Program

How Managed Care Works .... **X**

The Plan, Our Providers and You X

How to Use This Handbook .... **X**

Help from Member Services .... **X**

Auxiliary Aids and Services .... **X**

Your Health Plan ID Card .... **X**

How to Choose Your PCP .... **X**

How to Change Your PCP .... **X**

How to Get Regular Health Care .... **X**

How to Get Specialty Care – Referrals .... **X**

Out-of-Network Providers .... **X**

Get These Services from [insert Plan Name] Without a Referral .... **X**

Primary Care

Women's Health Care

Family Planning

Children's Screening and Local Health Department Services

Behavioral Health Services

Emergencies .... **X**

Urgent Care .... **X**

Care Outside North Carolina and the United States

Benefits .... **X**

Services Covered by [insert Plan Name]'s Network .... **X**

Regular Health Care

Maternity Care

Hospital Care

Home Health Services

Personal Care Services

Hospice Care
Vision Care
Pharmacy
Emergency Care
Specialty Care
Nursing Home Services
Behavioral Health Services (Mental Health and Substance Use Disorder Services)
Transportation Services
Long Term Services and Supports (LTSS)
Family Planning
Other Covered Services

Extra Support to Manage Your Health....... X

Help with Problems beyond Medical Care....... X

Other Programs to Help You Stay Healthy....... X
Opioid Misuse Prevention Program

Benefits You Can Get from [Insert Plan Name] OR a Medicaid Provider....... X
HIV and STI Screening
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Benefits You Can Get ONLY from a Medicaid Provider....... X

Services NOT Covered....... X
If You Get a Bill

Plan Member Copays....... X
Your Copays if You Have Medicaid*
Your Copays if Your Child Has NC Health Choice

How Often You Can Change Your PCP X

Service Authorization and Actions X
Service Authorization Requests for Children Under Age 21
What happens after we get your service authorization request:
Preauthorization and Timeframes
Information from Member Services
How You Can Help with Plan Policies

Appeals X
Timeframes for Appeals
Your Care While You Wait for a Decision
Fair Hearings
Your Care While You Wait for a Decision

If You Have Problems with Your Health Plan X
If You Are Unhappy with Your Plan: How to File a Complaint
What Happens Next

Your Care When You Change Health Plans or Doctors X

Member Rights and Responsibilities X

Your Responsibilities X

Disenrollment Options X
1. If YOU Want to Leave the Plan
   How to Change Plans
2. You Could Become Ineligible for Medicaid Managed Care
3. We Can Ask You to Leave [Insert Plan Name]

Advance Directives X
Living Will
Health Care Power of Attorney
Advance Instruction for Mental Health Treatment
Forms You Can Use to Make an Advance Directive

Fraud, Waste and Abuse X

Important Phone Numbers X

Keep Us Informed X

Medicaid Managed Care Ombudsman Program X

Welcome to [Insert Plan Name]'s North Carolina Medicaid Managed Care Program

This handbook will be your guide to the full range of Medicaid health care services available to you. If you have questions about the information in your welcome packet, this handbook or your new health plan, call Member Services at [insert Member Services Toll-Free Number] or visit our website at [insert hyperlinked web address].We can also help you make an appointment with your doctor and tell you more about the services you can get with your new health plan.

How Managed Care Works

The Plan, Our Providers and You

- Many people get their health benefits through managed care, which works like a central home for your health. Managed care helps coordinate and manage all your health care needs.
- [Insert Plan Name] has a contract with the North Carolina Department of Health and Human Services to meet the health care needs of people with North Carolina Medicaid. In turn, we partner with a group of health care providers to help us meet your needs. These providers (doctors, therapists, specialists, hospitals, home care providers and other health care facilities) make up our **provider network.** You will find a list in our provider directory. You can visit our website at [insert hyperlinked web address] to find the provider directory online. You can also call Member Services at [insert Member Services Toll-Free Number] to get a copy of the provider directory.
- When you join [insert Plan Name], our providers are here to support you. Most of the time, that person 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 [insert correct page reference] for details.

How to Use This Handbook

This handbook will tell you how [insert Plan Name] will work. This handbook is your guide to health and wellness services. It tells you the steps to take to make the plan work for you.

The first several pages will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time.

When you have a question, check this handbook, ask your Primary Care Provider (PCP) or call Member Services at [insert Member Services Toll-Free Number and TTY number]. You can also visit our website at [insert hyperlinked web address].

Help from Member Services

There is someone to help you at Member Services. Just call Member Services at [insert Member Services Toll-Free Number and the TTY phone number].

- For help with non-emergency issues and questions, call Member Services Monday – Saturday, 7 a.m. – 6 p.m. [Plans must insert instructions on how calls made during non-business hours will be handled or returned.]
- In case of a medical emergency, call 911.
- **You can call Member Services to get help anytime you have a question.** You may call us to choose or change your Primary Care Provider (PCP), to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report the birth of a new baby, or ask about any change that might affect you or your family's benefits.
- If you are or become pregnant, your child will become part of [insert Plan Name] on the day your child is born. You should call your plan and your local Department of Social Services right away if you become pregnant and let us help you to choose a doctor for both you and your newborn baby before he or she is born.
- **If English is not your first language (or if you are reading this on behalf of someone who doesn't read English), we can help.** We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk with you in your own language. We have a group of people who can help.
- **For people with disabilities:** If you use a wheelchair or have trouble hearing or understanding, call us if you need extra help. If you are reading this on behalf of someone who is blind, deaf-blind or has difficulty seeing, we can also help. We can tell you if a

