NC Medicaid Managed Care Behavioral Health and Intellectual/ Developmental Disabilities **Tailored Plan Member Handbook**

Effective February 1, 2024

Alliance Health

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Office of Communications

Rev. January 09, 2024
BKT056558EP00

Auxiliary Aids and Interpreter Services

You can request free auxiliary aids and services, including this material and other information in large print. Call **800-510-9132 or TTY/TDD: 711 or 800-735-2962**. If English is not your first language, we can help. Call **800-510-9132 or TTY/TDD: 711 or 800-735-2962**. We can give you, free of charge, the information in this material in your language orally or in writing, access to interpreter services, and can help answer your questions in your language.

Español (Spanish): Puede solicitar ayudas y servicios auxiliares gratuitos, incluido este material y otra información en letra grande. Llame al **800-510-9132 or TTY/TDD: 711 or 800-735-2962**. Si el inglés no es su lengua nativa, podemos ayudarle. Llame al **800-510-9132 or TTY/TDD: 711 or 800-735-2962**. Podemos ofrecerle, de forma gratuita, la información de este material en su idioma de forma oral o escrita, acceso a servicios de interpretación y podemos ayudarle a responder a sus preguntas en su idioma.

中国人 (Chinese): 您可以申请免费的辅助工具和服务，包括本资料和其他计划信息的大字版。请致电 **800-510-9132 or TTY/TDD: 711 or 800-735-2962**。如果英语不是您的首选语言，我们能提供帮助。请致电 **800-510-9132 or TTY/TDD: 711 or 800-735-2962**。我们可以通过口头或书面形式，用您使用的语言免费为您提供本资料中的信息，为您提供翻译服务，并且用您使用的语言帮助回答您的问题。

Tiếng Việt (Vietnamese): Bạn có thể yêu cầu các dịch vụ và hỗ trợ phụ trợ miễn phí, bao gồm tài liệu này và các thông tin khác dưới dạng bản in lớn. Gọi **800-510-9132 or TTY/TDD: 711 or 800-735-2962**. Nếu Tiếng Anh không phải là ngôn ngữ mẹ đẻ của quý vị, chúng tôi có thể giúp quý vị. Gọi đến **800-510-9132 or TTY/TDD: 711 or 800-735-2962.** Chúng tôi có thể cung cấp miễn phí cho quý vị thông tin trong tài liệu này bằng ngôn ngữ của quý vị dưới dạng lời nói hoặc văn bản, quyền tiếp cận các dịch vụ phiên dịch, và có thể giúp trả lời các câu hỏi của quý vị bằng chính ngôn ngữ của quý vị.

한국인 (Korean): 귀하는 무료 보조 자료 및 서비스를 요청할 수 있으며, 여기에는 큰 활자체의 자료 및 기타정보가있습니다. **800-510-9132 or TTY/TDD: 711 or 800-735-2962** 번으로 전화주시기 바랍니다. 영어가 모국어가 아닌 경우 저희가 도와드리겠습니다. **800-510-9132 or TTY/TDD: 711 or 800-735-2962**번으로 전화주시기 바랍니다. 저희는 귀하께 구두로 또는 서면으로 귀하의 언어로 된 자료의 정보를, 그리고 통역 서비스의 사용을 무료 제공해 드리며 귀하의 언어로 질문에 대한 답변을 제공해 드리겠습니다.

Français (French): Vous pouvez demander des aides et des services auxiliaires gratuits, y compris ce document et d'autres informations en gros caractères. Composez le **800-510-9132 or TTY/TDD: 711 or 800-735-2962.** Si votre langue maternelle n'est pas l'anglais, nous pouvons vous aider. Composez le **800-510-9132 or TTY/TDD: 711 or 800-735-2962**. Nous pouvons vous fournir gratuitement les informations contenues dans ce document dans votre langue, oralement ou par écrit, vous donner accès aux services d'un interprète et répondre à vos questions dans votre langue.

Hmoob (Hmong): Koj tuaj yeem thov tau cov khoom pab cuam thiab cov kev pab cuam, suav nrog rau tej ntaub ntawv no thiab lwm lub phiaj xwm tej ntaub ntawv kom muab luam ua tus ntawv loj. Hu rau **800-510-9132 or TTY/TDD: 711 or 800-735-2962**. Yog tias Lus Askiv tsis yog koj thawj hom lus hais, peb tuaj yeem pab tau. Hu rau **800-510-9132 or TTY/TDD: 711 or 800-735-2962**. Peb tuaj yeem muab tau rau koj yam tsis sau nqi txog ntawm tej ntaub ntawv muab txhais ua koj hom lus hais ntawm ncauj los sis sau ua ntawv, mus siv tau cov kev pab cuam txhais lus, thiab tuaj yeem pab teb koj cov lus nug hais ua koj hom lus.

عربي (Arabic):

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

800-510-9132 or TTY/TDD: 711 or 800-735-2962.

إذا كانت اللغة الإنجليزية ليست لغتك الأولى، فيمكننا المساعدة. اتصل على الرقم **800-510-9132 or TTY/TDD: 711 or 800-735-2962**.يمكننا أن نقدم لك المعلومات الواردة في هذه المستند بلغتك شفهيًا أو كتابيًا إلى خدمات

Русский (Russian): Вы можете запросить бесплатные вспомогательные средства и услуги, включая этот справочный материал и другую информацию напечатанную крупным шрифтом. Позвоните по номеру **800-510-9132 or TTY/TDD: 711 or 800-735-2962**. Если английский не является Вашим родным языком, мы можем Вам помочь. Позвоните по номеру **800-510-9132 or TTY/TDD: 711 or 800-735-2962**. Мы бесплатно предоставим Вам более подробную информацию этого справочного материала в устной или письменной форме, а также доступ к языковой поддержке и ответим на все вопросы на Вашем ро дном языке.

Tagalog (Tagalog): Maaari kang humiling ng libreng mga auxiliary aid at serbisyo, kabilang ang materyal na ito at iba pang impormasyon sa malaking print. Tumawag sa **800-510-9132 or TTY/TDD: 711 or 800-735-2962**. Kung hindi English ang iyong unang wika, makakatulong kami. Tumawag sa **800-510-9132 or TTY/TDD: 711 or 800-735-2962**. Maaari ka naming bigyan, nang libre, ng impormasyon sa materyal na ito sa iyong wika nang pasalita o nang pasulat, access sa mga serbisyo ng interpreter, at matutulungang sagutin ang mga tanong sa iyong wika.

ગુજરાતી (Gujarati): તમે મોટી પ્રિન્ટમાં આ સામગ્રી અને અન્ય માહિતી સહિત મફત સહાયક સહાય અને સેવાઓની વિનંતી કરી શકો છો. **800-510-9132 or TTY/TDD: 711 or 800-735-2962.** પર કૉલ કરો જો અંગ્રેજી તમારી પ્રથમ ભાષા ન હોય, તો અમે મદદ કરી શકીએ છીએ. **800-510-9132 or TTY/TDD: 711 or 800-735-2962.** પર કૉલ કરો તમારી ભાષામાં મૌખિક રીતે અથવા લેખિતમાં તમને આ સામગ્રીની માહિતી અમે વિના મૂલ્યે આપી શકીએ છીએ, દુભાષિયા સેવાઓની સુલભતા આપી શકીએ છીએ અને તમારી ભાષામાં તમારા પ્રશ્નોના જવાબ આપવામાં અમે સહાયતા કરી શકીએ છીએ.

ខ្មែរ (Khmer): អ្នកអាចស្នើសុំសម្ភារៈនិងសេវាជំនួយដោយឥតគិតថ្លៃរួមទាំងព័ត៌មានអំពីសម្ភារៈនេះ និងព័ត៌មានអំពី ផ្សងេទៀតនៅជាអក្សរពុម្ពធំ។ ហៅទូរសព្ទទៅលេខ **800-510-9132 or TTY/TDD: 711 or 800-735-2962** ។ ប្រសិនបើសាអង់គ្លេសមិនមែនជាភាសាទីមួយរបស់អ្នក យើងអាចជួយអ្នកបាន។ ហៅទូរសព្ទទៅលេខ **800-510-9132 or TTY/TDD: 711 or 800-735-2962** យើងអាចផ្តល់ជូនអ្នកដោយឥតគិតថ្លៃនូវព័ត៌មាននៅក្នុងឯកសារនេះជាភាសារបស់អ្នក ដោយផ្ទាល់មាត់ឬជាលាយលក្ខណ៍អក្សរ ទទួលបានសេវាអ្នកបកប្រែ និងអាចជួយឆ្លើយសំណួររបស់អ្នកជាភាសារបស់អ្នក ។

Deutsch (German): Sie können kostenlose Hilfsmittel und Services anfordern, darunter diese Unterlagen und andere informationen in Großdruck. Rufen Sie uns an unter **800-510-9132 or TTY/TDD: 711 or 800-735-2962**. Sollte Englisch nicht Ihre Muttersprache sein, können wir Ihnen behilflich sein. Rufen Sie uns an unter **800-510-9132 or TTY/TDD: 711 or 800-735-2962**. Wir können Ihnen die in diesen Unterlagen enthaltenen Informationen kostenlos mündlich oder schriftlich in Ihrer Sprache zur Verfügung stellen, Ihnen einen Dolmetscherdienst vermitteln und Ihre Fragen in Ihrer Sprache beantworten.

हिंदी (Hindi): आप इस सामग्री और अन्य की जानकारी बड़े प्रिंट में दिए जाने सहित मुफ्त अतिरिक्त सहायता और सेवाओं का अनुरोध कर सकते हैं। **800-510-9132 or TTY/TDD: 711 or 800-735-2962** पर कॉल करें। अगर अंग्रेजी आपकी पहली भाषा नहीं है, तो हम मदद कर सकते हैं। **800-510-9132 or TTY/TDD: 711 or 800-735-2962** पर कॉल करें। हम आपको मुफ्त में इस सामग्री की जानकारी आपकी भाषा में जबानी या लिखित रूप में दे सकते हैं, दुभाषिया सेवाओं तक पहुंच दे सकते हैं और आपकी भाषा में आपके सवालों के जवाब देने में मदद कर सकते हैं

ພາສາລາວ (Lao): ທ່ານສາມາດຂໍການຊ່ວຍເຫຼືອເສີມ ແລະ ການບໍລິການຕ່າງໆໄດ້ແບບຟຣີ, ລວມທັງເອກະສານນີ້ ແລະ ຂໍ້ມູນອື່ນ ໆເປັນຕົວພິມໃຫຍ່. ໂທຫາເບີ **800-510-9132 or TTY/TDD: 711 or 800-735-2962.** ຖ້າພາສາແມ່ຂອງທ່ານ ບໍ່ແມ່ນພາສາອັງກິດ, ພວກເຮົາສາມາດຊ່ວຍໄດ້. ໂທຫາເບີ **800-510-9132 or TTY/TDD: 711 or 800-735-2962.** ພວກເຮົາສາມາດໃຫ້ຂໍ້ມູນໃນເອກະສານນີ້ ເປັນພາສາຂອງທ່ານທາງປາກເປົ່າ ຫຼື ເປັນລາຍລັກອັກສອນ, ການເຂົ້າເຖິງການບໍລິການນາຍແປພາສາ ໃຫ້ແກ່ທ່ານໂດຍບໍ່ເສຍຄ່າຫຍັງ ແລະ ສາມາດຊ່ວຍຕອບຄຳຖາມຂອງທ່ານເປັນພາສາຂອງທ່ານ.

日本 (Japanese): この資料やその他の計画情報を大きな文字で表示するなど、無料の補助支援やサービスを要請することができます。**800-510-9132 or TTY/TDD: 711 or 800-735-2962**に電話してください。英語が母国語でない方はご相談ください。**800-510-9132 or TTY/TDD: 711 or 800-735-2962** に電話してください。この資料に記載されている情報を、お客様の言語で口頭または書面にて無料でお伝えするとともに、通訳サービスへのアクセスを提供し、お客様のご質問にもお客様の言語でお答えします。

Notice of Nondiscrimination

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

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

- Qualified American Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

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

- Qualified interpreters
- Information written in other languages

If you need these services, call **800-510-9132 or TTY/TDD: 711 or 800-735-2962**.

If you believe that Alliance Health has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability or sex, you can file a grievance with:

Office of Compliance and Risk Management
Alliance Health
5200 W. Paramount Parkway, Suite 200
Morrisville, NC 27560

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

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

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

Aviso de no discriminación

Alliance Health cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad, credo, afiliación religiosa, ascendencia, sexo, identidad o expresión de género u orientación sexual. Alliance Health no excluye a las personas ni las trata de forma diferente por motivos de raza, color, origen nacional, edad, discapacidad, credo, afiliación religiosa, ascendencia, sexo, género, identidad o expresión de género u orientación sexual.

Alliance Health proporciona ayuda y servicios auxiliares gratuitos a las personas con discapacidades para que se comuniquen eficazmente con nosotros, por ejemplo:

- Intérpretes calificados de lenguaje de señas americano
- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)

Alliance Health ofrece servicios lingüísticos gratuitos a las personas para las cual el idioma principal no es el inglés, por ejemplo:

- Intérpretes calificados
- Información escrita en otros idiomas

Si necesita estos servicios, llame al **800-510-9132 or TTY/TDD: 711 or 800-735-2962**.

