

**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 [Member Services Toll-Free Number].**

**If English is not your first language, we can help. Call [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 Contract,*](https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf) *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 [Health Plan] 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 [Member Services Toll-Free Number].) |
| Get this handbook in another format or language | Member Services at [Member Services Toll-Free Number and TTY number]. |
| Keep track of my appointments and health services | My PCP or Member Services at [Member Services Toll-Free Number]. |
| Get help with getting to and from my doctor’s appointments | Member Services at [Member Services Toll-Free Number]. You can also find more information on Transportation Services in this handbook on page [page number here]. |
| Get help to deal with my stress or anxiety | Behavioral Health Crisis Line at [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 [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 [Member Services Toll-Free Number] or the Medicaid Managed Care Ombudsman (advocate) Program at [phone number].  You can also find more information about the Ombudsman Program in this handbook on page [page number] or go to [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: [hyperlinked web page] |
| Find my plan’s health care provider directory or other general information about my plan | Visit our website at [hyperlinked web page] or call Member Services at [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.

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

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

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

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

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

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

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

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

**Children’s Screening Services**: A medical examination to monitor how a child is developing. Screening services can help identify concerns and problems early. The screenings assess social/emotional behavior, vision and hearing, motor skills and coordination, cognitive abilities, and language and speech. **Copay:** A fee you pay when you get certain health care services or a prescription. Federally recognized tribal members will not have a copay for any services.

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

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

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

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

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

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

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

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

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

**Fair Hearing:** See “State Fair Hearing”

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

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

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

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

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

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

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

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

**Medicaid:** **Medicaid is a health insurance plan.** The program helps some families or individuals who have low income or serious medical problems. It pays for many medical and mental health services you might need. The program is funded by the federal and state government. You must apply through your county’s Department of Social Services. When you qualify for Medicaid, you are entitled to certain rights and protections. See the websites below for more information about Medicaid and your rights: [weblink here] and <https://medicaid.ncdhhs.gov/medicaid/your-rights>

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

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

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

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

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

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

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

**Ombudsman Program:** An independently-operated, nonprofit organization whose only job is to ensure that individuals and families who receive North Carolina Medicaid and NC Health Choice get access to the care they need.

**Ongoing Course of Treatment:** When a member, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

**Ongoing Special Condition:** A condition that is serious enough to require treatment to avoid possible death or permanent harm. A condition that is life-threatening, degenerative, or disabling and requires treatment over an extended period. This includes certain situations related to pregnancy, surgeries, organ transplants, inpatient stays or being terminally ill.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Medicaid Managed Care Ombudsman Program

NC Medicaid Managed Care Program

This handbook will help you understand the Medicaid health care services available to you. You can also call Member Services with questions [Member Services Toll-Free Number] or visit our website at [hyperlinked web address].

# How Managed Care Works

**You Have a Health Care Team**

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

* [Health Plan] 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 [Health Plan], 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 [page number] for details.
* You can visit our website at [hyperlinked web address] to find the provider directory online or call Member Services at [Member Services Toll-Free Number] to get a copy of the provider directory.

# How to Use This Handbook

This handbook tells you how [Health Plan] works. It is your guide to health and wellness services.

Read pages X to X now. These pages have information that you need to start using your plan.

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

* Use this handbook
* Ask your Primary Care Provider (PCP)
* Call Member Services at [Member Services Toll-Free Number and TTY number]
* Visit our website at [hyperlinked web address]

# Help from Member Services

Member Services has people to help you. You can call Member Services at [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. to 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 when you have a question.** You may call us to choose or change your Primary Care Provider (PCP), to ask about benefits and services, to get help with referrals, to replace a lost Medicaid card, to report the birth of a new baby, or ask about any change that might affect you or your family’s benefits.