Other Ways We Can Help

- If you have basic questions or concerns about your health, you can call our Nurse Line at [insert Nurse Line Number] at any time, 24 hours a day, 7 days a week. 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 us the Behavioral Health Crisis Line at [insert Behavioral Health Crisis Line] at any time, 24 hours a day, 7 days a week, to speak with someone who will listen and help. We are here to help you with problems like stress, depression or anxiety. We can connect you to the support you need to feel better. **If you are in danger or need immediate medical attention, call 911.**

doctor's office is wheelchair accessible or is equipped with special communications devices. Also, we have services like:

- TTY machine. Our TTY phone number is [insert the health plan's TTY number].
- Information in large print
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your condition

Auxiliary Aids and Services

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

- A TTY machine. Our TTY phone number is [insert the health plan TTY number].
- Qualified American Sign Language interpreters
- Closed captioning
- Written information in other formats (like large print, audio, accessible electronic format, and other formats)
- [Plans must list any other available auxiliary services and aids]

These services are available to members with disabilities for free. To ask for aids or services, call Member Services at [insert Member Services Toll-Free Number and the TTY Number.]

[Insert Plan Name] 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 [insert Plan Name] failed to provide these services, you can file a complaint. To file a complaint or to learn more, call Member Services at [insert Member Services Toll-Free Number and the TTY Number.]

Your Health Plan ID Card

Your [insert Plan Name] ID card is mailed to you together with your welcome packet and member handbook within 7 days after you enroll in your health plan. We use the mailing address on file at your local Department of Social Services. Your card will have your Primary Care Provider's (PCP's) name and phone number on it. It will also have your Medicaid Identification Number and information on how you can contact us if you have any questions. If anything is wrong on your [insert Plan Name] ID card, call us right away. If you lose your card, we can help -- call Member Services at [insert Member Services Toll-Free Number and the TTY Number.] Carry your ID card always and show it each time you go for care.

[Along with making the member handbook available on their website, plans must also provide details on how members can access services prior to receiving their ID card in the mail on the plan website.]

[Plans must insert a high-resolution screenshot of a sample ID card here.]

PART I: First Things You Should Know

How to Choose Your PCP

- Your Primary Care Provider (PCP) is a doctor, nurse practitioner, physician assistant or another type of provider who will care for your health, coordinate your needs and help you get referrals for specialized services if you need them. When you enroll in [insert Plan Name], you will have an opportunity to choose your own PCP. To choose your PCP, call Member Services at [insert Member Services Toll-Free Number]. If you do not select a PCP, we will choose one for you. You can find your PCP's name and contact information on your ID card. (See "How to Change Your PCP" to learn how you can change your PCP.)
- When deciding on a PCP, you may want to find a PCP who:
    - You have seen before
    - Understands your health problems
    - Is taking new patients
    - Can serve you in your language
    - Is easy to get to

Advanced Medical Home Program

Your PCP may be taking part in a new Medicaid program called Advanced Medical Home (AMH). AMHs are practices that help manage and coordinate your care. The goal of the AMH program is to promote better care at the right time, in the right setting, for Medicaid members. The AMH program does not limit or affect your Medicaid benefits. If you want more information about the AMH program, call Member Services at [insert Member Services Toll-Free Number] or visit our website at [insert hyperlinked webpage address.]

- Each family member enrolled in [insert Plan Name] 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 [insert Member Services Toll-Free Number] to get help with choosing a PCP that is right for you and your family.
- You can find the list of all the doctors, clinics, hospitals, labs and others who partner with [insert Plan Name] in our provider directory. You can visit our website at [insert hyperlinked web address] to look at the provider directory online. You can also call Member Services at [insert Member Services Toll-Free Number] to get a copy of the provider directory.
- Women can choose an OB/GYN to serve as their PCP. Women do not need a PCP referral to see a plan OB/GYN doctor or another provider who offers women's health care services.

Women can get routine check-ups, follow-up care if needed and regular care during pregnancy.

- If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP. [**Plans must describe the process for choosing a specialist as PCP.**]
- If your provider leaves [insert Plan Name], we will tell you within 15 days from when we know about this. If the provider who leaves [insert Plan Name] is your PCP, we will contact you to help you choose another PCP within 7 days from when we know about this. **[Plans must insert information about the procedure for continuing to receive care from the terminated provider and the limitations of the extension. Plans must hyperlink to this information on their website, if available.]**

How to Change Your PCP

- You can find your Primary Care Provider's (PCP's) name and contact information on your ID card. You can change your assigned PCP within 30 days from the date you receive your [insert Plan Name] ID card. Just call Member Services at [insert Member Services Toll-Free Number]. After that, you can change your PCP up to one time each year. You do not have to give us a reason for the change.
- If you want to change your PCP more than once a year, you can change at any time if you have a good reason (good cause). For example, you may have good cause if you:
    - Disagree with your treatment plan
    - Your PCP moves to a different location that is not convenient for you
    - You have trouble communicating with your PCP because of a language barrier or another communication issue
    - Your PCP is not able to accommodate your special needs

Call Member Services at [insert Member Services Toll-Free Number] 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, give you advice when you need it, and refer you to the hospital or specialists when needed. It means you and your Primary Care Provider (PCP) work together to keep you well or to see that you get the care you need.
- Day or night, your PCP is only a phone call away. Be sure to call your PCP whenever you have a medical question or concern. If you call after hours or on weekends, leave a

message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how your health plan works.

- Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If ever you cannot keep an appointment, call to let your PCP know.
- **Making your first regular health care appointment.** As soon as you choose or are assigned a PCP, 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. Your PCP will need to know as much about your medical history as possible. Make a list of your medical background, any problems you have now and the questions you want to ask your PCP. Bring your medications and supplements with you that you are taking. In most cases, your first visit should be within three months of you joining the plan.