Si cree que Alliance Health no le ha prestado estos servicios o lo ha discriminado de alguna otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja ante:

Office of Compliance and Risk Management
Alliance Health
5200 W. Paramount Parkway, Suite 200
Morrisville, NC 27560

También puede presentar una queja de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los Estados Unidos:

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

Los formularios de quejas están disponibles en: hhs.gov/ocr/office/file/index.html.

Your Alliance Health Quick Reference Guide

I want to:	I can contact:
Find a doctor, specialist or health care service	My primary care provider (PCP). If you need help with choosing your PCP, call Member and Recipient Services at 800-510-9132.
Learn more about choosing or enrolling in a health care option	Call the Enrollment Broker toll free: 833-870-5500. Hours of operation: 7 a.m. to 5 p.m., Monday through Saturday.
Get this handbook in another format or language	Member and Recipient Services at 800-510-9132 or Relay: 711 or 800-735-2962
Keep track of my appointments and health services	My PCP or Member and Recipient Services at 800-510-9132
Get help with getting to and from my doctor's appointments	Modivcare at 855-759-9600. You can also find more information on Transportation Services in this handbook on page 16/17.
Get help to deal with thoughts of hurting myself or others, distress, severe stress or anxiety, or any other behavioral health crisis	Behavioral Health Crisis Line at 877-223-4617, 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 855-759-9400 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 and Recipient Services at 800-510-9132 or the NC Medicaid Ombudsman at 877-201-3750. You can also find more information about the NC Medicaid Ombudsman in this handbook on page 48.
Update my address	Call your local Department of Social Services (DSS) office to report an address change. A list of DSS locations can be found at ncdhhs.gov/divisions/social-services/local-dss-directory.
Find my health plan's health care provider directory or other general information about my health plan	Visit our website at AllianceTailoredPlan.org or call Member and Recipient Services at 800-510-9132.

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 Care Home	A licensed residential care setting with 7 or more beds for elderly or disabled people who need some additional supports. These homes offer supervision and personal care appropriate to the person's age and disability.
Adult Preventive Care	Care consisting of wellness checkups, patient counseling and regular screenings to prevent adult illness, disease and other health-related issues.
Advance Directive	A written set of directions about how medical or mental health treatment decisions are to be made if you lose the ability to make them for yourself.
Advanced Medical Home Plus (AMH+)	Certified primary care practices whose providers have experience delivering primary care services to Tailored Plan members, including people with behavioral health, intellectual/developmental disabilities (I/DD) or traumatic brain injuries (TBI). These providers are also certified to provide care management to you if you are assigned to their practice.
Adverse Benefit Determination	A decision your health plan can make to deny, reduce, stop or limit your health care services.
Appeal	If the health plan makes a decision you do not agree with, you can ask them to review it. This is called an "appeal." Ask for an appeal when you do not agree with your health care service being denied, reduced, stopped or limited. When you ask your health plan for an appeal, you will get a new decision within 30 days. This decision is called a "resolution." Appeals and grievances are different.
Behavioral Health and Intellectual/ Developmental Disabilities (I/DD) Tailored Plan	A North Carolina managed care health plan that offers physical health, pharmacy and behavioral health services, including services that are not offered by Standard Plans, for members who may have significant mental health needs, intellectual/developmental disabilities (I/DDs), traumatic brain injuries (TBIs) or severe substance use disorders. For this handbook, the Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plan will be referred to as the "Tailored Plan."
Behavioral Health Care	Mental health and substance use disorder treatment and recovery services.
Beneficiary	A person who is receiving Medicaid or NC Health Choice.
Benefits	A set of health care services covered by your health plan.

Care Coordination	A service where a care coordinator or care manager helps organize your health goals and information to help you achieve safer and more effective care. These services may include, but are not limited to, identification of health service needs, determination of level of care, addressing additional support services and resources, or monitoring treatment attendance.
Care Management	A service where a care manager can help you meet your health goals by coordinating your medical, social and behavioral health services and by assisting you in finding access resources like transportation, healthy food and safe housing.
Care Management Agency (CMA)	Provider organization with experience delivering behavioral health, I/DD and/or TBI services to Tailored Plan members and will deliver integrated, whole person care management services to Tailored Plan members. These providers are certified to provide care management to you.
Care Manager	A health professional who can help you meet your health goals by coordinating your medical, social and behavioral health services and helping you access resources like transportation, healthy food and safe housing.
Children's Screening Services	A medical examination to monitor how a child is developing. Screening services can help identify concerns and problems early. The screenings assess social/emotional behavior, vision and hearing, motor skills and coordination, cognitive abilities, language and speech.
Copayment (Copay)	An amount you pay when you get certain health care services or a prescription.
County Department of Social Services (DSS)	The local (county) public agency that is responsible for determining eligibility for Medicaid, NC Health Choice and other assistance programs.
Covered Services	Health care services that are provided by your health plan.
Crossover	The timeframe immediately before and after the start of NC Medicaid Managed Care.
Durable Medical Equipment	Certain items (like a walker or a wheelchair) your doctor can order for you to use at home if you have an illness or an injury.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	A Medicaid benefit that provides comprehensive and preventive health care services for children under 21 who receive Medicaid. When children need medical care, services are not limited by Alliance Health's coverage policies. Medicaid makes sure that members under age 21 can get the medical care they need, when they need it, including health care services to prevent future illnesses and medical conditions. The EPSDT benefit does not apply to children enrolled in NC Health Choice.

Early Intervention	Services and support available to babies and young children with developmental delays and disabilities and their families. Services may include speech and physical therapy and other types of services.
Emergency Department Care (Emergency Room Care)	Care you receive in a hospital if you are experiencing an emergency medical condition.
Emergency Medical Condition	A situation in which your life could be threatened, or you could be hurt permanently if you do not get care right away.
Emergency Medical Transportation	Ambulance transportation to the nearest hospital or medical facility for an emergency medical condition.
Emergency Services	Services you receive to treat your emergency medical condition.
Enrollment Broker	Unbiased, third-party entity that provides managed care choice counseling and enrollment assistance, and coordinates outreach and education to beneficiaries.
Excluded Services	Services covered by the NC Medicaid Direct program, but not by your health plan. You can get these services from any provider who takes Medicaid.
Fair Hearing	See “State Fair Hearing.”
Grievance	A complaint about your health plan, provider, care or services. Contact your plan and tell them you have a “grievance” about your services. Grievances and appeals are different.
Habilitation Services and Devices	Health care services that help you keep, learn or improve skills and functioning for daily living.
Health Care Option	Health care options include Standard Plans, Tailored Plans, EBCI Tribal Option and NC Medicaid Direct. These options are based on the individual beneficiary.
Health Plan (or Plan)	The organization providing you with health care services.
Home Health Care	Certain services you receive outside a hospital or a nursing home to help with daily activities of life, like home health aide services, skilled nursing or physical therapy services.
Hospice Services	Special services for patients and their families during the final stages of terminal illness and after death. Hospice services include certain physical, psychological, social and spiritual services that support terminally ill individuals and their families or caregivers.

Hospital Outpatient Care	Services you receive from a hospital or other medical setting that do not require hospitalization.
Hospitalization	Admission to a hospital for treatment that lasts more than 24 hours.
Innovations Waiver	The special federal program designed to meet the needs of people with intellectual/developmental disabilities (I/DD) who prefer to get long-term services and supports in their home or community rather than in an institutional setting.
Institution	Health care facility or setting that may provide physical and/or behavioral supports. Some examples include, but are not limited to, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), skilled nursing facility (SNF) and adult care home (ACH).
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)	Facility that provides residential, medical and other supports to people with intellectual/developmental disabilities who have behavioral and/or medical conditions.
Legal Guardian or Legally Responsible Person	A person appointed by a court of law to make decisions for an individual who is unable to make decisions on their own behalf (most often a family member or friend unless there is no one available, in which case a public employee is appointed).
Long-Term Services and Supports	Care provided in the home, in community-based settings or in facilities to help individuals with certain health conditions or disabilities with day-to-day activities. LTSS includes services like home health and personal care services. LTSS is not covered for children receiving NC Health Choice.
Managed Care	A health care program where North Carolina contracts with health plans, called managed care organizations (MCOs), to arrange for integrated and coordinated physical, behavioral health and other health services for Medicaid and NC Health Choice beneficiaries. In North Carolina, there are 3 types of managed care plans.
Medicaid	Medicaid is a health coverage program that helps certain families or individuals who have low income or serious medical problems. It is paid with federal, state and county dollars and covers many physical health, behavioral health and I/DD services you might need. You must apply through your local Department of Social Services. When you qualify for Medicaid, you are entitled to certain rights and protections. See the websites below for more information about Medicaid and your rights.
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 and Recipient Services	A phone number you can call to speak to someone and get help when you have a question. The number for Alliance Health is 800-510-9132 or Relay: 711 or 800-735-2962.
NC Department of Health and Human Services (NCDHHS)	The state agency that includes NC Medicaid (Division of Health Benefits), the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the State Division of Social Services, the Division of Aging and Adult Services, and other health and human services agencies. The NCDHHS website is ncdhhs.gov.
NC Health Choice	NC Health Choice offers health insurance coverage for children ages 6 through 18 when their families do not qualify for Medicaid. Medicaid and NC Health Choice are different. You must apply through your local Department of Social Services. NC Health Choice benefits are not the same as Medicaid benefits. The guarantees of Medicaid's "EPSDT benefit" and Non-Emergency Medical Transportation (NEMT) do not apply.
NC Medicaid (State Medicaid Agency)	Agency that manages Medicaid and NC Health Choice health care programs, pharmacy benefits and behavioral health services on behalf of the North Carolina Department of Health and Human Services.
NC Medicaid Direct	Previously known as Medicaid Fee-For-Service, this category of care includes those who are not a part of NC Medicaid Managed Care.
NC Medicaid Member Ombudsman	A Department program that provides education and advocacy for Medicaid beneficiaries whether they are in NC Medicaid Managed Care or NC Medicaid Direct. The NC Medicaid Ombudsman also provides issue resolution for NC Medicaid Managed Care members. A resource to be used when you have been unable to resolve issues with your health plan or PCP. The NC Medicaid Ombudsman program is separate and distinct from the Long-Term Care Ombudsman Program.
Network (or Provider Network)	A group of doctors, hospitals, pharmacies and other health professionals who have a contract with your health plan to provide health care services for members.
Network Provider	A provider that is in your health plan's provider network.
Non-Covered Services	Health care services that are not covered by your health plan.
Non-Emergency Medical Transportation (NEMT)	Transportation your 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 if you are enrolled in Medicaid. NEMT is not covered for NC Health Choice.

Ongoing Course of Treatment	When a member, in the absence of continued services reflected in a treatment or service plan or as otherwise clinically indicated, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
Ongoing Special Condition	A condition that is serious enough to require treatment to avoid possible death or permanent harm. A chronic illness or condition that is life-threatening, degenerative or disabling and requires treatment over an extended period. This definition also includes pregnancy in its second or third trimester, scheduled surgeries, organ transplants, scheduled inpatient care, or being terminally ill.
Out-of-network Provider	A provider that is not in your health plan's provider network.
Palliative Care	Specialized care for a patient and family that begins at diagnosis and treatment of a serious or terminal illness. This type of care is focused on providing relief from symptoms and stress of the illness with the goal of improving quality of life for you and your family.
Participant/ Individual/Member	A person enrolled in and covered by a health plan.
Physician	A person who is qualified to practice medicine.
Physician Services	Health care services you receive from a physician, nurse practitioner or physician assistant.
Postnatal	Pregnancy health care for a mother who has just given birth to a child.
Premium	The amount you pay for your health insurance every month. Most Medicaid and NC Health Choice beneficiaries do not have a premium.
Prenatal	Pregnancy health care for expectant mothers, prior to the birth of a child.
Prescription Drug Coverage	Refers to how the health plan helps pay for its members' prescription drugs and medications.
Prescription Drugs	A drug that, by law, requires a provider to order it before a beneficiary can receive it.
Primary Care	Services from a primary care provider that help you prevent illness (check-up, immunization) to manage a health condition you already have (like diabetes).
Primary Care Provider or Primary Care Physician (PCP)	The doctor or clinic where you get your primary care (immunizations, well-visits, sick visits, visits to help you manage an illness like diabetes). Your PCP should also be available after hours and on weekends to give you medical advice. They also refer you to specialists (cardiologists, behavioral health providers) if you need it. Your PCP should be your first call for care before going to the emergency department.