Other Ways We Can Help

* If you have basic questions or concerns about your health, you can call our Nurse Line at [Nurse Line Number] at any time, 24 hours a day, 7 days a week. This is a free call. You can get advice on when to go to your primary care provider or ask questions about symptoms or medications.
* If you are experiencing emotional or mental pain or distress, call the Behavioral Health Crisis Line at [Behavioral Health Crisis Line] at any time, 24 hours a day, 7 days a week, to speak with someone who will listen and help. This is a free call. We are here to help you with problems like stress, depression or anxiety. We can get you the support you need to feel better. **If you are in danger or need immediate medical attention, call 911.**
* If you are or become pregnant, your child will become part of [Health Plan] on the day your child is born. Call us and your local Department of Social Services right away if you become pregnant. We can help you to choose a doctor for both you and your baby.
* **If English is not your first language we can help.** Just call us and we will find a way to talk with you in your own language.
* For people with disabilities:
  + If you have difficulty hearing or need assistance communicating, please call us. If you are reading this on behalf of someone who is blind, deaf-blind or has difficulty seeing, we can help. We can tell you if a doctor’s office is equipped with special communications devices. Also, we have services like:
  + TTY machine. Our TTY phone number is [TTY number].
  + Information in large print
  + Help in making or getting to appointments
  + Names and addresses of providers who specialize in your condition
  + If you use a wheelchair, we can tell you if a doctor’s office is wheelchair accessible and assist in making or getting to appointments.

# Special Aids and Services

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

* A TTY machine. Our TTY phone number is [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 for free. To ask for services, call Member Services at [Member Services Toll-Free Number and the TTY Number.]

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

# Your Medicaid Card

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

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

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

If you lose your card, call Member Services at [Member Services Toll-Free Number and the TTY Number.] Always carry your Medicaid card with you. You will need to 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
  + help you get referrals for specialized services if you need them
* As a Medicaid beneficiary, you had an opportunity to choose your own PCP. If you did not select a PCP, we chose one for you based on your past health care. You can find your PCP’s name and contact information on your Medicaid card. If you would like to change your PCP, you have 30 days from the date of receiving this packet to make the change. (See “How to Change Your PCP” to learn how to make those changes.)
* When deciding on a PCP, you may want to find a PCP who:
  + You have seen before
  + Understands your health history
  + Is taking new patients
  + Can serve you in your language
  + Is easy to get to
* Each family member enrolled in [Health Plan] 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 [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 [Health Plan] in our provider directory. You can visit our website at [hyperlinked web address] to look at the provider directory online. You can also call Member Services at [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 Our Network

* If your provider leaves [Health Plan], we will tell you within 15 days from when we know about this. If the provider who leaves [Health Plan] is your PCP, we will contact you to help you choose another PCP within 7 days from when we know about this.
* If your provider leaves our network, we will help you find a new one.
* Even if your provider leaves our network, you may be able to stay with your provider for a while longer in certain situations.
* Please read “Your Care When You Change Health Care Providers” under Part III, Plan Procedures on page [page number]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 [**hyperlink here]** or call Member Services at [**information number here].**

# How to Change Your PCP

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

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

It’s best to visit your PCP within three months of joining the plan.

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

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

If are not getting the care you need within the time limits described above, call Member Services at [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 a specialist, we will pay for your care. Most specialists are [Health Plan] providers. Talk with your PCP to be sure you know how referrals work. See below for the process on referrals to a specialist who is not in our provider network.
* If you think a specialist does not meet your needs, talk with your PCP. Your PCP can help you find a different specialist.
* There are some treatments and services that your PCP must ask [Health Plan] 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 [Member Services Toll-Free Number].
* If [Health Plan] 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 [Health Plan] 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 [Health Plan] who can treat you. If you do not agree with our decision, you can **appeal** our decision. See page [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 similar to what you can get from a [Health Plan] provider. If you do not agree with our decision, you can **appeal** our decision. See page [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 more information about getting services from an out-of-network provider, talk to your Primary Care Provider (PCP) or call Member Services at [Member Services Toll-Free Number].

# Get These Services from [Health Plan] Without a Referral

You do not need a referral to get these services:

## Primary Care

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

## Women’s Health Care

You do not need a referral from your PCP if:

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

## Family Planning

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

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

## Children’s Screening

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

## Local Health Department Services

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

## Behavioral Health Services

You do not need a referral for your first behavioral health or substance use disorder assessment completed in a 12-month period. Ask your PCP or call Member Services at [Member Services Toll-Free Number] 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 [hyperlinked web address].