  If you need care before your first appointment, call your PCP's office to explain your concern. Your PCP will give you an earlier appointment. You should still keep the first appointment to talk about your medical history and ask questions.
- It is important to [insert Plan Name] that you can visit a doctor within a reasonable amount of time, depending on what the appointment is for. When you call for an appointment, use the Appointment Guide below to 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	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	immediately (available 24 hours a day, 365 days a year)
Initial prenatal visit (1st or 2nd trimester)	within 14 days
Initial 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)	immediately (available 24 hours a day, 365 days a year)
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)	immediately (available 24 hours a day, 365 days a year)

If you are having trouble getting the care you need within the time limits describe above, call Member Services at [insert Member Services Toll-Free Number].

How to Get Specialty Care – Referrals

- If you need specialized care that your Primary Care Provider (PCP) cannot give, your PCP will refer you to a **specialist** who can. A specialist is doctor who is trained and practices in a specific area of medicine (like a cardiologist or a surgeon). If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are [insert Plan Name] providers. Talk with your PCP to be sure you know how referrals work.
- If you think a specialist does not meet your needs, talk with your PCP. Your PCP can help you if you need to see a different specialist.
- There are some treatments and services that your PCP must ask [insert Plan Name] to approve before you can get them. Your PCP will be able to tell you what they are.
- If you have trouble getting a referral you think you need, contact Member Services at [insert Member Services Toll-Free Number].
- If [insert Plan Name] does not have a specialist in our provider network who can give you the care you need, we will refer you to a specialist outside our plan. This is called an **out-of- network referral**. Your PCP or another network provider must ask [insert Plan Name] for approval before you can get an out-of-network referral.

  [**Plans must insert a plan-specific process for how members can request care from specialists or providers outside the network. Include the timeframes for resolving the requests for out-of-network specialists/providers and a phone number for the member to use to contact the plan regarding the request.**]
- Sometimes we may not approve an out-of-network referral because we have a provider in [insert Plan Name] who can treat you. If you do not agree with our decision, you can **appeal** our decision. See page [insert appropriate page number] 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 not very different from what you can get from a [insert Plan Name] provider. If you do not agree with our decision, you can **appeal** our decision. See page [insert appropriate page number] 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. [**Plans must describe the process for choosing a specialist as PCP.**]

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 help and more information about getting services from an out-of-network provider, talk to your Primary Care Provider (PCP) or call Member Services at [insert Member Services Toll-Free Number].

Get These Services from [insert Plan Name] Without a Referral

You do not need a referral to get these services:

Primary Care

You do not need a referral to get primary care services. If you need a check-up or have a question about your health, call your Primary Care Provider (PCP) to make an appointment.

Women's Health Care

You do not need a referral from your PCP if:

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

Family Planning

You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can also visit one of our family planning providers. Either way, you do not need a referral from your PCP. You can get birth control, birth control devices (IUDs, implantable contraceptive devices, and others) that are available with a prescription, emergency contraception, and sterilization services. You can also see a family planning provider for HIV and sexually transmitted infection (STI) testing and treatment and counseling related to your test results. Screenings for cancer and other related conditions are also included in family planning visits.

Children's Screening and Local Health Department Services

> **If you believe you have an emergency, call 911 or go to the nearest emergency room.**
>
> - You **do not** need approval from your plan or your PCP before getting emergency care, and you are not required to use our hospitals or doctors.
> - **If you're not sure, call your PCP at any time, day or night.** Tell the person you speak with what is happening. Your PCP's team will:
>   - Tell you what to do at home;
>   - Tell you to come to the PCP's office; or
>   - Tell you to go to the nearest urgent care emergency room.
> - **If you are out of the area when you have an emergency:**
>   - Go to the nearest emergency room.
>
> **Remember:** Use the Emergency Department only if you have an emergency. If you have questions, call your PCP or [insert Plan Name] Member Services at [insert Member Services Toll-Free Number].

You do not need a referral to get children's screening services, school-based services or 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 [insert Member Services Toll-Free Number] for a list of mental health providers (who serve adults and children) and substance use disorder providers. You can also find a list of our behavioral health providers online at [insert appropriate hyperlinked web address].

Emergencies

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

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

- Drug overdose

Some examples of **non-emergencies** are colds, upset stomach or minor cuts and bruises. Non-emergencies may also be family issues or a break up. These may feel like an emergency, but they are not a reason to go to the emergency room.

Urgent Care

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

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

You can walk into an urgent care clinic to get care the same day or make an appointment for the next day. Whether you are at home or away, call your Primary Care Provider (PCP) any time, day or night. If you cannot reach your PCP, call Member Services at [insert Member Services Toll-Free Number]. 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, [Insert Plan Name] may pay for health care services you get from a provider located along the North Carolina border or in another state. Your PCP and [Insert Plan Name] 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,** [insert Plan Name] 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 [insert Member Services Toll-Free Number].

PART II: Your Benefits

The rest of this handbook is for your information when you need it. It lists covered and the non-covered services. If you are having problems with your health plan, the handbook tells you what to do. The handbook has other information you may find useful. Keep it handy for when you need it.

Benefits

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

[Insert Plan Name] will provide or arrange for most services that you will 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 [insert Plan Name]. Ask your Primary Care Provider (PCP) or call Member Services at [insert Member Services Toll-Free Number] 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 [insert appropriate page].

Services Covered by [insert Plan Name]'s Network

You must get the services below from the providers who are in [insert Plan Name]'s network. Services must be medically necessary, and provided, coordinated or referred by your PCP. Talk with your PCP or call Member Services at [insert Member Services Toll-Free Number] if you have any questions or need help with any health services.