Prior Authorization or Preauthorization	Approval you must have from your health plan before you can get or continue getting certain health care services or medicines.
Provider Network	Agencies or professionals under contract with Alliance Health to provide authorized services to eligible individuals.
Provider	A health care professional or a facility that delivers health care services, like a doctor, clinician, hospital or pharmacy.
Recipient	An individual who is getting a State-funded service or State-funded additional support (like care management or community inclusion services).
Referrals	A documented order from your provider for you to see a specialist or receive certain medical services.
Rehabilitation and Therapy Services and Devices	Health care services and equipment that help you recover from an illness, accident, injury or surgery. These services can include physical or speech therapy.
Service Limit	The maximum amount of a specific service that can be received.
Skilled Nursing Facility (SNF)	A facility that provides skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for injured, disabled or sick people.
Specialist	A provider who is trained and practices in a specific area of medicine.
Standard Plan	A Standard Plan is a NC Medicaid and NC Health Choice health plan that offers physical health, pharmacy, care management and basic mental health and substance use services for members. Standard Plans offer added services for members who qualify. Some added services may be different for each Standard Plan.
State Fair Hearing	When you do not agree with your health plan's resolution, you can ask for the state to review it. The NC Office of Administrative Hearings (OAH) will conduct your State Fair Hearing. The judge will carefully review Alliance Health's resolution. The judge does not work for your health plan. You may give the judge more medical updates. You may also ask questions directly to a member of the team who worked on your resolution.
State-funded Core Services	State-funded services that all Tailored Plans must offer.
State-funded Non-Core Services (Additional Services)	Additional State-funded services that Tailored Plans can choose to offer.

State-funded Services	Services for mental health, I/DD, TBI and substance use that are funded by the state or federal government outside of Medicaid.
Substance Use Disorder	A medical disorder that includes the misuse of or addiction to alcohol and/or legal or illegal drugs.
Tailored Care Management	Care management for members enrolled in Behavioral Health and I/DD Tailored Plans that is coordinated by a care manager who can help people with behavioral health, intellectual/developmental disability, and/or traumatic brain injury needs. The care manager works with you and a team of medical professionals and approved family members or other caregivers to consider your unique health-related needs and find the services you need in your community.
Telehealth	Use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations.
Transition of Care	Process of assisting you to move between health plans or to another Medicaid program, such as NC Medicaid Direct. The term “transition of care” also applies to the assistance provided to you when your provider is not enrolled in the health plan.
Transitions to Community Living (TCL) Program	Program that provides eligible adults living with serious mental health conditions the opportunity to live and work in their communities.
Traumatic Brain Injury Waiver (TBI Waiver)	Special federal program that provides long-term services and supports to allow people who experienced a traumatic brain injury (TBI) on or after their 18th birthday to remain in their homes and communities. The Tailored Plan providing services in Cumberland, Durham, Johnston, Mecklenburg, Orange or Wake counties manages this special program. The NC TBI Waiver does not operate in all geographic areas of the state.
Urgent Care	Care for a health condition that needs prompt medical attention but is not an emergency medical condition. You can get urgent care in a walk-in clinic for a non-life-threatening illness or injury.

Welcome to the Alliance Health NC Medicaid Managed Care **Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan**

NC Medicaid Managed Care
Behavioral Health and I/DD Tailored Plan

This handbook will help you understand the Medicaid health care services available to you. You can also call Member and Recipient Services with questions at 800-510-9132 or visit our website at AllianceTailoredPlan.org.

How the Tailored Plan Works

Welcome to Alliance Health's Tailored Plan. Alliance Health is a Tailored Plan approved by North Carolina. The Tailored Plan is a type of managed care health plan that provides Medicaid members with integrated physical health, pharmacy, behavioral health, intellectual/developmental disability (I/DD) and traumatic brain injury (TBI) services to meet their health care needs. In this handbook, "behavioral health" means mental health and substance use disorders.

We are a special health care plan with providers who have a lot of experience helping people who may need behavioral health, I/DD and/or TBI care to stay healthy. We also provide tailored care management services to work with you and a care team to keep you as healthy as possible and to make sure your services are well coordinated to meet your needs.

Many Medicaid members now get their health care through managed care. Managed care works like a central home to coordinate your health care needs. As a member of Alliance Health, you have all of the standard Medicaid benefits, plus additional behavioral health, I/DD and TBI services available to you to help keep you healthy.

Alliance Health offers:

- Physical health services
- Pharmacy services
- Certain long-term services and supports
- Medicaid covered behavioral health services, including 1915(i) services. (For more information on 1915(i) services see page 14)

Alliance Health offers eligible individuals:

- Specialized I/DD and NC Innovations Waiver services
- Specialized TBI waiver services
- Other State-funded behavioral health, I/DD and TBI services

As a member of Alliance Health, you may be eligible to have a care manager who will work with your health care providers to pay special attention to your complete care needs. The care manager can help make sure you get the medical, behavioral health, I/DD, TBI and additional care you may need, such as help with housing or food assistance.

You Have a Health Care Team. To meet the health care needs of people with NC Medicaid, Alliance Health partners 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 Alliance Health, our provider network is here to support you. 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 with how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases you can go to certain doctors for some services without checking with your PCP. See page 9 for details.
- You can visit our website at AllianceTailoredPlan.org to find the provider directory online or call Member and Recipient Services at 800-510-9132 to get a copy of the provider directory.

How to Use This Handbook

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

Read pages vi and vii now. These pages have information that you need to start using your health plan.

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

- Use this handbook
- Ask your primary care provider (PCP)
- Ask your care manager
- Call Member and Recipient Services at 800-510-9132 or Relay: 711 or 800-735-2962
- Visit our website at AllianceTailoredPlan.org

Help from Member and Recipient Services

Member and Recipient Services has people to help you. You can call Member and Recipient Services at 800-510-9132 or Relay: 711 or 800-735-2962.

- For help with non-emergency issues and questions, call Member and Recipient Services Monday – Saturday, 7 a.m. to 6 p.m. Please leave a message if you call us after business hours with a non-urgent request. We will call you back within 1 business day.
- **In case of a medical emergency, call 911.**
- **You can call Member and Recipient 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 to ask about any change that might affect your or your family's benefits.
- If you are or become pregnant, your child will be assigned to a Standard Plan on the day they are born. Call us and your local Department of Social Services right away if you become pregnant. We can help you choose a doctor for both you and your baby. You will be able to choose a different health plan for your child. Call the Enrollment Broker at 833-870-5500 for help choosing a health plan.
- **If English is not your first language, we can help**. Just call us at 800-510-9132 (TTY: 711) and we will find a way to talk with you in your own language.

Other Ways We Can Help

- If you have basic questions or concerns about your health, you can call our Nurse Line at 855-759-9400 at any time, 24 hours a day, 7 days a week. This is a free call. You can get advice on when to go to your PCP or ask questions about symptoms or medications.
- If you are experiencing thoughts of hurting yourself or others, or emotional or mental pain or distress, call the Behavioral Health Crisis Line at 877-223-4617 at any time, 24 hours a day, 7 days a week, to speak with someone who will listen and help. This is a free call. We are here to help you with problems like stress, depression or anxiety. We can get you the support you need to feel better. **If you are in danger or need immediate medical attention, call 911**.

For People with Hearing, Vision or Speech Disabilities

You have the right to receive information about your health plan, care and services in a format that you can understand and access. Alliance Health provides free services to help people communicate with us.

For People with Hearing Loss

If you are deaf, hard of hearing or deaf-blind, or you feel that you have difficulty hearing and need help communicating, there are resources to help. These include, but are not limited to:

- Qualified American Sign Language interpreters
- Certified deaf interpreters
- Communication Access Realtime Translation (CART) captioning
- Personal amplification listening devices (ALDs) for your use
- Information in large print
- Staff trained to appropriately handle your relay service calls (videophone, captioned phone and TTY)

For People with Vision Loss

If you have vision loss, resources available to help you include, but are not limited to:

- Written materials in accessible formats (large print, Braille, audio, accessible electronic format)

For People with Speech Disabilities

If you have a speech disability, some services may include, but are not limited to:

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

For People with Multiple Disabilities

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

Other Special Aids and Services for People with Disabilities

- Help in making or getting to appointments
- Care managers who can help you get the care you need
- Names and addresses of providers who specialize in your condition
- If you use a wheelchair, we can tell you if a doctor's office is wheelchair accessible and can help you in making or getting to appointments
- Easy access to and from services (like ADA accessible, ramps, handrails and other services)

To ask for services, call Member and Recipient Services at 800-510-9132 (TTY: 711).

Alliance Health complies with federal civil rights laws and does not leave out or treat people differently because of race, color, national origin, age, disability or sex. If you believe that Alliance Health failed to provide these services, you can file a complaint. To file a complaint or to learn more, call Member and Recipient Services at 800-510-9132 (TTY: 711). If you have issues that you have been unable to resolve with Alliance Health, you may contact the NC Medicaid Ombudsman at **1-877-201-3750** or ncmedicaidombudsman.org.

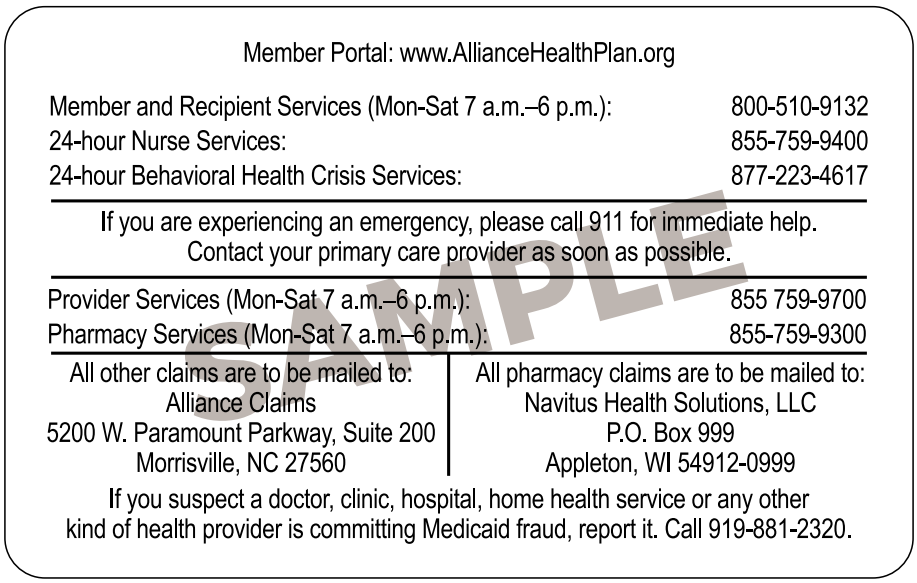
Your Medicaid Card

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 or if you lose your card, call Member and Recipient Services at 800-510-9132 (TTY: 711). Always carry your Medicaid card with you. You will need to show it each time you go for care.

If you have not yet received your card, you can still access your benefits. Simply call Member and Recipient Services, and we will help by making sure you and your PCP get any needed information. You can reach us toll-free at 800-510-9132, Monday-Saturday from 7 a.m. to 6 p.m.



How to Choose Your PCP

- Your primary care provider (PCP) is a doctor, nurse practitioner, physician assistant or other type of provider who will:
  - Care for your health
  - Coordinate your needs
  - Help you get referrals for specialized services if you need them
- As a Medicaid member, 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" on page 7 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 Alliance Health can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Call Member and Recipient Services at 800-510-9132 (TTY: 711) to get help with choosing a PCP that is right for you and your family.
- You can find the list of all the doctors, clinics, hospitals, labs and others who partner with Alliance Health in our provider directory. You can visit our website at AllianceHealthPlan.org to look at the provider directory online. You can also call Member and Recipient Services at 800-510-9132 (TTY: 711) to get a copy of the provider directory.
- Women can choose an OB/GYN to serve as their PCP. Women do not need a PCP referral to see a health plan OB/GYN doctor or another provider who offers women's health care services. Women can get routine check-ups, follow-up care if needed, and regular care during pregnancy.
- If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP. For more information and assistance in your selection, please contact Member and Recipient Services at 800-510-9132 Monday–Saturday from 7 a.m. to 6 p.m.
- If you did not choose your PCP and have not visited your current PCP within the last 12-18 months, Alliance Health may assign you a different PCP based on medical history.

If Your Provider Leaves Our Health Plan Network

- If your provider leaves Alliance Health, we will tell you within 15 days from when we know about this. If the provider who leaves Alliance Health is your PCP, we will tell you within 7 days and help make sure you select a new PCP within 30 days of contacting you.
- If your provider leaves our network, we can help you find a new one.
- Even if your provider leaves our network, you may be able to stay with your provider for a while longer in certain situations.
- Please read "Your Care When You Change Health Care Options or Providers" on page 37 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 at AllianceTailoredPlan.org or call Member and Recipient Services at 800-510-9132.

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 and Recipient Services at 800-510-9132. 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 (for example, does not set up hospital care or consult 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 patients are seen
    - You have trouble communicating with your PCP because of a language barrier or another issue
    - Your PCP is not able to accommodate your special needs
    - You and your PCP agree that a new PCP is better for your care

Call Member and Recipient Services at 800-510-9132 to learn more about how you can change your PCP.