# Emergencies

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

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

**Remember:** Use the Emergency Department only if you have an emergency. If you have questions, call your PCP or [Health Plan] Member Services at [insert Member Services Toll-Free Number].

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

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

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

# Urgent Care

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

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

You can walk into an urgent care clinic to get care the same day or make an appointment for the next day. Whether you are at home or away, call your Primary Care Provider (PCP) any time, day or night. If you cannot reach your PCP, call Member Services at [Member Services Toll-Free Number]. Tell the person who answers what is happening. They will tell you what to do.

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

* Call your PCP any time day or night.
* If you are unable to reach your PCP, call Member Services at [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, [Health Plan] may pay for health care services you get from a provider located along the North Carolina border or in another state. Your PCP and [Health Plan] 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**,** [Health Plan] 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 [Member Services Toll-Free Number].

# Part II: Your Benefits

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

This section describes:

* Covered and non-covered services. “Covered services” means [Health Plan] will pay for the services. These are also called benefits. “Non-covered services” means [Health Plan] will not pay for the services.
* What to do if you are having a problem with your health plan.
* [Add other things here.]

[Health Plan] 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 [Health Plan]. Ask your Primary Care Provider (PCP) or call Member Services at [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 [page number].

# Services Covered by [Health Plan]’s Network

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

## Regular Health Care

* Office visits with your PCP, including regular check-ups, routine labs and tests
* Referrals to specialists
* Eye/hearing exams
* Well-baby care
* Well-child care
* Immunizations (shots) for children and adults
* Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for members under age 21 (see page [page number] for more information about EPSDT services)
* Help with quitting smoking or other tobacco use

## Maternity Care

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

## Personal Care Services (Adults only)

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

## Vision Care

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

## Pharmacy

* Prescription drugs
* Some medicines sold without a prescription (also called “over-the-counter”), like allergy medicines
* Insulin and other diabetic supplies like syringes, test strips, lancets and pen needles
* Smoking cessation agents, including over-the-counter products
* Enteral formula (balanced nutrition designed for the tube-feeding of children)
* Emergency contraception
* Medical and surgical supplies

## 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 [page number].

## 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 [Health Plan]
* 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 [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.
* Nursing home services must come from a nursing home that is in [Health Plan]’s provider network. If you choose a nursing home outside of [Health Plan]’s network, and services are available in the plans network, you may have to transfer to another plan. Call Member Services at [state Medicaid number/hotline] for help with questions about nursing home providers and plan networks.
* Talk with your PCP or call Member Services at [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, like psychiatric residential treatment facilities or assertive community treatment, that your plan does not provide, talk with your PCP or call Member Services at [Member Services Toll-Free Number]. The following intensive behavior health services are not covered by this plan:**

## Transportation Services

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

**How to Get Non-Emergency Transportation.** Call [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 transportation services are denied, you have the right to appeal our decision. See [page number] for more information on appeals. If you have questions about transportation, call Member Services at [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 help through a [Health Plan] 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 [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. Call Member Services at [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 [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. You do not need a referral from your PCP for family planning services. Family planning services include:

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

## Other Covered Services

* Durable medical equipment/prosthetics/orthotics
* Hearing aid products and services
* Telemedicine
* Extra support to manage your health (see page [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 [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 [Health Plan], 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

[Health Plan] can also connect to you to a Care Manager who specializes in supporting:

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

At times, a member of your Primary Care Provider’s (PCP’s) team will be your Care Manager. To learn more about how you get can extra support to manage your health, talk to your PCP or call Member Services at [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 [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 connect you with the right program for support.

Call Member Services at [Member Services Number Toll-Free Number] 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. [Health Plan] supports safe and appropriate opioid use through our Opioid Misuse Prevention Program. If you have any questions about our program, call Member Services at [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 [Health Plan] OR a Medicaid Provider

You can choose where to get some services. You can get these services from providers in the [Health Plan] 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 [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 [Health Plan] doctors. When you get this service as part of a family planning visit, you can go to any doctor or clinic that takes Medicaid and offers family planning services. You do not need a referral when you get this service as part of a family planning visit.