Regular Health Care

- Office visits with your PCP, including regular check-ups, routine labs and tests
- Referrals to specialists

- Eye/hearing exams
- Well-baby care
- Well-child care
- Immunizations (shots) for children and adults
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for members under age 21 (see page [insert appropriate page] for more information about EPSDT services)
- Help with quitting smoking or dipping

Maternity Care

- Pregnancy care
- Childbirth education classes
- OB/GYN and hospital services
- One medically necessary post-partum home visit for newborn care and assessment following discharge (but no later than 60 days after delivery)
- Care management services for high-risk pregnancies during pregnancy and for two months after delivery (see page [insert appropriate page] 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 [insert Plan Name]
- Time-limited skilled nursing services
- Specialized therapies, including physical therapy, speech-language pathology and occupational therapy
- Home health aide services (help with activities such as bathing, dressing, preparing meals and housekeeping)
- Medical supplies

Personal Care Services

- Must be medically necessary and arranged by [insert Plan Name]

- Help with common activities of daily living, including eating, dressing and bathing, for individuals with disabilities and ongoing health conditions

Hospice Care

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

Vision Care

- Services provided by ophthalmologists and optometrists, including routine eye exams and medically necessary lenses.
- Specialist referrals for eye diseases or defects

Pharmacy

- Prescription drugs
- Some medicines sold without a prescription (also called "over-the-counter"), like allergy medicines
- Insulin and other diabetic supplies (like syringes, test strips, lancets and pen needles)
- Smoking cessation agents, including over-the-counter products
- Enteral formula
- Emergency contraception
- Medical and surgical supplies

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 [insert correct page reference].

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 [insert Plan Name]
- Includes short term, or rehabilitation, stays and long-term care for up to 90 days.
- If you need nursing care for more than 90 days, you may need to enroll in a different health plan. Talk with your PCP or call Member Services at [insert Member Services Toll-Free Number] 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.
- You must get this care from a nursing home that is in [insert Plan Name]'s provider network. If you choose a nursing home outside of [insert Plan Name]'s network, you may have to transfer to another plan. Call Member Services at [insert appropriate state Medicaid number/hotline] for help with questions about nursing home providers and plan networks.
- Talk with your PCP or call Member Services at [insert Member Services Toll-Free Number] for help finding a nursing home in our network.

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

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

- **Mental Health Services**
  - Services to help figure out if you have a mental health need (diagnostic assessment services)
  - Individual, group and family therapy
  - Mobile crisis management services
  - Facility-based crisis programs

- Specialized behavioral health services for children with autism
- Outpatient behavioral health services
- Outpatient behavioral health emergency room services
- Inpatient behavioral health services
- Research-based intensive behavioral health treatment
- Partial hospitalization

- **Substance Use Disorder Services**
  - Outpatient opioid treatment
  - Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)
  - Ambulatory detox
  - Non-hospital medical detox
  - Alcohol and drug abuse treatment center detox crisis stabilization

If you believe you need access to more intensive behavioral health services that your plan does not provide, talk with your PCP or call Member Services at [insert Member Services Toll-Free Number].

Transportation Services

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

  How to Get Non-Emergency Transportation. You can call us at [insert appropriate phone number] up to 2 business days before your appointment to arrange transportation to and from your appointment. [Plans must specify the type of transportation service provided, the name of the provider (if there is a single contractor), details on how members can request or cancel a trip, and outline the expected member conduct and procedures for no-shows.]

  If we deny you transportation services, you have the right to appeal our decision. See [insert appropriate page number] for more information on appeals. If you have questions about transportation, call Member Services at [insert Member Services Toll-Free Number].

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 the help you need

through a [insert Plan Name] benefit known as **Long Term Services and Supports (LTSS)**. LTSS includes services like home health and personal care services. You may get LTSS in your home, community or in a nursing home.

- If you need LTSS, you may have a Care Manager on your care team. A Care Manager is a specially trained health professional who works with you and your doctors and other providers of your choice to make sure you get the right care when and where you need it. For more information about what a Care Manager can do for you, see "Extra Support to Manage Your Health" on page [insert appropriate page number].
- 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 as needed. Call Member Services at [insert Toll-Free Member Services Number] 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 [insert Toll-Free Member Services Number].

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. Either way, you do not need a referral from your PCP. You can get birth control and birth control devices (IUDs, implantable contraceptive devices and others) that are available with a prescription, and emergency contraception and sterilization services. You can also see a family planning provider for human immunodeficiency virus (HIV) and sexually transmitted infection (STI) testing and treatment and counseling related to your test results. Screenings for cancer and other related conditions are also included in family planning visits.

Other Covered Services

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

If you have any questions about any of the benefits above, talk to your PCP or call Member Services at [insert Member Services Toll-Free Number].

Extra Support to Manage Your Health

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

Your Care Manager can:

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

[Insert Health Plan Name] 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 (like diabetes) or other concerns (like wanting help to quit smoking)
- Children from birth to age 5 who may live in stressful situations or have certain health conditions or disabilities

At times, a member of your Primary Care Provider's (PCP's) team will be your Care Manager. To learn more about our how you get can extra support to manage your health, talk to your PCP or call Member Services at [insert Member Services Toll-Free Number].

Help with Problems beyond Medical Care

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

Call Member Services at [insert Member Services Toll-Free Number] if you:

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

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

Other Programs to Help You Stay Healthy

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

Call Member Services at [insert Member Services Number Toll-Free Number] to learn more about:

- Tobacco Cessation Services (support to help you stop smoking or dipping)
- 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. [Insert Plan Name] supports safe and appropriate opioid use through our Opioid Misuse Prevention Program. If you have any questions about our program, call Member Services at [insert Member Services Toll-Free Number].

[Plans must insert information about any additional prevention and population health management programs that align with the Department's population health priorities as defined in the Quality Strategy and encourage improved health and wellness among members.]

Benefits You Can Get from [Insert Plan Name] OR a Medicaid Provider

For some services, you can choose where to get the care. You can get these services from providers in the [insert Plan Name] 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 [insert Member Services Toll-Free Number].