How to Get Regular Health Care

- "Regular health care" means exams, regular check-ups, shots or other treatments to keep you well and address illness or other symptoms. It also includes giving you advice when you need it and referring you to the hospital or specialists when needed. You and your primary care provider (PCP) work together to keep you well or to see that you get the care you need.
- Your PCP is always available. Call your PCP when you have a medical question or concern. If you call after hours or on weekends, leave a message with where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how your health plan works.
- Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If you ever cannot keep an appointment, call to let your PCP know.
- **Making your first regular health care appointment**. As soon as you choose or are assigned a PCP, if it is a new provider, call to make a first appointment. It is best to visit your PCP within 3 months of joining the health plan. There are several things you can do to help your PCP get to know you and your health care needs.
- How to prepare for your first visit with a new provider:
    - Request a transfer of medical records from your current provider to your new PCP.
    - Make a list of health concerns you have now, and be prepared to discuss your general health, past major illnesses, surgeries and other health issues.
    - Make a list of questions you want to ask your PCP.
    - Bring medications and supplements you are taking to your first appointment.
- **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 Alliance Health that you can visit a doctor within a reasonable amount of time. The Appointment Guide (below) lets you know how long you may have to wait to be seen.

Appointment Guide	
IF YOU CALL FOR THIS TYPE OF SERVICE:	**YOUR APPOINTMENT SHOULD TAKE PLACE:**
Adult preventive care (services like routine health check-ups or immunizations)	within 30 days
Pediatric preventive care (services like well-child check-ups)	within 14 days for members younger than 6 months; within 30 days for members 6 months or older
Urgent care services (care for problems like sprains, flu symptoms or minor cuts and wounds)	within 24 hours
Emergency or urgent care requested after normal business office hours	Go to a hospital emergency department immediately (available 24 hours a day, 365 days a year) or go to an urgent care clinic
First prenatal visit (first or second trimester)	within 14 days
First prenatal visit (third 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 an urgent care clinic
Mobile crisis management services	within 2 hours
Substance Use Disorders	
Routine services	within 48 hours
Urgent care services	within 24 hours
Emergency services (services to treat a life-threatening condition)	Go to a hospital emergency department immediately (available 24 hours a day, 365 days a year) or go to an urgent care clinic

If you are not getting the care you need within the time limits above, call Member and Recipient Services at 800-510-9132.

How to Get Specialty Care – Referrals

- If you need specialized care that your primary care provider (PCP) cannot give, your PCP will refer you to a specialist who can. A specialist is a doctor who is trained and practices in a specific area of medicine (like a cardiologist or a surgeon). If your PCP refers you to a specialist, we will pay for your care if it is medically necessary. Most specialists are Alliance Health providers. Talk with your PCP to be sure you know how referrals work. See below for the process on referrals to a specialist who is not in our provider network.
- If you think a specialist does not meet your needs, talk with your PCP. Your PCP can help you find a different specialist.
- There are some treatments and services that your PCP must ask Alliance Health to approve before you can get them. Your PCP will tell you what those services are.
- If you have trouble getting a referral you think you need, contact Member and Recipient Services at 800-510-9132.

Out-of-Network Referral

- If Alliance Health does not have a specialist in our provider network who can give you the care you need, we will refer you to a specialist outside our health plan. This is called an out-of-network referral. Your PCP or another network provider must ask Alliance Health for approval before you can get an out-of-network referral.
- If your provider makes a request to Alliance for you to see an out-of-network provider, Alliance will respond to the request based on the urgency of your needs and no later than 14 days. You can also get additional information about how to access an out-of-network specialist by calling Member and Recipient Services at 800-510-9132.
- Sometimes we may not approve an out-of-network referral because we have a provider in Alliance Health who can treat you. If you do not agree with our decision, you can appeal our decision. See page 33 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 an Alliance Health provider. If you do not agree with our decision, you can appeal our decision. See page 33 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. For more information and assistance in your selection, please contact Member and Recipient Services at 800-510-9132 Monday–Saturday from 7 a.m. to 6 p.m.

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 health 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 and Recipient Services at 800-510-9132.

Get These Services from Alliance Health Without a Referral

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

Primary Care

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

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 and Recipient Services at 800-510-9132 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 AllianceHealthPlan.org.

You do not need a referral from your PCP to get mobile crisis services. Mobile crisis services are teams who can meet you in a safe location, including your home, school or office to help you if you are experiencing a behavioral health crisis. Call the Behavioral Health Crisis Line at 877-223-4617, at any time, 24 hours a day, 7 days a week if you are experiencing a behavioral health crisis.

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.

Emergencies

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

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

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

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

- You can go to any hospital or other setting to get emergency care.
- You **do not** need approval from your health plan or your PCP before getting emergency care, and you are not required to use our hospitals or doctors.
- **If you are not sure, call your primary care provider (PCP) at any time, day or night.** Tell the person you speak with what is happening. Your PCP's team will:
  - Tell you what to do at home
  - Tell you to come to the PCP's office
  - Tell you about community services you can get, like a shelter
  - Tell you to go to the nearest urgent care emergency department

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

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

Remember: Use the Emergency Department only if you have an emergency. If you have questions, call your PCP or Alliance Health Member and Recipient Services at **800-510-9132**.

If you need help with a mental health or drug use situation, feel stressed or worried or need someone to talk to, you can call the Behavioral Health Crisis Line at 877-223-4617, at any time, 24 hours a day, 7 days a week.

Urgent Care

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

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

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

- Call your PCP any time day or night
- If you are unable to reach your PCP, call Member and Recipient Services at 800-510-9132. 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, Alliance Health may pay for health care services you get from a provider located along the North Carolina border or in another state. Your PCP and Alliance Health can give you more information about which providers and services are covered outside of North Carolina by your health plan and how you can get them if needed.

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

If you have any questions about getting care outside of North Carolina or the United States, talk with your PCP or call Member and Recipient Services at 800-510-9132.

Your Benefits

NC Medicaid Managed Care provides **benefits** or health care services covered by your health plan. The Tailored Plan provides a number of extra health care services you can get in addition to those you can get through other Medicaid health plans.

This section describes:

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

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

- Are pregnant
- Are sick or injured
- Experience a substance use disorder or have mental 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 Alliance Health. Ask your primary care provider (PCP) or call Member and Recipient Services at 800-510-9132 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, school-based services and some behavioral health services, including mobile crisis services. You can find more information about these services starting on page 10.

Services Covered by Alliance Health's Network

You must get the services below from the providers who are in Alliance Health's network. Services must be medically necessary and provided, coordinated or referred by your PCP. Talk with your PCP or call Member and Recipient Services at 800-510-9132 if you have questions or need help.

Regular Health Care

- Office visits with your PCP, including regular check-ups, routine labs and tests
- Referrals to specialists
- Vision/hearing exams
- Well-baby care
- Well-child care
- Immunizations (shots) for children and adults
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for members under age 21 (see page 26 for more information about EPSDT services)
- Help with quitting smoking or other tobacco use

Maternity Care

- Prenatal, delivery, and postpartum care
- Childbirth education classes
- Professional and hospital services related to maternal care and delivery
- 1 medically necessary postpartum home visit for newborn care and assessment following discharge, but no later than 60 days after delivery
- Care management services for high-risk pregnancies during pregnancy and for 2 months after delivery (see page 13 for more information)

Hospital Care

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

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

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

The behavioral health services **covered** by Alliance Health include:

- Assertive community treatment (ACT)
- Behavioral health crisis services and withdrawal management services
- Facility-based crisis services for children and adolescents
- Mobile crisis management services
- Professional treatment services in a facility-based crisis program
- Ambulatory detoxification services
- Medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization
- Non-hospital medical detoxification services
- Child and adolescent day treatment services
- Community support team (CST)
- Diagnostic assessment services
- Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) for members under age 21
- Multi-systemic therapy services

- Intensive in-home services
- Inpatient behavioral health services
- Outpatient behavioral health emergency department services
- Outpatient behavioral health services provided by direct-enrolled providers
- Partial hospitalization
- Peer support services
- Psychiatric residential treatment facilities (PRTFs)
- Psychological services in health departments and school-based health centers sponsored by health departments
- Psychosocial rehabilitation
- Research-based intensive behavioral health treatment
- Residential treatment facility services for children and adolescents
- Substance use disorder services
- Outpatient opioid treatment services
- Substance abuse comprehensive outpatient treatment (SACOT)
- Substance abuse intensive outpatient program (SAIOP)
- Substance abuse medically monitored residential treatment
- Substance abuse non-medical community residential treatment

Intellectual/Developmental Disabilities (I/DD) Services

The Tailored Plan covers special services for individuals with intellectual/developmental disabilities:

- Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)
- Innovations waiver services, for people enrolled in the NC Innovations Waiver

NC Innovations Waiver services support individuals with intellectual/developmental disabilities to live the life they choose. Individuals get services in their home or community.

- **Applying for NC Innovations Waiver services**. To find out whether you or a family member are eligible to get NC Innovations Waiver services, call Member and Recipient Services at 800-510-9132 or contact your care manager.

- **Eligibility for NC Innovations Waiver services**. A member who has an intellectual disability or a condition that results in the same needs as someone who has an intellectual disability may be eligible for NC Innovations Waiver services. You may be eligible to participate in the NC Innovations Waiver if you meet several requirements related to the level of your needs and your living arrangements.

NC Innovations Waiver services are limited. If you are determined to be potentially eligible and there are no slots available, your or your family member's name will be placed on the Registry of Unmet Needs, also known as the "Innovations waitlist." Alliance Health can help you or your family member get other supportive services, including 1915(i) or State-funded services, while you or your family member are on the waiting list.

NC Innovations Waiver participants can see the Member Handbook NC Innovations Waiver supplement for more information on the NC Innovations Waiver, call Member and Recipient Services at 800-510-9132, or contact your care manager.

1915(i) Services

Alliance Health offers additional services to address needs related to a mental health disorder, substance use disorder, I/DD or TBI. These include:

- Community living and support
- Community transition
- Individual and transitional support
- Respite
- Supported Employment Services

Traumatic Brain Injury Waiver Services

In counties served by Alliance Health, individuals with a traumatic brain injury (TBI) may be able to get special NC TBI Waiver services in their home or community.

- **Applying for NC TBI Waiver services**. To find out whether you or a family member are eligible to get NC TBI Waiver services, call Member and Recipient Services at 800-510-9132 or contact your care manager.
- **Eligibility for NC TBI Waiver services**. An adult member who has experienced a TBI before their 18th birthday with cognitive, behavioral and/or physical health needs may be eligible for NC TBI Waiver services. You may be eligible to participate in the NC TBI Waiver if you meet several requirements related to the level of your needs and your living arrangements.

  NC TBI Waiver services are limited. If service slots are full, your or your family member's name will be added to a waiting list. Alliance Health can help you or your family member get other supportive services while on the waiting list.

  NC TBI Waiver participants can see the Member Handbook NC TBI Waiver supplement for more information, or call Member and Recipient Services at 800-510-9132 or contact your care manager.

Home Health Services

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

Personal Care Services

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

Hospice Care

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

Vision Care

Alliance has contracted with Avesis to manage your vision benefit. Avesis and Alliance are available to help you access both routine vision care and eye treatment that requires the services of an eye care specialist. To contact Avesis directly to learn about your benefits or to find an in-network provider near you please call 866-425-9584. Alliance Member and Recipient Services is also available to provide you with this assistance and can be reached by calling 800-510-9132. The following is additional information about your vision benefit:

- Services provided by ophthalmologists and optometrists, including routine eye exams, medically necessary contact lenses, and dispensing fees for eyeglasses. Opticians may also fit and dispense medically necessary contact lenses and eyeglasses.
- Specialist referrals for eye diseases or defects, if necessary.

- Fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses and ophthalmic frames, is provided to you through the NC Medicaid Direct program. Although these eyeglasses are covered through NC Medicaid Direct, Alliance Health providers through Avesis - who work in an office that offers eye exams and eyeglasses - must give you your eyeglass prescription and will provide you with and help fit your eyeglasses that are covered by NC Medicaid Direct (see page 27 for more information on benefits covered by Medicaid but not through your Health Plan).

Pharmacy

- Prescription drugs
- Some medicines sold without a prescription (also called “over-the-counter”), like allergy medicines
- Insulin and other diabetic supplies like syringes, test strips, lancets and pen needles
- Smoking cessation agents, including over-the-counter products
- Emergency contraception
- Medical and surgical supplies available through DME pharmacies and suppliers
- We also provide a Beneficiary Management Lock-In Program that helps identify Members that are at risk for possible overuse or improper use of pain medications (opioid analgesics) and nerve medications (benzodiazepines and certain anxiolytics). See page 24 for more information on our pharmacy lock-in program.

Emergency Care

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

Specialty Care

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

Nursing Home Services

- Must be ordered by a physician and authorized by Alliance Health
- Includes short-term or rehabilitation stays and long-term care for up to 90 days in a row. After the 90th day, your nursing services will be covered by NC Medicaid Direct, not Alliance Health. Talk with your PCP or call Member and Recipient Services at 800-510-9132 (TTY: 711) if you have questions.
- Covered nursing home services include medical supervision, 24-hour nursing care, assistance with daily living, physical therapy, occupational therapy and speech-language pathology
- Nursing home services must come from a nursing home that is in Alliance Health’s provider network. Call Member and Recipient Services at 800-510-9132 (TTY: 711) for help with questions about nursing home providers and plan networks.