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

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

Members under 21 years old (excluding NC Health Choice members) have a broad menu of healthcare benefits. Medicaid calls this benefit “Early and Periodic Screening, Diagnosis and Treatment Services.” The “EPSDT guarantee” covers wellness visits and treatment services.

##### Early and Periodic Screening and Diagnosis

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

##### The “T” in EPSDT: Treatment for Members under 21 years old

Sometimes children need medical “treatment” for a health problem. Your Plan may not offer every service covered by the federal Medicaid program. When a child needs treatment, your Plan will pay for any service that the federal government’s Medicaid plan covers. The Plan must use a set of special rules that apply only to children. These rules are called EPSDT “medical necessity criteria.” A Plan cannot deny your child’s service just because of a policy limit. Also, a Plan cannot deny a service just because that service is not covered in the Plan’s policies. Your Plan must complete a special “EPSDT review” in these cases.

When your Plan approves services for children, important rules apply:

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

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

* Dental services
* Comprehensive health screening services (well-child checks, developmental screenings and immunizations)
* Health education
* Hearing services
* Home health services
* Hospice services
* Inpatient and outpatient hospital services
* Lab and X-ray services
* Mental health services
* Personal care services
* Physical and occupational therapy
* Prescription drugs
* Prosthetics
* Rehabilitative services for speech, hearing and language disorders
* Transportation to and from medical appointments
* Vision services
* Any other necessary health services to treat, fix or improve a health problem.

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

# Benefits You Can Get ONLY from a Medicaid Provider

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

* Dental services
* Services provided through the Program of All-Inclusive Care for the Elderly (PACE). Details about PACE maybe found on the [DHHS Medicaid webpage](https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/program-of-all-inclusive-care-for-the-elderly).
* Services provided by Local Education Agencies
* Services provided by Children’s Developmental Agencies that are included in your child’s Individualized Family Service Plan
* Fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses and ophthalmic frames

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

# Services NOT Covered

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

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

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

A provider who agrees to accept Medicaid generally cannot bill you. You may have to pay for any service that your PCP or [Health Plan] 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 [Health Plan].

[**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.**]

[Health Plan] 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 page [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 owe, do not ignore it. Call Member Services at [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, [Health Plan] will contact the provider and help fix the problem for you.

You have the right to ask for a State Fair Hearing if you think you are being asked to pay for something Medicaid or [Health Plan] should cover. A State Fair Hearing allows you or your representative to make your case before an administrative law judge. See the State Fair Hearing section on page [page number] 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. A “copay” is a fee you pay when you get certain health care services from a provider or pick up a prescription from a pharmacy.

**Copays if You Have Medicaid\***

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

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

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

A provider cannot refuse to provide services if you cannot pay. If you have any questions about Medicaid copays, please call Member Services at [Insert Member Services Toll-Free Number].

## 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 for each prescription |
| Brand prescription when generic is available | $3 for each prescription |
| Non-emergency Emergency Department visits | $10 per visit |
| **If you do pay an annual enrollment fee for your child or children:** | |
| Office visit  Outpatient hospital | $5 per visit |
| Generic prescription  Brand prescription when no generic is available  Over-the-counter medications | $1 for each prescription |
| Brand prescription when generic is available | $10 for each prescription |
| Non-emergency Emergency Department visits | $25 per visit |

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

If your PCP is not able to accommodate your special needs, call Member Services at [Member Services Toll-Free Number] to learn more about how you can change your PCP.

# Service Authorization and Actions

[Health Plan] will need to approve some treatments and services **before** you receive them. [Health Plan] 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:

**[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].**

## What happens after we get your service authorization request?

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

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

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

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

If you receive a denial and you do not agree with our decision, you may ask your Plan for an “appeal.” You can call your Plan, make your request online or send in the appeal form you will find with your decision notice. See page [INSERT HANDBOOK PAGE NUMBER HERE] for more information on appeals.