HIV and STI Screening

You can get human immunodeficiency virus (HIV) and sexually transmitted infection (STI) testing and treatment and counseling service any time from your PCP or [insert Plan Name]

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 county public health agency for diagnosis and/or treatment. You do not need a referral to go to the county public health agency.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Plan members under age 21 can get any treatment or health service that is medically necessary to treat, prevent or improve a health problem. This special set of benefits is called Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Members who need EPSDT benefits:

- Can get EPSDT services through their health plan or any Medicaid provider
- Do not have to pay any copays for EPSDT services
- Can get help with scheduling appointments and arranging for free transportation to and from the appointments
- EPSDT includes any medically necessary service that can help treat, prevent or improve a member’s health issue, including:
- Comprehensive health screening services (well-child checks, developmental screenings and immunizations)
- Dental services
- 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 services
- 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 Primary Care Provider (PCP). You can also find more information on EPSDT services online by visiting our website at [insert appropriate hyperlink here] or by visiting the NC Medicaid EPSDT webpage at [insert appropriate hyperlink here].

Benefits You Can Get ONLY from a Medicaid Provider

There are some services [insert Plan Name] does not provide. You can get these services from a provider outside of our health plan's provider network who takes Medicaid:

- Dental services
- Services provided through the Program of All-Inclusive Care for the Elderly (PACE)
- Services provided by Local Education Agencies
- Services provided by Children's Developmental Agencies that are included in your child's Individualized Family Service Plan
- Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses and ophthalmic frames

If you have questions or need help with accessing benefits you can only get through Medicaid, talk with your Primary Care Provider (PCP) or call Member Services at [insert Member Services Toll-Free Number].

Services NOT Covered

These are examples of some of the services that are **not available** from [insert Plan Name] **or** Medicaid. If you get any of these services, you may have to pay the bill:

- Cosmetic surgery if not medically necessary
- Personal and comfort items
- Routine foot care, except for beneficiaries with diabetes or a vascular disease
- Routine newborn circumcision
- Experimental drugs, procedures or diagnostic tests
- Infertility treatments
- Sterilization reversal

- Sterilization under age 21
- Medical photography
- Biofeedback
- Hypnosis
- Blood tests to determine paternity (contact your local child support enforcement agency)
- Chiropractic treatment unrelated to the treatment of subluxation
- Erectile dysfunction drugs
- Weight loss or weight gain drugs
- Liposuction
- Tummy tuck
- Ultrasound to determine sex of child
- Hearing aids for beneficiaries age 21 and older
- Services from a provider who is not part of [insert Plan Name], unless it is a provider you are allowed to see as described elsewhere in this handbook or [insert Plan Name], 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 country
- Tattoo removal
- Payment for copies of medical records

This list does not include all services that are not covered. To determine if a service is not covered, call Member Services at [insert Member Services Toll-Free Number].

You may have to pay for any service that your PCP or [insert Plan Name] 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 [insert Plan Name].

[**Plans that elect not to cover certain counseling or referral services because of an objection on moral or religious grounds must include the bullet and required information below.**]

[Insert Plan Name] can choose not to cover counseling or referral services because of an objection on moral or religious grounds. [**Insert a list of counseling or referral services that the plan does not cover because of moral or religious objection and instructions for how members can obtain information from the Department about how to access those services.**] If you want to leave our plan because of this objection, you have good cause and the right to do so. See [insert appropriate page number] for more information.

If You Get a Bill

If you get a bill for a treatment or service you do not think you should pay for, do not ignore it. Call Member Services at [insert Member Services Toll-Free Number] right away. We can help you understand why you may have gotten a bill. If you are not responsible for payment, [Insert Plan Name] will contact the provider and help fix the problem for you.

You have the right to ask for Fair Hearing if you think you are being asked to pay for something Medicaid or [insert Plan Name] should cover. A Fair Hearing allows you or your representative to make your case before an administrative law judge. See the Fair Hearing section on page [insert appropriate page] in this handbook for more information. If you have any questions, call Member Services at [Insert Member Services Toll-Free Number].

Plan Member Copays

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

Your Copays if You Have Medicaid*

Service	Your Copay
Physicians Outpatient services Podiatrists	$3 per visit
Generic and brand prescriptions	$3 per script
Chiropractic Optical services/supplies	$2 per visit
Optometrists Non-emergency Emergency Department visits	$3 per visit

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

- Members under age 21
- Members who are pregnant
- Members receiving hospice care

- Federally recognized American Indians/Alaska Natives
- 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

If you have any questions about Medicaid copays, please call Member Services at [Insert Member Services Toll-Free Number].

Your Copays if Your Child Has NC Health Choice

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

If you have any questions about NC Health Choice copays, call Member Services at [Insert Member Services Toll-Free Number].

PART III: Plan Procedures

How Often You Can Change Your PCP

When you enroll in [Insert Plan Name], you can select a Primary Care Provider (PCP) or we can choose one for you. You can find your PCP's name and contact information on your ID card. You can change your assigned PCP within 30 days from the date you receive your [insert Plan Name] ID card by calling Member Services at [insert Member Services Toll-Free Number]. After that, you can change your PCP up to one time per year. You do not have to give us a reason for the change.

- If you want to change your PCP more than once a year, you can change at any time if you have a good reason (good cause). For example, you may have good cause if you:
- Disagree with your treatment plan
- Your PCP moves to a location that is not convenient for you
- You have trouble communicating with your PCP because of a language barrier or another communication issue
- Your PCP is not able to accommodate your special needs

Call Member Services at [insert Member Services Toll-Free Number] to learn more about how you can change your PCP.

Service Authorization and Actions

[Insert Plan Name] will need to approve some treatments and services **before** you receive them. [Insert Plan Name] may also need to approve some treatments or services for you to **continue** receiving them. This is called **preauthorization**. You can ask for this. The following treatments and services must be approved before you get them:

[Plans must list services requiring preauthorization and the process for obtaining preauthorization. Plans must also include a hyperlink to the information on their website if available.]