Transportation Services

- **Emergency:** If you need emergency transportation (an ambulance), call 911.
- **Non-Emergency:** Alliance Health can arrange and pay for your transportation to help you get to and from your appointments for Medicaid-covered care. This service is free to you. If you need an attendant to go with you to your doctor’s appointment, or if your child (age 18 or younger) is a member of the health 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

Members should arrange for transportation as far in advance as possible, but no less than two business days before their appointment. Call 855-759-9600 to schedule transportation.

Alliance Health has contracted with Modivcare to provide non-emergency medical transportation. As an Alliance member there are several ways that you can access transportation. You may contact Modivcare directly up to 2 business days before your appointment at 855-759-9600. If you need urgent transportation you can schedule it at any time. A Modivcare Customer Service Representative is available 24/7 to assist you to book transportation. Additionally, you may schedule transportation through their web portal at www.modivcare.com/login. You will need your Medicaid number to schedule online. You can also contact Member and Recipient Services at 800-510-9132 up to 2 business days before your appointment to arrange transportation to and from your appointment.

Appointments covered are for Medicaid-covered services and will be to the nearest appropriate provider. Transportation mode will be based on your level of need. It can be in taxis, vans, mini-buses, mountain area transports, public transportation or personal vehicles.

If you have access to a vehicle or someone is available to provide you transport, under certain conditions you may qualify for fuel reimbursement. Member and Recipient Services will provide information on our fuel reimbursement program when you call.

When a driver arrives to pick you up, they will wait up to 5 minutes after arrival for pick-up. If you no longer need transportation to an appointment, please notify Modivcare at 855-759-9600 so they can release the scheduled driver. If we deny you transportation services, you have the right to appeal our decision. See page 33 for more information on appeals. If you have questions about transportation, call Member and Recipient Services at 800-510-9132.

For certain types of trips, Alliance Health may need to review the request or require additional information before we can schedule the trip. This is called “preauthorization” (see page 29 for more information on service authorization). The following types of trips must be reviewed by us and/or require additional information before we can schedule the trip:

- Trips greater than 75 miles
- Out of state trips that are further than 75 miles from the member’s pick-up location
- Non-emergent trips provided in an ambulance
- Trips that will require overnight stays

Lodging may be requested when a medical service requires the member (and attendant when required) to travel more than 3 hours to attend a medical appointment or when a member’s medical condition requires, or needed treatment would warrant, an overnight stay near the location of their treating provider.

Members, and attendants when required, are eligible for meal reimbursement as follows:

- Breakfast: When a member leaves for an appointment prior to 6 a.m.
- Lunch: When a member is approved for an overnight lodging
- Dinner: When a member will not return from a trip before 8 p.m.

You can get additional information on our Non-Emergency Medical Transportation policy by calling Member and Recipient Services at 800-510-9132.

Member and Recipient Services can provide information such as:

- How to request, schedule or cancel a trip
- Any limitations on Non-Emergency Medical Transportation services

- Expected member conduct and procedures for "no-shows"
- How to get mileage reimbursement if you use your own car

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

- Be able to arrive at your appointment on time and no sooner than 1 hour before the appointment
- Not to have to wait more than 1 hour after the appointment for a ride home
- Not to have to leave the appointment early

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

Long-Term Services and Supports (LTSS)

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

- If you need LTSS, you may have a care manager on your care team. A "care manager" is a specially trained health professional who works with you and your doctors and other providers of your choice to make sure you get the right care when and where you need it. For more information about what a care manager can do for you, see "Extra Support to Manage Your Health" on page 20.
- If you are leaving a nursing home and are worried about your living situation, we can help. Our Housing Specialist can connect you to housing options. Call Member and Recipient Services at 800-510-9132 to learn more.

If you have questions about using LTSS benefits, talk with your PCP, a member of your care team or call Member and Recipient Services at 800-510-9132.

Family Planning

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

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

Other Covered Services

- Durable medical equipment/prosthetics/orthotics
- Hearing aid products and services
- Telehealth
- Extra support to manage your health (see page 20 for more information)
- Home infusion therapy
- Rural Health Clinic (RHC) services
- Federally Qualified Health Center (FQHC) services
- Local health department services
- Free clinic services

Added Services

Alliance Health offers extra benefits at no cost to you. These are called added services. Some added services may only be available for members who qualify. Alliance Health offers the following added services:

Benefit	Description/Limits
Specialized health camps for youth, i.e. asthma, diabetes, YMCA for weight management and social interaction	Enrollment and participation in specialized camps and summer camps with a focus on health and wellness for youth under 18
GED/literacy classes	Enrollment fees for participation in GED and/or literacy classes
Quitline tobacco cessation assistance	Tobacco cessation support by trained coaches, web coaching and texting support, access to quit aids (nicotine patches and gum or lozenges)
Carpet cleaning (once annually, up to $100)	$100 annually for residential carpet cleaning for individuals with asthma
HEPA filter vacuum and replacement filters	$250 lifetime benefit for vacuum and HEPA filter replacements
Window or portable A/C unit	One time benefit for individuals with asthma/ respiratory illness (requires MD order)
Cooking classes	Enrollment fees for members/parents/guardians to participate in health cooking classes
Safelink smartphone program	Smartphones with 350 monthly calling minutes, unlimited texts and 1GB of monthly data

In Lieu of Services

Alliance Health offers services or settings that are medically appropriate, cost-effective substitutions for services covered by NC Medicaid. These are called “in lieu of” services.

Please see the “List of Available In Lieu of Services” insert provided with this handbook. For a full list of in lieu of services provided visit AllianceHealthPlan.org/tp/members/accessing-services/in-lieu-of-services-policy.

State-funded Services

Alliance Health offers additional behavioral health, I/DD and TBI services to residents who may not have Medicaid, are uninsured or may be underinsured. These services are called “State-funded services.” The availability of these services may be different from some Medicaid services and may be available on a limited basis.

If you have any questions about State-funded services, talk to your PCP or call Member and Recipient Services at 800-510-9132.

Extra Support to Manage Your Health (Tailored Care Management)

Managing your health care alone can be hard, especially if you are dealing with many health problems at the same time. If you need extra support to get and stay healthy, we can help. As a member of Alliance Health, you may be eligible to have a care manager on your health care team unless you are getting certain services that already provide care management. A "care manager" is a specially trained health care worker who works with you and all your health care providers, including your doctors, to make sure you get the right care when and where you need it. Your care manager knows what resources are available in your community and will work with local providers to get you the help you need.

Your care manager will belong to one of the following groups or organizations:

- **Advanced Medical Homes Plus (AMH+)**. Certain primary care providers (PCPs) across the state see a lot of Tailored Plan members. These providers are called Advanced Medical Homes Plus (AMH+) and have a lot of experience working with people with behavioral health conditions, intellectual/developmental disability (I/DD) or a traumatic brain injury (TBI), and will have care managers to help their patients.
- **A local behavioral health, I/DD or TBI services provider**. Certain service providers with experience working with people with behavioral health conditions, I/DD and TBI will work with Alliance Health to provide tailored care management for its members. These organizations are called **Tailored Care Management providers**.
- **Alliance Health**. Your care manager may work for us and will help you coordinate and connect you to local services to address your health-related needs.

If you are getting NC Innovations Waiver or NC TBI Waiver services (see Member Handbook waiver supplement for more information), your care manager will work with those providers and help you get those services.

Alliance Health will match you to a care manager that has specialized training to meet your needs. You may change your care manager twice a year for any reason and at any time with a good reason (good cause). You can choose not to have a care manager at any time by calling Member and Recipient Services at 800-510-9132.

Your care manager can:

- Help arrange your appointments and 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

To help you manage your health care needs, your care manager will ask about your health concerns and create a care plan, with your input in person, that lists your specific goals and ways to reach them. This care plan will cover your complete health and other related needs, including:

- Physical health
- Behavioral health
- I/DD
- TBI
- Long-term services and supports
- Health-related resource needs

Your care manager may use your health records, discussions with other health care and social services providers, and other documents to help create the care plan. The care plan will also list

services in the community that can help you reach your health goals. Your care manager will review your care plan at least once a year or when your circumstances, needs or health condition change significantly. You may also ask for a review of your care plan at any time.

Your care manager will work with a team of health care professionals, service providers and people with lives like yours (e.g., Peer Support Specialists) who will help you get services in your community to address your care needs. Your tailored care management team will generally include your PCP, behavioral health, I/DD and/or TBI providers, and other health care professionals who can help you with your needs and goals. Your care manager will task one of the members of your team to help you get each service listed in your care plan. Your care manager can work with family members and friends on this team if you want.

As part of the tailored care management process, your care manager will meet with you regularly, either in person, over the phone, or using video chat. Your care manager will also have regular conversations with your tailored care management team to make sure it is helping you make progress on your health goals and getting you the services that you need. Your care manager will also track and monitor the services you receive to ensure they are coordinated. Your health needs and goals will be at the center of the tailored care management process, and you will have an important role in creating your care plan and making decisions on your care.

You will get information from Alliance Health in the mail about:

- Your assigned Tailored Care Management Provider and how to make a change
- How to leave the tailored care management program
- When your information will be shared with others
- How to make appeals and grievances

Your care manager will be in touch with you soon after you enroll to find out what care you need and to help you with appointments. Your care manager or someone from your care team is available to you 24 hours a day, 7 days a week. To learn more about how you can get extra support to manage your health, talk to your PCP or care manager, or call Member and Recipient Services at 800-510-9132.

Community Inclusion

Some members may require services and supports that are sometimes provided in long-term facility settings, such as a state psychiatric hospital, adult care home (ACH) or intermediate care facility for individuals with intellectual/developmental disabilities (ICF-IID). Alliance Health will reach out to individuals living in these types of facilities to explain the choice members have to leave these facilities and live in community settings. Alliance Health may also contact family and friends with the member's permission. Alliance Health will work with members living in these types of facilities who choose to leave to create a plan to receive services in their homes and communities. A care manager will work with the member to prepare them for the move and will continue to work with them once they move to the community to make sure they have the right services and supports.

Members leaving facility settings who require long-term housing supports may also be eligible for the Transitions to Community Living (TCL) program. To learn more about Alliance Health's Community Inclusion and Transitions to Community Living programs, contact your care manager, or call Member and Recipient Services at 800-510-9132.

Diversion

Alliance Health will provide diversion interventions to eligible members who are at risk of requiring supports in an institutional setting or adult care home. We will work with you to provide information on and access to community-based services. For those who choose to remain in the community, we will work with you to create a community integration plan to ensure this decision was based on informed choice and to provide services and support, including permanent supported housing as needed.

System of Care

Alliance Health will use the System of Care model to support children and youth receiving behavioral health services. North Carolina's System of Care model brings together a group of community-based services, including those provided by Alliance Health and those provided through schools and other state agencies, such as juvenile justice or child welfare. System of Care Family Partners are available to support families to ensure the services that a child and their family are receiving are coordinated and address the specific needs and strengths of both child and family. Family Partners can also work with families on the development of care plans. For more information, families can contact their child's care manager or they can reach out to Member and Recipient Services at 800-510-9132. Families may also reach out to their local System of Care Community Collaborative at AllianceHealthPlan.org/members/services/children-and-family/system-of-care/ to learn about local resources for Alliance Health members.

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. Alliance Health can connect you to resources in your community to help you manage issues beyond your medical care.

Call Member and Recipient Services at 800-510-9132 if you:

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

Other Programs to Help You Stay Healthy

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

Call Member and Recipient Services at 800-510-9132 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. Alliance Health supports safe and appropriate opioid use through our Opioid Misuse Prevention Program. If you have any questions about our program, call Member and Recipient Services at 800-510-9132.

Pain Management

For people with chronic pain, responsible use of opioids can be an effective treatment, but the opioid misuse epidemic has called attention to the risks. There are nonopioid medications and other therapies that can be used to manage chronic pain. Your Tailored Plan care manager can help you work with your primary care doctor to connect you to resources to manage your chronic pain. Get more information on pain management at allianceforaction.org/individuals/pain-management-2/.

Lock Your Meds

Make sure your meds do not become part of the problem. Secure them properly or learn about disposal sites and options. Get more information on Lock Your Meds at allianceforaction.org/individuals/lock-or-dispose/.

Naloxone

Naloxone can help prevent opioid deaths by reversing the effects of opiates. Just like people with allergic reactions may carry epinephrine injectors, people carry naloxone in case of an opioid overdose. Naloxone can be given by a family member, friend or caregiver and often saves lives in the critical minutes until medical help arrives. You can request naloxone, without a prescription, at a pharmacy or your local health department through the North Carolina Standing Order for Naloxone. Get more information on Naloxone and participating pharmacies at allianceforaction.org/individuals/naloxone/.

Treatment

For people misusing opiates, recovery is possible. Alliance offers substance use treatment including Medication Assisted Treatment. Your Tailored Plan care manager can help link you to treatment or you can find a provider by calling Member and Recipient Services at 800-510-9132 or at AllianceHealthPlan.org.