**Prior Authorization Requests for Children Under Age 21**

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

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

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

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

## Important Details about Services Coverable by the federal EPSDT Guarantee:

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

**The Plan must approve these services with an “EPSDT review” *before* your provider gives them.**

To learn more about the Medicaid health plan for children (EPSDT), see page [page number], visit our website at [insert web link] and visit the state of North Carolina website for the EPSDT guarantee at <https://medicaid.ncdhhs.gov/medicaid/get-started/find-programs-and-services-right-you/medicaids-benefit-children-and-adolescents>

## Preauthorization and Timeframes

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

* **Standard review:** A decision will be made within 14 days after we receive your request.
* **Expedited (fast track) review:** A decision will be made and you will hear from us within 3 days of your request.
* In most cases, you will be given at least 10 days notice if any change (to reduce, stop or restrict services) is being made to current services. **If we approve a service and you have started to receive that service,** **we will not reduce, stop or restrict the service during the approval period unless we determine the approval was based on information that was known to be false or wrong.**
* If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills. **You will not have to pay for any care you received that was covered by 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 [Member Services Number Toll-Free Number] to get a Provider (PCP), to ask about benefits and services, to get help with referrals, to replace a lost Medicaid card, to report the birth of a new baby, or ask about any change that might affect you or your family’s benefits. We can answer any questions about the information in this handbook.

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

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

## You Can Help with Plan Policies

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

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

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

# Appeals

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

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

You can ask for an appeal yourself. You may also ask a friend, a family member, your provider or a lawyer to help you. You can call your PHP at [phone number] or visit our website at [web link] if you need help with your appeal request. It’s easy to ask your Plan for an appeal by using one of the options below:

* **MAIL:** Fill out and sign the Appeal Request Form in the notice you receive about our decision. Mail it to the addresses listed on the form. Your Plan must receive your form no later than 60 days after the date on this notice.
* **FAX:** Fill out, sign and fax the Appeal Request Form in the notice you receive about our decision. You will find the fax numbers listed on the form.
* **BY PHONE:** Call [phone number] and ask for an appeal. You will get help with your form during this call.
* **ONLINE:** Visit your Health Plan’s website at [weblink] and follow instructions there.

When you appeal, you and any person you have chosen to help you can see the health records and criteria your Plan used to make the decision. If you choose to have someone help you, you must give them written permission.

## Expedited (faster) Appeals

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

**If you or your provider need to ask for an expedited review, please call the Plan at [phone number]. We will help you to complete your request.**

**Provider Requests for Expedited Appeals**

If your provider asks us for an expedited appeal, we will give a decision no later than 72 hours after we get the request for an expedited appeal. We will call you and your provider as soon as there is a decision. We will send you and your provider a written notice of our decision within 3 days from your appeal.

**Member Requests for Expedited Appeals**

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

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

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

**Timelines for Standard Appeals**

If we have all the information we need, you will have a decision in writing within 30 days from your appeal. If we need more information to decide about your appeal, we will:

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

If you need more time to gather records and updates from your provider, just ask. You or a helper you name may ask us to delay your case until you are ready. Ask for an extension by calling Member Services at [PHP CUSTOMER CARE PHONE LINE] or writing to [PHP MAILING ADDRESS].

**Decisions on Appeals**

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

## State Fair Hearings

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

##### Free and Voluntary Mediations

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

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

##### State Fair Hearings

State Fair Hearings are held by the North Carolina Office of Administrative Hearings (OAH). An administrative law judge will give you a decision. You can give any updates and facts you need to at this hearing. A member of your Plan’s review team will attend. You may ask questions about the Plan’s decision. The judge in your State Fair Hearing is not a part of your health plan in any way.

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

* **MAIL:** Fill out and sign the State Fair Hearing Request Form that comes with your notice. Mail it to Office of Administrative Hearings (OAH), Attention: Clerk of Court 6714 Mail Service Center, Raleigh, NC 27699-6700. OAH must receive your form no later than 120 days after the date on your notice.
* **FAX:** Fill out, sign and fax the State Fair Hearing Request Form that comes with your notice. The fax number is 1-919-431-3100.
* **BY PHONE:** Call [PHP] at [PHONE NUMBER] and ask for a State Fair Hearing. You will get help with your form during this call.
* **ONLINE:** Visit your Health Plan’s website at [WEB ADDRESS] and follow instructions there.