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:

[Plans must insert instructions for submitting a service authorization request: e.g., You or your doctor may call Member Services at [Insert Member Services Number] or send your request in writing to [Insert Plan Address].

Service Authorization Requests for Children Under Age 21

Special rules apply to decisions to approve medical services for children under age 21 receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. To learn more about EPSDT services, see page [insert appropriate page number] or visit our website at [insert appropriate hyperlink here].

What happens after we get your service authorization request:

The health plan has a review team to be sure you get the services we promise. Qualified health care professionals are on the review team. Their job is to be sure that the treatment or service you asked for is covered by your plan and that it will help with your medical condition. They do this by checking your treatment plan against medically acceptable standards.

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **adverse action (or action).** These decisions will be made by a health care professional. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under either a **standard** or an **expedited** (faster) process. You or your doctor can ask for an expedited review if it is believed that a delay will cause serious harm to your health. If your request for an expedited review is denied, we will tell you and your case will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so but no later than described in the next section of this handbook.

We will tell you and your provider in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options you will have for an appeal or a Fair Hearing if you don't agree with our decision.

Preauthorization and Timeframes

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

- **Standard review:** We will make a decision about your request within 14 days after we receive it.
- **Expedited (fast track) review:** We will decide about your request and you will hear from us within 3 days.
- In most cases, if you are receiving a service and a new request is made to keep receiving a service, we must tell you at least 10 days before we change the service if we decide to reduce, stop or restrict the service. **If we approve a service and you have started to receive that service, we will not reduce, stop or restrict the service during the approval period unless we determine the approval was based on information that was known to be false or wrong.**

- If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills. **You will not have to pay for any care you received <u>that was covered</u> by your plan or by Medicaid, even if your plan later denies payment to the provider.**

Information from Member Services

You can call Member Services at [insert Member Services Number Toll-Free Number] to get help **anytime you have a question**. You may call us to choose or change your Primary Care Provider (PCP), to ask about benefits and services, to get help with referrals, to replace a lost 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 of the questions you may have about the information in this handbook.

- If English is not your first language (or if you are reading this on the behalf of someone who doesn't read English), we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk with you in your own language. We have a group of people who can help.
- **For people with disabilities:** If you use a wheelchair or have trouble hearing or understanding, call us if you need extra help. If you are reading this on behalf of someone who is blind, visually impaired or deaf-blind, we can also help. We can tell you if a particular doctor's office is wheelchair accessible or is equipped with special communications devices. Also, we have services like:
    - TTY machine. Our TTY phone number is [insert the health plan TTY number]
    - Information in large print
    - Help in making or getting to appointments
    - Names and addresses of providers who specialize in your disability

How You Can Help with Plan Policies

We value your ideas. You can help us develop policies that best serve our members. Maybe you would like to work with one of the member committees in our health plan or with North Carolina, like:

- [Insert Plan Name] Member Advisory Committee (MAC)
- [Insert Plan Name] Long Term Services and Supports (LTSS) Advisory Committee
- Medical Care Advisory Committee (MCAC)
- State Consumer and Family Advisory Committee (CFAC)

Call Member Services at [insert Member Services Toll-Free Number] to learn more about how you can help.

Appeals

If you are not satisfied with our decision about your care, you can file an appeal:

- If you are not satisfied with an action we took or what we decide about your service authorization request (see page [insert appropriate page number] about service authorizations and actions), **you can file an appeal or a request for us to review the decision.** You have 60 days after you get a written notice from us to file an appeal.
- You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services at [insert Member Services Number Toll-Free Number] or visit our website at [insert hyperlinked web page] if you need help filing an appeal.
- The appeal can be made by phone or in writing. **If you call us, you must also file your appeal in writing.** We can help you complete the appeal form.
- If your appeal review needs to be expedited (reviewed more quickly than the standard timeframe) because you have an immediate need for health services, you do not need to follow up in writing after you call us. We will let you know in writing that we received your request for an expedited appeal within 24 hours of receiving it.
- We will not treat you any differently or act badly toward you because you file an appeal.

To file an appeal, write to: [Insert address]

To file an appeal by phone, call Member Services at [insert Member Services Number Toll-Free Number]

- Before and during the appeal, you or your representative can see your case file, including medical records and any other documents and records being used to make a decision on your case.
- You can ask questions and give any information (including new medical documents from your providers) that you think will help us to approve your request. You may do that in-person, in writing or by phone.
- **If you need help with understanding the Appeals process**, you can contact the Medicaid **Managed Care Ombudsman Program** (see page [insert appropriate page] for more information about the Ombudsman Program).

Timeframes for Appeals

- **Standard appeals:** If we have all the information we need, we will tell you our decision in writing within 30 days from your appeal.
- **Expedited (fast track) appeals:** If we have all the information we need, we will call you and send you a written notice of our decision within 3 days from your appeal.

If we need more information to make either a standard or an expedited decision about your appeal, we will:

- Write you and tell you what information is needed. For expedited appeals, we will call you right away and send a written notice later.
- Explain why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

If you need more time to gather your documents and information, just ask. You, your provider or someone you trust may ask us to delay your case until you are ready. We want to make the decision that supports your best health. This can be done by calling Member Services at [insert Member Services Number Toll-Free Number] or writing to [insert appropriate address].