Pharmacy Lock-in Program

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

- Your medications will be ordered by one prescriber. You will have the chance to pick a prescriber in the Alliance Health network.
- You will have these prescriptions filled from one pharmacy. You will have the chance to pick a pharmacy in Alliance Health network.

If you qualify for the Beneficiary Management Lock-In Program, you will be in the program for a 2-year period. If you do not agree with our decision that you should be in the program, you can appeal our decision before you are placed in the program (see page 33 for more information on appeals).

Tobacco Cessation

Tobacco use and vaping cause serious health problems. Quitting can improve your health, protect your loved ones from secondhand smoke and save you money. Alliance partners with QuitlineNC to offer free 24/7 coaching support and nicotine replacement therapy. QuitlineNC's tobacco cessation program offers Medicaid beneficiaries 4 coaching sessions (with unlimited Web coaching or texting) along with 2 weeks of combination nicotine replacement therapy (NRT) (patches for addiction and gum/lozenges for urges) with a prescription to fill 12 additional weeks of NRT supplies under Medicaid.

To better support tobacco users with mental health conditions including substance use disorders, QuitlineNC now offers an intensive Tobacco Cessation Behavioral Health Program which includes 7 coaching sessions. Members will qualify for the intensive program if they let their quit coach know that they have a behavioral health condition when asked, and also let them know that their behavioral health condition will affect their ability to quit. See the QuitLineNC brochure quitlinenc.com/docs/patient-resources/QuitlineNC-BehavioralHealth-bro-WEB.pdf for more information.

QuitLineNC also offers a Pregnancy Protocol for those who are pregnant, planning to become pregnant in the next 3 months, breastfeeding, or 12 months postpartum. This program consists of 10 coaching sessions, unlimited online or texting support, and 8 weeks of nicotine gum or lozenges with a medical override.

The QuitLineNC's E-cigarette and vaping program offers online and texting support, and they have a specialized texting program targeted towards youth. Your provider or Tailored Plan care manager can refer you to QuitlineNC or you can contact them directly by calling 800-QUITNOW, go to quitlinenc.dph.ncdhhs.gov/index.html, or call Member and Recipient Services 800-510-9132 and we can assist you.

Tobacco Free Campuses

Breathe Easy NC is a statewide initiative to support people with behavioral health conditions and/or IDD/TBI in becoming tobacco free, by working with service providers to integrate tobacco use treatment and make campuses tobacco free. To support longer, healthier and happier lives, NC Medicaid will require contracted medical, behavioral health, and some IDD/TBI organizations to provide a **100% tobacco-free campus**. I/DD residential facilities under the Home and Community-Based Services (HCBS) rule are not required to be tobacco-free. The purpose of this requirement is to improve the health of the people we serve by supporting tobacco cessation and protecting people from secondhand smoke. For more information on tobacco free campuses visit FAQs for Clients, Families, and Staff from Breathe Easy NC (https://breatheeasync.org/faq-clients-families-staff/).

PRTF – Complex Case Management (CCM)

The Complex Case Management program helps our members achieve and maintain positive outcomes following discharge from the LEAP program – a specialty psychiatric residential treatment program for dually diagnosed children with mental health and co-occurring autism. Eligible members will work with care managers to complete assessments that will identify areas of need and develop individualized plans of care to address those needs.

Care managers will support the member's family in creating a multidisciplinary team that brings together community partners, medical staff, natural supports, and family in treatment planning and decision-making. The goals are to reduce barriers to discharge plans moving back into the community, and to ensure that the right services and supports are in place to maintain a successful life in the community.

Alliance continuously assesses our population, services, providers, and resources to evaluate the need for additional Complex Case Management programs.

Screening Programs

Co-Occurring MH-SUD Diagnoses Screening Program

Alliance Health has identified screening tools for providers to complete with members for co-occurring mental health and substance use disorders. These screening tools are designed to identify if members with mental health needs also have needs related to substance use and vice versa. These tools support you and your provider in developing a treatment plan to meet your needs.

Self-Screening Program

Behavioral health – which includes mental health, substance use, and more – is a key part of everyone's overall well-being. Brief screenings are the quickest way to determine if you or someone you care about should connect with a behavioral health professional. Because of this, Alliance Health has made a Self-Screening Program available to help encourage understanding of what members or their loved ones may be experiencing. This program is completely anonymous and confidential, and immediately following the brief questionnaire members can see their results, recommendations, and key resources. These screenings are powered by Screening for Mental Health/Mindwise, Inc.

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

You can choose where to get certain services. You can get these services from providers in the Alliance Health network or from another Medicaid provider. You do not need a referral from your primary care provider (PCP) to get these services. If you have any questions, talk to your PCP or call Member and Recipient Services at 800-510-9132.

HIV and STI Screening

You can get human immunodeficiency virus (HIV) and sexually transmitted infection (STI) testing, treatment and counseling services any time from your PCP or Alliance Health doctors. When you get this service as part of a family planning visit, you can go to any doctor or clinic that takes Medicaid and offers family planning services. You do not need a referral when you get this service as part of a family planning visit.

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

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): The Medicaid Health Benefit for Members under Age 21

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

Early and Periodic Screening and Diagnosis

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

The "T" in EPSDT: Treatment for Members under Age 21

Sometimes children need medical treatment for a health problem. Alliance Health might not offer every service covered by the federal Medicaid program. When a child needs treatment, we will pay for any service that the federal government's Medicaid plan covers. The proposed treatment must be evaluated on its ability to treat, fix or improve your child's health problem or condition. This decision is made specifically for your child. Alliance Health cannot deny your child's service just because of a policy limit. Also, we cannot deny a service just because that service is not included in our coverage policies. We must complete a special EPSDT review in these cases.

When Alliance Health approves services for children, important rules apply:

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

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

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

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

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

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

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

If you have questions or need help with accessing benefits you can only get through NC Medicaid Direct, talk with your primary care provider (PCP) or call Member and Recipient Services at 800-510-9132.

Services NOT Covered

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

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

This list does not include all services that are not covered. To determine if a service is not covered, call Member and Recipient Services at 800-510-9132.

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

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

If You Get a Bill

If you get a bill for a treatment or service you do not think you owe, do not ignore it. Call Member and Recipient Services at 800-510-9132 right away. We can help you understand why you received a bill. If you are not responsible for payment, Alliance Health will contact the provider and help fix the problem for you.

You have the right to ask for an appeal and a State Fair Hearing if you think you are being asked to pay for something Medicaid or Alliance Health should cover. See the Appeals section on page 33 in this handbook for more information. If you have any questions, call Member and Recipient Services at 800-510-9132.

Health Plan Member Copays

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

Copays if You Have Medicaid

Please see the "Health Plan Member Copays" insert provided with this handbook for information on services for which you have to pay a copay.

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

- Members under age 21
- Members who are pregnant
- Members receiving hospice care
- Federally recognized tribal members
- North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) beneficiaries
- Children in foster care
- People living in an institution who are receiving coverage for cost of care
- Behavioral health services
- Intellectual/developmental disability (I/DD) services
- Traumatic brain injury (TBI) services
- A provider cannot refuse to provide services if you cannot pay your copay at the time of service. If you have any questions about Medicaid copays, please call Member and Recipient Services at 800-510-9132.

Copays if Your Child Has NC Health Choice

Please see the "Health Plan Member Copays" insert provided with this handbook for information on services for wich you have to pay a copay if your child has NC Health Choice.

If you have any questions about NC Health Choice copays, call Member and Recipient Services at 800-510-9132.

If your PCP is not able to accommodate your special needs, call Member and Recipient Services at 800-510-9132 to learn more about how you can change your PCP.

Service Authorization and Actions

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

Physical health care services requiring prior authorization:

- All out-of-network services, excluding emergency services
- All services that may be considered experimental and/or investigational
- All miscellaneous/unlisted or not otherwise specified codes except for CPT Code 99499 Unlisted evaluation and Management - this service does not require Prior Authorization
- All services not listed on the Alliance Health Medicaid and NC Health Choice Fee Schedule
- All unlisted or miscellaneous items, regardless of cost
- Chiropractic care (prior authorization required for members ages 18 and under)
- Cochlear implantation
- Contact lenses (including dispensing fees)
- Durable medical equipment (DME)
    - Items with billed charges equal to or greater than $500
    - Implantable bone conduction hearing aids (BAHA) — must be FDA-approved over the state published quantity limits
- Elective air ambulance

- Elective procedures including, but not limited to, joint replacements, laminectomies, spinal fusions, discectomies, vein stripping, laparoscopic/exploratory surgeries
- Gastric restrictive procedure and surgeries
- Gastroenterology services
- Gender reassignment services
- Genetic testing
- Home-based services:
    - Home health care (physical, occupational and speech therapy) and skilled nursing (after unmanaged visits, regardless of modality)
    - Home infusion services and injections (see pharmacy list of HCPCS codes that require prior authorization)
    - Home health aide services
    - Private duty nursing (extended nursing services)
    - Personal care services
    - Hospice inpatient services
- Hyperbaric oxygen
- Hysterectomy (Hysterectomy Consent Form required)
- Implanted devices
- Inpatient services:
    - All inpatient hospital admissions including medical, surgical, skilled nursing, long-term acute and rehabilitation services
    - Obstetrical admissions, newborn deliveries exceeding 48 hours after vaginal delivery and 96 hours after cesarean section
    - Medical detoxification – Elective transfers for inpatient and/or outpatient services between acute care facilities - Long-term care initial placement (while enrolled with the plan — up to 90 days)
- Out-of-network specialty visits
- Pain management (including but not limited to):
    - External infusion pumps
    - Spinal cord neurostimulators
    - Implantable infusion pumps
    - Radiofrequency ablation
    - Nerve blocks
    - Epidural steroid injections
- Reconstructive plastic surgery
- Soft band bone conduction hearing aid
    - Replacement of identical replacement sound processor — not covered under warranty – replacement for sound processor when request is for an upgraded processor
    - Cochlear and auditory brainstem implant external parts replacement and repair
    - All speech processors not covered under warranty
    - Replacement for speech processor when request is for an upgraded processor
- Surgical services that may be considered cosmetic, including:
    - Blepharoplasty
    - Mastectomy for gynecomastia
    - Maxillofacial (all codes applicable)
    - Panniculectomy
    - Septoplasty
- Therapy (speech, occupational, physical)
    - Speech, occupational and physical therapy require prior authorization after unmanaged visits per modality per calendar year - this applies to private and outpatient facility-based services
- Termination of pregnancy prior approval is not required - however, the physician's certification of abortion must be completed in accordance with the instructions
- Transplants, including transplant evaluations
- Select radiology services

Behavioral health services requiring prior authorization:

- Assertive Community Treatment (ACT)
- All out-of-network services, except emergency services
- Ambulatory detoxification
- Behavioral health inpatient
- Behavioral health partial hospitalization
- Community Support Team (beyond unmanaged nits)
- Enhanced Mental Health and Substance Use Services
- Electroconvulsive therapy (ECT)
- Medically supervised or alcohol or drug abuse treatment center detoxification crisis stabilization/ADATC
- Mobile crisis management (for units beyond the initial 32)
- Professional treatment services in facility-based crisis programs (ADD PASSTHRU)
- Innovations Waiver services
- Intermediate Care Facilities for individuals with Intellectual Disabilities
- Nonhospital medical detoxification
- Outpatient opioid treatment
- Peer support services (following 24 unmanaged visits in a fiscal year)
- Psychiatric inpatient hospitalization, including Institute for Mental Disease
- Psychiatric Residential Treatment Facilities (PRTF)
- Psychological testing (beyond unmanaged visits)
- Research-Based Behavioral Health Treatment (BH-BHT) for autism
- Residential services
- State approved In-Lieu-of services
- TBI Waiver services

Long-Term Services and Supports (LTSS) requiring prior authorization

- Alliance will authorize LTSS based on a member's current needs assessment. Treatment will be consistent with the member's person-centered plan.

Asking for approval of a treatment or service is called a "service authorization request." To get approval for these treatments or services, your provider or Care Manager will submit an authorization request using the Alliance Claims System Portal. In addition to electronic submission, you or your provider may call Member and Recipient Services at 800-510-9132 for assistance submitting a service authorization request.

Some services do not require preauthorization. You may directly access the services listed below as they do not require preauthorization:

- Emergency services
- Family planning
- First Mental Health or substance use assessment completed in a 12-month period
- Children's screening services

What Happens after We Get Your Service Authorization Request?

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

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

Sometimes Alliance Health may deny or limit a request your provider makes. This decision is called an "adverse benefit determination." When this

happens, you can request any records, standards and policies we used to decide on your request.

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

Prior Authorization Requests for Children under Age 21 (Applies to Medicaid Members Only)

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

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

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

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

Important Details about Services Coverable by the Federal EPSDT Guarantee

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

Alliance Health must approve these services with an "EPSDT review" before they are provided.