For assistance with requesting a State Fair Hearing, please contact Member Services at [phone number] [TTY number]. You can call 24 hours a day, seven days a week.

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

**State Fair Hearings for Disenrollment Decisions**

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

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

* Deny your request to change plans; or
* Approve a request made by [Health Plan] for you to leave the plan.

You can ask for a State Fair Hearing within 30 days from the day you receive a notice informing you of the decision about your request to change plans or [PHP name]’s request for you to leave the health plan.

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

* Fax: 1-919-431-3100
* Mail: Office of Administrative Hearings (OAH), Attention: Clerk of Court 6714 Mail Service Center, Raleigh, NC 27699-6700

## Important Phone Numbers

The NC Mediation Network can be reached at 1-336-461-3300, Monday through Friday, 8 a.m. to 5 p.m.

**Continuation of Benefits During an Appeal**Sometimes a Plan’s decision reduces or stops a service you are already receiving. You can ask to continue this service without changes until your appeal is finished. You can also ask the person helping you with your appeal to make that request for you.

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

**There is a special rule about continuing your service during your appeal. Please read this section carefully!**

* You always have 30 days to ask your Plan to keep paying for your services until you get your appeal decision.
* Your Plan will always pay for your services to continue from the day that you ask.
* Your Plan will keep paying for your service every day until your appeal is decided.

You must do **two things** for your Plan to keep paying for services during your appeal or State Fair Hearing:

* Ask your Plan for an appeal, or ask for your State Fair Hearing;
* Ask for your service to stay the same while you appeal.

Remember to ask your Plan to continue your services as soon as possible. Three things may happen to your service, depending on when you ask your Plan.

1. When you do not ask for your Plan to keep paying for your service, the Plan will stop paying for it on the 10th day after the date on your Notice. You will also see the exact date your service will change on the first page of your Notice.
2. When you ask your Plan to keep your services the same **earlier than** the 10th day after your Notice date, your Plan will **pay for every day of your service** until your appeal is finished.
3. When you ask your Plan to keep your services the same **after** the 10th day after your Notice date, your Plan may stop paying for **some** days of your service.

The Plan will pay for 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 [phone number] 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 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.

Sometimes a provider may ask for less hours or amounts of your service than was approved in your old request. When this happens, youwill get the hours or amounts that your provider asked for in the new request until your appeal is decided. This will be less than the hours or amounts that were in the old approval.

# 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 [PHP HELPLINE] or write to [PHP MAILING ADDRESS]

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

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

You can contact us by phone or in writing:

* By phone, call Member Services at [PHP HELPLINE], 24 hours a day, 7 days a week. After business hours you may leave a message and we will contact you during the next business day.
* You can write us with your complaint to [PHP MAILING ADDRESS].

**Resolving your grievance**

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

* We will review your complaint and tell you how we resolved it in writing within 30 days from receiving your complaint.
* If your grievance is about your request for an expedited (faster) appeal, we will let you know quickly and in writing that we got your grievance. We will reply in writing within 24 hours after we get your grievance. We will review your complaint about the denial of an expedited appeal quickly. We will tell you how we resolved it in writing within 5 days of getting your complaint.

These issues will be handled according to our Grievance Procedures. You can find them online at [PHP WEBSITE / GRIEVANCES INFORMATION AND POLICY].

# Your Care When You Change Health Plans or Providers

* If you join [Health Plan] from another health plan, we will contact you at least 5 business days before your expected enrollment date with us. We will confirm the name of your previous plan, so we can add your health information, like your medical records and prescheduled appointments, into our records.
* You can finish receiving any services that have already been authorized by your previous health plan. After that, we will help you find a provider in our network to get any additional services if you need them.
* In almost all cases, your providers under your former plan will also be [Health Plan] 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 **[Health Plan].** You can continue to see your provider if:
  + At the time you join **[Health Plan],** 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 **[Health Plan]** 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 **[Health Plan]** 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 **[Health Plan],** we will tell you in writing within 15 days from when we know this will happen. If the provider who leaves **[Health Plan]** is your Primary Care Provider (PCP), we will contact you within 7 days from when we know this will happen. We will tell you how you can choose a new PCP or how we will choose one for you if you do not make a choice within 30 days.
* If you want to continue receiving care from a provider who is not in our network, [Plans must insert information about the procedure for continuing to receive care from the terminated provider including:]
  + The first step in the process and who initiates (form, call, follow-up from care manager, etc.)
  + Contact information for resource to assist member through the process
  + The timeline for the Plan to review the request and inform the member of the decision.
  + The method by which the Plan will notify the member of the decision (by written notice, etc.].