Your Care While You Wait for a Decision

- When the health plan's decision reduces or stops a service you are already receiving, you can ask to continue the services your provider had already ordered while we are making a decision on your appeal. You can also ask a trusted representative to make that request for you.
- You must ask us to continue your services within 10 days from the date of the notice that says your care will change or by the time the action takes effect. [**Plans must insert details on how members or authorized representatives can submit a request for a continuation of benefits**.]
- If you ask your health plan to continue services you already receive during your appeal, the health plan will pay for those services if your appeal is decided in your favor. **Your appeal might not change the decision the health plan made about your services. When your appeal doesn't change the health plan's decision, the health plan may require you to pay for the services you received while waiting for a decision.**

If you are unhappy with the result of your appeal, you can ask for a Fair Hearing (see next section in this handbook).

Fair Hearings

If you don't agree with a decision we made that reduced, stopped or restricted your services after you receive our decision about your appeal, you can ask for a **Fair Hearing** from North Carolina. A Fair Hearing is your opportunity to give more information and facts, and to ask questions about your decision before an administrative law judge. The judge in your Fair Hearing is not a part of your health plan in any way.

- You can ask for a fair hearing within 120 days from the day you hear from us about our decision about your appeal.

- When you request a Fair Hearing, you can also ask for an opportunity to mediate your disagreement. Mediation is an informal voluntary process to see if we can come to an agreement on your case. You do not have to ask for mediation to receive a Fair Hearing. Mediation is guided by a professional mediator who does not take sides. If we do not reach an agreement, you can still have a Fair Hearing. You can also decide not to go through mediation and just ask for a Fair Hearing.
- **If you need help with understanding the Fair Hearing or Mediation processes**, you can contact the
- Medicaid **Managed Care Ombudsman Program** (see page [insert appropriate page] for more information about the Ombudsman Program).

Your Care While You Wait for a Decision

- When the health plan's decision reduces or stops a service you are already receiving, you can ask to continue the services your provider had already ordered while we decide your case. You can also ask a trusted representative to make that request for you.
- You must ask us to continue your services within 10 days from the date of the notice that says your care will change or by the time the action takes effect. [**Plans must insert details on how members or authorized representatives can submit a request for a continuation of benefits**.]
- If you ask your health plan to continue services you already receive during your Fair Hearing case, the health plan will pay for those services if your case is decided in your favor. **Your Fair Hearing might not change the decision the health plan made about your services. When your Fair Hearing case doesn't change the health plan's decision, the health plan may require you to pay for the services you received while waiting for a decision.**

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

[insert appropriate contact information below:]

1. By phone –
2. By fax –
3. By internet –
4. By mail –

If you are unhappy with your Fair Hearing decision, you can contact the Medicaid **Managed Care Ombudsman Program** to get more information about your options. (see page [insert appropriate page] for more information about the Ombudsman Program).

If You Have Problems with Your Health Plan

We hope our health plan serves you well. If you have a problem, talk with your Primary Care Provider (PCP), call Member Services at [insert Member Services Number Toll-Free Number] or write to [insert appropriate address].

Most problems can be solved right away. If you have a problem with your health plan, care, provider or services, you can file a complaint with the plan. This is called a Grievance. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedures described below.

You can ask someone you trust (such as a legal representative, a family member or friend) to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services, or help filing out the forms, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

You can also contact the Medicaid **Managed Care Ombudsman Program** for help with problems you have with your health plan, care, provider or services. They will be able to assist you with your Grievance (see page [insert appropriate page] for more information about the Ombudsman Program).

If You Are Unhappy with Your Plan: How to File a Complaint

If you are unhappy with your health plan, provider, care or your health services, you can file a **Complaint** (also called a Grievance). You can file a complaint by phone or in writing at any time.

- To file by phone, call Member Services at [Insert Member Services number and the appropriate hours].
- To file in writing, you can write us with your complaint to [insert appropriate address].

What Happens Next

We will let you know in writing that we got your complaint 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 complaint is about the denial of an expedited appeal, we will let you know in writing that we got it within 24 hours of receiving it. We will review your complaint about the denial of an expedited appeal and tell you how we resolved it in writing within 5 days of receiving your complaint.

If you are not happy with how we resolved your issue, you can file a complaint with the Medicaid **Managed Care Ombudsman Program.** The Ombudsman Program can look into your concerns and help you with your issue (see page [insert appropriate page] for more information about the Ombudsman Program).

Your Care When You Change Health Plans or Doctors

If you join [insert Health Plan Name] from another health plan, we will contact you within 5 business days from your expected enrollment date with us. We will ask you for the name of your previous plan, so we can add your health information, like your medical records and prescheduled appointments, into our records.

- If you choose to leave [insert Health Plan Name], we will share your health information with your new plan within 5 business days of hearing from your new plan.
- You can finish receiving any services that have already been authorized by your previous health plan. After that, we will help you find a provider in our network to get any additional services if you need them.
- In almost all cases, your doctors will be [insert Health Plan Name] providers. There are some instances when you can still see another provider that you had before you joined [insert Health Plan Name]. You can continue to see your doctor if:
    - At the time you join [insert Plan Name], you are receiving an ongoing course of treatment or have an ongoing special health 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 [insert Plan Name] 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 [insert Plan Name] and you are receiving services from a behavioral health treatment provider. In that case, you can keep your provider until after your delivery.
- If your provider leaves [insert Plan Name], we will tell you in writing within 15 days from when we know about this. If the provider who leaves [insert Plan Name] is your Primary Care Provider (PCP), we will contact you within 7 days from when we know about this. We will tell you how you can choose a new PCP or choose one for you if you do not make a choice within 30 days. [**Plans must insert information about the procedure for continuing to receive care from the terminated PCP and the limitations of the extension.**]

If you have any questions, call Member Services at [insert Member Services Toll-Free Number].