To learn more about the Medicaid health plan for children (EPSDT), see page 25, visit our website at AllianceHealthPlan.org and visit the state of North Carolina website for the EPSDT guarantee at https://medicaid.ncdhhs.gov/epsdt.

Preauthorization and Timeframes

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

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

Information from Member and Recipient Services

You can call Member and Recipient Services at 800-510-9132 (TTY: 711) to get a PCP, to ask about benefits and services, to get help with referrals, to replace a lost Medicaid card, to report the birth of a new baby, or to ask about any change that might affect you or your family's benefits. We can answer any questions about the information in this handbook.

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

You Can Help with Plan Policies

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

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

Call Member and Recipient Services at 800-510-9132 to learn more about how you can help.

Medicaid Service Appeals

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

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

You can ask for an appeal yourself. You may also ask a friend, a family member, your provider or a lawyer to help you. You can call Alliance Health at 919-651-8545 or visit our website at AllianceHealthPlan.org if you need help with your appeal request. It is easy to ask for an appeal by using one of the options below:

- **MAIL:** Fill out and sign the Appeal Request Form in the notice you receive about our decision. Mail it to the address listed on the form. We must receive your form no later than 60 days after the date on the notice.
- **FAX:** Fill out, sign, and fax the Appeal Request Form in the notice you receive about our decision. You will find the fax number listed on the form. We must receive your form no later than 60 days after the date on the notice.
- **BY PHONE:** Call 919-651-8545 and ask for an appeal. When you appeal, you and any person you have chosen to help you can see the health records and criteria Alliance Health used to make the decision. If you choose to have someone help you, you must give them permission.

You can also contact the **NC Medicaid Ombudsman** to get more information about your options. See page 48 for more information about the NC Medicaid Ombudsman.

Expedited (Faster) Appeals

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

You and your provider can ask for an expedited appeal by calling us at 919-651-8545.

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

Provider Requests for Expedited Appeals

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

Member Requests for Expedited Appeals

Alliance Health will review all member requests for expedited appeals. If your request for an expedited appeal is denied, we will call you during our business hours promptly following our decision. We also will tell you and the provider in writing if your request for an expedited appeal is denied and our reason for the decision. Alliance Health will mail you a written notice within 2 calendar days.

If you do not agree with our decision to deny an expedited appeal request, you may file a grievance with us (see page 36 for more information on grievances).

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

Timelines for Standard Appeals

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

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

If you need more time to gather records and updates from your provider, just ask. You or a helper you name may ask us to delay your case until you are ready. Ask for an extension by calling Member and Recipient Services at 800-510-9132 or writing to:

Alliance Health
5200 W. Paramount Parkway, Suite 200
Morrisville, NC 27560

Decisions on Appeals

When we decide on 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 within 120 days from the date on the Notice of Decision.

State Fair Hearings

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

Free and Voluntary Mediations

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

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

State Fair Hearings

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

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

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

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

State Fair Hearings and Disenrollment Decisions

If you disagree about a decision to change your health plan, you can ask for a State Fair Hearing. The process to ask for a State Fair Hearing for disenrollment decisions is different from the process to ask for a State Fair Hearing when Alliance Health limits or denies a service that you requested. For more information about requesting a State Fair Hearing for disenrollment decisions, see page 44.

Continuation of Benefits During an Appeal

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

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

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

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

If you ask for your services to continue, Alliance Health will continue your services from the day you ask for them to continue until you the day get your appeal decision. You or your authorized representative may contact Member and Recipient Services at 800-510-9132 or contact the Appeals Coordinator on your adverse benefit determination letter to ask for your service to continue until you get a decision on your appeal.

Your appeal might not change the decision the health plan made about your services. When this happens, Medicaid allows Alliance Health to bill you for services we paid for during your appeal. We must get approval from NC Medicaid before we can bill you for services we paid for during your appeal. If Alliance chooses to seek to recover the cost of services provided to you during the appeal process, Alliance will develop a member hardship exemption process and obtain prior approval from NCDHHS for each instance Alliance seeks to recover.

Appeals During Your Transition Out of Alliance Health

If you decide to leave Alliance Health, your appeal may be impacted by this transition. Please see below for additional information on how we will process appeals at transition. If you will be transitioning out of our health plan soon and have an appeal with us, please contact Member and Recipient Services at 800-510-9132 for additional information.

If you transfer to another Medicaid health plan in the middle of an appeal, you should work with your provider to submit the request to your new Medicaid health plan. They may have different services than Alliance offers and your provider should be able to assist you in identifying the best services to meet your needs. For any service that Alliance has authorized we will transmit a copy of that authorization to your new Medicaid health plan as a part of your transition.

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 and Recipient Services at 800-510-9132 or write at any time to:

Alliance Health
Quality Management Department
Attn: Complaints and Grievances
5200 W. Paramount Parkway, Suite 200
Morrisville, NC 27560

BY EMAIL:
Complaints@AllianceHealthPlan.org

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

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

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

- By phone, call Member and Recipient Services at 800-510-9132, 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:

Alliance Health
Quality Management Department
Attn: Complaints and Grievances
5200 W. Paramount Parkway, Suite 200
Morrisville, NC 27560

BY EMAIL:
Complaints@AllianceHealthPlan.org

Resolving Your Grievance

When grievances are received, we ensure that the person or people addressing the grievance have not been involved in any previous level of decision-making related to the grievance. Grievances involving medical care are reviewed by Alliance Health Clinical Quality Review (CQR) committee. If there is reasonable cause to believe that an adult with a disability, a child, or an adolescent may be abused, neglected, or exploited, Alliance Health will contact the Department of Social Services (DSS).

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

We will initially attempt to resolve the issue through informal discussions to reach an agreement. We will not try to influence, limit, or interfere with your rights or decisions about a grievance. As part of the resolution process, we may:

- Offer a member alternative services
- Engage you and/or your provider in educational or clinical discussions
- Engage in informal attempts to resolve the issues

We will review your complaint and tell you how we resolved it in writing within 30 days of receiving your complaint.

If your grievance is about your request for an expedited (faster) appeal, we will tell you how we resolved it in writing within 5 days of getting your complaint. If you are not satisfied with the resolution of your grievance, you can file an appeal with Alliance's Chief Executive Officer (CEO) within 21 days of receiving your resolution letter. A decision about the appeal will be provided within 20 working days along with further appeal rights that may be available.

You may also contact the Department's Customer Service and Community Rights team at 984-236-5300 or toll-free at 855-262-1946 if you are not satisfied with the resolution of your grievance.

All grievances are processed in compliance with Alliance procedure #6503: *Management and Investigations of Grievances*.

Transition of Care

Your Care When You Change Health Care Options or Providers

- If you join Alliance Health from another health care option, we will work with your previous health care option to get your health information – like your service history, service authorizations, and other information about your current care – into our records.
- You can finish receiving any services that have already been authorized by your previous health care option. After that, if necessary, we will help you find a provider in our network to get any additional services if you need them.
- In almost all cases, your providers under your former health plan will also be Alliance Health providers. If your provider is not part of our network, there are some instances when you can still see the provider that you had before you joined Alliance Health. You can continue to see your provider if:

At the time you join Alliance Health, you are receiving an ongoing course of treatment or have an

ongoing special condition, such as an intellectual/developmental disability, mental health diagnosis, substance use disorder or traumatic brain injury. In that case, you can ask to keep your provider for up to 180 days.

You are more than 3 months pregnant when you join Alliance Health and you are getting prenatal care. In that case, you can keep your provider until after your delivery and for up to 60 days of postpartum care.

You are pregnant when you join Alliance Health and you are receiving services from a behavioral health treatment provider. In that case, you can keep your provider until after your delivery.

You have a surgery, organ transplant or inpatient stay already scheduled with your provider. 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 6 months or less to live. In that case, you can keep your provider for the remainder of your life.

- If your provider leaves Alliance Health, we will tell you in writing within 15 days from when we know this will happen. If the provider who leaves Alliance Health is your primary care provider (PCP), we will tell you in writing within 7 days from when we know this will happen. We will tell you how you can choose a new PCP or how we will choose one for you if you do not make a choice within 30 days.
- If you want to continue receiving care from a provider who is not in our network:
  - Under certain conditions, Alliance Health will assist you to continue to see the provider for a transition period.
  - You may contact Member and Recipient Services at 800-510-9132 for assistance. They will explain the options for continuing care with your provider. You may also notify your care manager at Alliance Health within 45 days of your provider's termination if you wish to continue to receive care from your provider.
  - There may be some reasons when Alliance Health will not be able to honor your request to see a provider that has terminated from our network. In these cases, we will let you know within 15 days of your request and assist with connecting you to other providers that can continue your care.
  - If information is available to make this decision in real time, we will inform you by phone. Decisions made after receiving your request will be communicated in writing.
- Alliance Health will help you move to a new care manager if necessary. Your current and new care manager will work together to come up with a plan to make sure you continue to receive the care you need.

If you have any questions, call Member and Recipient Services at 800-510-9132.

Member Rights and Responsibilities

As a member of Alliance Health, you have certain rights and responsibilities. Alliance Health will respect your rights and make sure that no one working for our health plan, or any of our providers, will prevent you from exercising your rights. Also, we will make sure that you are aware of your responsibilities as a member of our health plan. For a full list of your rights and responsibilities as a member of Alliance Health visit our website at AllianceHealthPlan.org/members/information/rights/ or call Member and Recipient Services at 800-510-9132 to get a copy.

Your Rights

As a member of Alliance Health, you have a right to:

- Be cared for with respect, dignity and privacy without regard for health status, sex, race, color, religion, national origin, age, marital status, sexual orientation or gender identity
- Be told what services are available to you
- Be told where, when and how to get the services you need from Alliance Health
- Be told of your options when getting services so you or your guardian can make an informed choice
- Be told by your primary care provider (PCP) what health issues you may have, what can be done for you and what will likely be the result, in a way you understand. This includes additional languages.
- Get a second opinion about your care
- Give your approval of any treatment
- Give your approval of any plan for your care after that plan has been fully explained to you
- Refuse care and be told what you may risk if you do
- Get information about your health care
- Get a copy of your medical record and talk about it with your PCP
- Ask, if needed, that your medical record be amended or corrected
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract or with your approval
- Use the Alliance Health complaint process to settle complaints. You can also contact the NC Medicaid Ombudsman any time you feel you were not fairly treated (see page 48 for more information about the NC Medicaid Ombudsman)
- Use the State Fair Hearing system
- Appoint someone you trust (relative, friend or lawyer) to speak for you if you are unable to speak for yourself about your care and treatment
- Receive considerate and respectful care in a clean and safe environment, free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation

Additionally, if you are an NC Health Choice Member, Alliance Health will make sure that we do not refer you to publicly supported health care resources to avoid costs for covered benefits and services.

Your Rights if You Are a Minor

Minors have the right to agree to some treatments and services without the consent of a parent or guardian:

- Treatment for sexually transmitted diseases
- Services related to pregnancy
- Services to help with alcohol and/or other substance use disorders
- Services to help with emotional conditions

Your Responsibilities

As a member of Alliance Health, you agree to:

- Work with your PCP to protect and improve your health
- Find out how your health plan coverage works
- Listen to your PCP's advice and ask questions
- Call or go back to your PCP if you do not get better or ask for a second opinion
- Treat health care staff with respect
- Tell us if you have problems with any health care staff by calling Member and Recipient Services at 800-510-9132
- 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

Changes to Your Health Care Option (Disenrollment)

You are enrolled in Alliance Health, an NC Medicaid Managed Care Behavioral Health and I/DD Tailored Plan because of the health care services that you need that may only be offered by our health plan. Your Tailored Plan is based on the county of your Medicaid eligibility. Only one Tailored Plan provides services in each county in the state, so you cannot choose a different Tailored Plan.

You are enrolled in Alliance Health, but you may choose to get health care services from a different NC Medicaid health care option that you qualify for. In addition to the Tailored Plan, other health care options that you **may** qualify for include:

- **Standard Plan**. A Standard Plan is a NC Medicaid and NC Health Choice health plan that offers physical health, pharmacy, care management and basic behavioral health services for members. A Standard Plan offers added services for members who qualify. The added services may be different for each Standard Plan.
- **EBCI Tribal Option**. The EBCI Tribal Option is the primary care case management entity (PCCMe) created by the Cherokee Indian Hospital Authority (CIHA). It manages the primary care needs of federally recognized tribal members and others who qualify for services through Indian Health Service and live in Cherokee, Haywood, Graham, Jackson or Swain County, or in a neighboring county of the 5-county region. The EBCI Tribal Option includes care coordination by Vaya Health for a mental health disorder, substance use disorder, intellectual/developmental disability or traumatic brain injury. The EBCI Tribal Option offers added services for members who qualify.
- **NC Medicaid Direct**. NC Medicaid Direct is North Carolina's health care program for Medicaid beneficiaries who are not enrolled in NC Medicaid Managed Care. NC Medicaid Direct includes care coordination provided by Community Care of North Carolina, the PCCMe, and 6 LME/MCOs that coordinate services for a mental health disorder, substance use disorder, intellectual/developmental disability or traumatic brain injury.