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

# Member Rights and Responsibilities

## Your Rights

As a member of [Health Plan], 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 [Health Plan]
* Be told by your PCP what health issues you may have, what can be done for you and what will likely be the result, in language you understand
* Get a second opinion about your care
* Give your approval of any treatment
* Give your approval of any plan for your care after that plan has been fully explained to you
* Refuse care and be told what you may risk if you do
* Get a copy of your medical record and talk about it with your PCP
* Ask, if needed, that your medical record be amended or corrected
* Be sure that your medical record is private and will not be shared with anyone except as required by law, contract or with your approval
* Use the [Health Plan] complaint process to settle complaints. You can also contact the **Medicaid** **Managed Care Ombudsman Program** any time you feel you were not fairly treated (see page [page number] 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 [Health Plan], you agree to:

* Work with your PCP to protect and improve your health
* Find out how your health plan coverage works
* Listen to your PCP’s advice and ask questions
* Call or go back to your PCP if you do not get better or ask for a second opinion
* Treat health care staff with the respect
* Tell us if you have problems with any health care staff by calling Member Services at [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 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 [Health Plan] and join another health plan at any time during the 90 days.
* You can switch health plans once every 12 months.
* If you want to leave [Health Plan] at any other time, you can do so **only** with a good reason (good cause). Some examples of good cause include:
  + You move out of our service area
  + We do not offer a Medicaid Managed Care service that you can get from another health plan in your area
  + You need a service that is related to a benefit we have chosen not to cover and getting the service separately would put your health at risk
  + You have a complex medical condition and another health plan or Medicaid program (e.g., Medicaid Direct, LME/MCO) can better meet your needs
  + We have not been able to provide services to you as we are required to under our contract with the North Carolina Department of Health and Human Services.

[**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.**]

[Health Plan] can choose not to cover counseling or referral services because of an objection based 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.

### 2. How to Change Plans

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

**[Enrollment Broker contact information]**

You will get a notice that the change will take place by a certain date. [Health Plan] will provide the care you need until then.

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

## You Could Become Ineligible for Medicaid Managed Care

You may have to leave [Health Plan] if you:

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

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

## 3. We Can Ask You to Leave [Health Plan]

You can lose your [Health Plan] membership, if you:

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

## 4. You can appeal a disenrollment decision

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

* deny your request to change plans; or
* approve a request made by [Health Plan] for you to leave the plan.

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

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

* We deny your request to change plans or
* [Health Plan]’s request for you to leave the health plan.

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

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

* By fax – [fax number]
* By mail – [mailing address]

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

## State Fair Hearings for disenrollment decisions

You have the right to ask for a State Fair Hearing if you disagree with a decision on disenrollment that changed your health plan. A State Fair Hearing allows you or your representative to make your case before a judge who rules on laws that regulate government agencies. If you have any questions, call Member Services at [Member Services Toll-Free Number].

# Advance Directives

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

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

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

## Living Will

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

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

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

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

## Health Care Power of Attorney

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

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

## Advance Instruction for Mental Health Treatment

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

## Forms You Can Use to Make an Advance Directive

You can find the advance directive forms at [www.sosnc.gov/ahcdr](http://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 qualityhealth 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 [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 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 [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, nonprofit organization whose only job is to ensure that individuals and families who receive North Carolina Medicaid and NC Health Choice get access to the care that they need.

The Ombudsman Program can:

* Answer your questions about benefits
* Help you understand your rights and responsibilities
* Provide information about Medicaid and Medicaid Managed Care
* Answer your questions about enrolling 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:

[**toll-free telephone, email, hyperlink to website and hours of operation**