Member Rights and Responsibilities

Your Rights

As a member of [insert Plan Name], you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, sexual orientation or gender identity

- Be told where, when and how to get the services you need from [insert Plan Name]
- Be told by your Primary Care Provider (PCP) what is wrong, what can be done for you and what will likely be the result, in language you understand
- Get a second opinion about your care
- Give your approval of any treatment or plan for your care after that plan has been fully explained to you
- Refuse care and be told what you may risk if you do
- Get a copy of your medical record and talk about it with your PCP, and to 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 [insert Plan Name] complaint process to settle complaints, or you can contact the **Medicaid Managed Care Ombudsman Program** any time you feel you were not fairly treated (see page [insert appropriate page] for more information about the Ombudsman Program).
- Use the State Fair Hearing system
- Appoint someone you trust (relative, friend or lawyer) to speak for you if you are unable to speak for yourself about your care and treatment
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints

Your Responsibilities

As a member of [insert Plan Name], you agree to:

- Work with your PCP to protect and improve your health
- Find out how your health plan coverage works
- Listen to your PCP's advice and ask questions when you are in doubt
- Call or go back to your PCP if you do not get better or ask for a second opinion
- Treat health care staff with the respect you expect yourself
- Tell us if you have problems with any health care staff by calling Member Services at [insert Member Services Number Toll-Free Number]
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency department only for real emergencies

- Call your PCP when you need medical care, even if it is after-hours

Disenrollment Options

1. If YOU Want to Leave the Plan

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

[**Plans that elect not to cover certain counseling or referral services because of an objection on moral or religious grounds must include the bullet and required information below.**]

[Insert Plan Name] can choose not to cover counseling or referral services because of an objection on moral or religious grounds. [**Insert a list of counseling or referral services that the plan does not cover because of moral or religious objection and instructions for how members can obtain information from the Department about how to access those services**.] If you want to leave our plan because of this objection, you have the right to do so. It is considered a good cause.

How to Change Plans

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

[insert contact Information for the Enrollment Broker]

You will get a notice that the change will take place by a certain date. [Insert Plan Name] 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 added damage to your health. In that case, you will get a notice about your request to leave the plan within 3 days of making the request that you want to leave the plan.

2. You Could Become Ineligible for Medicaid Managed Care

You may have to leave [insert Plan Name] if you:

- Are no longer eligible for Medicaid Managed Care
- If you stay in a nursing home for more than 90 days in a row
- If you become eligible for and are transferred for treatment to a state-owned Neuro-Medical Center or a Department of Military & Veteran Affairs-operated Veterans Home
- If you begin receiving Medicare

If you become ineligible for Medicaid, all your services may stop. If this happens, call [DHB to insert appropriate contact and phone number]. You can also contact the Medicaid Managed Care Ombudsman Program to discuss your options for appeal (see page [insert appropriate page] for more information about the Ombudsman Program).

3. We Can Ask You to Leave [Insert Plan Name]

You can also lose your [Insert Plan Name] membership, if you:

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

Advance Directives

There may come a time when you become unable to manage your own health care and a family member or other person close to you is 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 cognitive loss and it is highly unlikely the condition will be reserved

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. Discussing your wishes and friends, family and your doctor now is strongly encouraged so that they can help make sure that you get the level of care you want at the end of your life.

Health Care Power of Attorney

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

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

Advance Instruction for Mental Health Treatment

An **advance instruction for mental health treatment** is a legal document that tells doctors and mental health providers what mental health treatments you would want and what treatments you would not want if you later become unable to decide for yourself. It can also be used to nominate a person to serve as guardian if guardianship proceedings are started. Your advance instruction for behavioral health treatment can be a separate document or combined with a health care power of attorney or a general power of attorney. An advance instruction for behavioral health may be followed by a doctor or behavioral health provider when your doctor or an eligible psychologist determines in writing that you are no longer able to make or communicate behavioral health decisions.

Forms You Can Use to Make an Advance Directive

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

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

You can change your mind and 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 can't speak for yourself. Talk to your Primary Care Provider (PCP) or call Member Services at [insert Member Services Toll-Free Number] if you have any questions about advance directives.

Fraud, Waste and Abuse

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

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

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

- Call the Medicaid Fraud, Waste and Program Abuse Tip Line at 1-877-DMA-TIP1 (1-877-362-8471)
- Call the State's 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

[At a minimum, plans must insert the following phone numbers and hours of operation:

- The plan's toll-free Member Services line
- The plan's BH Crisis line
- The plan's Nurse line

- Enrollment Broker
- Medicaid Managed Care Ombudsman Program
- NC Medicaid Contact Center
- The plan's Provider Service line
- The plan's Prescriber Service line
- The NC Mediation Network
- Free Legal Services line
- Advance Health Care Directive Registry phone number
- NC Medicaid Fraud, Waste and Abuse Tip Line
- State Auditor Waste Line
- U.S. Office of Inspector General Fraud Line]

Keep Us Informed

Call Member Services at [insert Member Services Number Toll-Free Number] 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.

Medicaid Managed Care Ombudsman Program

The Medicaid Managed Care Ombudsman Program is a resource you can contact if you need help with your health care needs. The Ombudsman Program is an independently-operated, non-profit organization whose number one priority is to ensure that individuals and families that receive North Carolina Medicaid and NC Health Choice get access to the care that they need.

The Ombudsman Program can:

- Answer your questions about your benefits
- Help you to understand your rights and responsibilities
- Provide information about Medicaid and Medicaid Managed Care
- Answer your questions about enrolling or disenrolling with a health plan

- Help you understand a notice you have received
- Refer you to other agencies that may also be able to assist you with your health care needs
- Help to resolve issues you are having with your health care provider or health plan
- Be an advocate for Members dealing with an issue or a complaint affecting access to health care
- Provide information to assist you with your appeal, grievance, mediation or fair hearing
- Connect you to legal help if you need it to help resolve a problem with your health care

Here is how you can contact the Ombudsman Program:
[**insert appropriate toll-free telephone, email, hyperlink to website and hours of operation**