You **may** qualify to get care and services from one of the health care options listed above. To get more information on the health care options that you qualify for, you can contact the Enrollment Broker using any of the following ways:

- Go to ncmedicaidplans.gov.
- Use the NC Medicaid Managed Care mobile app. To get the free app, search for **NC Medicaid Managed Care** on Google Play or the App Store.
- Call the Enrollment Broker at 833-870-5500 (TTY: 711 or RelayNC.com).

Remember: There are certain services for a mental health disorder, substance use disorder, intellectual/developmental disability or traumatic brain injury that you may need that are only offered by the Tailored Plan. For more information on the services only offered by Tailored Plans, see page 1.

If you qualify, you can ask to move to a different health care option at any time and for any reason. See below for instructions on how to ask to move to a different health care option.

How to Request to Move to a Standard Plan

You can ask to move to a Standard Plan by contacting the Enrollment Broker. To choose a Standard Plan, you can enroll in one of these ways:

- Call the Enrollment Broker at **833-870-5500** (TTY: 711 or RelayNC.com).
  - If you call, the Enrollment Broker will explain your choices. You will need to confirm your decision to choose a Standard Plan before the Enrollment Broker will move you to a Standard Plan.
- Mail or fax an enrollment form to the Enrollment Broker. You can get an enrollment form by going to ncmedicaidplans.gov or by calling the Enrollment Broker.
  - **MAIL:** You can mail the enrollment form to the following address:

    NC Medicaid
    PO Box 613
    Morrisville NC 27560
  - **FAX:** You can fax the enrollment form to **833-898-9655**.

If you mail or fax the enrollment form, the Enrollment Broker will call you to explain your choices. You will need to confirm your decision to choose a Standard Plan before the Enrollment Broker will move you to a Standard Plan. If the Enrollment Broker cannot reach you to explain your choices, your request to move a Standard Plan will be denied. If you disagree with the decision to deny your request to move to a Standard Plan, you can appeal by requesting a State Fair Hearing. For more information on how to request a State Fair Hearing for disenrollment decisions, see page 44.

How to Request to Move to a Standard Plan if Getting Certain Services

If you are currently getting any of the following services, there are more steps that you must take before you can ask to move to a Standard Plan:

- Services through the NC Innovations Waiver program:
  - NC Innovations Waiver participants can choose to leave their waiver program at any time. If you are currently getting NC Innovations Waiver services, you must leave the waiver program before asking to move to a Standard Plan. **If you leave the NC Innovations Waiver program, you will lose access to the NC Innovations Waiver services**.
  - If you want to leave the NC Innovations Waiver, you can contact your care manager or Member and Recipient Services at 800-510-9132 (TTY: 711). Alliance Health will require you to sign a document saying you want to leave the NC Innovations Waiver program.
  - After you have finished the process to leave the NC Innovations Waiver program, you will follow the steps in the "How to Request to Move to a Standard Plan" section listed on page 41 to contact the Enrollment Broker to ask to move to a Standard Plan (disenroll).
- Services through the NC TBI Waiver program
  - NC Traumatic Brain Injury (TBI) Waiver participants can choose to leave the NC TBI Waiver program at any time. If you are currently getting NC TBI Waiver services, you must leave the NC TBI Waiver program before asking to move to a Standard Plan. **If you leave the NC TBI Waiver program, you will lose access to NC TBI Waiver services**.

- If you want to leave the NC TBI Waiver program, you can contact your care manager or Member and Recipient Services at 800-510-9132 (TTY: 711). Alliance Health will require you to sign a document saying you want to leave the NC TBI Waiver program.
- After you have finished the process to leave the NC TBI waiver program, you will follow the steps in the "How to Request to Move to a Standard Plan" section listed on page 41 to contact the Enrollment Broker to ask to move to a Standard Plan (disenroll).

- Services through the Transitions to Community Living (TCL) program
  - You can choose to leave the TCL program at any time. If you are currently in the TCL program, you must leave the program before asking to move to a Standard Plan. **If you leave the TCL program, you may lose access to some services, including your housing funding**.
  - If you want to leave the TCL program, you can contact your care manager or Member and Recipient Services at 800-510-9132 (TTY: 711). Alliance Health will require you to sign a document saying you want to leave the TCL program.
  - After you have finished the process to leave the TCL program, you will follow the steps in the "How to Request to Move to a Standard Plan" section listed on page 41 to contact the Enrollment Broker to ask to move to a Standard Plan (disenroll).
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)
  - You can choose to leave an ICF-IID at any time. If you are currently living in an ICF-IID, you must leave the ICF-IID before asking to move to a Standard Plan. **If you leave the ICF-IID, you may not be able to return to that facility even if you stay in or move back to the Tailored Plan**.
  - If you want to leave the ICF-IID, you must contact your care manager or Member and Recipient Services at 800-510-9132 (TTY: 711) to make them aware you are leaving.
  - After you have contacted Alliance Health, you will follow the steps in the "How to Request to Move to a Standard Plan" section listed on page 41 to contact the Enrollment Broker to ask to move to a Standard Plan (disenroll).
- Non-Medicaid (State-funded) Services program
  - You can choose to leave the State-funded Services program at any time. If you are currently in the State-funded Services program, including State-funded Residential Services program, you must leave the program before asking to move to a Standard Plan. **If you leave the State-funded Services program, you may not be able to return to the program or the State-funded residential home, even if you stay in or move back to the Tailored Plan**.
  - If you want to leave the placement where you are getting State-funded Services, you must contact your care manager or Member and Recipient Services at 800-510-9132 (TTY: 711) to make them aware you are leaving.
  - After you have contacted Alliance Health, you will follow the steps in the "How to Request to Move to a Standard Plan" section listed on page 41 to contact the Enrollment Broker to ask to move to a Standard Plan (disenroll).

How to Request to Move to the EBCI Tribal Option or NC Medicaid Direct

If you qualify, you may leave Alliance Health and move to the EBCI Tribal Option or NC Medicaid Direct at any time.

To move to the EBCI Tribal Option or NC Medicaid Direct, you can contact the Enrollment Broker using any of the following ways:

- Go to ncmedicaidplans.gov
- Use the NC Medicaid Managed Care mobile app. To get the free app, search for **NC Medicaid Managed Care** on Google Play or the App Store.

- Call the Enrollment Broker at 833-870-5500 (TTY: 711 or RelayNC.com)

How to Request to Move Back to the Tailored Plan

If you move to a different health care option, but then need a service that is only offered by a Tailored Plan, you can ask to move back to Alliance Health at any time. To ask to move back to Alliance Health, you can contact the Enrollment Broker in any of the following ways:

- Go to ncmedicaidplans.gov
- Use the NC Medicaid Managed Care mobile app. To get the free app, search for **NC Medicaid Managed Care** on Google Play or the App Store.
- Call the Enrollment Broker at 833-870-5500 (TTY: 711 or RelayNC.com).

If you still qualify for the Tailored Plan, you will be moved back. If you no longer qualify for the Tailored Plan, you may complete the Request to Move to the Tailored Plan: Beneficiary Form or your provider can complete the Request to Move to the Tailored Plan: Provider Form. You can find both forms at ncmedicaidplans.gov or you can call the Enrollment Broker at 833-870-5500 (TTY: 711 or RelayNC.com) to have the form sent to you.

Remember: There is not a guarantee that you will be able to return to your previous waiver program or your previous residential placement if you move to a Standard Plan but then decide to move back to the Tailored Plan.

Expedited Requests to Change Health Care Options

If you believe you have an **urgent medical need**, you can ask for faster action (expedited review) of your request to change health care options (disenroll). An urgent medical need means that the timing of the regular process will cause your life, your physical or mental health, or your ability to attain, maintain or regain maximum function to be in danger. If your request for an expedited review is approved, you will get a notice about your request to leave the Tailored Plan within 3 days of making the request.

Decisions on Requests to Change Health Care Options

If your request to change health care options is approved, you will get a notice in the mail telling you when the change starts (effective date). The effective date will be no later than the first day of the second month after the month that you asked to change health care options. If your request to change health care options is denied, you will get a notice in the mail telling you why your request was denied and how to appeal if you disagree with the decision.

Reasons Why You May Have to Leave Alliance Health

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

- If you lose your eligibility for the Tailored Plan:
  - You may lose your eligibility for the Tailored Plan if you do not have a qualifying mental health disorder, substance use disorder, I/DD or TBI condition, or have not used certain behavioral health services over a 24-month period.
  - If you are no longer eligible for the Tailored Plan, you will receive a letter letting you know that you will be moved to a Standard Plan to receive your benefits and services. If this happens, you can call the NC Medicaid Contact Center at 888-245-0179 for help.
- If you lose your Medicaid Managed Care program eligibility
  - You may lose your eligibility for the Medicaid Managed Care program if any of the following happens:
    - You stay in a nursing home for more than 90 days in a row (see page 16 for more information on nursing services).

- You become eligible for and are transferred for treatment to a state-owned Neuro-Medical Center or a Department of Military & Veteran Affairs-operated Veterans Home.
- You change Medicaid eligibility category.
- You become incarcerated.
- You begin receiving Medicare.

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

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

State Fair Hearings for Disenrollment Decisions

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

Requesting a State Fair Hearing for Disenrollment Decisions

If you disagree with a disenrollment decision, you have **30 days** from the date on the letter telling you of the decision to ask for a State Fair Hearing. You can ask for a State Fair Hearing yourself. You may also ask a friend, a family member, your provider or a lawyer to help you. You can call the Enrollment Broker at **833-870-5500** (TTY: 711 or RelayNC.com) if you need help with your State Fair Hearing request.

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

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

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

Advance Directives

There may come a time when you become unable to manage your own health care. If this happens, you may want a family member or other person close to you making decisions on your behalf. By planning in advance, you can arrange now for your wishes to be

carried out. An advance directive is a set of written 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 3 ways for you to make a formal advance directive. These include living wills, health care power of attorney and advance instructions for mental health treatment.

Living Will

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

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

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

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

Health Care Power of Attorney

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

Again, it is always helpful to discuss your wishes with your family, friends and your doctor. A health care power of attorney will go into effect when a doctor states in writing that you are not able to make or 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 register your advance directive with the NC Secretary of State's Office so that your wishes will be available to medical professionals. You can find the advance directive forms at www.sosnc.gov/ahcdr. The forms meet all the rules for a formal advance directive. For more information, you can also call 919-807-2167 or write to:

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

You can change your mind and update these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you cannot speak for yourself.

Talk to your primary care provider (PCP) or call Member and Recipient Services at 800-510-9132 if you have any questions about advance directives.

Concerns About Abuse, Neglect and Exploitation

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

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

For additional information on how to report concerns, contact your care manager or Member and Recipient Services at 800-510-9132 (TTY: 711).

Fraud, Waste and Abuse

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

- An individual does not report all income or other health insurance when applying for Medicaid
- An individual who does not get Medicaid uses a Medicaid member's card with or without the member's permission
- A doctor or a clinic 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: 877-362-8471
- Call the State Auditor's Waste Line at 800-730-TIPS: 800-730-8477
- Call the U.S. Office of Inspector General's Fraud Line at 800-HHS-TIPS: 800-447-8477
- Alliance Compliance Line: 855-727-6721

Important Phone Numbers

Alliance Health Member and Recipient Services Line	800-510-9132 Monday-Saturday from 7 a.m. to 6 p.m.
Alliance Health Behavioral Health Crisis line	877-223-4617 Available 24 hours a day, 7 days a week
Alliance Health Nurse line	855-759-9400 Available 24 hours a day, 7 days a week
Enrollment Broker	833-870-5500 Monday-Saturday from 7:00 a.m. to 5:00 p.m.
NC Medicaid Ombudsman	877-201-3750 Monday-Friday from 8:00 a.m. to 5:00 p.m.
NC Medicaid Contact Center	888-245-0179 Monday-Friday from 8:00 a.m. to 5:00 p.m.
Alliance Health Provider Service line	855-759-9700 Monday-Saturday from 7:00 a.m. to 6:00 p.m.
Alliance Health Prescriber Service line	855-759-9300 Monday-Saturday from 7:00 a.m. to 6:00 p.m.
The NC Mediation Network	336-461-3300 Monday-Friday from 8:00 a.m. to 5:00 p.m.
Free Legal Services line	866-219-5262 Monday-Friday from 8:30 a.m. to 4:30 p.m. Monday and Thursday 5:30 p.m. to 8:30 p.m.
File a grievance/complaint Advance Health Care Directive Registry phone number	919-814-5100 Monday-Friday from 8:00 a.m. to 5:00 p.m.
NC Medicaid Fraud, Waste and Abuse Tip line	877-DMA-TIP1 (877-362-8471)
State Auditor Waste	800-730-TIPS (800-730-8477)
U.S. Office of Inspector General Fraud line	800-447-8477
Alliance Health Appeals line	919-651-8545 Monday-Friday 8:30 a.m. to 5:30 p.m.

Keep Us Informed

Call Member and Recipient Services at 800-510-9132 whenever these changes happen in your life:

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

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

NC Medicaid Ombudsman

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

The NC Medicaid Ombudsman can:

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

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